

Original Research Article

Access to mental healthcare and coping strategies among rural women: a qualitative study from Amroha district, Uttar Pradesh, India

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ABSTRACT

Background: Rural women in India are often confronted with situations that make it difficult for them to access formal mental health services such as inaccessibility, internalized stigma, believing that suffering is due to external causes and gender inequalities. These barriers delay receiving formal care for mental health and make these women resort to informal ways of coping such as community support and local faith healers.

Methods: This study aimed to explore the informal coping strategies and beliefs around mental health among 100 rural women over the age of 18 years residing in Amroha district of Uttar Pradesh, India. Being a qualitative study, the method employed for the survey was focused group discussions and the participants were included through a convenience snowball sampling. The discussions were held in Hindi language for the ease of the participants and were recorded for analysis which was done through a thematic analysis approach.

Results: The results highlighted six broad themes: (1) burden of responsibilities and emotional burnout, (2) physiological manifestations of psychological distress, (3) normalization of chronic stress, (4) psychological distress arising from marital conflict and gender-based adversity, (5) reliance on spiritual and informal coping strategies in place of formal mental healthcare, and (6) emotional suppression and silent tolerance.

Conclusions: The findings suggest the urgent need to design culturally aligned psychotherapeutic interventions that focus on creating awareness through psychoeducation that could reduce stigma as well as helping rural women deal with their unmet mental health challenges.

Keywords: Amroha, Coping strategies, India, Mental healthcare, Rural healthcare, Rural women

INTRODUCTION

Mental health has become a major issue in global public health discussions, but it is still under-researched and under-served in many low- and middle-income countries (LMICs). The World Health Organization (WHO) defines mental health as a state of well-being in which individuals recognize their own potential, employ adaptive coping strategies to manage everyday stressors, and contribute meaningfully to their communities.¹ Despite growing recognition of its importance, mental health support and services remain structurally inadequate and

geographically inaccessible across much of rural India. Systemic barriers- including chronic underfunding of mental health infrastructure, an acute shortage of trained mental health professionals, and the near-total absence of community-based psychiatric services- continue to widen the treatment gap, particularly in rural and semi-urban regions.²

The ground level challenge that adds up to this fundamental gap is the prominent lapse in awareness of psychological health concerns present in individuals residing in rural areas. Many communities still don't

recognize or even acknowledge emotional distress as a term and a prevalent health concern. Psychological concerns causing suffering are usually viewed and interpreted through a cultural, religious, spiritual and even somatic lens than medical ones. This often makes it difficult for individuals to acknowledge and recognize what they are possibly going through and delays treatment. The lack of awareness and understanding surrounding mental health concerns makes it even more stigmatized by attaching beliefs such as character weakness, deviation from being normal and supernatural explanations leading to delayed and more expensive help seeking.³ Therefore, emotional suffering is either suppressed, accepted and normalized rather than being spoken about and seek professional help for, through the right channels.

Other concerns that arise due to limited knowledge of mental health is the belief that there are external causes of psychological distress. A common belief among many rural communities in India is that any psychological suffering could be blamed on destiny, act of God, evil eye and supernatural powers instead of physiological processes of the brain or any social factors. This belief system suggesting deeply rooted religious and cosmic ideologies usually restrict a proper understanding of mental health conditions that just end up delaying treatment as evidence-based clinical treatments become out of question in such beliefs. It motivates individuals to seek help and rely on informal ways such as religious rituals, spiritual healers and influential elders in the community.⁴

Rural women in India face a particularly acute and intersecting set of vulnerabilities. Gender-based discrimination, restricted access to education, financial dependence, and the disproportionate burden of domestic and caregiving responsibilities collectively heightens their exposure to chronic stress, anxiety, and depression.² Women in rural settings are frequently expected to fulfil multiple social roles- as wives, mothers, daughters-in-law, and agricultural labourers- with minimal autonomy and negligible institutional support. The literature consistently documents the severity of psychological distress experienced by women navigating these compounding demands, often in contexts of marital conflict, economic precarity, and social isolation.⁵ The lack of access to formal psychological healthcare services and external limitations such as cultural and spiritual dependence to deal with stress makes it essential to explore coping mechanisms of individuals. Coping is usually understood as the cognitive and behavioural ways that an individual engages in to be able to regulate his/her emotions around external situations that could be challenging and beyond their capacity.⁶ Coping mechanisms could be either problem, emotion or meaning focused depending on the choices the individual makes. Culture, accessibility to resources and socioeconomic conditions can play an important role in shaping these coping strategies for each individual.

Coping is not very individualistic in collectivistic cultures like the one that is quite normal and prevailing in India and especially rural parts of the country. Distress is usually worked upon through social and community-based practices such as discussing stories, adapting rituals and depending on relatives or community networks.⁷ A greater dependence over informal ways of coping has been observed among individuals who belong to the low-income class as there is less access to professional mental health care services. Offering prayers, receiving direction from religious entities and indulging in devotional offerings makes individuals experience emotional oneness with the higher power and emotional support for deriving sense of their problems.⁸ Inclination towards medicinal relief but not having them prescribed through qualified or formal practitioners has been another way of coping which highlights the lack of understanding towards proper channels to seek psychological help has also been.⁴ There is a striking difference in the ratio of mental health professionals to individuals suffering with psychological disorders or distress and the distance to the nearest psychiatric centre makes it even more non feasible to get formal help.³ The inaccessibility of formal help compels individuals to turn towards informal ways such as faith healers and community networks.^{3,4} Even though the informal ways of help could be more accessible and approachable, they do not have any evidence backed ways of functioning and might even make the suffering more difficult or encourage maladaptive ways of coping such as denial or suppression.^{9,10} There is a vicious connection between lack of awareness, depending on informal ways of coping, believing that external causes are responsible for suffering, stigma and accepting suffering like its normal. This connection usually keeps people away from seeking help that just encourages them to not address their stress.^{11,12} Women are not likely to seek formal help if they do not believe that the central theme of their suffering is psychological and not due to pure fate or luck and the act of god. They fear judgement from the society if and when they have to speak about their emotional concerns.^{13,14} Structural and personal hurdles like these make the rural women population in India the most underprivileged in terms of receiving psychological health services.^{2,5}

Even though there is ample literature on mental health in India, the coping mechanisms and help-seeking behaviours of women in rural northern India still remain understudied and less focused on. The research that exists largely focuses on clinical populations or urban settings, leaving the lived experiences of rural women, particularly those navigating distress without access to formal care, underrepresented in the academic literature. The current study attempts to address this gap by exploring the informal ways of coping, perceptions around psychological distress, and help-seeking behaviours of rural women in Amroha district, Uttar Pradesh. Through maintaining a focus on the voices and experiences of these women through focused group discussions, the

study aims to uncover situation specific and deep insights that can encourage the development of culturally embedded, evidence based psychological interventions tailored to meet the requirements of this underserved population.

Objectives of the study

To explore common stressors and triggers of psychological distress among rural women of Amroha district. To draw an understanding of the views and beliefs about psychological and emotional concerns faced by rural women within the community. To identify how rural women typically cope with their mental health concerns and the nature of support and services available to them in these areas.

METHODS

The present study aimed to explore perceptions of mental health and the coping mechanisms adopted by rural women residing in the Amroha district of Uttar Pradesh, India.

Research design

The study adopted a qualitative exploratory research design to examine the mental health concerns of rural women and their coping strategies to deal with emotional problems. Through focused group discussions (FGDs) with these women, the study sought to identify patterns in coping mechanisms, support systems, help-seeking behaviours, and perceptions around psychological and emotional health.

Study location and sample

The study was conducted in Amroha District, Uttar Pradesh, India- a region characterized by a predominantly rural population and limited to no accessibility to formal mental health services. The study sample comprised 100 rural women, with discussions conducted in groups of approximately 10-15 participants. All participants were above 18 years of age.

Sampling technique

Data were collected through a combination of convenience and snowball sampling. Participants referred their neighbours, friends, and family members for inclusion in the discussions. The sample size reflected thematic saturation and meaningful representation of rural women across the villages studied.

Data collection and analysis

Data for the current study were collected through focused group discussions using a semi-structured discussion guide with 100 rural women between December 2025 and

January 2026 in Amroha district, Uttar Pradesh. Questions were designed to explore participants' everyday mental health concerns, coping strategies, perceptions around help-seeking and mental health, and awareness of available healthcare resources and services. The discussion guide was developed in Hindi, in keeping with the participants' linguistic capabilities and local language. Following data collection, the transcripts of the discussions were subjected to thematic analysis to identify common themes and patterns across all focused group interactions.

RESULTS

Data for the current study were collected through focused group discussions with 100 rural women residing in Amroha district, Uttar Pradesh. Following data collection, the discussion transcripts were analysed using thematic analysis. The comprehensive analysis yielded six themes that collectively illuminate the coping mechanisms, help-seeking behaviours, and perceptions around mental health concerns and awareness among the participants.

Theme 1: burden of responsibilities and emotional burnout

The majority of participants (n=93; 93%) reported working continuously from morning to night, resulting in pervasive exhaustion and emotional burnout. Their accounts reflect the relentless nature of their domestic and caregiving responsibilities:

“Subah se shaam tak lagatar kaam karna padta hai”.

Translation: I have to work from morning to evening without any breaks.

“Subah se shaam tak kaam karne se mann bhot thak jata hai”.

Translation: I feel emotionally exhausted because of working from morning until night.

Theme 2: physiological manifestation of psychological distress

A substantial proportion of participants (n=98; 98%) reported physical symptoms that commonly accompanied their psychological distress, including dizziness, headaches, and elevated blood pressure. These somatic presentations are consistent with the somatization of psychological suffering in the absence of mental health literacy and formal care:

“Jab tension hoti hai, toh chakkar aane lagte hai”.

Translation: I begin to feel dizzy every time I feel stressed.

“Zyada sochne ke kaaran sar mein dard ho jata hai”.

Translation: I get a headache due to overthinking.

“Zyada sochne ki wajah se bp high ho jata hai”.

Translation: My blood pressure usually rises when I overthink.

Theme 3: normalizing chronic stress

A significant number of participants (n=81; 81%) reported having experienced stress over prolonged periods, to the extent that it had become indistinguishable from everyday life. Rather than recognizing chronic stress as a condition warranting attention, these women had come to accept it as an inevitable feature of their existence:

“Badhti umar mein toh pareshaaniya aur tension badhenge hi na”.

Translation: With growing age, it is normal to experience stress and tension.

“Ab itne time se ye stress hai, ki ab pata bhi nahi chalta kab zyada soch rahi hu”.

Translation: I have been experiencing psychological distress for so long now that I no longer consciously realize when the overthinking process begins.

Theme 4: psychological distress due to marital conflict and gender-based adversity

A considerable proportion of participants (n=86; 86%) identified marital conflict as a significant source of psychological distress. Several women reported experiencing verbal abuse from their husbands following alcohol consumption, yet expressed a sense of helplessness regarding their ability to address or change the situation:

“Pati daaru peeke bohot jhagda karte hai jisse tanav bana rehta hai”.

Translation: My husband quarrels with me a great deal after getting drunk, which keeps my stress constant.

“Daaru pee lete hai aur gandi gaaliya bhi dete hai aur tension badh jaati hai”.

Translation: My husband gets drunk and uses abusive language, which only adds to my stress.

Theme 5: resorting to spiritual and informal coping rather than formal psychological care

A large majority of participants (n=93; 93%) reported relying on informal and spiritual methods to manage their psychological distress, with none mentioning recourse to

formal psychological care. Talking to elders, engaging in prayer, and seeking social support from peers were the most commonly cited strategies:

“Bade buzurg vyakti se baatcheet karne se mann shaant mahsoos hota hai”.

Translation: Talking to an elder brings a great deal of calm in times of distress.

“Pooja mein mann lagaane se mann shaant ho jata hai”.

Translation: Diverting my attention to prayers helps me feel more at peace emotionally.

“Aapas mein baithkar aur baat kar ke mann halka ho jata hai”.

Translation: Sitting and talking with others helps my heart feel lighter.

Theme 6: silent tolerance and emotional denial

The accounts of the majority of participants (n=80; 80%) reflected a maladaptive pattern of emotional management characterized by silence, suppression, and passive endurance. Rather than seeking support or articulating their distress, these women chose to internalize their suffering and wait for it to resolve on its own:

“Jitna zyada baat karenge dikkat utni badhi dikhaayi degi isliye chup rehna behtar hai”.

Translation: It is better to keep quiet about problems, as speaking about them only makes them appear larger.

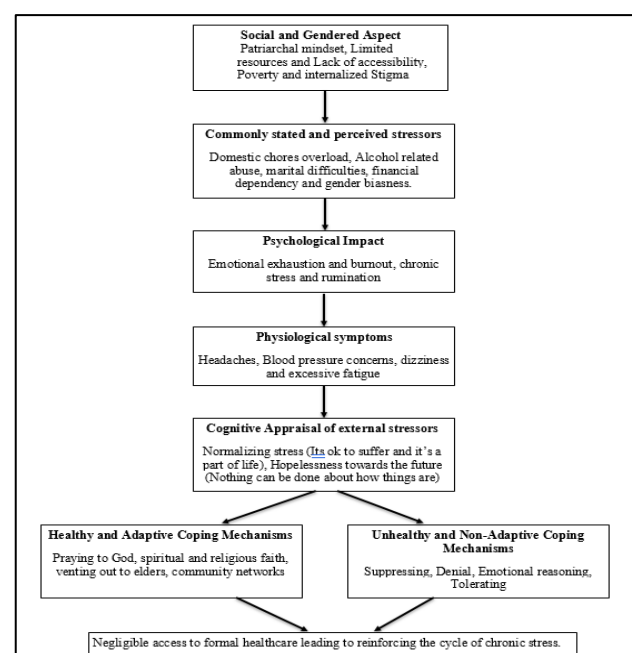


Figure 1: A modular explanation of the themes.

DISCUSSION

The present study sought to explore and understand the informal coping mechanisms employed by women residing in rural Amroha, situated within a broader context of severely limited mental health resources and services. The findings illuminate a complex interplay of systemic neglect, cultural conditioning, and individual-level barriers that collectively shape how rural women perceive, experience, and respond to psychological distress. Factors such as poverty, limited mental health awareness, gender-based discrimination, and the burden of multiple social roles emerged as undeniable contributors to the deterioration of mental health among this population.

A deeper insight into the subjective and lived experiences of these women was achieved through focused group discussions with 100 participants. The discussions surfaced critical dimensions of vulnerability, including marital conflict, excessive domestic responsibilities, and the near-total absence of formal mental healthcare resources. A particularly salient theme was the physiological manifestation of psychological distress, which underscores the extent to which emotional suppression and limited mental health literacy led to the somatization of psychological suffering. These findings are consistent with previous study in which rural women from the Vidarbha region similarly reported somatic symptoms, including chest pain, headaches, and dizziness, without identifiable physical aetiology.⁴

The normalization of chronic stress emerged as a deeply concerning theme, reflecting a broader pattern in which prolonged exposure to hardship is mistaken for an inevitable feature of life rather than a condition warranting intervention. This phenomenon is theoretically consistent with the concept of learned helplessness, wherein repeated exposure to uncontrollable stressors, including marital conflict, constrained autonomy, and financial dependence, engenders a pervasive sense of powerlessness and hopelessness.¹⁵ The themes of chosen silence and emotional suppression further corroborate this interpretation, suggesting that many participants had internalized the belief that their circumstances were immutable and beyond the reach of change.

The predominance of spiritual and informal coping strategies among participants reflects both the cultural salience of religious practice in rural Indian communities and the structural absence of accessible formal alternatives. Spiritual coping encompassing prayer, devotional engagement, and consultation with religious elders served as a primary source of emotional regulation and meaning-making for the majority of participants. The role of spirituality as a coping resource and facilitator of problem-solving is well established in the literature, and its prominence in the present study is consistent with broader patterns of religious coping observed in collectivist, low-income communities.^{9,16} However, it is

important to note that while spiritual and informal coping may provide genuine emotional relief, their predominance in the absence of formal care may also function as a mechanism of avoidance, deferring engagement with psychological distress rather than addressing its underlying causes.

The most pressing concern illuminated by the present study remains the pervasive pattern of chosen silence and emotional suppression as a normalized and socially sanctioned mode of coping. This pattern not only reflects a common adaptive strategy but also speaks to the enduring, unaddressed struggles of rural women that have yet to be engaged through any systematic or institutional channel. While these women have demonstrated considerable resilience through their reliance on informal support networks and spiritual practices, the persistence of emotional suppression and denial points to deeply entangled knots of unresolved distress that informal coping alone cannot adequately address.

CONCLUSION

The study makes a compelling case for the urgent need to raise awareness about psychological health in rural communities, dismantle the stigma associated with mental illness, and establish feasible, culturally attuned mental health resources that are accessible to women in underserved rural areas. Interventions must be designed with sensitivity to the cultural frameworks, belief systems, and lived realities of rural women, integrating community-based support structures, training informal healthcare workers in basic psychological first aid, and challenging the externalised and fatalistic attributions of distress that currently impede help-seeking. Addressing both the systemic barriers of inaccessible services and the individual-level barriers of limited awareness and stigma will be essential to meaningfully improving the mental health outcomes of rural women in India.

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REFERENCES

1. World Health Organization. World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022. Available from: <https://www.who.int/publications/i/item/9789240049338>. Accessed on 3 June 2026.
2. Malhotra S, Shah R. Women and mental health in India: an overview. *Indian J Psychiatr*. 2015;57(2).

3. Kermode M, Bowen K, Arole S, Pathare S, Jorm AF. Attitudes to people with mental disorders: a mental health literacy survey in a rural area of Maharashtra, India. *Soc Psychiatr Psychiatr Epidemiol*. 2009;44(12):1087-96.
4. Gawai JP, Tendolkar SA. Mental health literacy and help-seeking behaviour among rural women in Vidarbha, Maharashtra. *Indian J Soc Psychiatr*. 2019;35(2):136-43.
5. 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*. 2010;39(6):1510-21.
6. Lazarus RS, Folkman S. *Stress, appraisal, and coping*. New York: Springer; 1984.
7. Triandis HC. *Individualism and collectivism*. Boulder (CO): Westview Press; 1995.
8. Pargament KI. *The psychology of religion and coping: theory, research, practice*. New York: Guilford Press; 1997.
9. Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, De Silva M, et al. Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet*. 2007;370(9591):991-1005.
10. Thara R, Patel V. Role of non-governmental organizations in mental health in India. *Indian J Psychiatry*. 2010;52(1).
11. Shidhaye R, Kermode M. Stigma and discrimination as barriers to mental health service utilization in India. *Int Health*. 2013;5(1):6-8.
12. Lauber C, Rössler W. Stigma towards people with mental illness in developing countries in Asia. *Int Rev Psychiatr*. 2007;19(2):157-78.
13. Raguram R, Weiss MG, Channabasavanna SM, Devins GM. Stigma, depression, and somatization in South India. *Am J Psychiatr*. 1996;153(8):1043-1049.
14. Champion J, Bhugra D. Experiences of religious healing in psychiatric patients in South India. *Soc Psychiatry Psychiatr Epidemiol*. 1997;32(4):215-21.
15. Seligman MEP. *Helplessness: on depression, development, and death*. San Francisco: W. H. Freeman; 1975.
16. Krok D. The role of spirituality in coping: examining the relationships between spiritual dimensions and coping styles. *Ment Health Relig Cult*. 2008;11(7):643-53.

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