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PREVALENCE OF GENERALIZED ANXIETY DISORDER AMONG FEMALE MEDICAL UNDERGRADUATES WITH DISORDERED EATING: A CROSS-SECTIONAL STUDY

DR SOWMYA PEYOUSE[1], DR PRIYA SIVASHANKAR[2], SHAIJA THOMAS[3], ANILA C EAPEN[4]

[1]POST-GRADUATE, DEPARTMENT OF PSYCHIATRY, SREE BALAJI MEDICAL COLLEGE AND HOSPITAL, CHROMEPET, CHENNAI, INDIA. BHARATH INSTITUTE OF HIGHER EDUCATION AND RESEARCH (BIHER)
EMAIL ID: thejussr84@gmail.com
[2]PROFESSOR AND HOD, DEPARTMENT OF PSYCHIATRY, SREE BALAJI MEDICAL COLLEGE AND HOSPITAL, CHROMEPET, CHENNAI, INDIA.
BHARATH INSTITUTE OF HIGHER EDUCATION AND RESEARCH (BIHER)
EMAIL ID: priyasivashankar63@gmail.com
[3]PHD SCHOLAR, BHARATH INSTITUTE OF HIGHER EDUCATION AND RESEARCH (BIHER)
CHENNAI, THAMIL NADU, INDIA, EMAIL ID: shaijathomas81@gmail.com
[4]PHD SCHOLAR BHARATH INSTITUTE OF HIGHER EDUCATION AND RESEARCH (BIHER)
EMAIL ID: anilaceapen@gmail.com

Abstract
Generalized Anxiety Disorder (GAD) and disordered eating behaviours are co-occurring psychological challenges faced by female medical students. This study investigates the prevalence of GAD and its association with disordered eating in a high-stress academic environment. The cross-sectional study was conducted at Sree Balaji Medical College and Hospital in Chennai, India, over four months (April 2025- July 2025) and involved 362 female MBBS students aged 18 to 25 years. Anxiety symptoms and the risk of disordered eating were measured using standardized screening tools: the GAD-7 and EAT-26, along with a demographic proforma. Prevalence and associations were determined through descriptive statistics, chi-square tests, and binary logistic regression. Findings indicate that 35.6 percent of participants exhibit GAD symptoms, with 13.5 percent experiencing moderate anxiety and 7.5 percent suffering from severe anxiety. At the same time, 28.2 percent of students surpassed the cutoff for disordered eating, and more than two-thirds of these individuals exhibited moderate-to-severe GAD. Disordered eating is also a significant predictor of GAD (adjusted OR = 4.78), even when accounting for academic stress and poor sleep quality. The results highlight a severe comorbidity, likely stemming from maladaptive coping, perfectionism, and performance anxiety prevalent in competitive medical environments. The research underscores the necessity for combined mental health screening and institutional support interventions tailored specifically for female medical students. Early identification, coupled with mental health promotion within the curriculum and a peer support system, is crucial for providing psychological support and building resilience in this population

Keywords: GAD, female medical students, disordered eating, mental health.

INTRODUCTION:

Generalized Anxiety Disorder (GAD) is a continuous and extreme stress that hinders normal functioning, especially in cognitive and emotional aspects. Anxiety disorders are among the most common psychiatric conditions worldwide, and GAD is often underdiagnosed due to its disabling character. The student mental health project by the World Health Organization highlights that GAD is especially common among college students, and medical students are among the most vulnerable groups, as their training is intense and they face the emotional stress of clinical duties (Auerbach et al., 2016). Research evidence indicates that psychological distress among medical undergraduates stems from high workloads, academic competition, and a lack of recreational time (Li et al., 2022).

Women medical students are particularly susceptible to anxiety and related disorders, often reports extreme stress in response to academic and sociocultural demands. Several overlapping pressures, including gender-based role conflicts and clinical performance anxiety, increase their vulnerability to developing GAD (Karyotaki et al., 2020). These stressors are further compounded by family and societal expectations regarding academic performance, which tend to discourage emotional openness and help-seeking behaviour (Solanki & Kashyap, 2014).

Disordered eating behaviours have become increasingly common among young female populations, particularly in high-stress academic environments. Although such behaviours do not necessarily meet clinical diagnostic criteria for

eating disorders, restrictive dieting, compulsive overeating, and guilt-related fasting are prevalent among medical students. Studies suggest that these behaviours reflect not merely lifestyle preferences but symptomatic responses to internalized stress and dissatisfaction with body image (Singh & Gadiraju, 2020). This trend is especially pronounced in South Asian cultures, where femininity and academic success are both culturally idealized, placing double pressure on women to excel academically and conform physically.

There is a neurobiological basis for the psychological comorbidity between anxiety and disordered eating, involving serotonergic transmission dysregulation and increased hypothalamic-pituitary-adrenal (HPA) axis reactivity. A review of eating disorders highlights that such conditions are often driven by psychological traits such as perfectionism, impulsivity, and ineffective emotional coping (Attia & Walsh, 2025). Academically oriented young women may adopt maladaptive coping mechanisms, controlling food intake as a substitute for perceived life control, particularly under unpredictable or stressful circumstances (Cheng et al., 2014).

The burden of these problems is widely acknowledged when considered independently, but very few studies examine the co-occurrence of GAD and disordered eating, particularly among female medical students in developing countries like India. Most previous studies consider anxiety or eating pathology in isolation, without addressing their interrelation or mutual reinforcement (Puthran et al., 2016). suicide risks are significantly increased when both disorders coexist, which further underscores the clinical importance of dual diagnosis and timely intervention (Preti et al., 2011).

This disparity is further aggravated by the absence of culturally and demographically specific data. Although global estimates provide valuable context, psychosocial stressors in Indian medical colleges, including hierarchical teaching, rote-based assessments, and little mental health infrastructure, require contextual investigation (Saraswathi et al., 2020). According to a recent meta-analysis, depression and anxiety in medical students are underreported and undertreated and are often normalized as an inseparable component of academic life (Pei et al., 2024). Internalization of these experiences without proper support predisposes coexisting mental health conditions to a great extent.

Biological and emotional intertwining of GAD and disordered eating usually starts at the age of early adulthood, which is the most frequent age of occurrence of both disorders (Rapee et al., 2019). It is a crucial period when students have to make career-defining academic choices, go through social changes, and develop their identity under the pressure of performance. The culture of medical students, especially, is socialized in the professional culture of emotional detachment and endurance rather than self-care (American Psychiatric Association, 2022). As a result, they can postpone the recognition of emotional difficulties, which strengthens maladaptive cycles.

Research also indicates that Indian medical institutions are usually ill-equipped to deal with psychological morbidity using formal support systems. The stigma and the fear of confidentiality restrict the use of institutional counselling even in the presence of such a service (Rawat, 2025). Female students are particularly reluctant to find help because of the fear of judgment or the effect it will have on their academic status. This silence adds more pain and enables symptoms to worsen without any check (Shahaf et al., 2021).

Each of these disorders (anxiety and disordered eating) has significant health and academic implications, the interaction of the two disorders generates a cumulative psychological burden that has not been well-studied in the Indian population. The detailed overview of mental health among students worldwide shows that one psychiatric disorder tends to predispose another one, which is why integrated screening and care models should be used (Zhou et al., 2021). The students with both anxiety and disordered eating often report lower academic satisfaction and increased dropout intentions (Ibrahim et al., 2013).

In this light, the present research examines the co-prevalence and co-morbidity of GAD and disordered eating behaviours among undergraduate female medical students at one of the Indian medical colleges. The main aim is to find out the prevalence of GAD in students with disordered eating symptoms. The second goal is to analyse the magnitude and the direction of the relationship between the severity of disordered eating and the scores of GAD. In a cross-sectional design, this research aims to produce context-specific evidence on an under-researched yet clinically important matter by employing standardized instruments (GAD-7 and EAT-26)

2. MATERIALS AND METHODS

2.1 Study Design

The research is based on a cross-sectional observational study design to estimate the prevalence of Generalized Anxiety Disorder (GAD) and its connection with disordered eating behaviours in female undergraduates pursuing medical courses. The design allowed the evaluation of the anxiety levels and eating patterns in a specific population at the same time, without any manipulation of the study environment. The cross-sectional design was suitable because the aim of the study was to determine the patterns and correlations, but not the causal relations, and the observational design maintained the naturalistic conditions of data collection.

2.2 Setting and Participants

The research was carried out in Sree Balaji Medical College and Hospital in Chennai, India, which is a privately owned tertiary teaching hospital and medical college based in Chennai, India, during the four-month period between April and july 2025. The target population was all the female MBBS students aged 18-25 years of the first to final year batches. The choice of the setting was based on its high academic standards and a wide range of students, which is typical of metropolitan Indian medical schools. The respondents were recruited during school time in classrooms

and hostel common places. The inclusion criteria included the desire to give informed consent, being a current undergraduate medical student, and not having been diagnosed with a psychiatric illness. The exclusion criteria were the intake of psychotropic drugs, psychiatric hospitalization, or unwillingness to participate. These criteria created a homogenous population with no confounding of treatment and one that was appropriate to estimate the prevalence in a high-stress academic setting.

2.3 Sampling Method

The convenience sampling technique was employed to select the participants, and the aim was to cover a wide range of academic years and backgrounds. This approach was not probabilistic, but it enabled a quick recruitment and high response rates in a short time, and a sufficient representation of various academic levels. The calculation of the sample size was performed based on the formula, where the prevalence of GAD among medical students was 27-32%, which was reported in previous studies.

$$n = \frac{Z^2 \cdot p \cdot (1-p)}{d^2}$$

The required sample size was estimated to be 323 with a confidence level of 95 percent (Z = 1.96), an expected prevalence (p) of 0.30, and a margin of error (d) of 5 percent. To overcome the non-response and incomplete forms, 10 percent was added to the total, and this made the target 355. After the screening, 362 valid responses were finally analysed.

2.4 Data Collection Tools

Data collection was done through three validated instruments. To begin with, the Generalized Anxiety Disorder-7 (GAD-7) scale was used to assess the intensity of the symptoms of anxiety. The questionnaire is a 7-item self-report questionnaire, and the responses are scored on a 4-point Likert scale of 0 (not at all) to 3 (nearly every day), giving a total score of 0 to 21. The cut-off values of 5, 10, and 15 refer to mild, moderate, and severe anxiety, respectively. Cronbach's alpha of GAD-7 is 0.89, and it is validated in students in various languages.

Second, disordered eating behaviours were measured with the help of the Eating Attitudes Test-26 (EAT-26). The questionnaire has 26 items and has three subscales: dieting, bulimia/food preoccupation, and oral control. The rating is done on a 6-point scale, and a score of 20 or above means the risk of an eating disorder. The EAT-26 has been found to have good internal consistency (alpha = 0.88) and construct validity in adolescent and young adult females in India and other countries in the world.

Lastly, a demographic pro forma was filled in, which details age, academic year, BMI (computed using self-reported height and weight), menstrual regularity, perceived academic pressure (Likert scale), sleep quality, and family history of psychiatric illness were recorded. The tools were all in English, which is the language of instruction in the institution.

2.5 Procedure

The data were gathered using a survey that was conducted using Google Forms and shared in WhatsApp groups of students, academic mailing lists, and QR codes placed in hostels and lecture halls. The electronic version was selected to make it accessible and anonymous. At the beginning of the survey, each of the participants was shown a digital informed consent form. Only electronically consenting people were given the go-ahead.

All the information was gathered anonymously and safely stored in an institutional account with a password. The involvement was voluntary, and the students were free to withdraw at any time without any consequence. No personal data was gathered, including names, email addresses, or student IDs. It took people 12-15 minutes on average to complete the survey. Students who scored in the severe anxiety range or were found to be distressed were offered follow-up support by the mental health counselling unit of the college.

2.6 Statistical Analysis

The data were downloaded in an Excel format, cleaned of missing and inconsistent data, and analysed in IBM SPSS. To describe the demographics and GAD-7 scores and EAT-26 scores, descriptive statistics were applied. The continuous variables, including age and BMI, were presented in the form of means with standard deviations, whereas the categorical variables, including academic year, GAD levels, and eating disorder risk status, were presented in the form of frequencies and percentages.

Chi-square tests were used to conduct bivariate analyses, which assessed the relationship between categorical variables (i.e., GAD category and disordered eating risk) and independent-samples t-tests, which compared the mean GAD scores of binary demographic groups. A binary logistic regression model was thereafter fitted to determine the relationship between disordered eating and GAD, controlling for confounding factors such as age, BMI, academic stress, and sleep quality. The magnitude of association was quantified using adjusted odds ratios (OR) and 95 percent confidence intervals (CI). All inferential analyses were regarded as significant at p-value <0.05.

3. RESULTS

3.1 Demographic Characteristics

The study involved 362 undergraduate medical students of female sex, and the mean age of the female students was 20.4 ± 1.5 years. The distribution of the academic years was fairly balanced, having 23.2 percent in the first year, 24.9 percent in the second year, 25.1 percent in the third year, and 26.8 percent in the final year. The mean Body Mass Index (BMI) of the respondents was 21.9 ± 3.4 kg/m², and 18.7 percent were underweight, 69.3 percent were in the normal category, and 12 percent were overweight or obese according to WHO classification. On

socioeconomic status, most of them (66.3%) were in middle-income families, 21.5% were in high-income families, and 12.2% were in low-income backgrounds. A significant percentage (56.1%) of the respondents stated that they had a high level of academic stress, and 38.7% said that they did not have good sleep in the last two weeks, as per Table 1.

Table 1. Demographic Characteristics of Study Participants

Variable	Category	Frequency (n)	Percentage (%)
Age (mean ± SD)	—	—	20.4 ± 1.5
Academic Year	First Year	84	23.2%
	Second Year	90	24.9%
	Third Year	91	25.1%
	Final Year	97	26.8%
BMI Classification	Underweight	68	18.7%
	Normal	251	69.3%
	Overweight/Obese	43	12.0%
Socioeconomic Status	Low	44	12.2%
	Middle	240	66.3%
	High	78	21.5%
Academic Stress Level	High	203	56.1%
Sleep Quality	Poor	140	38.7%

3.2 Prevalence Rates

According to the GAD-7 scale, 35.6 percent (n = 129) of the participants showed symptoms of GAD. Among them, 14.6 percent (n = 53) had mild anxiety (GAD-7 score 510), 13.5 percent (n = 49) had moderate anxiety (GAD-7 score 1014), and 7.5 percent (n = 27) had severe anxiety (GAD-7 score 15). The average GAD-7 score was 7.1 (4.8), which means that the level of anxiety was moderate in general.

Of the students, 28.2 percent (n = 102) were at risk of disordered eating behaviours with a score of 20 and above on the EAT-26 scale. Of these, the items on dieting gave the most average subscale score (11.3 + 4.5), followed by bulimia and food preoccupation (5.6 + 2.7) and oral control (4.9 + 1.9). Overlap analysis showed that 67 students (out of 102) with a risk of disordered eating also fit the criteria of moderate to severe GAD, as shown in Table 2 and shown in Figure 1.

Table 2. Prevalence of GAD and Disordered Eating Risk

Parameter	Category	Frequency (n)	Percentage (%)
GAD Severity	None (0–4)	233	64.4%
	Mild (5–9)	53	14.6%

Parameter	Category	Frequency (n)	Percentage (%)
	Moderate (10–14)	49	13.5%
	Severe (15–21)	27	7.5%
Disordered Eating (EAT-26)	Score < 20	260	71.8%
	Score ≥ 20 (At risk)	102	28.2%

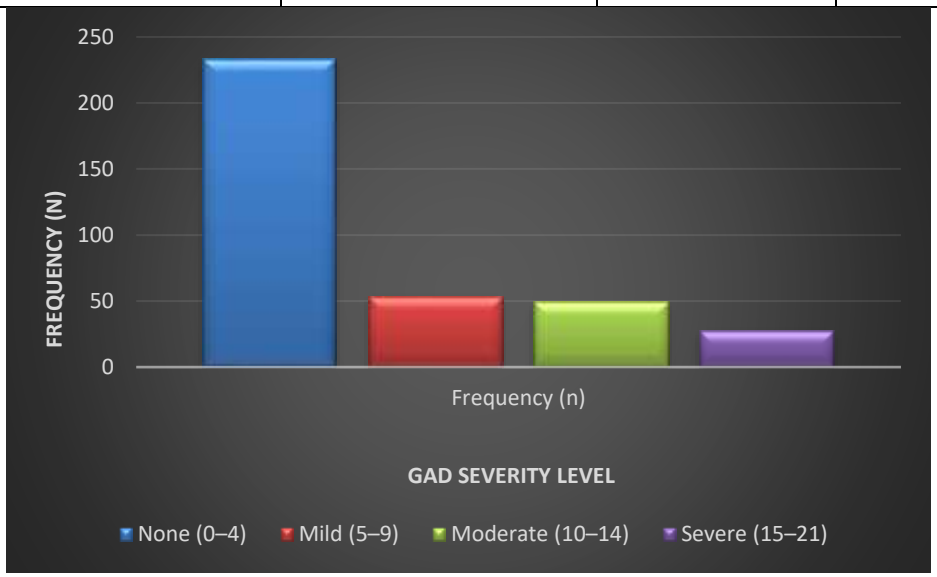

Figure 1. Distribution of GAD Severity Among Participants

3.3 Association Between GAD and Disordered Eating

Chi-square analysis showed that there is a statistically significant relationship between GAD categories and disordered eating risk (26.84, $p < 0.001$). 65.7% of the students with a risk of eating disorder had moderate to severe anxiety as compared to only 21.4% of the students with no eating disorder risk. The probability of GAD was 5.89 times more likely in disordered eating behaviour students than in normal students (OR = 5.89, 95% CI = 3.4510.05, $p < 0.001$) as indicated in Table 3 and Figure 2.

Table 3. Association Between GAD and Disordered Eating Risk

GAD Level	EAT-26 Score < 20	EAT-26 Score ≥ 20	Total (n)	p-value
None/Mild	205	35	240	
Moderate/Severe	55	67	122	
Total	260	102	362	<0.001

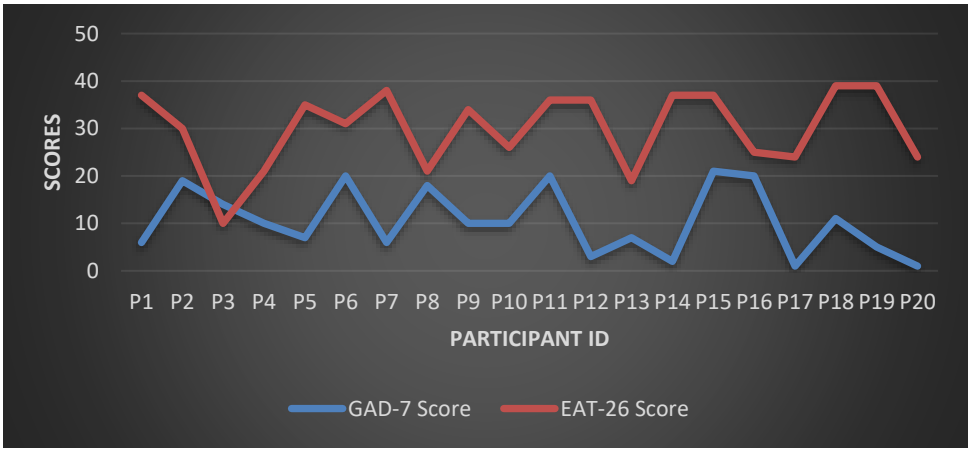

Figure 2. Correlation Between GAD-7 and EAT-26 Scores

3.4 Regression Model Results

To determine independent predictors of GAD among the study participants, binary logistic regression was carried out. Disordered eating behaviour was a significant and strong predictor of GAD even after controlling for the covariate factors (age, academic year, sleep quality, and BMI) (adjusted OR = 4.78, 95% CI = 2.91, 8.25, $p < 0.001$). Also, the perceived academic stress (adjusted OR = 2.34, 95% CI = 1.413.89, $p = 0.001$) and sleep quality (adjusted OR = 1.96, 95% CI = 1.123.46, $p = 0.017$) were significant predictors of the GAD. Table 4 summarises these findings.

Table 4. Logistic Regression Model for Predictors of GAD

Predictor Variable	Adjusted OR	95% CI	p-value
Disordered Eating (Yes)	4.78	2.91–8.25	<0.001
Academic Stress (High)	2.34	1.41–3.89	0.001
Sleep Quality (Poor)	1.96	1.12–3.46	0.017
Age	1.05	0.93–1.18	0.402
BMI	1.02	0.97–1.08	0.391

4. DISCUSSION

The research examined the prevalence of GAD and its relationship with disordered eating behaviours in female medical undergraduate students and came up with important clinical and epidemiological results. Table 2 indicates that 35.6 percent of the participants showed symptoms of GAD, with a worrying 13.5 percent and 7.5 percent showing moderate and severe symptoms, respectively, as indicated in Figure 1. At the same time, 28.2 percent of the students had a score above the clinical cut-off on the EAT-26, which indicated the high probability of disordered eating behaviour.

The anxiety and disordered eating comorbidity were extreme- over two-thirds of students with disordered eating were also determined to have moderate to severe GAD, highlighting a potentially dangerous comorbidity in this at-risk group. As Table 3 indicates, there is a strong relationship between these variables ($p < 0.001$), which is also confirmed by the positive correlation between the scores of GAD-7 and EAT-26 depicted in Figure 2. The regression model (Table 4) confirmed disordered eating to be the most potent independent predictor of GAD (adjusted OR = 4.78) even after the influence of confounding factors, including academic stress and sleep quality. The results indicate that medical students with disordered eating habits are much more likely to develop clinically significant symptoms of anxiety, especially in the case of female students. Theoretically, it is possible to explain this relationship using the cognitive-behavioural perspective, when maladaptive thought patterns caused by anxiety, negative self-appraisal, and perfectionism lead to disordered eating behaviours as a way of perceived control or emotional regulation (Agras & Bohon, 2021).

Anxiety usually stems from the sense of threat to performance or self-worth, especially in high-stakes academic settings such as medical schools. Students can then resort to dietary restriction or binge-purge cycles as coping strategies, and this will strengthen both behavioural patterns and psychological distress. Conversely, disordered eating may also lead to anxiety, since it may cause hormonal imbalance, nutritional deficiencies, and shame or guilt, resulting in a two-way feedback loop, which makes both conditions more severe (Masan & Çobanoğlu, 2024). This feedback loop is probably made worse by the stressful environment of medical education, which focuses on performance, long study hours, sleep deprivation, and competitive peer culture. Such stressors not only augment psychological pressure but also decrease the possibility of students seeking help because of time limits or stigma, especially in highly gendered educational environments where the need to be composed and successful is internalized at an early age (Pei et al., 2024).

The current findings of the relationship between anxiety and disordered eating can be seen as part of a larger psychological trend that occurs in high-stress academic environments and contributes to an emerging body of knowledge regarding comorbid internalizing symptoms in young adult women. Although the rates presented here are in line with those reported in international contexts, the cultural peculiarities of beauty ideals, parental expectations, and stigmatization of mental illnesses might have a unique influence on the development of these problems among Indian female medical students. The Indian urban learning environments tend to reflect both the traditional and contemporary pressures, such as family expectations, social media-induced body image comparisons, etc. The stress of excelling academically and at the same time meeting the idealized standards of appearance can add to psychological conflict, particularly when there are weak or non-existent support systems in the institution. This weakness seems to be exacerbated during crises, including pandemics, where students have been found to experience high levels of anxiety, depression, and suicidal thoughts in most of the studies conducted all over the world (Zhou et al., 2021).

The results of these studies have serious implications for clinical practice and academic policy in medical institutions. The first step is that medical colleges should implement frequent mental health check-ups, which involve both

anxiety and disordered eating assessment. Validated and easy instruments like GAD-7 and EAT-26 can be easily used at semester check-ins, entrance health testing, or confidential wellness websites. Second, the institutional resources should be increased to contain the presence of psychological counselling, dietetic consultations, stress-management workshops, and peer-support groups. Availing these services in forms that do not violate the privacy and the academic timetable of the students will increase the participation. Moreover, the incorporation of the materials about stress, emotional control, and self-care into the official curriculum would contribute to the creation of an openness and prevention culture. The gap between the needy students and the services can also be filled through peer-led mental health education campaigns, wellness retreats, and anonymous helplines. The advantages of the research are a large sample size, psychometrically validated measures, and multivariate analysis that helps to identify the best predictors of anxiety.

The stratification by academic years also enabled us to see more detailed insights into the evolution of psychological stressors during the medical training. Figures 1 and 2 are provided to complement the statistical results and help to conceive the psychological load that this population carries. However, certain limitations should be admitted. The cross-sectional nature of the research does not allow for a conclusion on the causality between anxiety and disordered eating; that is, the direction of the association cannot be established completely. The use of self-report tools also creates a risk of underreporting or overreporting because of the social desirability bias, especially on sensitive issues such as eating habits and psychological distress. In spite of the fact that the study was based on well-validated instruments, the lack of formal psychiatric or clinical interviews restricts the accuracy of diagnosis.

The single-institution nature also limits the external validity of the results to other geographical areas, particularly to rural non-English speaking or less academically oriented colleges. Other factors that are not evaluated, like personal trauma history, family mental health background, or coping strategies, can also be crucial and should be investigated in further research. Nevertheless, the findings of this study are consistent with a large body of previous data that showed high levels of depression and anxiety in medical and university students, especially women (Ibrahim et al., 2013). Also, longitudinal studies of medical cohorts in different countries indicate that the risk of psychiatric symptoms grows with the advancement of the academic years, highlighting the build-up of the medical education burden (Puthran et al., 2016).

Eating disorders in themselves can also indicate underlying psychiatric complexities and are increasingly being viewed as serious mental disorders that require both nutritional as well as psychological treatment (Attia & Walsh, 2025). Future research should also use longitudinal designs, which will enable the researcher to monitor the development and relationship between anxiety and disordered eating. Tracking students in the initial year of medical school to graduation may provide essential information on the timing and nature of the development of these symptoms and whether institutional efforts can alter that process.

Studies that provide interventions, such as randomized controlled trials of the efficacy of campus-based wellness programs, therapy groups, or nutrition workshops, would also be useful in determining scalable mental health solutions. External validity would be improved by extending this study to several colleges in culturally and geographically diverse areas, and be able to make regional comparisons. The qualitative interviews, as a mixed method, would give more insight into student lives and cultural processes. The future studies could also take into account the inclusion of biological indicators, including cortisol, neuroendocrine profiles, or even neuroimaging, to better comprehend the physiological effects of prolonged academic stress and unhealthy eating habits. To conclude, the results of the present study highlight the serious mental health issues of female medical students, especially those who have disordered eating behaviours. It is necessary to identify early, perform integrated screening, enhance the mental health infrastructure in institutions, and reform the curriculum to focus on emotional well-being. This research contributes to the increasing number of studies that encourage the systematic transformation of the way academic institutions address the issue of mental health and can be viewed as a call to action to foster resilience, prevent mental decline, and the overall growth of future healthcare specialists.

5. CONCLUSION

This study indicates that there is a large prevalence of Generalized Anxiety Disorder (GAD) and disordered eating behaviours among undergraduate medical students (female), and a strong correlation between the two disorders. Over a third of the respondents were suffering symptoms of GAD, and almost a third of them were vulnerable to eating disorders. The correlation between the two psychological problems was statistically significant, and disordered eating was a great independent predictor of GAD. The results can be attributed to the increased psychological fragility of female students in stressful academic settings, especially in the field of medicine, where the pressure to perform, sleep deprivation, and social demands are the factors that lead to emotional distress. Because of the possible long-term effects of untreated anxiety and disordered eating, this research highlights the necessity of early identification and active mental health approaches. The incorporation of proven screening measures, including GAD-7 and EAT-26, into regular health checkups may assist in locating the students at risk early and may assist in informing early interventions. Also, institutional support systems should be oriented toward the development of structured mental health programs such as counselling services, stress management workshops, and nutrition education. The medical curriculum needs to change and include mental health awareness and self-care training as holistic professional development. The emotional needs of future healthcare providers should be identified and addressed not only to guarantee their well-being but also to ensure the sustainability of compassionate, resilient, and competent medical

professionals

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