International Journal of Social Science and Economic Research

ISSN: 2455-8834

Volume:11, Issue:08 "August 2026"

Examining the Relationship between Indian Women's Household Decision-making and Mental Health Help-seeking Stigma

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DOI: 10.46609/IJSSER.2026.v11i08.047 URL: https://doi.org/10.46609/IJSSER.2026.v11i08.047
Received: 14 August 2026 / Accepted: 26 August 2026 / Published: 30 August 2026

ABSTRACT

Mental health help-seeking stigma remains a significant barrier to accessing psychological support, particularly among women, whose well-being is influenced by social and cultural factors like autonomy and decision-making within the household. The present study examined the relationship between women's household decision-making autonomy and mental health help-seeking stigma and explored whether family type, employment status, and educational attainment influenced their decisions. A quantitative survey was conducted among 40 women residing in India using items adapted from the EMERGE women's role in household decision-making scale. At the same time, mental health help-seeking stigma was measured using items adapted from the stigma and self-stigma scales for attitudes to mental health problems. Pearson's correlation and Mann–Whitney U tests were conducted to analyse the data. The findings revealed a positive relationship between household decision-making autonomy and mental health help-seeking stigma. Working women demonstrated higher household decision-making autonomy than non-working women. These findings highlight the relationship between women's autonomy and attitudes towards mental health help-seeking and emphasise the importance of promoting women's empowerment and mental health awareness to support their overall well-being.

Keywords: Household decision-making, Indian women, mental health stigma, behavioural economics and autonomy

Introduction

Over the past decade, mental health has been recognised as a major challenge for public health worldwide. In 2022, it was estimated that more than a thousand million people around the globe are living with neurological or mental disorders, with nearly two-thirds never seeking help for their conditions (WHO, 2022). Stressors of the COVID-19 pandemic have led to an increase in anxiety, psychological distress and depression around the world (McGINTY, 2023).

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Consequently, there is an increased demand for services that deliver effective mental health care, as more and more people suffer from unmet mental health needs.

People who need help are unable to access mental health services for several reasons. One major concern that prevents people from seeking professional help is the stigma attached to it (Schomerus & Angermeyer, 2008). People who suffer from mental health issues are often labelled as unfit and are socially isolated (Corrigan, 2004). Fear of being judged further makes people reluctant to seek professional help.

Gender is a critical determinant of many mental health illnesses. The biological and genetic make-up makes women more prone to psychological distress than men (Malhotra & Shah, 2015). In collectivistic cultures, psychological distress also occurs due to societal norms and gender roles, leading to numerous mental health concerns (Gaiha et al., 2020). Socio-economic constraints, discrimination, domestic violence and disparity in social structures affect women's mental well-being. In these cultures, women's roles include homemaker or caregiver responsibilities, i.e., taking care of children and other family members while simultaneously managing a career (Gaiha et al., 2020). This often creates difficulties in which their well-being is neglected, and their despair is considered the identity of a family (Gaiha et al., 2020). In India, studies on mental health reported that public stigma influences help-seeking. In India, studies have reported that stigma influences women's willingness to seek professional help for mental health problems, as fear of social judgement and misconceptions surrounding mental illness discourage many women from accessing mental healthcare (Jaykrishna & Krupp, 2024)

While stigma influences women's willingness to seek mental health support, another factor that may play an important role in shaping help-seeking behaviour is their ability to make independent decisions. Autonomy is central to people's lives and influences physical and mental health outcomes. Healthcare decision-making autonomy refers to 'the capability and freedom to direct or determine actions regarding one's own health and that of their dependents'(Idayu Badilla Idris et al., 2023). Women's ability to make decisions, i.e., accessing information, health services, and having economic security for oneself and one's dependents, impacts their overall well-being (Idayu Badilla Idris et al., 2023b). Their status within the household and family structure plays a key role in determining decision-making, access to health facilities, and healthcare-seeking behaviour (Malhotra & Shah, 2015b). Autonomy within the household can influence health-related attitudes and beliefs and contribute to self-esteem and self-efficacy. Despite the evidence on decision-making and better mental health and well-being, many women may not demonstrate decision-making autonomy within their families.

The mental health help-seeking stigma is widely perceived to cause interference with help-seeking behaviours among people. In many cases, the stigma is higher among women in

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countries where their social status is low, and dominance is highly prevalent(Gaiha et al., 2020b). While increasing household decision-making can give women confidence and may influence them to seek and receive psychological support, less is known about whether household decision-making is associated with professional help-seeking(Gaiha et al., 2020b) among women. The present research aims to explore whether having more autonomy in households makes women more prone towards seeking professional mental health help. Quantitative survey-based research was used to collect data from women to assess decision-making and mental health help-seeking stigma**.**

Methodology

Tools Used

The survey consisted of three main sections measuring women's household decision-making autonomy and professional help-seeking behaviour. Section one consisted of demographic questions that included descriptive information about the sample group, such as age, educational attainment, family type, place of residence, occupational status, and marital status.

Section two was for unmarried women, and section three was for married women. These sections assessed household decision-making autonomy. The items were adopted from the Health Survey Women's Status Module done by the UN Foundation in 2015. The assessment consists of women's involvement in decisions related to employment, healthcare, finances, ownership and control of assets, mobility, participation in community activities, voting behaviour, and family decision-making. Participants responded to multiple-choice and rating-scale format questions.

Section four focuses on attitudes towards professional help-seeking, adapted from the stigma and self-stigma scales for attitudes to mental health problems (Docksey et al., 2022). It consists of the following sub-scales: stigma to others, anticipated stigma, self-stigma, and help-seeking behaviour. Participants rated their agreement on a five-point Likert scale ranging from strongly disagree to strongly agree. Higher scores reflect greater mental health stigma and negative attitudes toward seeking psychological help, whereas lower scores indicated openness toward mental health support.

Sample characteristic

The study includes 40 women respondents aged 41–50 years (57.5%), followed by 31–40 years (20.0%) and 51 years and above (20.0%), while only 2.5% were aged 18–25 years. Nearly half of the respondents (45.0%) had completed a bachelor's degree, 37.5% held a master's degree, 15.0% had an MPhil/PhD qualification, and 2.5% had completed High School. The majority (70.0%) belonged to joint families, whereas 30.0% lived in nuclear families. Most respondents

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resided in Delhi and the National Capital Region (72.5%), with others from Raipur (15.0%), Gurugram/Gurgaon (5.0%), Faridabad (5.0%), and Gwalior (2.5%). About 37.5% of the women were engaged in paid work or self-employment, while 62.5% were unemployed. Working respondents represented a diverse range of occupations, including business owners, teachers, journalists, consultants, boutique owners, café owners, stock market professionals, and entrepreneurs. Most respondents (92.5%) were married, and among the entire sample, 72.5% reported arranged marriages while 20.0% reported love marriages. Married women (82.5%) had two children, with smaller proportions having one child or no children.

Ethical considerations

Before participating, respondents were briefed through a short paragraph regarding the aim and objective of the study. Informed consent was obtained from them after this. They were informed that any personal information provided would remain anonymous and confidential. The participants were informed beforehand that they could withdraw from the research at any time and refuse to participate.

Data collection procedure

The data used for this study were collected through an independent survey via Google Forms. Google Forms is a user-friendly platform and allows responses to be collected easily and in an organised way. The participants were all living in India and reached out directly through texting and in person. Clear instructions were given so that respondents could easily answer the survey. This ensured that all the answers were as accurate as possible. All responses were collected automatically upon submission through Google Forms, which made the data easier to analyse.

Data analysis strategy

To analyse the data, descriptive and inferential statistics were used to examine the relationship between women's household decision-making autonomy and mental health help-seeking stigma. Graphical representations were used to present the demographic characteristics of the respondents and illustrate variables such as family type and household decision-making patterns. Furthermore, all responses were compiled and analysed using Pearson's correlation to examine the relationship between household decision-making autonomy and mental health help-seeking stigma. In addition, Mann–Whitney U tests were conducted to compare household decision-making autonomy and mental health help-seeking stigma across family type, employment status, and education level. The results of these analyses were compiled into tables. This data analysis strategy provided a clear representation of the collected data and enabled the testing of the research objectives and hypotheses.

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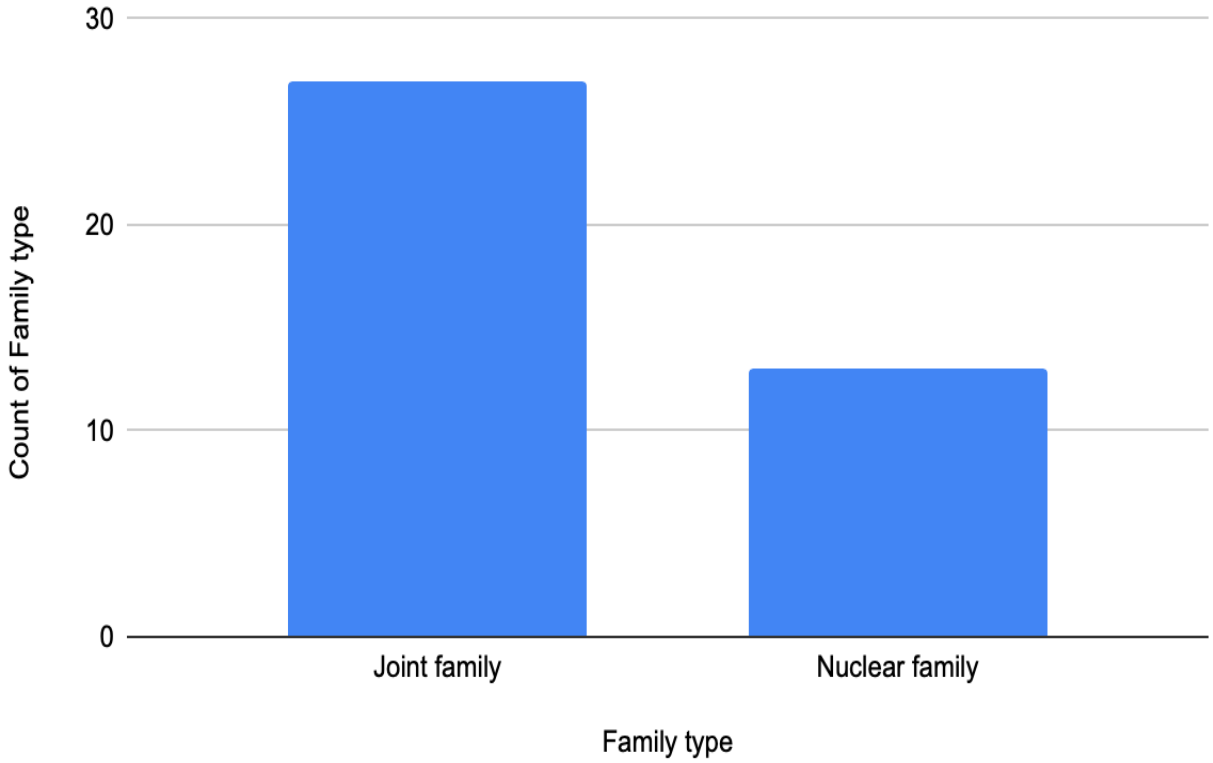
Results and Discussion

In Figure 1, it can be observed that the majority of the respondents belong to joint families, with 27 respondents, while 13 respondents belong to nuclear families. This indicates that joint family structures are more common among the surveyed population. The higher representation of joint families reflects the social and cultural background of the respondents, suggesting that many participants live in extended family settings where multiple generations reside together.

Figure 1: Graphical representation of family types among respondents (N = 40).



In Figure 2, it can be observed that the husband/partner most commonly has the final say on whether the respondent should work to earn money, with 14 responses. This is followed by the respondent herself with 10 responses, and joint decision-making between the respondent and her husband with 9 responses. A smaller number of respondents (4) reported that the decision was not made or was not applicable. Overall, the findings suggest that while many women have some degree of autonomy or shared decision-making regarding employment, husbands or partners remain the primary decision-makers in a considerable proportion of households.

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Figure 2: Graphical representation of who has the final say on whether respondents should work to earn money

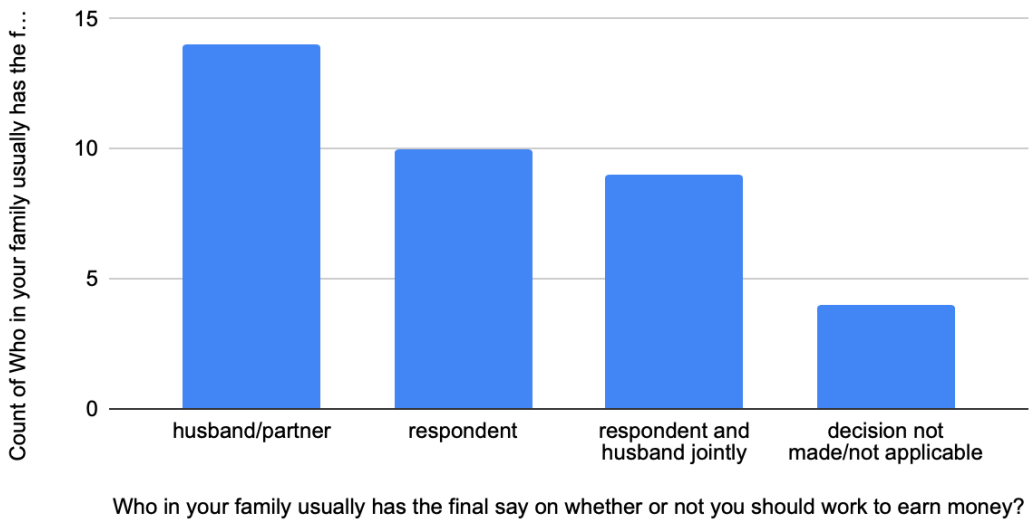

Table 1 depicts the average for the two measures of the study. The highest score for household decision-making autonomy is 65, and the average is 50.32, indicating that women do not make some household decisions. The highest score for mental health help-seeking stigma is 113, whereas the mean is 70.27, portraying stigma towards seeking professional help for mental health.

Table 1: Mean and standard deviation of Mental health help-seeking stigma and household decision-making autonomy.

Measures	Mean	SD
Mental Health Stigma	70.27	17.89
Household decision-making autonomy	50.32	9.27

A Pearson correlation coefficient was calculated to evaluate the relationship between household decision-making and mental health stigma seeking (Table 2). There was a significant moderate positive relationship between household decision-making and mental health stigma seeking, $r(38) = 0.39(5)$, $p>0.05$.

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Table 2: Pearson correlation analysis between mental health stigma and household decision-making autonomy among women.

Measures	Household decision-making	Mental health stigma seeking
Household decision-making	1	0.39*
Mental health stigma seeking	0.39*	1

*Note: $p<0.05$**

Table 3 depicts the comparisons of household decision-making and mental health stigma as per family type and employment status. The results indicated that there was no significant difference in household decision-making (U = 55 or z = -1.26, p> 0.05) and mental health stigma (U = 79 or z = -0.28, p = 0.77) between joint family and nuclear family set-up. Significant differences were found among employed and unemployed women. Employed women had significantly higher household decision-making than the not working group, U = 62 or z = -2.10, p<0.05. However, no significant difference was found in mental health stigma based on employment (U = 97.5 or z = -0.62, p>0.05. Similar insignificant differences were found for household decision-making (U = 135 or z = -1.33, p = 0.18) and mental health stigma (U = 165.5 or z = -0.43, p = 0.66) as per educational attainment.

Table 3: Mann-Whitney U test analysis between mental health stigma and household decision-making autonomy as per family type and employment status.

Variable	**Category**	**Rank Sum**	**U**	**z**	**p**
Household decision-making	Joint Family	146	55	-1.26	0.21
	Nuclear Family	179			
Mental health stigma	Joint family	170	79	-0.28	0.77
	Nuclear family	181			
Household decision making	Employed	283	62	-2.1	0.03*
	Not employed	182			

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Mental health stigma	Employed	247.5	97.5	-0.62	0.53
	Not employed	217.5			
Household decision-making	Graduate and less	416	135	-1.33	0.18
	Master's and higher degree	325			
Mental health stigma	Graduate and less	355.5	165.5	-0.43	0.66
	Master's and higher degree	385.5			

*Note: $p<0.05$**

Discussion

This study aimed to understand whether women's household decision-making autonomy is related to mental health help-seeking stigma. The findings showed a significant, moderate positive relationship between household decision-making autonomy and mental health help-seeking stigma, meaning that the two variables were related. Another important finding was that working women had significantly higher household decision-making autonomy than women who were not working.

Another main finding was that working women had significantly higher household decision-making autonomy than women who were not working. This might happen because earning an income gives women more financial independence and self-confidence to take part in household decisions more readily. Kabeer (1999) described that economic independence improves women's bargaining power within the family, which could explain the link. Likewise, Jejeebhoy (2001) observed that employed women in India often show more involvement in decisions related to healthcare, finances, and family matters than women who aren't employed. It also aligns with earlier research, which has shown that women with greater autonomy often carry more confidence when it comes to making decisions for their own health and wellbeing (Bloom et al., 2001; Pratley, 2016).

The study also noted no significant difference in household decision-making autonomy among women residing with joint or nuclear families. Many studies (Jejeebhoy & Sathar, 2001; Bloom, Wypij & Gupta, 2001; Allendorf, 2007) stated that women in nuclear families have more freedom as fewer people are involved in decision-making. One plausible reason is that most

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participants were from metropolitan cities like Delhi-NCR, where traditional family roles are shifting slowly, and women are becoming more engaged in household decisions irrespective of family structure (Desai & Andrist, 2010).

Another finding was that education level did not significantly affect household decision-making autonomy or mental health help-seeking stigma. This may be because education itself does not necessarily lead to greater independence. Even well-educated women may still follow the traditional family expectations and social norms, especially in Indian homes where important decisions are often made together. Thus, the influence of family values and culture may be more pronounced than education per se (Ranganathan & Mendonca, 2023).

No differences were found in mental health help-seeking stigma by family type, employment status or education level. This indicates that stigma against mental health persists among different groups of women. Earlier studies in India have found that fear of being judged, social stigma and lack of awareness are barriers for many seeking professional psychological help (Corrigan, 2004).

Overall, the findings suggest that while employment may improve women's participation in household decision-making, reducing mental health stigma requires greater awareness, education and acceptance of mental health issues in society. The findings of this study can be useful in different ways. Firstly, they highlight the importance of encouraging women's employment, as working women were found to have greater household decision-making autonomy. Programmes that support women's education, employment and financial independence may also help improve their confidence and participation in family decisions. Secondly, the findings show that mental health stigma continues to exist regardless of family type, education or employment. Therefore, awareness campaigns, counselling services, and mental health education programmes should focus on reducing stigma and encouraging women to seek professional help when needed. The findings may also be useful for psychologists, counsellors, NGOs, and policymakers who work in the areas of women's empowerment and mental health.

However, the study has a few limitations, such as a small sample size (40), so the findings cannot be generalised to all women in India. Most participants were from Delhi-NCR, which limits the representation of women from other parts of the country. Convenience sampling was used, which may have introduced sampling bias. The study was based on self-report questionnaires, so some participants may have given socially desirable responses instead of answering honestly. Since this was a cross-sectional study, it only shows relationships between variables and cannot establish cause-and-effect.

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Conclusion

This study aimed to examine the relationship between women's household decision-making autonomy and mental health help-seeking stigma. The findings revealed a relationship between household decision-making autonomy and mental health help-seeking stigma. In addition, working women reported higher household decision-making autonomy than non-working women. These findings highlight the importance of understanding the role of women's autonomy in shaping attitudes towards mental health and contribute to the growing body of research on women's empowerment and psychological well-being in the Indian context. Future research should include larger and more diverse samples from different regions of India to improve the generalisability of the findings. Researchers may also explore additional factors such as income, family support, mental health literacy, cultural beliefs and access to mental health services, as these may further explain women's attitudes towards seeking professional psychological help. Qualitative and longitudinal studies could also provide a deeper understanding of how women's autonomy develops over time and how it influences mental health help-seeking behaviour.

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