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Women's Mental Health in Contemporary India: Resilience Through Institutional Reform

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ABSTRACT

Categorically and consistently, problems plaguing women have always been nonexistent, or magically nonexistent, and thus had to take a back seat in getting resolved. From a myriad of problems faced by women in contemporary India, if one were to focus on the mental landscape of psychological distress, it would be evident that these are shaped by gender norms and expectations. These norms, expectations and moral policing that women are forced to experience, result in gender based violence, socio-economic inequality, lack of support in familiar duties and roles, as well as in occupational settings. COVID 19 has further intensified these challenges. Even with the attention and changes recommended by the policy makers, psychological struggles of women remain often unheard or marginalised. This paper aims to understand how psychological resilience is or can be developed and maintained for long term in India for women. The paper aims to also analyze initiatives like Nae Disha, Girl First, and others state projects to improve women's health and resilience. The paper argues, further, that psychological resilience cannot simply be understood only in the individual's capacity and strength to endure or deal with distress; it must be seen as community-based support and support the interventions aimed at improving resilience. To foster long term well-being and psychological resilience, mental health support systems need to be set up to be free of bias and prejudice, easily accessible, and sensitive to women's specific life contexts, which in turn will improve recovery and actively support them. An approach that demands changes in the current system to mental health must address the structural inequalities, ensure consistent care, prioritize emotional realities of women; and it must be added that access to such services is must for policy makers and executions of such policies.

Keywords: *resilience, gender bias in mental health, institutional response*

Introduction

Historically, mythologically, and in every other manner of retelling of the past that is controlled by any authority on what gets passed on to the next generation, women's problems and issues related to their overall well-being have not gained any importance; they either magically disappear or are considered to have never existed. In the twenty-first century India, women continue to be forced to adhere to expectations shaped by gender norms, moral policing by

people of different age and gender, and deal with the uneven power structures at home and outside of it. With the novel coronavirus pandemic of 2019, people across the globe were locked in their own homes and had restricted movements. This led to people being left with limited social interactions and physical and mental feelings of being caged. These restriction movements, that were necessary and quite literally life saving, led to social isolations that were physical in nature, further reducing the amount of social support people were used to. The social support was reduced to a limited or completely not available as such for women across the globe following the social isolation and other pandemic protocols. Several researches prior to the pandemic had found that social isolation to have had an adverse impact on overall health and well-being (House, 2001; Cacioppo, 2014; Leigh-Hunt & et al, 2017). Social isolation, coupled with the proceeding impact of it on society caused a domino effect, one of them being mental health concerns and overall deterioration of it in the populace. The addition of social distancing, lack of or no social support, and lack or ease of availability of day-to-day goods, made Indian women a particularly vulnerable group with mental health becoming a growing health challenge. Women in India (and around the world as well) who typically face gendered stressors like being the sole caregiving for the entire family or one or two medically inept individuals, discrimination and/or harassment at workplace, lack of or limited autonomy, domestic violence, financial abuse, to name a few. This distress is normalized, silenced, or sadly glamorized in the media, with little to no long lasting solutions that may aid their safety or well-being. General health systems, much less mental health, are not satisfactorily tailored to their actualities and difficulties. To put it plainly, the health systems existing in India are gender blind to the circumstances faced by women. This often results in them becoming a vulnerable group which is expected to suffer and / or cope silently.

Resilience, as defined by Masten (2001), refers to the ability to adapt positively despite adversity, gaining importance. Psychological resilience, as popularised by Emmy Werner and taking the definition of Sisto et al, is the ability to adapt positively to life conditions. It is, thus, a dynamic process that evolves over a period of time, and may involve more than just the individual, and is definitely a fixed personality trait. However, when resilience is treated merely as an individual's capacity to "stay strong," it risks blaming women for not coping, while ignoring the structural and social pressures they face. Feminist scholarship argues that resilience for women cannot be separated from questions of access, equity, and justice. Today, the persistence of neglect is evident even in academic scholarship: Vindhya (2007) notes that

psychological research in India has historically sidelined women's mental health, work and family stresses, and violence, often leaving these to be studied by advocacy groups rather than mainstream researchers. Her critique underscores the need for scholarship that not only includes women's experiences but interrogates the structural and gendered contexts that shape them. She further purports that women's "psychological disorders often go undiagnosed and untreated" largely because of persistent gender norms, responsibilities, and violence, thus pointing to the necessity of contextual, justice-oriented approaches rather than individualizing distress. This strengthens the rationale of the paper: exploring resilience among women in India must go beyond individual traits to consider the structural, cultural, and institutional gaps that have long rendered women's mental health invisible.

This paper positions resilience as a relational and systematic construct, rather than personal strength. This is made possible by the presence or absence of supportive communities, accessible care, and policies that are providing equity. This becomes even more pertinent when we see the national trends in suicides linked to mental illness in India; the numbers have surged by 44% between 2018 and 2022, with the pandemic years driving the steepest rise. 2020 alone saw a 25% increase over 2019, followed by another 6% uptick by 2022. Strikingly, housewives consistently constitute a significant share of female suicide victims. In 2021 and 2020, they represented over half of all female suicides, with NCRB data showing percentages ranging from 50% to 54% across multiple years. Research attributes this to a complex interplay of economic dependence, gendered expectations, domestic abuse, early / arranged marriage, and chronic lack of autonomy or recognition. It should be noted that experts caution that women's suicides are often underreported, misclassified as accidents or concealed due to stigma and legal concerns (e.g., dowry-related pressures).

Theoretical Framework

Psychological resilience is no longer understood as merely a personal characteristic-it reflects a dynamic process shaped across multiple levels: individual, family, community, and broader society. Experts now agree that resilience involves not just internal strength but the surrounding support and resources that help people cope and adapt (Southwick & Charney, 2012; Masten, 2021). At the micro level, factors like optimism, self-efficacy, adaptive coping, and even biological or neural responses help individuals navigate adversity. These include mechanisms

such as emotion regulation, problem-solving skills, and positive personality traits, which enable resilience to manifest (Carver, 1998; Southwick, Vythilingam & Charney, 2005). At the macro level, environmental influences, such as supportive family environments, access to education and healthcare, community cohesion, and societal norms or policies, play a pivotal role. The mentioned systems work to either reinforce or weaken individuals' abilities to withstand hardship (Ungar, 2011; Masten & Barnes, 2018).

Other models, such as the multisystemic and psycho-social-ecological approaches, explain that resilience rises when an individual's personal abilities are connected effectively with their social networks and the environmental conditions (Ungar et al, 2021); thus effectively citing multiple sources and parts of community in personal growth and maintenance of that growth as well as well-being.

Another important concept of resilience is the Pathway Diversity. This emphasizes that all individuals benefit from having multiple options and strategies to adapt to changes happening in real time. This means that resilience thrives when people can shift paths in response to evolving challenges; that is when an individual can integrate personal choices with external resources over time (Lade, Walker & Haider, 2019). In other words, there is no right or wrong way, or rather one single manner in which an individual could adapt, cope or recover. One can build resilience using different strategies, depending on their situation, available resources, and personal strengths and social connections.

The feminist perspective talks about how women's mental health and resilience are deeply shaped by entrenched socio-cultural structures. These include domestic responsibilities, gender-based violence, and limited agency of coping. In the Indian context, these forces are further compounded by caste, class, and religious identities. As Undurti vividly argues in "Mental Health of Indian Women: A Feminist Agenda" and the edited volume "Mental Health from a Gender Perspective", where it is observed that focus has always been solely on individual coping over what is actually the systemic roots of distress. Meaning instead of focusing on what is wrong, it needs to shift to what is happening or what has caused the distress from its roots. These systematic roots are often shifted to the background, and blame is placed on the woman - something is wrong with her instead of something wrong has happened to her.

And while focusing on symptoms provides relief, Undurti argues against stopping here, and treat the disease itself.

Similarly, her 2007 review, "Quality of Women's Lives in India" highlights just how much psychological research has historically marginalized women's struggles. She instead calls for research that engages critically with gender-based oppression (Undurti, 2007). As dealing with systematic roots that cause mental anguish and hinder the overall well-being of women, is to change the narrative that it is the individual that is broken and needs to be fixed, and focus on systems with societal structures and norms, as well as those who uphold them with rigidity.

Finally, institutional and community systems play a decisive role in sustaining resilience. Individual capacity alone is often insufficient; people need reliable structures for support and recovery. For example, grassroots organizations like the MINDS Foundation in India utilize a three-phase model, education, free treatment, and reintegration, to foster resilience in rural settings by integrating community engagement with affordable care. The MINDS Foundation (Mental Illness and Neurological Disorders) adopts a three phase, research-informed approach to reduce stigma and improve mental health in rural communities of Gujarat. Their model is highly effective because it blends education, treatment, and community reintegration in a seamless, context sensitive way.

Similarly, state led initiatives such as Maharashtra's Udaan program, which is a a collaboration between Tata Trusts and the state government, leveraged ASHA workers for door-to-door mental health screenings, outpatient care, and counselling, thus achieving a full recovery rate of 66% and vastly improving rural access to mental health services. Udaan includes a technical support unit that provides training, data systems, and policy analytics to improve mental health governance statewide. Both programs highlight that psychological resilience flourishes when supported by community and institutional systems, not merely with only individual effort.

Mental Health Trends

The data gathered by the National Mental Health Survey, 2015-16 - Summary Report by Ministry of Health and Family Welfare, Government of India, which is one of the most comprehensive sources on India's mental health landscape, shows that more than 10% of

Indian adults experience mental health issues. Yet about 70–90% of those affected do not receive treatment. Suicide trends reflect the severity of the crisis. Between 2018 and 2022, suicides linked to mental health issues rose by 44%, with 3 out of 5 occurring in the 18 - 45 age group, particularly vulnerable demographic. In 2022, India recorded approximately 171,000 suicides, a 27% increase since 2018, and the highest rate in over a decade.

The picture is further complicated by intersectional factors. Women in middle age (40-59 years) report higher rates of mental disorders, yet access to care remains limited. The state-level variations, often linked to class, caste, religion, and rural–urban divides, influence both distress and care-seeking behaviour. Studies also show that nearly one-third of ever-married women (aged 18-49) experienced intimate partner violence (from here on: IPV) in the past year, with physical violence being the most common form (approximately 28%) followed by emotional (approximately 14%) and sexual violence(approximately 6%). IPV has been found to have strong correlates with depression, anxiety, and suicidal ideation, not just in india but also globally (Beydoun et al., 2012; Devries et al., 2013; Chandra et al., 2009; Vachher & Sharma, 2010). Meanwhile, structural barriers like stigma, social pressure, and financial dependence, can further hinder help seeking behaviour.

The novel coronavirus pandemic further escalated these vulnerabilities. Reports from the National Commission for Women (of India) show a significant rise in domestic violence complaints during lockdowns, and global data shows the same (National Commission for Women, 2022; UN Women, 2020; Wenham et al., 2020). Coupled with global data and gendered analyses, research confirms that lockdowns disproportionately increased women's unpaid burdens, like those of care - care of children, elderly, household, medical emergencies, and adding further to the already existing emotional stress and burnout. Meanwhile, with the economic turmoil, high turnovers, and reduced ease of availability of commodities, and mobility restrictions further isolated women from support systems that could have helped in sharing and reducing the burdens. The support systems spoken here are the informal support system like family, friends, neighbours, community members like vendors and so on.

Maternal mental health is another high-risk area when considering women's mental health and well-being. Recent reviews estimate that postpartum depression affects 19-22% of new

mothers in India (Upadhyay et al, 2023), with higher rates in southern states (approximately 26%) and lower in northern regions (approximately 15%). Despite such high rates, postpartum depression is largely undiagnosed or untreated, in most of the health systems.

Women between the ages of 18 to 45 are often balancing multiple concerns; early career aspirations, identity formation, building a family, and caregiving responsibilities that need balancing with education and / or careers. It would be imperative to address these as building blocks of future mental health and well-being. A 2021 survey during COVID 19 found that women reported significantly higher psychological distress (about 66%) compared to men, particularly those aged 21-35 (Verma et al, 2021). When we talk about the stressors experienced by this age group, they include multiple, ever increasing and consistent domestic responsibilities, information overload because of access to the internet as well as social connections, and this may not reflect the reality or necessity, and also perceived or actual lack of opportunities. A recent study done in LM College of pharmacy in Ahmedabad, found that 44% of young adults (18-40) experienced poor sleep, and this was strongly linked to high stress levels and excessive screen usage before bed. Poor rest, in turn, contributes to anxiety and further irritation.

The lockdowns led to house arrest for many women as well as added roles of being a full-time caregiver, that was often without support from others or break from, in the form of schools for children, office for spouse, or aid from the domestic help. This added burden has been found to have given rise to increase in anxiety felt, experiencing exhaustion more frequently, and overall emotional distress. Data from the Indian National Commission for Women has shown that there was a more than 100 percent increase in domestic violence complaints when compared to previous years to the early lockdown phase. This only shows the compounding fear and stress many women faced as they were confined to unsafe homes. A 2023 study published in Indian Journal of Social Psychiatry stated that the closure of schools and childcare centers left working mothers juggling not only work from home demands, but also caregiving. It stipulates further that the pandemic caused women's mental health to be compromised since there was a higher burden of mental health issues in women than men (Das et al., 2023). In order to meet the demand, many women opted for or were forced to reduce working hours, quit jobs, or fired, leading to financial stress, emotional fatigue, and overall reduced self-esteem.

Also, there was a significant increase in pregnancy and perinatal stress experienced during the pandemic. A large study on the psychosocial impact of covid-19 in India revealed a significant gender disparity. The research identified key risk factors that predicted the worst mental health outcomes during the pandemic, with female gender and a homemaker were major predictors. This only highlighted the immense psychological pressure placed on women managing household and also caregiving duties during lockdown (Mani et al, 2023).

The conclusion drawn from these research and data highlights that the women between the ages of 18 to 45 are a particularly vulnerable group to mental health challenges, and these challenges seem to be amplified by societal, economical, and added pandemic burdens. Addressing the needs requires a system built and supported by empathetic and broadened mental health policies, gender sensitive support systems, accessible and affordable care, and social structures to uphold these with an open mind. This is highly required for this at-risk, high-risk, and overlooked vulnerable group.

Institutional Responses, Gaps, and Recommendations

The first mental health institutions in India were established by the Britishers to cater to their European soldiers and only later, much later, extended to Indians. While the establishment was acknowledging mental health and need for caring for it, these institutions mostly prioritized containment over actual care a patient may need. This only reinforced stigma towards mental health and promoted isolation as an actual cure/method of dealing with mental health crises.

With the Indian Lunacy Act of 1912, there were regulatory norms, renamed “lunatic asylums” as “mental hospitals,” and shifted authority from police to medical officials. It also aimed to systematize admission and discharge procedures. However, the institutions remained custodial and detached from community contexts. Women with mental illness were particularly vulnerable to involuntary institutionalization, often subjected to neglect, abuse, or being labeled mentally unstable without proper assessment. This reflects broader patriarchal control within institutional systems. Many were admitted not just for medical reasons but due to family disputes, domestic violence, or social stigma. In some cases, women were labeled “mentally unstable” without proper clinical evaluation, often as a way to control their property, inheritance, or behaviour. Women, particularly those experiencing social or familial conflicts,

were often confined without substantive medical assessment, reflecting how psychiatric labels could be wielded to control or silence them (Potdukhe et al., 2023). A study published in Community Mental Health Journal (2023), by Bhattacharya, Camacho, & Lukens, states that women admitted to psychiatric institutions frequently encounter intersecting marginalizations, stemming from gender, lack of family support, and economic hardship, that not only does it lead to institutionalization, but also greatly hinders their reintegration into the society and community at large.

Over the last two decades India has expanded both legal protections and mental-health programs. Yet gaps remain between laws on paper and services on the ground. Two key legal frameworks matter for women's mental health - Mental Healthcare Act (MHCA) 2017 and Protection of Women from Domestic Violence Act (PWDVA) 2005. This act is a right based law that has been made to guarantee access to mental health care, protect patients' rights, and aims to reduce discrimination against those with mental health conditions and disorders, among other positive changes required in health systems. This act made sure there is proper government planning and budgets are allotted where there is requirement for services and care. Though it has many positive points, the implementation has been quite slow and uneven in different states, with some states yet to be notified of full act and the action required, and in some, appropriates resources to be in place. Similarly, PWDVA provides civil remedies, various protection orders, and support services that include shelter, medical aid, and legal aid, for women who are victims of domestic violence, a growing concern in India. This as well has found inconsistency in terms of access to protection, functioning shelters and aid that is given on time, throughout states and districts. The National Mental Health Programme and District Mental Health Programme were created to integrate mental health into general health services. The aim for these programmes was to decentralize care to primary health centres, but found limited human resources, training, and drug supplies.

The Indian government tried with multiple partners to aid these shortages and to expand providing access and care quickly and to remote places and launched a few programmes. One of them was the national helpline during covid 19 crisis to reach out for mental health care. The KIRAN helpline that is a mental health rehabilitation helpline, and TeleMANAS that sought to provide support all around the clock and was available in multiple languages. Though

these helplines were immensely helpful in providing aid, telephone support is not enough. It can also not replace the local and ongoing care, especially for women who require safe, private spaces to be able speak about or disclose abuse or chronic stress.

There are other state programmes for women's health, increasing resilience and well-being that have shown positive response. Like Udaan in Maharashtra integrates mental health into primary and community care. The programmes function by having door to door screening by ASHA workers, training the local staff at the primary health centers, providing outpatient services, home counseling, and leading awareness drives in the community. It has managed to screen a significant number of people, thus helping in treatments of thousands, and reported significant recovery rates in all of its pilot districts. Similarly, the MINDS Foundation, operating in Gujarat and now has plans to expand into other states, combines educating the community, screening, free treatment, as well as providing rehabilitation into a program that has helped transform lives. Their model emphasizes that local awareness is needed to reduce stigma for seeking help.

Nae Disha is a community and group-based resilience and mental health curriculum for adolescents and young adults, designed to improve mental health literacy and build resilience. The evaluation of the pilots in Dehradun found significant improvements in reports of anxiety, depression and strong support for gender equality. However, some studies note that gains in self-efficacy can fade without sustained follow - up or community linkages. Nae Disha shows that short, peer-led programs can help, especially in low- and middle-income resource urban settings, if they are followed by ongoing support.

The Girl First programme in the rural districts of Bihar implemented, through randomized control trial, a resilience and health curriculum with adolescent girls. The results from the trials showed improvements in psychosocial outcomes and physical health, especially when they were combined with health education. This just proves that school and curriculum-based approaches can be promising in building long term protective skills.

The mentioned programmes have their own pros and cons, and more crucially, missing one or the other point. While short term and small group programmes are sustainable and scaleable,

without state finance or a dedicated budget from the center, the gain will not reach women nationwide. Government programmes miss out often the most marginalized population, women who belong to the adivasi, Dalits, migrant, sex workers, LGBTQ+, and/or in remote areas. Programmes that are conducted in schools or urban areas, leave out the girls who dropped out and/or older girls/women. While legal protection exists, mental health and protection services are poor at the local level. Women escaping violence need safe housing, medical and legal aid, trauma informed care/psychotherapy, all together. And this integration is rare to find in India. Primary care staff and ASHAs need more systematic mental-health training and supervision to handle complex cases, including gender-based trauma.

While short term and group programmes show benefits, resilience requires ongoing social, economic and other support like earning livelihood, childcare and sustained counselling. Supporting sessions that are linked to local services and communities being involved are often absent.

For long lasting resilience in women, India needs to move the successful pilots to step-by-step scale, that is, to fund state adapting proven programmes to integrate mental health with women's protection and other services, train and support frontline workers, and target the most excluded groups with inclusive cultural and linguistic diversity. Programmes like Udaan, MINDS Foundation offer roadans, and Nae Disha and Girl First prove how school and curriculum design can build resilience. The scaled-up versions will require political will, budgeting, long term planning, and training. Resilience flourished when women have supportive environment. School, college, women's groups (Mahila mandals), and community centers provide safe spaces where skills are practiced and social bonds are strengthened, thus providing a safety net. These mentors, educators, and peers trained in building resilience require sustainable and culturally relevant efforts. Psychological resilience isn't an inner trait, it grows with the environment, support system and opportunities. For women in India, resilience is best fostered when community, education, and tailored support are provided at the right time. In communities, peer support systems (like women's self-help groups, activity groups) offer mutual understanding, form of group therapy, and sharing of resources. Adding mental health into these structures aids in reaching more people and reducing stigma. When a community actively engages in improving mental health, resilience is strengthened. Take for

example, when peer groups and local activity clubs offer safe space for women to share their experience and problems, this normalises de-stressing and helps in modelling healthy coping strategies. Peer support of this kind is powerful in informal settlements, rural and remote areas where formal services are not always available.

Women's groups, like Mahila Chetna Kendras, or activity groups, like Mahila Samaj or Mandals, that incorporate mental health dialogue with advocacy help build confidence, know their rights and how to access them. These communal bonds create emotional safety and mutual aid. Volunteer networks, where civilians/citizens volunteer and can be trained to recognise mental distress, adds a layer of local trust and aids early detection and prevention.

School-based resilience programmes (Nae Disha, Girl First) teach young girls and women to identify emotions, deal with stress, resolve conflict and know how to self-care. Using educational institutes opens both knowledge and possibilities as well structures to be used to practise. Schools that include resilience in its curriculum help students develop lifelong coping skills. Literacy (including financial, health, and legal) and empowerment classes for adults helps include out of schoolgirls and/or older women. Training, upgrading and support for frontline workers helps long term. For example, empowering and supporting teachers, Anganwadi workers, community or youth leaders that openly speak about mental health and health seeking behaviour by promoting awareness of schemes and access to them. This ensures that when there is a need, someone knows how to respond.

Community and education help, but for some women, they require case specific care, targeted programmes and follow up, for example, women who have faced IPV required trauma counselling, for those who have been financially abused require financial literacy, training, and opportunity to be financially independent.

Community and education help widely, but some women need case-level care, targeted follow-up for their unique situations like; Trauma-informed counselling, where women facing intimate partner violence, abuse, or severe distress benefit from counselling that understands trauma, avoids blaming, and builds safety and self-worth. Practical support and psychological support

aren't separate tasks, while aiding women from low-income groups, they are interconnected and resilience is strongest when they are combined.

And finally, a follow up mechanism, where regular follow up helps stabilize gains.

Recommendations

To take these building blocks from isolated projects to mainstream impact, here's what our strategies could include

- Adopt proven models into government schemes: Scale up Nae Disha and Girls First resilience curricula within state education boards. Make them part of standard school programs, especially in low-resource urban and rural settings. Expand Udaan and MINDS models through the NMHP and embedding mental health screening and community reintegration into primary health systems.
- Fund community resilience hubs: Establish "Resilience Hubs" in local communities, ideally co-located with Mahila Kendra or Anganwadi centres, staffed by trained peer counselors, with links to health and legal services. Support women's self-help groups to run mental health awareness and support circles.
- Train frontline workers and teachers: Incorporate mental health modules into ASHA, Anganwadi, and schoolteacher training. They can detect early distress signs, provide basic support, and refer to complex cases. Offer refresher training and mentorship via digital platforms or district mental health teams.
- Create multi-service referral systems: Link mental health, domestic violence response, maternal health, education, and livelihood services so women can access comprehensive help through one entry point. Use District Mental Health Program teams to coordinate this inter-sectoral support.
- Ensure follow up and sustainability: Design interventions with built-in follow-ups, for example, peer support circles, booster sessions for school programs, etc. Also planning and budgeting programs for multiple years, instead of just one semester or year, and that too not just from one grant. This ensures robust and continued resilience.
- Focus on equity and data tracking: targeting outreach to marginalized groups by tracking service access by gender, caste, and region. Disaggregate mental health data in routine surveys to measure reach and adjust policy as needed.

By investing in community, education, and case-level supports, and weaving them into existing policy structures, India can build sustainable, equitable psychological resilience among women. This approach helps move from project-based wins to lasting, systemic change.

Conclusion

This paper is focused on the fact that psychological resilience is not an isolated trait but emerges through relationships, community bonds, and supportive institutions. The findings show that community engagement, education, and individualized case care together create stronger, more sustainable psychological outcomes for women. Crucially, resilience must be understood as relational and institutional, shaped by family, peers, schools, workplaces, and policies as much as by individual effort.

For policies and programs to be truly effective, they must be intersectional and inclusive, recognizing the layered realities of caste, class, gender, disability, sexuality, and geography. Mental health interventions should be care-sensitive, emphasizing dignity, trust, and safety alongside clinical care. Building resilience at scale will require integrating these approaches into education, healthcare, and community systems, ensuring that women across contexts can access timely, culturally relevant, and empowering support.

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