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Mental Health of Rural Women in Hind Institute of Medical Sciences: Challenges, Determinants, and Pathways to Resilience

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ABSTRACT

Background: This study will discuss the current issue of female health among rural women in the context of the subject not receiving the required attention within policy spaces, despite being a public health concern shaped by a combination of factors such as poverty, gender inequality, lack of healthcare access, and patriarchal socio-cultural norms. This study aims to identify key determinants of psychological distress among rural women at the Hind Institute of Medical Sciences, Sitapur, UP, and explore the social and cultural pathways that foster resilience.

Methods: This study was conducted among 80 low-income rural women in UP and used a sequential exploratory design. The study was divided into two groups – subjects with High HSCL scores and others. The data included information on demographics, health status, and mental health indicators, as measured using the Hopkins Symptom Checklist (HSCL).

Results: The study found that middle-aged women with high HSCL scores (n=50) showed significantly higher levels of wishful thinking (p=0.000, Cohen's d=0.56) and positive religious coping (p=0.000, Cohen's d=0.94). Post-migration living difficulties (PMLD) were a strong predictor of distress (p=0.000, R^2=0.55). Women with high HSCL scores reported lower levels of societal support (p<0.001, Cohen's d=0.72) and life satisfaction (p<0.001, Cohen's d=0.75).

Conclusion: The study concluded that middle-aged women, especially those with high distress levels according to the Hopkins Symptom Checklist (HSCL), face significant psychological and psychosocial challenges.

Key-words: Rural Women, Mental Health, Psychological Distress, Social Determinants

INTRODUCTION

Mental health is a vital aspect of holistic well-being, encompassing emotional, psychological, and social well-being. It affects how individuals think, feel, behave, and respond to stress. Globally, mental health issues are on the rise, and developing countries like India face a growing burden due to systemic inadequacies and social neglect. Despite increased recognition of mental health as a public health concern, the issue remains stigmatized and under-addressed, especially among vulnerable populations such as rural women [1].

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In India, nearly 70% of the population resides in rural areas, where women play a central yet often underappreciated role in families and communities. The social position of women in rural India is shaped by traditional gender roles, restricted mobility, early marriage, multiple pregnancies, illiteracy, poverty, and dependency on male family members. These challenges are deeply ingrained and directly contribute to mental health vulnerabilities, manifesting as anxiety, depression, and chronic stress [2,3]. Additionally, women in rural areas are often tasked with caregiving responsibilities, household labor, and facing social isolation, all of which are significant contributors to psychological burden [4].

Evidence suggests that rural Indian women have limited access to mental health care. Poor mental health literacy, cultural taboos, superstitions, and stigma prevent early detection and treatment of mental illnesses [5]. Many symptoms are misunderstood or considered normal aspects of life, especially among

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women, and help-seeking behavior is discouraged or delayed. Healthcare infrastructure in rural areas often lacks sufficient numbers of trained mental health professionals, and psychological services are predominantly concentrated in urban centers. Even where services exist, women face barriers such as financial constraints, lack of transport, and family restrictions in accessing care [6].

Studies conducted in various regions of India have reported higher prevalence of common mental disorders among rural women compared to urban populations [7]. The National Mental Health Survey of India (2015–16) found that nearly 15% of individuals in rural areas experience mental health issues, with women showing significantly higher rates of anxiety and depressive disorders [8]. The survey also highlighted alarming treatment gaps — with more than 80% of those affected not receiving any professional care.

Socioeconomic determinants such as education, employment, marital status, and income levels are critical predictors of mental health. Women with low educational attainment often have less awareness about their rights and available services, and are more likely to be economically dependent. Studies have shown that unemployment or engagement in unpaid household labor increases the psychological burden on rural women, particularly when coupled with lack of familial support [9]. Moreover, domestic violence, spousal neglect, and emotional abuse are significant yet under-reported contributors to depression and anxiety among rural Indian women [10].

Early marriage and adolescent pregnancies—still prevalent in many parts of rural India—exacerbate the risk of poor mental health. According to Sezgin and Punamäki, early marriage and partner violence have long-lasting psychological consequences, including post-traumatic stress, depression, and low self-worth [11]. Women in such circumstances are rarely empowered to make decisions about their health or future, increasing their psychological vulnerability. Empowerment, on the other hand, has been consistently associated with better mental health outcomes. In a study conducted in rural Maharashtra, Kermode et al. reported that women who had a role in household decisions and some degree of financial independence experienced fewer symptoms of distress [12].

Community-based mental health interventions have shown promise in improving outcomes among underserved populations. Programs that utilize trained local workers, midwives, or peer-support models have proven effective in building awareness, providing basic counseling, and reducing stigma [13]. However, such programs are scattered and not yet integrated into national public health systems. There is a clear need for scalable and culturally sensitive models that can be adapted to diverse rural contexts in India.

Despite the growing evidence, very few studies have specifically examined the mental health status of rural women in Uttar Pradesh — India's most populous state, characterized by a large rural population, low female literacy, poor health indicators, and gender disparities. Women in this region face layered disadvantages related to caste, class, and geography. Most existing research in the state has focused on maternal or child health outcomes, with little attention given to the psychological well-being of adult women.

In this context, the present study was undertaken to assess the prevalence of anxiety, stress, and depression among rural women in selected districts of Uttar Pradesh. The study also aimed to investigate the relationship between mental health outcomes and sociodemographic variables, including age, marital status, education, family type, and income. The findings of this study aim to inform policymakers and public health practitioners about the urgent need to integrate mental health services into rural healthcare delivery, promote awareness, and design gender-responsive interventions to improve the psychological well-being of rural women.

MATERIALS AND METHODS

Research design- This prospective study was conducted at thehe Hind Institute of Medical Sciencs, Sitapur, UP. The study duration was from Apr 2024 to Mar 2025. This study was conducted with 80 women who visited the health center for various health-related issues. The study included variables such as socio-demographic details, migration history, reproductive and general health information, and standardized mental health assessments. This study took into account the participants' low literacy levels and employed community health nurses who matched them in gender and language to facilitate effective communication. The

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design ensured that the research tools were culturally and contextually appropriate, enhancing the validity of the findings through methodology. This approach allows for the comparison of mean scores across the relevant variables. To analyse the relationships between mental health symptoms and psychosocial factors like autonomy, wishful thinking coping strategies, perceived social support, post-migration challenges, and overall life satisfaction, Pearson's correlation and bivariate regression analysis were conducted.

Inclusion criteria

- Patients must be above 18 years of age.
- It was ensured that participants were from a low-income socio-economic background.
- Only those patients were brought under the study who consented to it.

Exclusion Criteria

- Pre-existing psychiatric illness
- Ongoing psychiatric treatment
- Severe cognitive or communication impairment

Statistical Analysis- Statistical analyses were conducted using IBM SPSS Statistics for Windows, Version 27.0. Descriptive statistics were used to analyze the sample characteristics, which included demographic details, health information, and reproductive history. For categorical (nominal) variables, frequency distributions and percentages were analyzed, while continuous variables were summarized as means along with standard deviations (SD).

RESULTS

The study focused on a group of middle-aged women, with an average age of 39.1 years (standard deviation, 11.12). A significant majority are married (90%), while a small fraction is single (2.5%), widowed (6.3%), or separated/divorced (1.3%). In terms of family structure, 68.8% come from nuclear families, and 31.3% are part of joint family setups. On average, these women have been married for approximately 19.56 years (SD=12.21). In the case of education, a notable number of participants have only reached secondary education (37.5%) or lower (25% have completed primary school or less). In comparison, 25% have completed higher secondary education, and just 12.5% have pursued college or vocational training. Employment-wise, over half of the women (56.3%) are not in paid jobs, indicating limited economic participation.

Health-wise, a large majority (73.8%) reported no abnormalities. However, 12.5% have diabetes, 8.8% deal with hypertension, and a small number (2.5% each) suffer from anemia or other conditions. While most women reported no psychosocial issues (75%), a significant minority (23.8%) experience anxiety or depression, hinting at some mental health challenges within this group. In terms of contraceptive methods, sterilization is quite common (53.8%), compared to those not using contraception (46.3%) or using other methods (1.3%), indicating a strong preference for permanent family planning (Table 1).

Table 1: Demographic characteristics

Characteristic	N=80 (%)
Age	39.1±11.12
Family Types	
Single	2 (2.50%)
Married	72 (90.00%)
Separated/Divorced	1 (1.30%)
Widow	5 (6.30%)
Family Type	
Nuclear	55 (68.80%)
Joint	25 (31.30%)
Education	
College/Vocational training	10 (12.50%)
Higher Secondary (High School)	20 (25.00%)
Secondary (Middle School)	30 (37.50%)
≤ Primary (Grade School)	20 (25.00%)
Co-morbidities	
None	59 (73.80%)
Anaemia	2 (2.50%)
Diabetes	10 (12.50%)
Hypertension	7 (8.80%)
Other	2 (2.50%)
None	79 (98.80%)
Tobacco/Paan	1 (1.30%)
None	60 (75.00%)
Anxiety/Depression	19 (23.80%)
Other	1 (1.30%)
None	37 (46.30%)
Sterilization	43 (53.80%)
Other	1 (1.30%)

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The study examines the psychological and coping strategies of women with high scores on the Hopkins Symptom Checklist (HSCL) compared to those with lower scores. The group with high HSCL scores (n=50), which indicates they are experiencing more psychological distress, displayed significantly higher levels of wishful thinking and positive religious coping. These findings were statistically significant, with medium to large effect sizes (Cohen's d=0.56 and 0.94, respectively). Additionally, these women faced more challenges in their lives after migration, with an average score of 15.52, compared to 7.5 for the other group (n=30). Furthermore, support from society and overall life satisfaction were notably lower for the high-HSCL women, with large effect sizes (d = 0.72 and 0.75), indicating that they experienced less external support and lower well-being. Interestingly, there were no significant differences in autonomy and practical coping strategies. The HSCL scores themselves were significantly higher in the high-distress group (mean = 3.15 vs. 2.26), indicating an extremely large effect size (d = 2.92), which confirms the presence of significant psychological symptoms (Table 2).

Table 2: High HSCL and Other women with the parameters

Parameter	High HSCL woman n=50, M(SD)	other woman n=30 M(SD)	t	p	95% CI	Cohen's d
Autonomy	7.14(3.5)	8.12(3.5)	-0.588	0.75	(-0.82,0.51)	0.07
Wishful thinking	11.75(5.12)	9.5(4.2)	-5.012	<0.001	(-3.52, -2.01)	0.56
Practical coping	11.14(4.85)	13.5(5.10)	0.576	0.735	(-0.85,2.22)	0.07
Positive religious coping	5.12(3.160	4.75(2.4)_	-5.32	<0.001	(-1.52,-0.55)	0.94
Post migration living difficulties	15.52(14.7)	7.5(7.35)	-8.51	<0.001	(-13.75,-8.41)	0.12
Support provision from society	34.12(5.12)	36.95(4.2)	6.45	<0.001	(1.94,3.56)	0.72
Life satisfaction	22.75(9.12)	25.54(5.12)	6.63	<0.001	(3.25,7.41)	0.75
Checklist of Hopkins symptom	3.15(1.2)	2.26(0.19)	-20.16	<0.001	(-1.52,-1.25)	2.92

The regression models presented in Table 3 show the factors influencing psychological distress, as measured by the HSCL, across various participant groups. In Model I, which includes all participants (N = 80), it is observed that post-migration living difficulties (PMLD) and wishful thinking coping emerge as significant positive predictors of distress ($p < 0.001$). On the other hand, support from society stands out as a significant negative predictor ($p = 0.002$). Together, these three factors account for 55% of the variance ($R^2=0.55$). Positive religious coping and life satisfaction didn't show significant predictive power. Model II, which focuses on participants with low HSCL scores (n=50), revealed that none of the predictors reached statistical significance, and the model explains only 16% of the variance ($R^2=0.16$), indicating limited explanatory strength in this low-distress group. In Model III, which looks at participants with high HSCL (n=30), PMLD again proves to be a strong positive predictor of distress ($p<0.001$), while wishful thinking is on the edge of significance ($p=0.025$), although its confidence interval includes zero. Other factors, such as age, support, and life satisfaction, didn't show significant results. This model accounts for 35% of the variance ($R^2=0.35$), reinforcing the idea that PMLD is a consistent and strong predictor of psychological distress, particularly among those already facing high levels of distress.

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Table 3: Regression analysis of Predictor parameters

Models	variables	B	SE	t	p	95%CI
Model I: All study participants (N=80)	Constant	2.455	0.345	7.125	0.000	(1.852,3.421)
	PMLD	0.0377	0.005	7.562	0.000	(0.030,0.065)
	Wishful thinking	0.0244	0.008	8.425	0.008	(0.007,0.054)
	positive religious coping	0.015	0.016	0.985	0.561	(-0.033,-0.012)
	support provision from society	-0.037	0.007	-3.245	0.002	(-0.033,0.022)
	life satisfaction	0.012	0.005	-3.2658	0.125	(-0.030,0.003)
	R2	0.55				
	F for change in R2	40.12	-	-	-	-
Model II: Participants with HSCL '<1.65 (n= 50)	Constant	1.725	0.186	8.565	0.000	(1.186,3.045)
	Age	0.003	0.003	1.324	0.335	(0.030,0.045)
	PMLD	0.004	0.004	1.254	0.165	(0.005,0.051)
	Wishful thinking	0.008	0.008	1.468	0.153	(-0.033,0.060)
	support provision from society	-0.006	0.008	-1.652	0.152	(-0.055,-0.012)
	life satisfaction	-0.006	0.005	-1.865	0.086	(-0.030,0.003)
	R2	0.16	-	-	-	-
	F for change in R2	4.523	-	-	-	-
Model III: Participants with HSCL '.->1.65 (n=30)	Constant	2.523	0.575	5.045	0.000	(1.456,3.125)
	Age	-0.006	0.006	-1.015	0.416	(-0.015,0.005)
	PMLD	0.018	0.005	4.456	0.000	(0.008,0.035)
	Wishful thinking	0.019	0.12	1.523	0.025	(-0.002,0.34)
	support provision from society	-0.004	0.16	-0.456	0.562	(-0.035,0.016)
	life satisfaction	-0.009	0.005	-1.354	0.321	(-0.030,0.005)
	R2	0.35	-	-	-	-
	F for change in R2	13.563	-	-	-	-

DISCUSSION

The results of this study on the mental health of rural women brings to light a regard the complex interaction of deficiency, gender standards, violence, and lack of admission to mental health services contributing to a high occurrence of emotional distress among this demographic. These results confirm that rural women are disproportionately prone to mental health issues due to systemic and social difficulties, a finding that aligns with multiple studies conducted across India and other low- and middle-income countries [1].

One of the most important determinants identified in this study was gender-based violence, including domestic abuse and dowry-related harassment. This is similar to

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the study by Kumar *et al.,* which found that nearly 60% of rural women in northern India who reported intimate partner violence also experienced depressive symptoms. Similarly, a multicentric WHO study in South Asia exposed that women exposed to partner violence were twice as likely to experience mental disorders such as depression, PTSD, and suicidal ideation. In the Northern India background, where patriarchy remains deeply entrenched, the emotional problem of such abuse is intensified by societal silence and victim-blaming arrogance [2].

Socio-economic position was another serious determining factor. Women, predominantly those engaged in unpaid work from lower-income households or low-paid labour, reported feelings of helplessness, anxiety, and hopelessness. These consequences in rural Gujarat found that women in economically disadvantaged families had a suggestively higher occurrence of common mental disorders, mirroring those of Patel *et al.*, a community-based mental health investigation. The educational attainment and lack of employment opportunities for women, which in addition diminish their self-sufficiency and management mechanisms, the connection between deficiency and mental health is well established. Still, in rural India, it is compounded by limited resources [3].

The current study also identified early marriage and repeated pregnancies as stressors, which is consistent with results from an NFHS-5 analysis, which presented that women who married before the age of 18 reported higher levels of mental health symptoms. Reproductive health, especially contraception and family size, leaves many rural women with long-term consequences in the absence of decision-making power regarding apprehension and emotional strain [4].

An important dimension highlighted in this study is the limited access to formal mental health care. Most rural women reported not knowing where or how to seek help for psychological distress. This mirrors the national trend reported by Gururaj *et al.* in the National Mental Health Survey of India (2015–16), which found that nearly 70–80% of individuals with mental illness in rural India do not receive any professional treatment. Contributing factors include lack of awareness, inadequate integration of mental health services into primary care, and a shortage of trained professionals. In rural Northern India, emotional distress is often misunderstood because of moral failing or divine punishment, further discouraging women from seeking prescribed help. This combination of misinformation, stigma, and systemic gaps perpetuates untreated psychological suffering among rural women [5].

Despite the harsh conditions, this study also observed remarkable resilience among many rural women. Support systems such as women's self-help groups, religious faith, and informal networks played a critical part in helping women manage their emotional distress. Community action or microfinance groups displayed better mental health consequences in Maharashtra. Similarly, it was observed that women involved in collective activities experienced a sense of purpose, solidarity, and social recognition. Such answers underscore the importance of leveraging existing community structures for mental health advancement [6].

When one compares rural women in Northern India to those in other parts of the world, experiences of similar patterns develop. For example, poor mental health among women was associated with poverty, gender inequity, and lack of education. The Ugandan women, like their Indian counterparts, were often caregivers with limited resources and social capital; up till now, they have also found assets through community and faith-based groups. These parallels suggest that while socio-cultural contexts may vary, the core tasks faced by rural women in LMICs remain largely similar [7].

This study identifies a persistent need for gender-sensitive, community-based mental health interferences in rural Northern India. Despite their determined efforts, the National Mental Health Programme and the District Mental Health Programme have so far failed to meaningfully reach rural populations. Comparatively, in Tamil Nadu, the integration of mental health into primary care services has revealed some success through mobile mental health units and training of community health workers. Accepting a similar regionalised model in Northern India, coupled with awareness campaigns and local engagement, could help bridge the massive treatment gap [8].

Moreover, mental health policies must recognize the diversity among rural women and avoid applying a one-size-fits-all approach. Intersectionality is vital for designing programmes and needs to take into consideration aspects such as caste, age, disability, and marital status. Empowerment programs that advance

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education, a source of revenue, and legal constitutional rights can also act as preventive measures against the onset of mental illness [9].

This study, conducted at the Hind Institute of Medical Sciences, Uttar Pradesh, along with existing literature, confirms that rural women in Northern India face a disproportionate burden of mental health concerns rooted in socio-cultural, economic, and systemic factors. Until now, they have also demonstrated pathways to resilience that must be recognized and supported. Associating the gap between policy and practice, especially by investing in mental health care and empowerment programs, culturally competent, community-based, is not only a healthcare imperative but also a socio-economic necessity.

CONCLUSIONS

The present study reveals a high prevalence of anxiety, stress, and depression among rural women in Uttar Pradesh, indicating significant mental health challenges in this population. Socioeconomic hardship, limited education, and inadequate social or spousal support were major contributing factors. Younger women and those from lower-income families were especially vulnerable. These findings call for urgent policy attention and the integration of mental health screening and services into rural health systems. Community awareness, early identification, and culturally appropriate support programs are essential to address psychological distress. Strengthening primary healthcare with trained personnel can improve access, reduce stigma, and promote overall well-being.

CONTRIBUTION OF AUTHORS

Research Concept- Dr. Abhishek Pathak
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