Indian Journal of Mental Health and Neurosciences
Volume 9, Issue 1, 2026, pp. 1–5
DOI: 10.54646/ijmhns.2026.09
www.ijmhns.com

VIEWPOINT

Mental health crisis in Indian nursing students: need for institutional support

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Received: 15 April 2026; **Accepted:** 05 May 2026; **Published:** XX May 2026

Abstract

Mental health problems among nursing students have emerged as a significant concern in India, affecting academic performance, professional development, and future workforce sustainability. Nursing students experience multiple stressors, including academic pressure, clinical exposure, examination anxiety, digital overexposure, and inadequate institutional support. Evidence from recent studies indicates a high prevalence of anxiety, depression, and burnout among undergraduate nursing students. The COVID-19 pandemic further intensified these challenges, and its effects continue to persist in the post-pandemic period. This viewpoint critically examines the current mental health crisis among Indian nursing students, explores its underlying structural and institutional determinants, and highlights existing gaps in mental health infrastructure within nursing education. The article also proposes evidence-based recommendations, including integration of mental health literacy into the curriculum, establishment of counseling services, faculty training in mental health first aid, structured clinical debriefing, peer-support programs, and regulatory accountability. Strengthening institutional support systems is essential to promote psychological well-being, improve educational outcomes, and ensure a resilient nursing workforce for the future healthcare needs of India.

Keywords: nursing students, mental health, anxiety, depression, burnout, academic stress, institutional support, nursing education

Introduction

Nursing students in India, are undertaking one of the most psychologically challenging academic and professional paths in modern higher education. They must simultaneously handle the emotional burden of direct patient contact, perform in high-stakes clinical settings, and absorb a complex theoretical curriculum—often without sufficient institutional scaffolding or psychological preparation. The COVID-19 pandemic's disruptions and the growing demands of digitally mediated learning have added to the cumulative impact of these stresses over the previous 5 years, resulting in a quantifiable and alarming decline in this population's mental health.

The most common health issues among nursing students worldwide are mental health disorders, such as anxiety, depression, and burnout (1). This problem has ramifications that go well beyond the individual student in India, where the nurse-to-population ratio is still significantly below the World Health Organization's

How to Cite this Article:
Dhiraj L S. Mental health crisis in Indian nursing students: need for institutional support. *Indian J. Ment. Health Neurosci.* 2026; 9(1): pp. 1–5. DOI: https://doi.org/10.54646/ijmhns.2026.09

(WHO) target of 1:300 and where cultural stigma around mental illness continues to stifle help-seeking behavior (2). It is unrealistic to expect a nursing workforce that starts professional practice in a psychologically compromised state to provide the high-quality, safe, and compassionate care that the Indian healthcare system so needs. This essay offers practical suggestions for institutional transformation while critically analyzing the current mental health problem among Indian undergraduate nursing students and examining its structural causes.

Current scenario

The material that is now available from India presents a depressing image. According to research done in South Indian nursing schools, between 42% and 51% of undergraduate nursing students exhibit clinically significant anxiety symptoms as determined by validated instruments like the Generalized Anxiety Disorder-7 (GAD-7) scale, and between 33% and 38% of them test positive for depressive episodes using the Patient Health Questionnaire-9 (PHQ-9) (3). Over 60% of nursing students experience burnout in their second and third years of training, which coincides with the peak of clinical posting intensity. Burnout is characterized by emotional weariness, depersonalization, and diminishing personal accomplishment (4).

An important source of stress was the COVID-19 epidemic. During institutional emergencies, a large number of nursing students were sent into active clinical support positions, sometimes without proper training, supervision, or psychological debriefing. Peer networks, supervised clinical practice, and organized routines—all of which are essential to students' well-being and the development of their professional identities—were disturbed by the sudden shift to online learning (5). When compared to pre-pandemic baseline data, a nationwide cross-sectional survey conducted in 2021 revealed statistically substantial increases in nursing students' perceptions of stress, sleep disorders, and subclinical drug use during the pandemic (5).

Crucially, balance has not been restored in the post-pandemic era. Rather, it has created a new set of stressors: a backlog of university and practical exams, interruptions to academic schedules, ongoing financial instability in student families, and a general feeling of career uncertainty among graduates. Therefore, it is better to see the mental health trajectory of Indian nursing students throughout the 2020–2025 period as a persistent and worsening issue with structural foundations rather than as a transient pandemic-related anomaly.

Contributing factors

Academic pressure and examination anxiety

One of the most exam-intensive pre-professional programs in the Indian higher education system is the undergraduate nursing curriculum, which is overseen by the Indian Nursing Council (INC). A persistent feeling of performance anxiety is brought on by the weight and frequency of summative tests as well as the scant attention paid to formative, student-centered evaluation (3). For many nursing students, especially those who are the first in their family to pursue higher education, the perceived repercussions of academic failure go beyond the individual and include expectations from the community, financial investment, and family honor. Routine academic support services are ill-prepared to handle the kind of psychological load created by this convergence of academic and socioeconomic pressure.

Clinical stress and moral distress

Nursing students are exposed to human suffering, death, end-of-life care, and ethical quandaries in clinical training settings during a developmental moment when they have not yet solidified the psychological resources necessary to handle such events adaptively. In the resource-constrained environments typical of much Indian hospital-based training, moral distress—which is defined as the psychological suffering experienced when one is aware of the morally right course of action but is prevented from enacting it by institutional constraints—is especially common (6). Students frequently internalize this discomfort without disclosure or resolution in the absence of peer debriefing procedures, professional supervision with a psychosocial component, or organized reflective practice sessions.

Digital overexposure and social media stress

Nursing students now face a qualitatively unique set of psychological risks as a result of the post-pandemic normalization of digital learning. Anxiety and depressed symptomatology in young adults are now known to be influenced by screen fatigue, information overload, disturbed sleep architecture due to nocturnal device usage, and the psychosocial risks of social media comparison (7). A study conducted on nursing students in North India found a strong correlation between daily screen time exceeding six hours and higher GAD-7 scores; screen time at night was

particularly associated with increased cortisol reactivity and fragmented sleep. The lack of organized digital limits and recreational options significantly increases these dangers for hostel-resident students, who make up a sizable majority of the nursing student body (7).

Inadequate social and institutional support

The widespread lack of institutional mental health infrastructure in Indian nursing institutions may be the most significant contributing factor. The majority of institutions don't have peer support programs, qualified psychological counselors, or private disclosure procedures (4). Rarely are faculty members, who have the closest supervisory contact with students, educated in trauma-informed teaching, mental health first aid (MHFA), or early psychological distress detection. The cultural mandate of stoicism, which is especially prevalent in the feminine, career-focused nursing profession, runs uncontested in this setting, thus preventing prompt help-seeking.

Gender, socioeconomic, and residential vulnerabilities

Gender-specific stressors are disproportionately carried by nursing students in India due to the overwhelming feminization of the nursing profession. These stressors include discrimination within hospital hierarchies, worries about residential safety, family expectations regarding early marriage, and the psychological burden of navigating patriarchal institutional cultures. In addition, students from lower-caste, rural, or economically disadvantaged origins must deal with the interlocking challenges of cultural relocation, unstable finances, and restricted access to family-based emotional support networks, all of which exacerbate psychological vulnerability.

Discussion

The aforementioned data points to a conclusion that is hard to refute: the mental health crisis among Indian nursing students is mostly structurally caused by their training rather than occurring as a side effect. It results from the combination of an academically harsh curriculum, emotionally taxing therapeutic settings, insufficient institutional psychosocial services, and deeply rooted societal narratives that elevate self-sufficiency and pathologize weakness. Therefore, more than individual-level treatments are needed to properly address it. It necessitates a comprehensive reconsideration of how student welfare is conceptualized in Indian nursing education.

The global approach to nursing students' mental health has changed significantly. Student-to-counselor ratios, mandatory wellness curricula within nursing programs, and institutional mental health frameworks like the Stepchange model—which views student psychological well-being as an institutional responsibility rather than an individual prerogative—have all been implemented in nations like the United Kingdom, Australia, and Canada (8). India has one of the largest nursing student populations in the world, but it hasn't yet transformed the pertinent data into institutional or national structural advancements. There are serious and real repercussions if nothing is done. Clinical errors, a lack of empathy, poor therapeutic communication, and early departure from the profession have all been often associated with psychological pain in nursing students (1). The early loss of qualified nurses from stress or mental illness is a compounded failure of the healthcare system in a nation facing a severe nursing shortage. Additionally, nurses who join clinical practice with unresolved psychological loads are more likely to experience secondary traumatic stress disorder and compassion fatigue, both of which gradually impair well-being and professional performance.

It is crucial to avoid framing this dilemma simply as an issue of inadequate personal resilience. This kind of conceptualization misidentifies the source of misery and focuses resources on treating symptoms rather than structural change. A more comprehensive and useful framework for comprehending and addressing the mental health needs of nursing students in India is provided by a socioecological model of mental health, which identifies the causes of distress at the intersection of individual, interpersonal, institutional, and policy-level factors.

Institutional gaps

A thorough evaluation of the Indian nursing education system identifies a number of serious institutional flaws that need to be specifically addressed if change is to have any real impact. First, there is a noticeable lack of mental health as a self-relevant learning topic in the nursing curriculum. The psychological well-being of the student as a professional-in-training is not covered in any organized curriculum, despite the fact that psychiatric nursing is taught as a clinical specialty that focuses on the assessment and treatment of mental disease in patients. The myth that mental health issues only affect patients and not nurses is maintained by this curricular blind area.

Second, the INC's regulatory framework lacks legally binding requirements pertaining to institutional mental health infrastructure, despite being thorough in defining clinical competency criteria. There is no standardized procedure for identifying and referring students who are mentally at-risk, no required student-to-counselor ratio for nursing schools, and no accreditation requirement related to

the psychological well-being of students (2). This regulatory silence effectively separates student mental health results from institutional responsibility.

Third, training in trauma-informed pedagogy, MHFA, and identifying student distress is seldom included in faculty development programs in Indian nursing institutes. Despite holding the most fundamentally important supervisory role in nursing students' everyday life, faculty members are often ill-prepared for this aspect of their jobs. This disparity is particularly noticeable in facilities located in tier-2 and tier-3 cities, where there is little access to outside mental health specialists.

Fourth, the dormitory system, which houses a significant number of nursing students, is designed more for compliance and discipline than for emotional support and well-being. Students in residential settings often experience chronic loneliness, limited autonomy, and a lack of restorative social activity—conditions that are both individually and collectively detrimental to good mental health—and hostel wardens usually lack expertise in psychosocial assistance.

Recommendations

The following recommendations are proposed for nursing education institutions, regulatory authorities, and health policymakers:

1. **Curricular Integration of Mental Health Literacy:** Within the first and second years of the undergraduate nursing program, the INC should require the inclusion of a specific module on student psychological well-being, professional resilience, stress inoculation strategies, and mental health literacy. Instead of teaching this material through didactic examination-focused delivery, it should be taught experientially through reflective diaries, group conversations, and mindfulness-based exercises.
2. **Institutional Counseling Services:** A minimum of one licensed mental health professional, such as a clinical psychologist or psychiatric social worker, shall be employed by or affiliated with every accredited nursing college, with a student-to-counselor ratio of no more than 100:1. Through partnerships with recognized mental health care providers, institutions in remote locations should be assisted in setting up synchronous teletherapy arrangements.
3. **Mandatory Faculty Training in MHFA:** All nursing schools should make it mandatory for faculty development programs to include biennial training in approved MHFA. Without replacing the work of the professional counselor, such training enables educators to recognize early signs of student distress, start encouraging talks, and arrange necessary referrals.
4. **Structured Clinical Debriefing Protocols:** Formal debriefing sessions should be made a required part of the clinical training schedule after high-emotional-intensity clinical assignments, particularly in critical care units, cancer wards, emergency departments, and palliative care settings. Faculty members with reflective practice training or, if possible, mental health specialists who are part of the clinical training team should lead these sessions.
5. **Peer Support and Mentorship Programs:** Institutions should create organized peer mentoring programs where senior nursing students who have received psychological first aid training function as easily accessible and de-stigmatized initial points of contact for junior students who are in distress. These programs are inexpensive, scalable, and culturally appropriate, and they have proven effective in foreign nursing education settings.
6. **Regulatory Accountability Through Accreditation:** Both the INC and the National Assessment and Accreditation Council (NAAC) should explicitly include student mental health infrastructure as a criterion in their accreditation and periodic inspection procedures. Institutional investment in student mental health will continue to be voluntary, uneven, and inadequate in the absence of regulatory accountability.
7. **Research Investment and Data Generation:** Funding for long-term, multi-institutional studies on the mental health trajectories of nursing students, with data broken down by gender, geographic location, socioeconomic status, and academic year, should be given top priority by the Indian Council of Medical Research (ICMR) and the Ministry of Health and Family Welfare. Although suggestive, the present body of information is still insufficient to support the exact, locally tailored policy responses required by the magnitude of this catastrophe.

Conclusion

The mental health crisis among Indian nursing students is a major and systemic danger to the caliber, sustainability, and humanity of India's nursing workforce, not a minor issue on the periphery of health professional education. The institutional deficiencies are discernible, the data is consistent, and the contributory variables are thoroughly described. The institutional will to convert recognition into change has been absent.

From the very beginning of their professional development, nursing students commit themselves to the care of others. They see pain, take in clinical complexity, and are expected to remain therapeutically composed in situations that would put even the most experienced practitioner to the test. They deserve—and the healthcare system they will serve requires—academic environments that take their psychological well-being as seriously as their clinical competence. Institutions that practice institutional apathy toward the caregivers themselves cannot teach compassionate care.

The call to action is clear: in order to create the institutional framework that Indian nursing students deserve, nursing education institutions, the INC, health policymakers, and mental health experts must work together, act quickly, and remain committed. The mental well-being of the nurses who will treat future patients has a significant impact on their health.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The work was conducted as an independent scholarly contribution by the author without any external financial support.

Acknowledgments

The author gratefully acknowledges the Nursing Scholar Society and INSSR, ITM University, Gwalior, for providing the academic environment and scholarly community that supported the conceptualization and writing of this viewpoint. The author also acknowledges the contributions of the broader nursing research community whose published work forms the evidentiary foundation of this article. No individuals provided direct assistance in the preparation of this manuscript beyond those acknowledged in the author affiliations.

Conflict of interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Generative AI Statement

During the preparation of this manuscript, the author used generative artificial intelligence (AI) tools for language editing, grammar refinement, and improvement of manuscript readability. The author carefully reviewed, edited, and takes full responsibility for the accuracy, originality, and integrity of the final content submitted for publication.

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