Research Square

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Titled: Qualitative exploratory analysis of psychosocial stressors and systemic barriers to mental well-being among urban poor married women in India

Naveena Dheeraj
Christ University
Chhaya Kurhade
chhaya.kurhade@sihs.edu.in
Symbiosis International University

Research Article

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Abstract

Background:

Urban poor married women (UPMW) are vulnerable due to socio-economic and cultural factors that adversely affect their mental well-being.

Aims

This study aimed to explore mental health related psychosocial stressors, and coping strategies among urban poor married women and to identify systemic barriers through stakeholder recommendations for strengthening the mental health services.

Methods:

An exploratory qualitative design was employed. Participants were purposively recruited from urban communities in Coimbatore, Tamil Nadu, India. Data were collected between June 2024 and November 2024 from urban poor married women (n = 11) and key stakeholders (n = 6). Semi-structured interview guides were used for in-depth interviews and focused group discussions. Each session lasted 45–60 minutes and was audio-recorded. Data were analyzed using inductive thematic analysis following Braun and Clarke's model to integrate both data sources. Ethical approval was obtained from the university, and written informed consent was secured.

Results:

Four major themes emerged: (1) Mental health illiteracy (2) Barrier to access mental health care and services (3): Psychosocial stressors with coping strategies (4) Recommendation to improve mental health care. Limited awareness of mental health and fear of social labelling discouraged help-seeking. Psychological distress included financial insecurity, husbands' alcohol use, and unequal gender roles to. Access to professional mental health services was minimal and suggested recommendation to improve mental health care through various strategies to implement in the community.

Conclusion:

The findings highlight the need for community-based mental health awareness initiatives, accessible services, and livelihood-oriented empowerment interventions to improve the mental well-being of urban poor married women.

Introduction

Mental health is defined as one's ability to cope with normal life stressors, work effectively and contributes to society, rather than merely absence of disorders. Globally, mental disorders substantially contribute to 5.4% of total disability-adjusted life years (DALYs), in 2021, with highest proportion of depression and anxiety disorders adding to disability[1]. National Mental Health Survey (2016), estimated that 5.8% of women aged 18 to 49 years, experience common mental disorders (CMDs) including depression and anxiety disorder with 80% treatment gap in India [2]. The epidemiological studies consistently demonstrate that women bear disproportionated burden of mental health disorders[3–8]. However, there are numerous studies encounters that urbanization, lifestyle, vulnerability to violence, cultural inequality, and social changes in urban communities could be reasons for disturb mental health among women [9, 10]. On the other hand, some studies concluded that women have higher rate of depression and anxiety secondary to socio-cultural and economic factors[11–13]. Therefore, women's mental health important and should be recognized as an essential public health priority.

Despite growing research evidence on women's mental health in India, urban poor married women remain an understudied yet highly vulnerable group in the society. Urban poor families are under persistent psychological stress due to rapid urbanization, economic instability and overcrowded places [2, 4, 14–19]. On the other hand, married women in urban communities often seen carry the double burden of domestic and financial responsibility[11, 13, 20–24]. Evidences suggests that women in low-income urban communities experiences higher rates of psychological distress due to caregiving and financial burden, interpersonal conflicts, substance disorder dependency in spouses, domestic violence [22, 25–30]. There has been clear distinction that urban poor married women and mental health vulnerabilities. Therefore, there is need for prioritization of urban poor married women's mental health as they face double vulnerability from both from structural and cultural aspects.

Over past years, studies reported in low-income urban communities working mothers and married women have heavy domestic workload, and job related pressure, marital conflict and lack of support in child care, these factors significantly contributes to stress, severe depression including suicidal ideation [6, 24] Similarly, other studies contributes that mental health issues positively correlated with socio-economic hardship, lower education and substance issues in spouse [4, 31, 32]. In additions, to this some studies have scrutinized that domestic violence, intimate partner violence, emotional abuse, marital conflict impact the mental health of married women[13, 20, 33, 34]. Social determinates such as poverty, overcrowded, financial stress, job insecurity, poor housing shows as reasons for depression and anxiety among married women[13, 20, 33–35]. Women often expressed distress through using 'tension' imbedded in gender roles, marital conflict, financial strain, limited autonomy[21].

Some studies identified key barriers to healthcare were lack of awareness, stigma, perception of services were irrelevant to their needs, limited access to services[36, 37]. Others studies on coping strategies reported cognitive reframing, somatic release, self-talk, mindfulness and religious activities and social engagement in generic women population[24, 38–40]. Nevertheless, the existing qualitative studies on women's mental health contained imperative insights from low-income working mothers and married women in poor urban communities. However, there is no current studies which provide a comprehensive enquiry on urban poor married women. Therefore, there is paucity understanding on urban poor married women in community and gendered related vulnerabilities intersect in this population. Hence, the present qualitative study aims to explore the mental health perspectives, psychosocial-stressors and coping strategies among urban poor married women, and recommendations from different stakeholders to improve systemic gaps between community needs and existing mental health services in Coimbatore, Tamil Nadu.

Contexts of the study:

Urban Poor married women (UPMW) exemplify the highly vulnerable section of society and has limit to access healthcare due structural and cultural inequalities. The structural inequalities include poverty, limited employment opportunities, housing insecurity as results of urbanizations. Cultural aspect such as gender norms and expectations, which are traditionally rooted in their marital roles. As earlier studies focused on mental health among low-income urban women (working mothers, married working women, poor urban women) in India. In this context, the study seeks to explore the perspectives of urban poor married women and generate insights from key stakeholders which will be helpful in bridging the systemic gap between needs and mental health services in urban community.

Materials and methods

Study design and setting

The study employed an exploratory qualitative design to examine mental health perspective, psychosocial stressors, and coping strategies among urban poor married women (UPMW), and to identify the systemic barriers and recommendations from stakeholders to improve mental health services in Coimbatore, Tamil Nadu, India.

Sampling and Participants:

Urban poor married women were selected using purposive sampling. Participants from study included aged between 18 to 50 years, residing in the urban community for at least one year and those with acute or severe psychiatric or major mental health disorder such as untreated mental health conditions, intellectual disabilities, hearing impairments, or speech difficulties were excluded. Similarly, inclusion criteria for the stakeholders aged between 18–50 years with both genders. These were from various filed such as counsellors, social workers, and outreach professionals with affiliation with any one of the non-governmental organizations (NGOs) in community who works on women's mental health with 3 to 6 years of minimum work experiences.

Tools and techniques

A semi-structured interview guide was developed based on the objectives of study and gaps identified from the literature. The content validation of semi structure tool is performed by two faculties from Department of Social Work. Semi structure tool was used to conducted the in-depth interviews with urban poor married on mental health perspective, the importance of maintaining mental health, attitudes towards help seeking, key psychosocial-stressors related to family, financial, and society, their impact on well-being, and coping strategies. Whereas the focused group discussions conducted with stakeholders to covered on barriers to access services, existing mental support systems, and recommendations to improve mental health intervention.

Ethical considerations:

Ethical approval

was obtained from the Institutional Review Board (IRB) (Ref: 20240924/2337849/DSSWRES) from the Department of Social Work, CHRIST (Deemed to be University), Bangalore. All the participants of study were informed about their right to withdraw from the study at any point time without any consequences. The written informed consent was obtained from all participants. The clinical trial number not applicable for this study.

Data collection and analysis

Data were collected from 1st June 2024 to 30th November 2024. Semi-structure interview guide used for both in-depth with urban poor married women (n = 11) and focused group discussion with stakeholders (n = 6). All the sessions were conducted in local language, audio recorded with consent and later transcribed verbatim. Transcripts were anonymized using participant codes (P1–P11 for interviews; C1–SP for FGD participants). During translation of data the prioritization was given to conceptual relevance rather than literal accuracy [41]. The data was analyzed using the inductive thematic analysis followed Braun and Clarke (2006) model, which allows researchers to identify the patterns that emerge directly from the data. However, the in-depth-interviews and focused group discussion (FGDs) were analyzed together as a single data set while maintaining scientific rigors and clear distinction of participants data. The data coding completed using word file and excel-sheet and codes listed down manually.

Data organized using the six steps as given below; steps 1) Familiarization: all the transcript were read multiple times by researchers to know the data well. 2) Generated coding: in we have identified the similar verbatim from both interviews and FGD transcripts were coded together, without using a pre-existing framework. 3) Code Comparison and Integration: Codes collected from interviews and FGD data were compared for similarities and differences. Overlapping codes were merged, while unique codes were retained in the study. 4) Category Development: Related codes were grouped into broader categories through constant comparison. 5) Theme Generation: Categories were further refined into overarching themes that captured patterned meanings across both data sources. 6) Review and Refinement: Themes were reviewed against the dataset to ensure coherence, consistency, and representativeness to answer the objective of the study[42].

Reflexivity

Throughout this study, we had practice to keep notes about from researcher end on addressing personal and professional judgement in the academics meeting which help us examining our thought related to study. We are aware how these factors influence our study but recognized that this might help us to enrich other hand can limit our study.

Results

Socio-demographic details UPMW (Table 1): The study results revealed that Urban poor married women (UPMW) belong to the 20–29 years and 40–49 age groups. A significant proportion, 41.6% of participants, had completed their undergraduate with 8.3% postgraduate degrees. 33.3.% of them were employed (Table 2)

Table 1
Sociodemographic Details of In-depth Interview Participants (n = 11)

Participant ID	Age	Number of Children	Educational Qualification	Income Level	Employment Status
P1	44	2	Primary	EWS*	Homemaker
P2	40	2	Primary	EWS	Homemaker
P3	28	1	Postgraduate	EWS	Student
P4	33	2	Undergraduate	EWS	Employed
P5	30	1	Undergraduate	EWS	Homemaker
P6	38	1	Postgraduate	EWS	Homemaker
P7	27	1	Undergraduate	EWS	Employed
P8	49	2	Secondary	EWS	Homemaker
P9	28	1	Undergraduate	LIG*	Employed
P10	39	2	Secondary	EWS	Homemaker
P11	38	1	Secondary	EWS	Employed
Note :					
• EWS – Economically Weaker Section					
• LIG – Lower Income Group					

Table 2
Descriptive analysis of Sociodemographic Details of In-depth Interview Participants

Variable	Category	Frequency	Percentage
Age Group	20–29 years	4	33.3%
	30–39 years	5	41.6%
	40–49 years	3	25.0%
Number of Children	One child	7	58.3%
	Two children	5	41.7%
Educational Qualification	Primary	2	16.6%
	Secondary	3	25.0%
	Undergraduate	5	41.6%
	Postgraduate	1	8.3%
Income Group	Economically Weaker Section (EWS)	1	8.3%
	Lower Income Group (LIG)	11	91.6%
Employment Status	Homemaker	7	58.3%
	Employed	4	33.3%
	Student	1	8.3%

On the other hand, focus group discussion (Table 3**)** involved six stakeholders aged 24–31 years with 6 years of work experience. In terms of their educational background, the majority had completed their master's in social work. The occupational status of stakeholders included two counselors, and others four were working as outreach social workers.

Table 3
Sociodemographic Details of Focus Group Discussion

Participant ID	Age	Sex	Years of Experience	Occupation
C1	26	Female	5	Counsellor
C2	24	Female	3	Counsellor
GS	25	Female	3	Grassroots Social worker
OS	27	Male	5	Outreach Specialist
EX	56	Male	5	Social Work Expert
SP	31	Male	6	Social Work Practitioner

Table 4 : **Thematic analysis of Data**

Table 4
Thematic analysis of Data

Themes	Subthemes	Codes
Mental health literacy	Unfamiliarity with mental health	- *I don't know about mental health word* - *Hear about the hospital but not gone to hospital* - *Read on WhatsApp quotes anger and frustration lead to mental health issues*
	Perception about mental health	- *Have cognitive impairment* - *Have Behavioral Change* - *Mental state as a relief.* - *Mental health is in good state* - *Having family to talk and staying happy.* - *Changes according situations* - *Control over mind's restlessness* - *Focusing on present moment.*
Barriers to access mental health care and services	Internal barriers	- *Preference for family* - *Approach on the behavioral changes* - *Misconception about treatment*
	External barriers	- *Lack of trust on doctors* - *Stigma on being judged or labelled* - *Expensive*
Psychosocial Stressors with coping strategies	Psychosocial stressors	- *Family stressors* - *Financial stressors* - *Gender related responsibilities* - *Worried about physical health*
	Coping strategies	- *Distraction techniques* - *Religious activities*
Recommendation to improve mental health care	Creating awareness	- *Via social media* - *Role play or street-play* - *Advertisements of toll-free number provided by the government* - *Mental health camps* - *Referral services*
	Skill development	- *Beautician course* - *Tailoring courses*
	Empowerment strategies	- *De-addiction center in community* - *Making Rigid laws for women safety* - *Recreational programmer* - *Self-defense*

Themes	Subthemes	Codes
		- Providing houses to women

The inductive coding is used for data analysis which yield four themes across the data. These themes highlight on understanding the women's perspective, psychosocial stressors, coping strategies and stakeholders' recommendation to improve the mental health. For more detail on themes refer to **(**Table 4**).**

Theme 1: Mental health literacy

The majority of participants indicated a lack of acquaintance with mental health concepts, declaring their ignorance and suggesting that the researcher consult a subject matter expert. Some have stated they read Quotes on WhatsApp and heard about hospital but not accessed mental health services. There certainly perception about mentally ill people identified using cognitive impairments and behavioral abnormalities as cues. However, majority of the participants were denied that mental health issues exist emphasis on controlling their mind's restless and having good state of mind or focusing on present moment and having family to talk.

The participants expressed unfamiliar with the term called '*mental health'* which clearly indicate lack of awareness on mental health conditions and services.

"*I have heard that in hospitals, there's a doctor for mental health. But I haven't gone to one" (P11).*

"*No, I don't know, I haven't heard about that word. I don't tame myself to others' mindset. Will not speak about things I don't know. Mostly it has turned out to be the better option." (P1).*

"*I don't know how to tell. Maybe you should talk to somebody who is bold enough will be able to give you information". (P5)*

Some of the participants described that mental health often determined by ability to understand and behavioral changes which were different than normal in mentally affected person.

Yes, I do know the term Mental Health. But I believe I understand 85%. I don't know15%. I was provided some insights about mental health by a male mentor; he is my close friend since 9th grade till date even after marriage. If I face any problem, I call him up. For whatever we want to do, we need mental health. I have referred people to psychiatric services. Once, I saw some variations in speech and movements, so I recommended psychiatric services for my close friend's relative. The psychiatrist had prescribed tablets to that person".(P3)

Participants stressed the focus on self-regulation and on what can be done to maintain mental health.

"*We must not think of something and let our minds get tangled. We must not think of something and let our minds get tangled. We must only think of what we need to do today and nothing about tomorrow or what happened yesterday. We must not compare ourselves with others. We must save up even the small amount for daily needs. If I am engaged in something like household chores, or tailoring, I will not tangle my mind. When people say something positive, I take it. If it is something negative, I leave it then and there. Our job is to take care of our children and husband. We should help them to achieve. We should focus on their positives and not their flaws. We must encourage them based on their strengths. Desires will ruin our lives. If the desire is something within our capacity, then it is alright. But the desires that are beyond our capacity, will destroy us. We must move forward in our life with what we have. One must not long for unreachable desires. (P2)*

In the focused group discussion, various other stakeholders have collaborated on similar information that there is lack of awareness and knowledge about mental health in the community among urban poor married women. Expressed the reluctance to inform parents about child having Attention Deficient Hyperactive Disorder (ADHD), symptoms because they consider the child is to be most active in community compared to other children. Other

the hand, some have stated that mental health is not given more important due to their struggle fulfill the basic needs at most concern in developing countries like India.

“I cannot go and tell their mothers that your child might have ADHD, you can try to get him screened at the hospital. If I did so, they would respond back asking “Why would I take my child to a hospital if he is the most active child in the whole neighborhood?” It is understandable, because they might not be aware, it is all because of lack of awareness.” (FGD-C2)

‘In developed nations, mental health is given more importance. But in developing nations, basic needs are still unmet. When we try to talk about mental health, people are unable to understand. Their focus is to ensure physical health. If they need to also focus on mental health, more awareness needs to be created. Even bureaucrats lack enough knowledge about mental health, which is a major problem.” (FGD-SP)

Theme 2 : Barriers to access mental health care and services

Participants have reported internal barriers and external barriers as one of hinder to mental health services. In this internal barrier constitute from lack believe on mental health professionals such lack of trust of doctors, expensive and waste of money, misconception about treatment, preference to family, and stigma being judge or label by people.

Some participants share that they like to rely on self or family to resolve any problem and if there no family support is available then they can approach for professional help.

“We need not go, we just have to sort it out amongst our family by talking” (P7)

“I think if people are able to speak something that we are unable to share something to our family, but we can share it with this professional. It is similar to how our friends will give us some hope to manage better. There is nothing wrong. Everybody needs this. For physical health we go to the doctor, we need mental health. It is gender’s nature that male is this way and female are this way. Then why would they do hypnosis, they are trying to find. Like how we need air, water and food. People around us should also support us. Everybody will think that moving from a joint family to a nuclear family is the best option, but once they grow older they will feel loneliness.”(P6)

One of the participants shared that using mental health services are waste as they make more addictive to medicines.

“I would say it is a waste. We can take care of them at home. It is a waste going to them. My husband is from the medical field. So we know things. They just prescribe medicines. With the doctors we have seen, they are all in for the money. The tablets' effects are severe. It becomes an addiction. I don’t know about others. These days doctors are not good. Maybe the senior doctors are genuine, and provide good counselling. Tablets are like drugs. It shouldn't be consumed, it will make us feel like we can only sleep after having it. But that is not true. We are made to feel that we can only feel relaxed, or sleep or go to that state after having that”.(P10)

Some of participants and stakeholder reflected that there is internal stigma among urban poor married women of being judge or label by the society based on mental health issues.

“I don't want people to know about my mental health issues. I don’t want to reveal to people that I am like this. People might look down upon us. They will label me as “crazy”, I don’t want such an identity. That is the reason I engaged myself in beautician and tailoring works. Now I won’t have such an identity. So, I don't want to access anything from the government. I didn't even get a single penny from the government nor have I got any certificate or schemes from them because I don't want that identity. Housing is provided for people with mental health issues. But we did not avail those, because we will have that identity. Although we have a lot of expenses for children’s stationeries and others, my husband says that I don’t require that identity because I function and interact well with people and that is for extreme cases.” (P3)

“Actually, they know it themselves, but because of the stereotypes they hesitate to consult a psychiatrist. It is only their cultural stereotypes that stops them from consulting a psychiatrist or counsellor. They are ready to seek professional help. They are scared of being labelled. They are very scared that they will be put into mental hospitals. If you go to the community and try to understand, you will see the neighbors if they get to know, they will not even ask what had happened rather the person will be sealed and labelled as a “crazy”. The low-income families must be provided awareness. I had a patient who came from an interior location, she was told by her sons that she would be connected to electricity and given vibrations, they would gather all the truth and take you to another state of consciousness. Because this mother was told this, she did not seek counselling despite being admitted in hospital for 45 days for radiation. After I carried out a session with her, I asked her if I have given her any electric shocks. And then the mother cried to me saying that her children gave the wrong idea and if it was talking, she felt heard and good during the session. For them what they watch in movies of electroconvulsive therapy, they have become molded that this is how a psychiatric hospital will be. If we change these by conducting talks and creating awareness or somehow if we debunk the myths, I think it will change or influence the perspectives.” (FGD-C1)

“*Women hesitate to seek help because they think, “am I crazy? Is something wrong with me?” People don't understand the difference between counselling and psychiatric services. If I say I want to hold a counselling session, they would ask “Do you think I'm crazy? Why should I go for counselling?”. This is their mind set. We have to first explain what meant you help is and only then should we talk about counselling. For those who are open to counselling there is a lack of accessibility. And there is a noticeable gap between the women and men when it comes to getting counselling services. We need to fill in that gap. There are organizations, but it is mostly the educated crowd that reaches out to them. But people in economically weaker sections or below are often left behind. However, the lower- and middle-income groups might seek counselling because they have a bit more awareness as they are often graduates or have some education. We need to think about how organizations can offer services that are accessible to everyone, regardless of their economics status. One way to start with the basic session that explains counselling and how it works. (FGD-OS)*

The participants expressed fear of psychiatric admission after witnessing a neighbor’s negative experience in a de-addiction center, which created concerns about worsening symptoms, loss of awareness, relapse, and inability to function or support family.

I feel scared to admit him in a mental hospital, because once my neighbour was admitted in a deaddiction centre, and he started acting psychotic. He stopped drinking. Then he started acting like a “mental”. He seemed like he was completely unaware of his own identity or the surrounding. But he started drinking again, it doesn't seem like he is going to stop. He is not working, nor is he able to provide to his family. So this makes me scared to seek mental health services. (P11)

The participants showed reluctance to seek psychiatric help and shows lack of trust on mental health professionals with reasons stated due to perceiving services as profit-oriented and overly medication-focused, with fears that psychiatric medicines are addictive, harmful, and unnecessary compared to home-based care.

“I don't want to go to psychiatric services. I haven't gone too. I don't intend to. I will try to sort it out by myself. We should manage ourselves. Whatever it is, I should be able to suffer from it. I should believe that today's problems will change and that I will overcome it. If we go they try to understand our emotions and with that they can talk and think. I don’t know what to tell. There are chances for change or might not. I have doubt if the doctors will think that we are making the problem. I don't go, if I have any problem I tell god. I talk to myself sorting out. I talk to my soul. I talk to God”. (P10)

I would say it is a waste. We can take care of them at home. It is a waste going to them. My husband is from the medical field. So we know things. They just prescribe medicines. With the doctors we have seen, they are all in for the money. The tablets' effects are severe. It becomes an addiction. I dont know about others. These days doctors are not good. Maybe the senior doctors are genuine, and provide good counselling. Tablets are like drugs. It

shouldn't be consumed, it will make us feel like we can only sleep after having it. But that is not true. We are made to feel that we can only feel relaxed, or sleep or go to that state after having that.(P9)

The participants highlighted structural barriers for children with intellectual disabilities, there is lack of services for children with mentally retarded and expensive treatment for consultations. These facilities are away from mainstream schools, and limited accessibility of supportive services.

“There are many children who are mentally retarded, but there is no school for them. We can’t keep them in home also. They feel like they are put in a jail and closed inside, and there is no freedom. There is a school in Kuniyamuthur. Children don't get on the bus. Families with mentally retarded children cannot mostly afford an auto or bus every day. It is somewhat okay for the children like him. If we are accessing government services are done with consideration due to his condition. But there are no schools. We can't put them into normal schools. Government schools take them. But they don't fit in at all with government school space. If they are studying 7th grade, 1st graders, younger children tease him. So, we can't send him. They have it all very far. It is after 7–8 towns where these schools are located. We cannot travel. We cannot take them in the bus, before we get in, they start off before we get in. so that is why we keep them in our homes. It is not okay when it comes to normal families. If it is a home where the woman can drive two-wheeler and wait until the session and then bring them back. If it was somewhere nearby like Selvapuram it would have been better. But there are no such facilities. We can't get inside the bus with them quickly. Government school children do not welcome abnormal children. Now he is in a stage where he understands what I am saying. This is all because the doctor has told us. They suggested more classes that are effective, since the fee is high, we didn't go for it. Whatever is around 1000 rupees we had put our child in” (P4)

Theme 3: Psychosocial stressors with coping strategies

Participants emphasis on psychosocial stressors such as family issues, financial constraint, concern related to physical health and gendered related responsibilities. Some have illustrated on feeling burden on taking care of the special child at home. In these majority of participants experiences that stressor related to husband’s alcohol issues, having an affair or having contacted with his first spouse. Some of them expressed their emotional distress arising from feeling unheard by her husband, particularly when he ignores her opinions in decision-making, highlighting relational strain and lack of communication.

The participant described significant stress due to her husband’s alcohol use, which creates financial hardship, emotional pain, and difficulty managing household responsibilities, despite some family support and absence of overt conflict.

“When my husband doesn’t listen to me. It does affect me when my husband doesn’t respond quite well or listen to my inputs about a decision.” (P5)

“My husband's drinking is my stress. Our hard-earned salary is going in vain. Why do we need to give out all the money for drinking? It is a sin, that is a worry that I carry always. We poured blood and sweat to make this money. And he chooses to give that money off to the toddy shop. That makes my heart burn. I'm unable to digest it. For how many women like me, the day the toddy shops are a problem ? Yet, they don't shut it down. Even on the days all these are shut, they gather the spare change just ready to get their hands on alcohol ! Money is the only problem. There's always no money to spend. He gives us 100 rupees daily. My mother and my sister gives me some money, and food to eat. Somehow we manage with my salary. For a week he gets 4000. But he finishes half drinking. The left over 2000, we have commitments. We have, loan to repay, an advance on our house. My daughter gets unwell, during that time things gets difficult for me. My sisters help me. My husband does not quarrel or fight after drinking. He sleeps off after coming home drunk. He doesn't drink water or eat anything after drinking. Why is there such a drive to get high / intoxicated? He has told that he has body pain. He has a lot of mental pain.” (P11)

The participant expressed health-related worries associated with a family history of diabetes where managing with dietary control, emotional frustration to handle academic pressure and balancing motherhood and studies

due to handing multiple roles.

“My mom and dad had blood sugar. Maybe because of their bodies, I might have got blood sugar. I used to worry. I used to eat sweets. Then my body has become bad. But I mostly eat sweets. People ask what's your blood sugar. Whatever we need we should buy, we can control it for a few days. Because I felt weak after all the specific diet, I have been eating everything. I feel angry when people order or when they say they are waiting for me. If they request it, I will help them. I will deny help if they order me or are expecting me completely to do the job. (P1)

“I do have some problems that makes me feel low. But not in my home. But from my college, when I have exam pressure I get stressed. Sometimes, my professor targets me a little. Most of the students are unmarried, Only one or two are married. We have the pressure to manage our kids and our academics. I have to take an off when my son is unwell. He is a toddler. Then when the percentage is affected, I do feel low. Since I am married, I am unable to manage academics previously. Now I am managing better. As I have sacrificed a lot for my studies so I am very keen in not dropping out for any reason. By god's grace I have come this far. In fact, I am very bold usually, but during that time I had many breakdowns. My home is always pleasant for me. I do not have any problems that disturbs me within home. But only outside home. (P3)

The focused group discussion highlighted women having multiple role burden and majorly contributes to income generation as well as household tasks, and caregiving responsibilities while coping with concerns about children’s education and husbands’ alcohol use, reflecting gendered stress and workload imbalance.

“*Mostly it is the women who go for work. Women are running the households, be it income or anything. Mostly the work, for sewage or corporation or house help or fruit vendors or flower shops. But there unaware if their children are going to study, or their husband is drinking. After they come home from work, they have to cook meals”. (FGD-GS)*

There are two main coping techniques used to deal with these stresses: distraction techniques and engaging in religious and spiritual activities that help to feel emotional comfort and resilience.

Some have shown the engagement in the religion activity as coping strategies such changing, prayers, visiting temple or church.

“In order to come out of any hopelessness or sadness, I chant “Om Sri Sadguru Yaye Namaha”. Sometimes, when I feel extreme happiness. When I feel like my chest is heavier, I share with my friends. (P10)

“I pray to Jesus. When I am feeling stressed I think about God. There is a sister (nun), she consoles. This day is God's creation. God will have a different plan for tomorrow. Whatever he has planned for us, he will give it to us. This is how it is going. will become tired. I will be unable to do anything. Nothing works. So I take a day off or two from work. I will go to church and pray. I will feel peaceful. All my stress is taken away by Him, God. I release all my stress over there. Going elsewhere doesn't help” (P11).

Another way of coping was seeing distraction which included watching television, scrolling phone or using mobile, listening to music or playing with child or talking to family or friends. Which is also collaborated with stakeholders in their discussion about coping.

“If I have any pressure or any tension, I will try not to think of it. I stay away, and not get angry, but putting rangoli or doing household chores like cleaning house, something whenever I am in tension helps.” (P4)

“I will watch television and phone. If we are at home, it feels boring. Who will be there at home ? I will only be there. If I keep being at home, I feel like talking to people, or watching TV or feel bored”. (P1)

I face the problem. When I feel low I listen to music. I enjoy it. I can shift my mind from the problem easily through music. When I am disturbed, my main outlet is music. I love piano music. I listen to piano music that plays on the lift. If not, comedy is my go-to. I watch television channels like Aditya, Siripoli like that. (p2)

“Talk to my close ones when I am low. I listen to songs. I forget my problems when my daughter is around. I am engaged with her. I watch something or I try to read or listen to stories. I try to solve the problems by speaking to the person. Mostly, family solves the problem, as my parents are nearby. (P5)

“Their relaxation is watching TV, something like news, soap operas or something. Beside this there are women who consume tobacco or alcohol There are five people here, something similar to a self-help group. They join with an existing self-help group and organized trips. They use the savings to go on trips to visit temples. There are also women who attend temples functions, or visiting temples on auspicious days.”(FGD- C1)

“There is no major entertainment for them. These days they are involved in digital media, festivals and through other things they are coping. People who do not have purchasing power, cannot afford good things in society”. (FGD-SP)

Theme 4 : Recommendation to improve mental health care

The key recommendations were proposed in these were awareness-raising, skills development, empowerment strategies and systemic challenges. Creating awareness on mental health is must which include like setting up mental health which can be used for referral services later. Otherwise using social-media platforms for advertisements in between drama, television and soap opera for showcasing the government services on mental health such as Tele MANAS programme which provide toll free number or schemes like Pradhan Mantri Awaj yojana or National Old Age Schemes, housing for giving information on services for poor. Other ways of spreading awareness could be street play or role pay in the community.

“We must create awareness about the symptoms and they will reach out to somebody when they have a persistent low mood that is affecting their day-to-day activities. They must be provided the awareness that they need to share with somebody or atleast a counselor. creating awareness through street-play or role plays can help them as they watch it with interest. “Therukoothu” street play is something they will stand watching, its like their love language, it's their language of culture. So if we use street plays to convey about mental health, I think it will change." (C2)

Also, I'm not sure how far this is possible for it to happen. One thing that everybody is connected to is through television. Daily regardless of what they watch or not, they will watch soap operas for sure. But I'm not sure, some soap operas themselves will give mental pressure to the woman like “what will he do to him, what will that guy do to the other guy”. We can create awareness if these soap operas could show something like advising to seek professional help or how much of a big problem this will end up as. They need not portray that the person will be admitted to the mental hospital, it isn't true not everybody is a patient and will be put into asylums: We have depression and other mental health disorders for which we can remediate at home, they just need some support from people, through advertisements or drama we could create awareness. (C1-FDP)

Another point of discussion was skill development to strengthening their financial situations they need skills equip with training such as beautician courses or tailoring course to managed their situations.

“In some slums, the local NGO, it provides skill development in tailoring. This way we are ensuring assistance to the urban poor and our beneficiaries for skill training programs. You know, according to our tenements area we identified locations to provide training. Tailoring is conventional and very essential. It also gives mental relief as well as economic development of the family. We implemented tailoring. Now we have beautician courses for urban poor married women. This provides economic development to the family”.(EX-FDP)

Other insisted the needs to empower the urban married women by giving the self-defense training, and having recreational programmer or support group might help urban married poor women. Some have mentioned on having De-addiction center in the community for rehabilitation to resolve their husband’s alcohol issues which might directly impact their wellbeing.

“Women can be taught self-defense. If given training, maybe they can be safe”. (FGD GS)

“It is not just merely awareness programmers that we can conduct. We must also identify ideas to help them overcome these issues. We must give them an opportunity after providing awareness to get to the next level. For example, awareness for education should not stop with just awareness, rather some opportunities can be provided. Like for people who smoke a lot, have gums. And for those who have a drinking problem it is de-addiction centers. We can do rehabilitation. We must give the urban poor whatever helps them to overcome an addiction or whatever. In order to manage stress, our mind must become distracted from the problem. Our mind will focus on whatever that we spend time more in. Only if we understand this will our field develop.”(FGD-OS)

“Women who are at home, training can be provided or engage them in recreation activities in their locality. Opportunities like this can eliminate stressor (FGD-OS)

Discussion

The study aims to serve two primary goals: to explore the perspective on mental health, stressors, and coping mechanisms of participants, and provide recommendations from stakeholders to improve the mental health of urban poor married women (UPMW). Our results indicate that there is limited awareness among the majority of them, who had no prior information about mental health. On the contrary, a few of them presented their emotional state to understand mental health; this finding aligns with previous studies[43–46]. Some have related the importance of mental health in two aspects: one with daily functioning, like physical health, concentration, relation with mind and body connection, being at peace, and the second with self-care, including rest, and indulging in music, meditation, and remaining happy.

Our study results were consistent with the existing literature on social, structural, and attitudinal stigma. Barriers to accessing mental health care, mainly social stigma and misconceptions, such as silence, shame, and delayed help-seeking[47–49] were significant. Whereas structural barriers emphasis on affordability, high treatment costs, and limited financial resources, limit access to professional care for women from low-income urban communities[50, 51]. However, the attitudinal barriers expressed a hesitation to approach formal services due to concerns about confidentiality, lack of trust in the healthcare system, and a general preference for informal support networks[52, 53]. On the other hand, some stated openness to professional support for mental health issues in case of unavailability of support from formal care. The majority of data suggest that there is a negative attitude towards seeking mental health support among the urban poor married women (UPMW).

In addition to our study provide insight on stressors related to marital life were observed closely align with prior research that highlights challenges[44, 54–56], such as financial constraints, lack of validation, child and special needs, spouse identity issues, physical abuse, alcohol issues, restricted gender norms, safety concerns, health issues, and academic stress among UPMW. Similarly, existing literature on coping strategies reflected positive ones, including religious practices of chanting, praying, and connecting with others. However, the distractive activities involved escape from or diverting the mind from stress [22, 57, 58].

Recommendations received from stakeholders on improving mental health were focused on two key areas: enhancing individual well-being and promoting community awareness. A study [20, 59], has observed similar results on promoting well-being on both individual and community levels. Furthermore, our results were consistent[4, 17, 34, 55], with individual-level strategies to promote well-being included encouraging physical activity, strengthening social supports (family, peers, and workplace support groups), and offering avenues for skill development. Similarly, educational advancement consists of preparing for competitive exams for empowerment. The economic empowerment is associated with facilitating access to livelihood options and schemes provided by governments, such as SHG and PMKVY.

On the other hand, study results were similar to previous studies [13, 33] based on the community level, strategies were suggested to promote mental health literacy using conventional and non-conventional media to raise awareness and reduce stigma. This primarily addresses the included addiction-related issues among men, which are seen as contributing factors to psychological distress among women. The challenges reported while working

in the community were a lack of awareness among government servants and inadequate funds and resources. Some of these factors are seen as obstacles to initiating the mental health program in urban communities. Our study has highlighted that urban poor married women face unique challenges and need culturally responsive and sustainable interventions. To promote mental health literacy, improve access, and reduce stigma in the community and at the individual level to strengthen mental health services. This would help in inclusive policy changes and make mental health care more accessible in urban poor settings.

Conclusion

This study sheds light on urban poor married women face stigma, low awareness, and affordability issues in accessing mental health care. The study suggests individual and community-level strategies and calls for inclusive, multifaceted approaches to improve access and shape responsive mental health policies in urban settings.

Limitation

One limitation of the study is a small sample size, despite providing valuable insight from participants and stakeholders focused on barriers, factors preventing access to mental health, and recommendations to improve mental health on individual and community levels. Secondly, this focuses on a non-clinical understanding of mental health and limits the broader applicability of results to other geographic areas as findings are context-specific for to UPMW in Coimbatore.

Declarations

Conflict of Interests

The authors declare that they have no conflict of interests.

Ethical approval:

All study participants provided informed consent to participate in the study and were informed about their freedom to withdraw from participating at any points during the data collection and at their own will.

Ethics and Guidelines

This study was approved by the Institutional Ethics Committee (IEC) under the Department of Social Work, CHRIST (Deemed to be University), Bengaluru, India (Protocol No. 20240924/2337849/DSSWRES). The study was conducted in accordance with the institutional research ethics regulations of CHRIST (Deemed to be University) and the ethical guidelines for research involving human participants issued by the Indian Council of Medical Research under the National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. Written informed consent was obtained from all participants.

Consent to participate:

All study participants provided written inform consent prior to data collection in the study and hardcopies of same are maintained with authors.

Consent to publish:

All authors have given consent for publication of the data.

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Author Contribution

1. N.D. has completed data collection and completed initial writing of draft as well as data analysis during her Master in Social Work at Christ University, Bangalore. 3. C. K. has completed the revision of article writing as we as the correct the verified the finalized the outcome from the data. Both authors have reviewed the manuscripts.

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Data Availability

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

References

1. Ferrari AJ, Santomauro DF, Aali A, Abate YH, Abbafati C, Abbastabar H, et al. Global incidence, prevalence, years lived with disability (YLDs), disability-adjusted life-years (DALYs), and healthy life expectancy (HALE) for 371 diseases and injuries in 204 countries and territories and 811 subnational locations, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. Lancet. 2024;403(10440):2133–61.
2. Annajigowda HH, Nirisha LP, Ganjekar S, Rao GN, Gururaj G, Varghese M, et al. Common mental disorders among women in reproductive age group: An analysis of national mental health survey, India 2016. Indian J Psychiatry. 2023;65(12):1238–43.
3. Jayasankar P, Manjunatha N, Rao GN, Gururaj G, Varghese M, Benegal V. Epidemiology of common mental disorders: results from National Mental Health Survey of India, 2016. Indian J Psychiatry. 2022;64(1):13–9.
4. Nair AR, Shivanna YKG, Illimoottil JP, Rachana A, Mahasampath GS, Abraham S, et al. Common mental disorders among women and its social correlates in an urban marginalized populace in South India. Int J Soc Psychiatry. 2022;68(7):1394–402.
5. Poongothai S, Pradeepa R, Ganesan A, Mohan V. Prevalence of Depression in a Large Urban South Indian Population — The Chennai Urban Rural Epidemiology Study (Cures – 70). PLoS ONE [Internet] 2009 [cited 2025 Nov 25];4(9):e7185. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC2748692/
6. Ramesh K, R U, Vm A, Rj C. V N. Exploring the Pathway towards Depression among Working Married Women – A Qualitative Study Done In Urban Area of Kancheepuram District, Tamil Nadu. Natl J Community Med [Internet] 2022 [cited 2025 July 19];13(02):90–5. Available from: https://www.njcmindia.com/index.php/file/article/view/156
7. Srinivasan M, Reddy MM, Sarkar S, Menon V, Depression. Anxiety, and Stress among Rural South Indian Women—Prevalence and Correlates: A Community-Based Study. J Neurosci Rural Pract [Internet] 2020 [cited 2025 July 23];11(1):78–83. Available from: https://ruralneuropractice.com/depression-anxiety-and-stress-among-rural-south-indian-women-prevalence-and-correlates-a-community-based-study/
8. Thresa SS, Krishnamurthy L, Swetha T, Pandraveti KS, Bala SI. Prevalence of depression and its determinants among women of the reproductive age group in a rural area of Tamil Nadu - A community-based cross-

sectional study. J Dr YSR Univ Health Sci [Internet] 2022 [cited 2025 Nov 25];11(4):344. Available from: https://journals.lww.com/jdyu/fulltext/2022/11040/prevalence_of_depression_and_its_determinants.15.aspx

9. Okkels N, Kristiansen CB, Munk-Jørgensen P, Sartorius N. Urban mental health: challenges and perspectives. Curr Opin Psychiatry. 2018;31(3):258–64.
10. Ventriglio A, Torales J, Castaldelli-Maia JM, De Berardis D, Bhugra D. Urbanization and emerging mental health issues. CNS Spectr. 2021;26(1):43–50.
11. Kanougiya S, Daruwalla N, Osrin D. Mental health on two continua: mental wellbeing and common mental disorders in a community-based cross-sectional study with women in urban informal settlements in India. BMC Womens Health [Internet] 2024 [cited 2025 July 19];24(1):555. Available from: https://doi.org/10.1186/s12905-024-03389-1
12. Patel V. Social and cultural determinants of mental health. Mental Health Care Resource Book: Concepts and Praxis for Social Workers and Mental Health Professionals. Springer; 2024. pp. 55–70.
13. Roberts LR, Sadan V, Siva R, Sathiyaseelan M, Rosalind SE, Suresh P, et al. Factors Predicting Mental Health Among Women in Low-Income Communities of a Changing Society: A Mixed-Methods Study. Int J Womens Health. 2023;15:381–94.
14. Bezerra H, de Alves S, Nunes RM, Barbosa ADd. IR. Prevalence and Associated Factors of Common Mental Disorders in Women: A Systematic Review. Public Health Rev [Internet] 2021 [cited 2025 Nov 28];42:1604234. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC8419231/
15. Dhamija G, Roychowdhury P, Shankar B. Does urbanization empower women? Evidence from India. J Popul Econ. 2025;38(1):27.
16. Patel V. Urban women and mental health concerns in India. Gend Ment Health Comb Theory Pract 2020;129–42.
17. Shidhaye R, Patel V. Association of socio-economic, gender and health factors with common mental disorders in women: a population-based study of 5703 married rural women in India. Int J Epidemiol [Internet] 2010 [cited 2025 July 27];39(6):1510. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC2992631/
18. Singh S, Mk SP. U, S S. Prevalence of common mental disorders and perspective toward mental health in an urban resettlement colony of Delhi, India: A mixed-method study. J Educ Health Promot [Internet] 2024 [cited 2025 July 27];13. Available from: https://pubmed.ncbi.nlm.nih.gov/39679017/?utm_source=chatgpt.com
19. Trivedi JK, Sareen H, Dhyani M. Rapid urbanization - Its impact on mental health: A South Asian perspective. Indian J Psychiatry [Internet] 2008 [cited 2025 Nov 28];50(3):161–5. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC2738359/
20. Abdi F, Rahnemaei FA, Shojaei P, Afsahi F, Mahmoodi Z. Social determinants of mental health of women living in slum: a systematic review. Obstet Gynecol Sci [Internet] 2021 [cited 2025 July 5];64(2):143–55. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7990997/
21. Atal S, Foster J. A woman's life is tension: A gendered analysis of women's distress in poor urban India. Transcult Psychiatry. 2021;58(3):404–13.
22. Kumar S, Jeyaseelan L, Suresh S, Ahuja RC. Domestic violence and its mental health correlates in Indian women. Br J Psychiatry J Ment Sci. 2005;187:62–7.
23. Sharma S, Patnaik L, Sahu T. Effect of lifestyle interventions to reduce depression, anxiety and stress among married women of reproductive age group: A non-randomised controlled trial in urban slums of Bhubaneswar. J Educ Health Promot [Internet] 2023 [cited 2025 July 19];12:347. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10743840/
24. Travasso SM, Rajaraman D, Heymann SJ. A qualitative study of factors affecting mental health amongst low-income working mothers in Bangalore, India. BMC Womens Health [Internet] 2014 [cited 2025 June 28];14(1):22. Available from: https://doi.org/10.1186/1472-6874-14-22
25. Chate SU, Mahantshetti G. Intimate Partner Violence and Psychiatric Morbidity among Ever Married Women in Urban Area. Natl J Community Med. 2020;11(06):235–9.

26. Haobijam S, Singh KA. Socioeconomic Determinants of Domestic Violence in Northeast India: Evidence From the National Family Health Survey (NFHS-4). J Interpers Violence [Internet] 2022 [cited 2025 July 23];37(15–16):NP13162–81. Available from: https://doi.org/10.1177/08862605211005133
27. Mishra SK, Pradhan G, Pradhan SK, Choubey G. Prevalence and Predictors of Domestic Violence in India: Complex Sample Analysis of a Nationally Representative Study Conducted Between 2019 and 2021. Cureus. 2024;16(8):e66113.
28. Narasimha Vranda M, Naveen Kumar C, Muralidhar D, Janardhana N, Thangaraju Sivakumar P. Intimate Partner Violence, Lifetime Victimization, and Sociodemographic and Clinical Profile of Women with Psychiatric Illness at a Tertiary Care Psychiatric Hospital in India. Indian J Psychol Med [Internet] 2021 [cited 2025 July 23];43(6):525–30. Available from: https://doi.org/10.1177/0253717620938870
29. Singh D, Nasir S, Sharma J, Giménez-Llort L, Shahnawaz MG. Psychological Distress in Low-Income and Economically Marginalized Populations in India: Protective and Risk Factors. Behav Sci [Internet] 2024 [cited 2025 Nov 28];14(2):92. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC10886196/
30. Subhashchandra K, Selvaraj V, Jain T, Dutta R. Domestic violence and its associated factors among married women in urban Chennai: A cross-sectional study. J Fam Med Prim Care. 2022;11(2):633–7.
31. Panigrahi A, Panigrahi M, Padhy AP, Das SC. Common mental disorder and its socio-demographic correlates among married women residing in slum areas of Bhubaneswar, India. Women Health. 2017;57(5):521–33.
32. Solanki RS, Kulkarni RN. Insight into depression: a cross sectional study from urban slums in Mumbai. MRIMS J Health Sci [Internet] 2017 [cited 2025 Nov 28];5(4):149. Available from: https://journals.lww.com/mjhs/abstract/2017/05040/insight_into_depression__a_cross_sectional_study.8.aspx?utm_source=chatgpt.com
33. Parkar SR, Fernandes J, Weiss MG. Contextualizing mental health: gendered experiences in a Mumbai slum. Anthropol Med. 2003;10(3):291–308.
34. Subbaraman R, Nolan L, Shitole T, Sawant K, Shitole S, Sood K et al. The psychological toll of slum living in Mumbai, India: a mixed methods study. Soc Sci Med 1982 [Internet] 2014 [cited 2025 July 27];119:155–69. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4252879/
35. Banerjee KJA, Kumar B, Bhatnagar R, Singh N. A. Women's Empowerment and Mental Health: A Cross-sectional Study among Married Women in Delhi. 2025.
36. Miranda J, Green BL. The need for mental health services research focusing on poor young women. J Ment Health Policy Econ. 1999;2(2):73–80.
37. Ernst K, Dasilva G, Srivastav M, Campson A, Soto P, Puvvala A et al. Challenges in Accessing Mental Health Services in Underserved Pregnant and Postpartum Women: A Scoping Review. Women [Internet] 2025 [cited 2025 Nov 29];5(3):31. Available from: https://www.mdpi.com/2673-4184/5/3/31
38. A Latent Class Analysis of Coping Strategies Among Women. in Informal Settlements in Nairobi, Kenya. J Ment Health Clin Psychol [Internet] 2025 [cited 2025 Nov 29];9(2). Available from: https://www.mentalhealthjournal.org/articles/a-latent-class-analysis-of-coping-strategies-among-women-in-informal-settlements-in-nairobi-kenya.html?utm_source=chatgpt.com
39. Weaver LJ, Jagielski A, Ningaiah N, Madhivanan P, Jaykrishna P, Krupp K. Coping strategies and perceptions of mental health services among women in South India. PLOS Ment Health [Internet] 2024 [cited 2025 Nov 29];1(6):e0000142. Available from: https://journals.plos.org/mentalhealth/article?id=10.1371/journal.pmen.0000142
40. Ward EC, Clark LO, Heidrich S. African American Women's beliefs, coping behaviors, and barriers to seeking mental health services. Qual Health Res. 2009;19(11):1589–601.
41. Temple B, Young A. Qualitative Research and Translation Dilemmas. Qual Res [Internet] 2004 [cited 2025 July 9];4(2):161–78. Available from: https://doi.org/10.1177/1468794104044430
42. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol [Internet] 2006 [cited 2025 July 9];3(2):77–101. Available from: https://www.tandfonline.com/doi/abs/10.1191/1478088706qp063oa

43. Kermode M, Herrman H, Arole R, White J, Premkumar R, Patel V. Empowerment of women and mental health promotion: a qualitative study in rural Maharashtra, India. BMC Public Health [Internet] 2007 [cited 2025 July 23];7(1):225. Available from: https://doi.org/10.1186/1471-2458-7-225
44. Malhotra S, Shah R. Women and mental health in India: An overview. Indian J Psychiatry [Internet] 2015 [cited 2022 July 12];57(Suppl 2):S205–11. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539863/
45. Mboweni EN, Mphasha MH, Skaal L. Exploring Mental Health Awareness: A Study on Knowledge and Perceptions of Mental Health Disorders among Residents of Matsafeni Village, Mbombela, Mpumalanga Province. Healthcare [Internet] 2023 [cited 2025 July 24];12(1):85. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10779020/
46. Ohrnberger J, Fichera E, Sutton M. The relationship between physical and mental health: A mediation analysis. Soc Sci Med [Internet] 2017 [cited 2025 July 5];195:42–9. Available from: https://www.sciencedirect.com/science/article/pii/S0277953617306639
47. Druss B, Perlick D. The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. Psychol Sci Public Interest. 2014;15:37–70.
48. Stangl AL, Earnshaw VA, Logie CH, van Brakel W, Simbayi C, Barré L. I, The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Med [Internet] 2019 [cited 2020 Feb 25];17(1):31. Available from: https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-019-1271-3
49. Weaver LJ, Karasz A, Muralidhar K, Jaykrishna P, Krupp K, Madhivanan P. Will increasing access to mental health treatment close India's mental health gap? SSM - Ment Health [Internet] 2023 [cited 2025 July 19];3:100184. Available from: https://www.sciencedirect.com/science/article/pii/S2666560322001244
50. Arahanthabailu P, Praharaj SK, Purohith AN, Yesodharan R, Rege S, Appaji R. Exploring barriers to seek mental health services among patients with severe mental illness and their caregivers in a modified assertive community treatment program: A qualitative thematic analysis. Indian J Psychiatry [Internet] 2024 [cited 2025 July 19];66(7):621–9. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11382755/
51. Kaur A, Kallakuri S, Mukherjee A, Wahid SS, Kohrt BA, Thornicroft G et al. Mental health related stigma, service provision and utilization in Northern India: situational analysis. Int J Ment Health Syst [Internet] 2023 [cited 2025 July 19];17(1):10. Available from: https://doi.org/10.1186/s13033-023-00577-8
52. Choudhry F, Khan N, Munawar K. Barriers and facilitators to mental health care: A systematic review in Pakistan. Int J Ment Health. 2021;52:1–39.
53. Salaheddin K, Mason B. Identifying barriers to mental health help-seeking among young adults in the UK: a cross-sectional survey. Br J Gen Pract [Internet] 2016 [cited 2025 July 19];66(651):e686–92. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5033305/
54. Habeeb S. Pallavi. Mental Health among Working Women. J Psychosoc Well-Being. 2022;03:46–51.
55. Panigrahi A, Padhy AP, Panigrahi M. Mental Health Status among Married Working Women Residing in Bhubaneswar City, India: A Psychosocial Survey. BioMed Res Int [Internet] 2014 [cited 2025 July 24];2014:979827. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3988941/
56. Sinha S, Sharma S, Shrivastava P, Bankwar V. Prevalence of mental illness among women in an urban slum area of Jaipur: A cross- sectional study. J Prev Med Holist Health. 2023;9:86–96.
57. Jyothsna KA, Shetty KV, Kumar S, Baruah U, Jyothi HP, Amritha KS, et al. Psychosocial distress, perceived social support, and coping in women survivors of domestic violence seeking help from a women's helpline in urban India. J Educ Health Promot. 2023;12:158.
58. Kanougiya S, Daruwalla N, Gram L, Gupta AD, Sivakami M, Osrin D. Economic abuse and its associations with symptoms of common mental disorders among women in a cross-sectional survey in informal settlements in Mumbai, India. BMC Public Health. 2021;21(1):842.
59. Barry MM, Kuosmanen T, Keppler T, Dowling K, Harte P. Priority actions for promoting population mental health and wellbeing. Ment Health Prev [Internet] 2024 [cited 2025 July 25];33:200312. Available from:

https://www.sciencedirect.com/science/article/pii/S2212657023000533

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