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UNDERSTANDING AWARENESS, COPING STRATEGIES AND BARRIERS TO MENTAL HEALTH AMONG WOMEN AGED 25-55 IN BENGALURU- AN EXPLORATORY STUDY

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ABSTRACT

Mental health has emerged as a critical component of overall well-being, yet its understanding, acceptance, and accessibility remain uneven across different demographic groups. In the Indian sociocultural context, women occupy complex and multifaceted roles that often expose them to unique psychological stressors while simultaneously limiting their ability to seek help. This qualitative exploratory study aims to examine the awareness, coping strategies, and barriers to mental health among women aged 25–55 residing in Bengaluru.

Findings indicate that while awareness of mental health has increased across all age groups, it is often conflated with general stress or emotional discomfort. There is insufficient awareness of the professional resources available to help. Coping strategies were found to be deeply rooted in cultural and relational contexts, with a strong reliance on family support, spirituality, and avoidance-based mechanisms. Significant barriers to help-seeking include lack of awareness of professional psychological help, stigma, time constraints, financial limitations, and deeply internalized gender roles that prioritize caregiving over self-care.

Keywords: mental health, women, qualitative research, coping strategies, awareness stigma, India, awareness

1. INTRODUCTION

Women in urban settings such as Bengaluru navigate a dynamic interplay of traditional and modern influences. While increased access to education, employment opportunities, and exposure to global discourses has enhanced awareness levels, Bengaluru is also home to NIMHANS—the premier institute for mental health and neurosciences. The presence of NIMHANS has created a mental health ecosystem. However, deeply rooted cultural norms continue to shape attitudes toward mental health. Women are often

expected to embody resilience, self-sacrifice, and emotional endurance, which can lead to the normalization of psychological distress and the suppression of help-seeking behaviors.

Coping strategies refer to the cognitive and behavioral efforts employed by individuals to manage stress and adversity. In collectivist cultures like India, coping is often relational and community-oriented. Women frequently rely on informal support systems such as family members, friends, and religious practices.

Barriers to mental health care operate at multiple levels—individual, interpersonal, and structural. At the individual level, lack of awareness and internalized stigma can prevent recognition of psychological distress. Interpersonally, fear of judgment and lack of support from family members can discourage help-seeking.

Despite increasing attention to mental health, there remains a gap in understanding how women in urban Indian settings experience and navigate psychological challenges. Much of the existing research relies on quantitative methods, which, while valuable, may not fully capture the depth and complexity of lived experiences. This study adopts a qualitative approach to address this gap, allowing for a detailed exploration of participants' perspectives. By focusing on awareness, coping strategies, and barriers simultaneously, the research provides a comprehensive understanding of mental health among women in Bengaluru.

2. REVIEW OF LITERATURE

2.1 Mental health awareness and literacy

Women's mental health represents a particularly salient subfield within this broader domain. Women experience higher rates of certain internalizing disorders such as depression and anxiety compared to men, a disparity that has been consistently documented across diverse cultural contexts (WHO, 2005). In India, the National Institute of Mental Health and Neuro Sciences (NIMHANS) has reported elevated prevalence of depression and anxiety-related conditions among women, attributable to a combination of hormonal factors, gender-based stressors, and social role demands.

The concept of coping refers to the cognitive and behavioral efforts individuals employ to manage the internal and external demands of stressful situations. The foundational transactional model of stress and coping developed by Lazarus and Folkman (1984) remains the dominant theoretical framework in this domain, distinguishing between problem-focused coping (efforts directed at changing the stressor itself) and emotion-focused coping (efforts to regulate emotional responses, including seeking social support, acceptance, or engagement in spiritual practices). Subsequently meaning-focused coping and avoidant coping, characterized by denial, withdrawal, or substance use have been added as well (Carver, 1997).

2.2 Coping and help-seeking

In Indian contexts, the coping landscape is significantly shaped by collectivist cultural values that emphasize family cohesion, social harmony, and religious or spiritual orientation. Rao and Thomas (2022) examined spiritual coping among midlife women in India, documenting that prayer, temple visits, meditation, and engagement with religious community constituted primary coping resources for this demographic. The authors argued that spiritual coping in this context functions not merely as emotion regulation but as a mechanism for meaning-making—enabling women to interpret adversity within a framework that provides deeper understanding and community belonging.

Stigma surrounding mental illness—encompassing social stigma, self-stigma, and structural stigma—remains among the most powerful barriers to help-seeking in India. Shidhaye et al. (2020) conducted a systematic review of mental health stigma interventions in India, documenting that stigma is deeply embedded in everyday social interactions and that women are particularly vulnerable to its consequences. Women who seek psychological help risk being labeled as 'weak,' 'unstable,' or unfit for marriage—judgments with material consequences in social contexts where feminine identity is closely bound to familial roles and relational protocols.

2.3 Barriers and stigma in the Indian context

For women bearing substantial caregiving responsibilities, the time demands of professional help-seeking may themselves constitute a significant barrier. Menon and Pillai (2022) documented that role overload among midlife Indian women—arising from the simultaneous demands of childcare, elder care, marital obligations, and employment—limited both the time and psychological energy available for self-care. Cultural norms that valorize female self-sacrifice, emotional stoicism, and the prioritization of family well-being over personal needs further constrain help-seeking.

3. METHODOLOGY

3.1 Research design

The methodology chapter forms the backbone of any research study more so in qualitative research, methodology assumes even greater importance, as it establishes the credibility, depth, and interpretive richness of the findings. The present study adopts a qualitative exploratory approach to investigate mental health awareness, coping strategies, and barriers among women aged 25–55 in Bengaluru. It was felt that a qualitative framework is particularly suited to capturing the complexity and nuance of participants' lived realities.

Unlike quantitative approaches that seek to measure and generalize, qualitative research aims to understand meanings, interpretations, and lived experiences. Mental health, particularly within the sociocultural context of India, is not a static or universally defined construct. It is shaped by language, relationships, cultural beliefs, and individual experiences. Therefore, a qualitative approach enables the researcher to explore how participants themselves conceptualize mental health, rather than imposing predefined categories.

3.2 Participants and sampling

The study is informed by a social constructivist perspective, which theorizes that knowledge and meaning are co-created through social interactions and cultural contexts. From this standpoint, mental health is not merely an internal state but a socially mediated experience, coping strategies are shaped by cultural norms and relational dynamics, and barriers to help-seeking are embedded in societal structures. This orientation guides both data collection and analysis, ensuring that participants' voices remain central to the interpretation.

The study includes 10 participants across each of the three age groups (N = 30), consistent with qualitative research norms that prioritize depth over breadth. This sample size is considered sufficient to achieve thematic saturation, capture diverse perspectives, and allow for detailed analysis.

3.3 Data collection procedure

A purposive sampling technique was employed to select participants who could provide rich, relevant, and meaningful data. Criteria for selection included women within the specified age range, residents of Bengaluru, and willingness to share personal experiences. Purposive sampling ensures that participants are not randomly selected but chosen based on their ability to contribute to the research objectives.

Data were analyzed using thematic analysis, following the framework proposed by Braun and Clarke (2006). This method is widely used in qualitative research for identifying, analyzing, and reporting patterns within data.

3.4 Data analysis

The methodology adopted in this study is designed to capture the complexity of women's mental health experiences in a culturally nuanced manner. By employing a qualitative, exploratory approach and thematic analysis, the study provides a robust framework for understanding awareness, coping strategies, and barriers.

4. RESULTS

4.1 Theme 1: Awareness and Conceptualization of Mental Health

Awareness emerged as a foundational theme influencing how participants perceived, interpreted, and responded to basic understanding of mental health. While most participants demonstrated some level of familiarity with the concept, their understanding was often fragmented, simplified, or shaped by cultural language rather than clinical knowledge.

A dominant pattern across responses was the tendency to equate mental health with 'stress,' 'tension,' or 'overthinking.' Participants often described mental health in everyday language rather than psychological terminology. Emotional distress was normalized and framed as a routine part of life rather than a condition requiring attention. This reflects a cultural translation of psychological concepts, where complex mental health conditions are reduced to familiar, socially acceptable terms. While this makes the concept accessible, it also minimizes severity, delays recognition of disorders, and reduces the likelihood of seeking professional help. This finding aligns with existing literature indicating that mental health literacy in India often remains at a surface level (Pillai et al., 2022).

4.2 Theme 2: Gendered Perspective on Mental Health

The study identifies three distinct generational perspectives on why women face unique psychological challenges. Women aged 25–35 focused on cognitive and hormonal sensitivity, citing the 'pressure to prove equality with men' as a primary driver of stress, alongside habitual rumination and overthinking. Women aged 35–45 were characterized by the 'Superwoman Syndrome,' experiencing acute pressure to manage professional and domestic roles perfectly, compounded by hormonal imbalances. Women aged 45–55 reported distress rooted in structural inequality, including emotional burdens from caregiving roles and a lack of financial independence despite bearing significant responsibilities. Women across all groups described managing multiple roles simultaneously, leading to chronic stress, fatigue, and neglect of self-care.

4.3 Theme 3: Coping Strategies and Help-Seeking Behavior

Coping strategies emerged as a central theme reflecting how women manage stress and emotional challenges. These strategies were deeply embedded in cultural, relational, and personal contexts.

A significant number of participants reported turning to family members, friends, and close social networks for emotional support. This highlights the collectivist nature of coping in Indian society. Social relationships serve as primary support systems, often replacing formal mental health services. While beneficial, this reliance may also limit professional intervention and reinforce normalization of distress.

Participants frequently reported coping through ignoring problems, engaging in distractions such as work and household tasks, and suppressing emotions. These strategies reflect avoidance coping, which is commonly observed in high-role-burden populations. While effective in the short term, avoidance prevents emotional processing and increases long-term psychological distress.

4.4 Theme 4: Barriers to Help-Seeking

Barriers to help-seeking emerged as one of the most significant themes, highlighting the gap between experiencing distress and accessing support.

Participants expressed concerns about being judged, being labeled as 'weak,' and the impact on family reputation. Stigma operates as a powerful deterrent, particularly for women whose social identity is closely tied to family roles.

5. DISCUSSION

The analysis revealed notable generational differences in attitudes toward mental health. Younger women demonstrated greater openness, awareness, and willingness to discuss mental health openly. Older women were more reserved and held more stigmatized views, often normalizing distress as a part of life. This reflects a transitional shift in societal attitudes, with increasing acceptance among younger generations, while older generations remain influenced by more traditional frameworks.

Table 1

Comparative Perspectives on Mental Health Seeking Among Women

Variable	Age 25–35	Age 35–45	Age 45–55
Willingness to seek help	High; seen as self-investment	Moderate; requires crisis to initiate	Low; done secretly or for children only
Stigma perception	Present but openly discussed	Strong; something seriously wrong	Severe; fear of huchchu label
Digital coping	Instagram/LinkedIn; therapist-influencers	Facebook/WhatsApp; social connection	WhatsApp/YouTube; spiritual wellness content
Enablers	Peer support; social media awareness	Financial independence; personal resilience	Supportive family environment
Service suggestions	Community spaces; expressive arts	Women-led awareness networks	Counseling in public offices; school programs

6. SUMMARY/CONCLUSION

The present study underscores that mental health among women in Bengaluru is not merely an individual phenomenon but a socially embedded experience shaped by gender roles, cultural expectations, digital influences, and systemic factors. Awareness has increased—partly driven by social media—but remains insufficient in depth and application. Coping strategies are heavily influenced by cultural norms and often prioritize relational harmony and spiritual meaning over evidence-based intervention. Significant barriers—particularly stigma, role burden, time poverty, financial dependence, and cultural skepticism toward professional care—continue to restrict access to formal psychological support.

Across all groups, family support remains foundational, formal mental health systems remain underutilized, and there is a clear need for a shift from awareness to action, from informal coping to adaptive strategies, and from silence to open dialogue.

7. IMPLICATIONS OF THE STUDY

The study contributes to the existing body of knowledge by providing a qualitative, culturally grounded understanding of women's mental health in urban India. The identification of the 'Social Risk Assessment' as a distinct help-seeking barrier, and the documentation of social media's dual role, extend existing theoretical models in meaningful ways.

The findings call for culturally sensitive therapeutic approaches that engage with Indian family systems rather than positioning individual autonomy against collectivist values. Interventions should build on existing relational and spiritual coping frameworks.

The awareness-utilization gap identified for Tele-MANAS and DMHP services calls for targeted outreach campaigns. Mental health services must be decentralized and de-medicalized, integrated into existing social structures such as workplaces and community centers. Digital platforms should be harnessed for structured, evidence-based mental health communication, particularly given their demonstrated reach among younger urban women.

8. LIMITATIONS

Coping strategies employed by participants were found to be deeply embedded in cultural and relational contexts. The most commonly reported strategies included seeking emotional support from family and friends, engaging in religious or spiritual practices, using distraction or avoidance mechanisms, and suppressing emotional expression. While these strategies provided immediate relief, many of them were passive or avoidant in nature, potentially limiting long-term psychological well-being. The reliance on informal coping mechanisms reflects both the strength of social support systems and the lack of engagement with formal mental health services.

The study identified several barriers that prevent women from accessing mental health support. Stigma—manifesting as fear of judgment, labeling, and social consequences—emerged as the most significant barrier, with mental health issues often associated with weakness or instability. Role burden and time constraints limited women's ability to prioritize their own mental health. Financial constraints and the perceived cost of therapy constituted additional deterrents. Participants often lacked knowledge about where and how to seek professional help. These barriers were not isolated but interacted with one another, creating a complex system of constraints.

9. FUTURE RESEARCH

This chapter presents a comprehensive synthesis of the study, integrating findings with the research objectives and existing literature. It outlines the key insights derived from the analysis, provides a nuanced conclusion, and offers detailed recommendations at multiple levels. The chapter also highlights the implications of the study for research, practice, and policy, followed by suggestions for future research.

The findings have important implications for mental health practitioners, including the need for culturally sensitive therapeutic approaches, the importance of integrating family systems into intervention, and the emphasis on psychoeducation and awareness building. A 'one-size-fits-all' approach to women's mental health is insufficient: while younger women require skill-based intervention, older women require systemic validation and the removal of associated stigma. Future policies should focus on integrating mental health into existing social structures—such as offices and community centers—to normalize care as part of everyday life.

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