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Mental Health Stigma in Urban and Rural India

Exploring Perceptions, Beliefs, and Impacts on Help-Seeking and Care System

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Abstract

Mental health stigma remains a major barrier to accessing care in India, particularly in rural and underserved regions. Despite increasing awareness, stigma continues to be deeply rooted within cultural beliefs, social norms, and institutional practices. This study explores mental health stigma in both urban and rural contexts, with a specific focus on Madhya Pradesh. Employing a mixed-method approach—combining quantitative survey data (N=764) and qualitative interviews (N=6) with community members, students, caregivers, and NGO workers—the research examines how stigma is shaped, experienced, and internalized in varied settings.

Findings indicate that understandings of mental illness are shaped by dual belief systems, where traditional and spiritual explanations coexist with biomedical models. Rural participants were more likely to attribute mental illness to supernatural or religious causes, while urban respondents highlighted issues such as societal judgment, privacy concerns, and shame. Gender also emerged as a significant factor, with young women reporting higher levels of internalized stigma. Notably, exposure to psychiatry—whether through personal experience or educational settings—was associated with reduced

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negative attitudes and increased empathy, especially among medical students. By integrating experiences and perceptions from across diverse social groups, this study addresses key gaps in existing literature that often overlook comparative, lived realities. The findings emphasize the importance of culturally rooted, community-based anti-stigma initiatives that work within existing belief systems rather than disregarding them. This research contributes to both academic understanding and practical strategies for mental health planning within India's complex socio-cultural landscape.

Keywords: Mental health stigma, urban-rural comparison, India, dual belief systems, psychiatric literacy, mixed-method research

1. Introduction

1.1 Understanding the Landscape of Mental Health Stigma in India

Once overlooked, mental health is now receiving greater attention in both public discussions and policy frameworks in global and national health agendas. However, in India, mental illness continues to carry a dual burden—clinical complexity and deeply rooted social stigma. This stigma presents itself in many forms: social exclusion, discrimination, myths, and fear-driven behaviours, which together contribute to a striking treatment gap. According to the National Mental Health Survey (2016), nearly 91% of individuals with mental health conditions in India do not receive adequate care, primarily due to low awareness, limited accessibility, and cultural prejudice [1].

Stigma in India is deeply shaped by religious and socio-cultural worldviews. In rural areas, mental illness is still frequently attributed to supernatural causes, such as possession, karma, or divine punishment. As a result, individuals often turn to traditional or religious healers before seeking psychiatric help [2,3]. Even in urban areas, where awareness is higher, people often harbor subtle misconceptions—associating mental illness with weakness, unpredictability, or moral failing [4].

The impact of this stigma is not limited to individuals living with mental illness. Family members often experience "courtesy stigma"—a form of social penalty for being associated with the affected person [5]. This dynamic has been well-documented globally as “courtesy stigma,” where family members bear the burden of social exclusion and shame [6], a reality echoed in our qualitative data.

Health professionals themselves are not immune to biases. Studies have shown that doctors and medical students, particularly those with less clinical exposure to psychiatry, often hold stigmatizing views, especially toward disorders like schizophrenia and substance abuse [7,8]. On the other hand, students who had undergone psychiatry rotations demonstrated more empathetic and informed attitudes.

Vulnerable groups such as adolescents, women, and tribal communities face layered forms of stigma. For instance, young women in rural areas often conceal mental health issues due to concerns over marriage prospects and family reputation [9,10]. In tribal communities, traditional healing systems continue to dominate because they align more closely with cultural beliefs and are more accessible than clinical care [11].

Against this backdrop, it becomes critical to explore how stigma is lived, negotiated, and sometimes resisted in everyday Indian life. A deeper understanding of the interplay between local beliefs and structural limitations is necessary for shaping mental health initiatives that are not only scientifically sound but also culturally sensitive and locally rooted.

1.2 Literature Review

Over the past two decades, mental health research in India has shifted from a predominantly clinical focus to one that increasingly acknowledges the socio-cultural and public health dimensions of mental illness. Among these, stigma—both internalized and perceived—emerges as a key barrier to care, shaping public attitudes, help-seeking behaviour, and even the structure of healthcare delivery [4,12].

Stigma Among General Populations

Across India, studies consistently show that public understanding of mental illness is strongly influenced by cultural beliefs, limited literacy, and media portrayals. In both urban and rural contexts, mental illness is frequently attributed to supernatural causes or moral weakness, particularly in regions with low mental health awareness [2,11]. For example, in a study from Madhya Pradesh, families often oscillated between traditional healers and psychiatric services—highlighting the tension between biomedical and spiritual models of care [13].

Research from Vellore (Tamil Nadu) and Khurda (Odisha) confirms that stigma extends beyond the individual, affecting families and caregivers, who often experience social isolation and internalized shame [14,5]. Interestingly, several studies report that while awareness about mental illness is gradually improving, attitudes are slower to change. This suggests a gap between knowledge and acceptance [15].

Youth and Mental Health Literacy

Youth, especially university students, represent a vital demographic for mental health awareness. A study conducted at Amity University, Rajasthan, revealed that while 43% of students could recognize symptoms of depression, only 1.5% identified schizophrenia—showing a clear blind spot for more complex conditions [16]. Similar studies confirm that stigma remains high even in educated populations, although female students tend to show greater empathy but also higher internalized stigma due to social expectations [17,8].

The dominant sources of help among youth are often informal—family, peers, and social media—indicating the need for formal education on mental health in schools and colleges [7,18].

Stigma in Healthcare Professionals

Perhaps most concerning is the presence of stigma among healthcare providers themselves. A prospective survey among doctors in Hyderabad found that many practitioners, especially those unfamiliar with psychiatry, held negative attitudes toward people with schizophrenia and substance use disorders [19]. Similarly, research on medical students revealed that those who had not undergone psychiatry rotations were more likely to agree with restrictive or punitive statements about patients [8].

Exposure to psychiatry during clinical postings significantly improved students' opinions and empathy levels, emphasizing the importance of contact-based learning and training [7,11]. However, a lack of emphasis on community-based psychiatry in medical curricula may contribute to a disconnect between professionals and the culturally grounded needs of patients.

Cultural and Structural Dimensions

Cultural beliefs continue to shape how mental illness is perceived, especially in rural and tribal areas where formal psychiatric infrastructure is weak. For example, tribal communities in central India often perceive mental distress through spiritual or ancestral frameworks, and reject biomedical explanations [11,3]. Even when services are available, community mistrust, affordability concerns, and gender dynamics can limit access—particularly for women and lower-income families [9,10].

At the structural level, the National Mental Health Survey (2016) reported a national treatment gap of 83%, which rises to 91% in states like Madhya Pradesh. This gap is exacerbated by underfunding—only 0.2% of the state's health budget is allocated to mental health—and by a critical shortage of trained professionals [1]. Digital and tele-mental health initiatives, like the SMART Mental Health Project, have shown promise in extending access, but continue to face challenges related to technological literacy and cultural acceptance [20]. A recent scoping review further supports these challenges, noting that tele-mental health adoption in India still faces infrastructural and regulatory barriers, particularly in underserved regions [21].

Gaps Identified in Prior Literature

While the existing literature has provided meaningful insights, important questions remain unaddressed. Notably, several recurring gaps continue to limit our understanding of stigma's full scope in the Indian context:

- A lack of comparative studies between urban and rural settings on stigma perception and coping behaviours.
- Limited focus on lived experiences and qualitative narratives, especially from rural communities, caregivers, and non-clinical populations.
- Minimal inclusion of culturally rooted explanatory models, such as those based on family, religion, or traditional healing.
- Underrepresentation of tribal, adolescent, and low-income groups in large-scale mental health studies.
- A deficit of intervention-based or action-research models targeting stigma reduction in community settings.

1.3 Research Gap

Despite the growing body of literature on mental health stigma in India, several important gaps continue to hinder a holistic understanding of the issue—especially when it comes to regional, cultural, and comparative insights.

One of the most prominent limitations is the **lack of comparative studies** between urban and rural settings. Most existing research tends to isolate one context—either focusing on urban college students or rural tribal populations—without examining the intersections or contrasts between them [2,11]. As a result, little is known about how similar stigmas may be expressed differently across geography, class, or education level.

Another major gap lies in the **underrepresentation of qualitative, lived experiences**. While quantitative scales like the OMI or CAMI offer useful trends, they often miss the

emotional and social nuances that define how stigma is felt, internalized, or resisted in daily life. Few studies center the voices of caregivers, NGO workers, traditional healers, or community leaders, despite their central roles in navigating mental healthcare [14,3].

Similarly, **culturally rooted explanatory models** remain inadequately explored. Intersectional factors such as gender and geography are rarely examined together. For example, rural young women may experience compounded stigma due to overlapping disadvantages—such as reduced autonomy, marriage-related pressures, and limited mobility—making them less likely to seek help [22].

While many studies acknowledge the influence of spirituality, karma, or ancestral beliefs in how mental illness is understood—particularly in tribal and rural areas—they often treat these frameworks as barriers rather than alternative paradigms worthy of dialogue [11,10]. This creates a disconnection between formal psychiatry and the belief systems of the people it seeks to serve.

Furthermore, **specific demographic groups**—such as adolescents, tribal communities, and women in conservative settings—are either marginally studied or treated as monolithic categories. For example, youth studies often lump all college students together, even though data shows sharp differences in stigma levels between genders, disciplines, and urban-rural backgrounds [16,17].

Finally, there is a **shortage of intervention-based research**, particularly models that test stigma reduction strategies in real-world, community settings. Programs like school-based awareness drives, culturally adapted digital platforms, or contact-based education for health workers remain largely under-evaluated in the Indian context [20,7].

In sum, the current literature lacks both depth and diversity when it comes to understanding how mental health stigma operates in everyday Indian life. There is an urgent need

for **context-specific, mixed-method research** that not only maps stigma patterns but also engages with the cultural logics and community realities that sustain them.

1.4 Study Objectives

In light of the literature gaps outlined above, this study was designed to bridge regional and cultural divides by comparing how stigma operates across different Indian settings—particularly urban and rural areas—with a specific focus on Madhya Pradesh and its surrounding communities. By using a mixed-method approach, the research offers a deeper, more grounded understanding of how mental illness is perceived, discussed, and responded to within real-life contexts.

The objectives of this study are as follows, and each is supported by existing research gaps:

1. **To understand the socio-cultural beliefs and perceptions that shape mental health stigma in both urban and rural communities.**

   Supported by findings from Kermode et al. [2], Isaac et al. [11], and Sharma & Ramaswamy [10], which highlight that deeply held cultural and spiritual beliefs influence how people make sense of mental illness, often reinforcing stigma. However, few studies have compared these patterns across geographical settings.

2. **To identify the differences and similarities in how stigma is experienced and expressed across urban and rural settings.**

   Existing studies, like those by Singh et al. [16] and Poreddi et al. [14], tend to focus exclusively on either urban college students or rural populations. Comparative data remains scarce, which limits our understanding of how regional variations influence stigma.

3. **To examine the roles of family, religion, media, and healthcare systems in either reinforcing or reducing stigma.**

As discussed in Jain et al. [3] and Raj et al. [7], family attitudes, religious interpretations, media portrayals, and professional bias all serve as key sources of either support or stigma. Yet, most studies isolate these variables rather than analyzing their interrelationship.

4. **To amplify the voices of grassroots actors—including community members, NGO workers, and caregivers—through open-ended, narrative-based interviews.**
   The literature strongly suggests that community stakeholders are rarely included in mental health research, despite being central to care delivery and decision-making [14,9]. This objective fills a vital qualitative gap.
5. **To contribute to the development of localized, culturally appropriate anti-stigma interventions, particularly in underserved regions such as Madhya Pradesh.**
   Intervention-based research in India is limited, especially in central and tribal regions. Projects like SMART Mental Health [20] offer a foundation, but localized strategies that engage with cultural beliefs remain underexplored.

By grounding these objectives in existing research gaps and regional needs, the study contributes both to the academic literature and to real-world strategies for stigma reduction. It bridges the urban-rural divide and adds human-centered insight to policy conversations on mental health in India.

2. Methodology

Quantitative Tool Introduction

To comprehensively explore the patterns and depth of mental health stigma across India, a standardized questionnaire was developed as the primary quantitative tool in this study. Rooted in both validated scales and culturally specific insights from Indian literature, the questionnaire was meticulously designed to capture five major domains: *stigma, perceptions, beliefs, help-seeking behaviour, and access to mental health care systems.* Each domain reflects

sociocultural themes uniquely embedded in Indian society—such as the role of family reputation, supernatural causality, and reliance on traditional healers.

Originally conceptualized for a sample size of 384 participants, the questionnaire eventually reached 764 respondents across diverse geographical and social backgrounds in India, including rural, urban, and semi-urban areas. This unexpectedly high response rate greatly enhanced the depth and generalizability of the findings, allowing for rich statistical analysis and deeper cross-sectional comparisons.

The tool comprises 35 statements distributed over 5 sections, each using a 5-point Likert scale (from "Strongly Disagree" to "Strongly Agree"). These sections include:

1. Mental Health Stigma – assessing socially held prejudices, fears, and exclusionary attitudes.
2. Perceptions about Mental Health – measuring conceptual understanding and acknowledgment of mental health as a legitimate health issue.
3. Beliefs about Mental Health – evaluating cultural, spiritual, and supernatural explanations of mental illness.
4. Help-Seeking Behaviours – gauging willingness to seek support from professional, familial, or traditional avenues.
5. Care Systems – lightly assessing awareness of and barriers to mental health services.

Each item was designed to be culturally sensitive and linguistically simple, ensuring accessibility across populations with varying educational levels. Items such as "Mental illness affects marriage prospects" or "Mental illness can be caused by karma or evil spirits" reflect real-world beliefs that often go unmeasured in Western-influenced scales.

The questionnaire draws conceptually from internationally recognized scales like CAMI (Community Attitudes toward Mental Illness), MHSAS (Mental Help-Seeking Attitudes Scale), and SSMI (Stigma Scale for Mental Illness)—but was contextually adapted through

literature review and pilot testing. Statements were validated for content and construct validity and aligned with findings from recent Indian studies. A pilot study with 30 respondents ensured reliability and clarity, especially in rural settings, leading to revisions for regional comprehension and cultural appropriateness.

The tool was administered through a mixed-mode approach: online surveys (Google Forms) were used in urban and semi-urban contexts, while paper-based and verbal administration (via phone calls or community facilitators) was conducted in rural settings. Using both digital and offline methods made it easier to reach participants with limited literacy or internet access.

By covering a wide demographic spread—age, gender, caste, education, location, and occupation—the tool enables an intersectional analysis of mental health stigma in India. It also provides the groundwork for correlating stigma levels with sociocultural variables, service accessibility, and belief systems.

The questionnaire was adapted using items and constructs drawn from validated tools such as the CAMI [24], the MHSAS [28], and the Stigma Scale for Mental Illness [27].

Qualitative Tool Introduction

To complement the large-scale quantitative analysis and provide deeper insights into the lived realities of mental health stigma across India, this study employed a semi-structured interview guide as a qualitative tool. Designed to elicit rich, narrative data, the guide was grounded in themes drawn from Indian literature and public health reports and covered five core domains: mental health stigma, perceptions, cultural beliefs, help-seeking behaviour, and care systems.

The guide features 20 open-ended questions divided across these domains and was tailored to suit different stakeholder groups—mental health professionals, social service providers, community members, ASHA workers, and traditional healers. Each question was

constructed using culturally sensitive language and adapted to reflect specific Indian contexts, such as:

- Family reputation and marriage prospects,
- Belief in supernatural causes (e.g., evil spirits, karma, nazar),
- Use of traditional healing systems (ojhas, babas, tantriks),
- Access to care through government hospitals or informal support.

Interviews were conducted with six participants representing a diverse cross-section of Indian society—geographically (urban, semi-urban, and rural), socially (tribal, SC/OBC/General), and professionally (NGO workers, teachers, Anganwadi supervisors, ASHA workers, counsellors, traditional healers). This diversity ensured a wide range of perspectives and helped reveal the complex ways in which stigma intersects with gender, religion, caste, geography, and age.

Interviews were conducted face-to-face and virtually (Zoom/Google Meet), depending on feasibility and participant comfort. Conversations lasted approximately 20–30 minutes and were recorded (with consent) or documented through detailed summaries. This flexible approach respected logistical constraints while preserving data integrity.

The interviews brought out subtle, context-specific insights that a structured survey might miss—such as:

- The silence and shame women face in seeking therapy after domestic violence.
- The generational divide in mental health language and beliefs.
- How tribal communities frame mental illness through spiritual or environmental metaphors.
- The everyday barriers of stigma, from gossip in urban apartments to exclusion in rural marriages.

Thematic analysis following [25], was chosen as the method of qualitative analysis, allowing for coding and synthesis of dominant themes like:

- "Faith Healers as First Responders"
- "Mental Illness as Family Dishonour"
- "Gendered Expressions of Distress"
- "Cultural Beliefs vs Medical Models"

This approach aligns with recommendations by Indian scholars who argue that qualitative narratives—particularly those from marginalized voices—reveal contextual stigma that standardized tools often fail to capture [23].

Thematic analysis, following Braun and Clarke's [25] approach, was used to identify and interpret patterns across the qualitative interviews. This method enables the extraction of themes grounded in participants' narratives, and is well-suited to culturally contextual data.

2.1 Data Collection

The data collection process for this study was carefully designed to ensure a broad representation of Indian communities, encompassing diverse geographies, social groups, and belief systems. A mixed-methods approach was employed, consisting of a standardized quantitative questionnaire and semi-structured qualitative interviews, both culturally adapted to reflect the complex realities of mental health stigma in India.

Quantitative Data Collection: Survey Administration

The standardized questionnaire was distributed to a total of 764 respondents, far exceeding the initial target of 384. This large sample provided a robust base for statistical analysis. The survey was deployed using a hybrid strategy:

- Online forms (Google Forms) were used primarily for urban and semi-urban populations, particularly among students, working professionals, and educated youth.

- In rural and under-connected areas, the survey was administered via paper-based formats and phone interviews, with the help of local facilitators and community health workers.

Demographic data—such as age, gender, caste, religion, education, occupation, and location—was collected to enable intersectional analysis. The use of a 5-point Likert scale across 35 items allowed for detailed insights into participant attitudes, beliefs, and experiences related to mental health.

To ensure clarity and inclusiveness, the questionnaire was translated and simplified for verbal administration in regions where literacy or language posed a barrier. All participants were informed about the voluntary nature of the study and gave consent prior to participation.

Qualitative Data Collection: Semi-Structured Interviews

In parallel with the survey, six semi-structured interviews were conducted with diverse stakeholders, who were purposively chosen to reflect India's cultural and social spectrum. These included:

- A social worker (urban slum development, Madhya Pradesh),
- An ASHA health worker (rural Madhya Pradesh),
- An NGO counsellor (semi-urban Uttar Pradesh),
- A retired school teacher (urban Bhopal),
- A women's program coordinator (urban Tamil Nadu),
- A tribal healer and community elder (deep rural Chhattisgarh),
- An Anganwadi supervisor (rural Rajasthan).

Interviews were conducted in-person and virtually (via Zoom or Google Meet), depending on feasibility and participant preference. Each session lasted 20–30 minutes and followed a structured yet flexible guide that encouraged storytelling, reflections, and real-life examples.

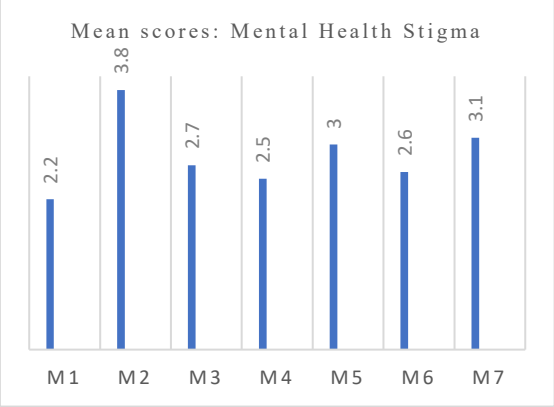
Verbal or written consent was obtained in all cases, and anonymity was maintained through pseudonyms and data anonymization during transcription.

The interviews captured localized narratives, community beliefs, service barriers, and stigma dynamics that go beyond what quantitative scales can measure. This qualitative layer added richness, depth, and authenticity to the study, ensuring that the voices of marginalized and underrepresented groups—such as rural women, tribal elders, and grassroots health workers—were fully integrated.

3. Results and Interpretation

This section presents and interprets the findings of the study based on data collected through a standardized quantitative survey of 764 participants and in-depth qualitative interviews with six stakeholders across urban, semi-urban, rural, and tribal settings in India. Combining both methods made it possible to identify broader patterns while also understanding the lived realities behind mental health stigma, perceptions, beliefs, help-seeking behaviours, and care system access.

3.1 Mental Health Stigma



(Figure 1: Mental Health Stigma)

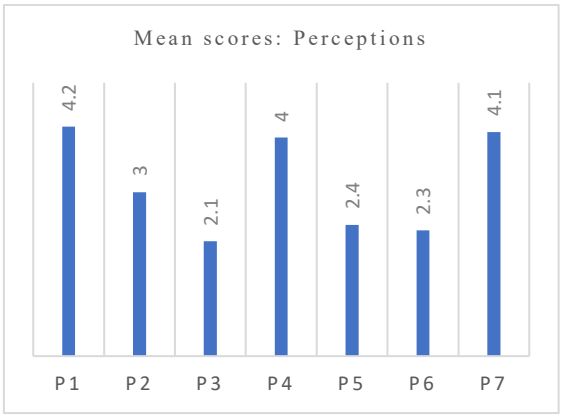
Quantitative Insight: Responses to the stigma-related items (M1–M7) revealed that blatant stigmatizing views are declining. The mean score across items was approximately 2.75 on a 5-point Likert scale. Most participants rejected notions that the mentally ill are inherently

dangerous (M1), should be hidden (M6), or cannot hold responsible jobs (M3). However, marriage-related stigma (M2) and mild social discomfort (M5, M7) remain significant—especially in rural and less educated groups.

Qualitative Insight: Interviews reaffirmed this divide. A rural ASHA worker reported that mental illness still leads to family-wide stigma, particularly for young women whose marriage prospects suffer. An urban NGO worker shared that while attitudes are changing among youth, mental illness is still whispered about, especially when women seek counselling.

Interpretation: Stigma is evolving from overt rejection to subtle forms of exclusion and fear, particularly around family honour and gender roles. Education and urban exposure are protective factors, but cultural norms still influence social judgments.

3.2 Perceptions about Mental Health



(Figure 2: Perceptions about mental health)

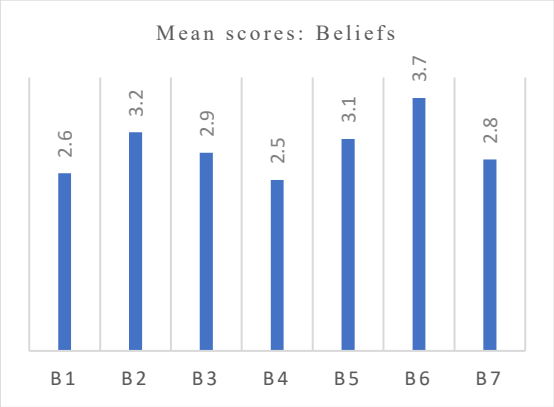
Quantitative Insight: The mean score for perception items (P1–P7) was 3.12, reflecting a growing awareness of mental health as a legitimate concern. Items like "mental illness is a medical condition" (P1), "depression is common" (P4), and "people can recover with support" (P7) received strong agreement. Respondents largely rejected trivializing statements, like mental illness being exaggerated or less serious than cancer.

Qualitative Insight: Several participants highlighted this gap in understanding. A retired teacher admitted he once dismissed emotional issues as moodiness. A tribal elder explained

that in his culture, the concept of mental health isn't medical but emotional or spiritual—described as "tired spirits" or "forest disturbances." In both urban and rural interviews, generational differences were noted—youth express more awareness, while elders often revert to older models of understanding.

Interpretation: While mental illness is increasingly seen as real and treatable, disparities in understanding remain wide, especially across generations, regions, and educational backgrounds. The language used to describe mental distress still differs significantly between cultural groups.

3.3 Beliefs about Mental Health



(Figure 3: Beliefs about mental health)

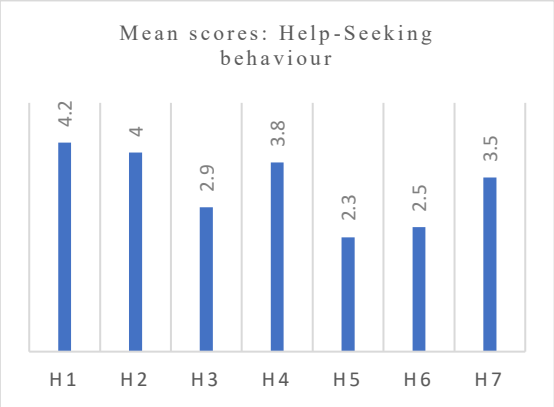
Quantitative Insight: Section 3 recorded a mean of 2.84, indicating dual belief systems. While the highest agreement was with the biomedical statement ("mental illness is caused by a chemical imbalance" – B6), many also agreed with karma-based (B2) and traditional healer (B5) explanations. Belief in evil spirits (B1) or divine punishment (B4) was less common but still present in rural areas.

Qualitative Insight: The tribal elder explained how emotional issues are seen as the result of broken taboos or ancestral spirits. The Anganwadi worker from Rajasthan recalled a woman with postpartum psychosis being tied with ropes because her in-laws believed she was

possessed. Even in urban areas, religious explanations like “nazar” or “punishment” still influence how families respond.

Interpretation: India's population simultaneously holds modern scientific and traditional spiritual beliefs. This coexistence of modern and traditional beliefs significantly shapes how mental illness is interpreted, how families respond, and where individuals choose to seek help. Any awareness campaign must respect and engage with these belief systems to be effective.

3.4 Help-Seeking Behaviour



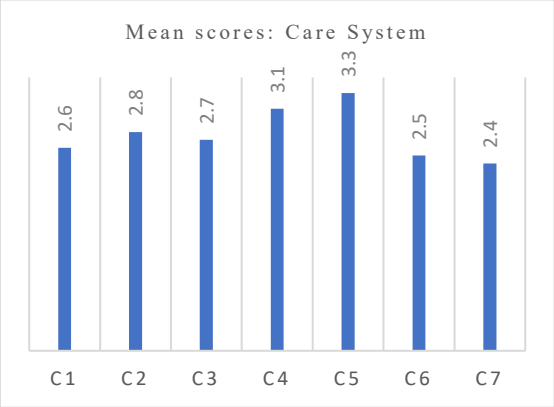
(Figure 4: Help-Seeking behaviour)

Quantitative Insight: Help-seeking behaviour had a mean score of 3.15, showing high willingness to seek help, especially from psychiatrists (H1), family (H2), and even online platforms (H7). Stigma-related barriers like shame (H6) or weakness (H5) received low agreement, indicating progressive attitudes, especially among urban, educated, and female respondents.

Qualitative Insight: Despite growing openness, interviews revealed significant barriers: fear of gossip, limited privacy, and lack of knowledge. The NGO counsellor in UP noted that patients asked, “Will this be recorded?” or “Will people find out?” The Anganwadi worker explained that in rural households, mobile phones are shared, and private online therapy is nearly impossible.

Interpretation: While the desire to seek help is growing, especially in cities, practical barriers (privacy, cost, digital access) and internalized shame still deter many, especially women in patriarchal households or youth in rural regions.

3.5 Care Systems



(Figure 5: Care System)

Quantitative Insight: This section had the lowest average score (2.95). Participants widely expressed dissatisfaction with accessibility (C1), affordability (C5), and trust in government services (C6). There was low awareness about the mental health roles of ASHA workers (C7). Institutional stigma from doctors and counsellors (C4) was moderately agreed upon.

Qualitative Insight: Participants frequently cited lack of infrastructure, absence of trained staff, and distrust in the public health system. The ASHA worker expressed frustration over being untrained in dealing with suicide or postpartum depression. The program coordinator in Chennai emphasized the need for partnerships between NGOs, hospitals, and community leaders.

Interpretation: There is a significant disconnect between rising help-seeking behaviour and the readiness of the system to respond. Mental health infrastructure in India remains patchy, underfunded, and poorly integrated into primary health care.

General Synthesis: Both quantitative and qualitative data confirm that mental health stigma in India is slowly declining, particularly in urban, educated populations. However, traditional

beliefs, structural barriers, and social silence persist, especially in rural, tribal, and conservative communities.

Respondents demonstrate an openness to biomedical explanations and therapy, but lack of access, affordability, and trust in institutions remain key challenges. The belief systems shaping mental health perceptions are deeply embedded in culture, religion, gender roles, and family dynamics—which must be acknowledged in any future intervention.

4. Discussion

The findings of this study reinforce the idea that mental health stigma in India is shaped by a complex interplay of cultural beliefs, regional contexts, social institutions, and access to care. While previous research has highlighted these factors individually, the comparative approach in this study offers a more layered understanding of how stigma functions differently across urban and rural environments.

For instance, as observed in earlier studies [2,11], rural communities continue to rely heavily on supernatural causation models and reliance on traditional healers. Our results confirm this pattern, with a substantial proportion of rural respondents endorsing beliefs linked to karma, evil spirits, or ancestral punishment. However, unlike prior studies that treated such beliefs as purely obstructive, our qualitative findings reveal that many individuals simultaneously believe in both traditional and biomedical models—what might be called a "dual-belief system." This nuance is rarely captured in standard surveys and adds to the growing call for culturally sensitive models of care [3].

Among youth, consistent with Singh et al. [16], we found relatively higher openness to discussing mental health, but limited diagnostic literacy—particularly around conditions like schizophrenia. The gendered differences in internalized stigma observed in our data also align with earlier findings by Verma & Mehta [17], where young women reported more shame and concealment behaviours due to fear of social judgment, particularly in marriage contexts.

One of the more sobering insights was the persistence of stigma even among healthcare-related populations. This echoes the findings of Raj et al. [7] and Neeraj et al. [8], where medical students without psychiatry exposure demonstrated more negative opinions about mental illness. Encouragingly, our data also reflect the positive influence of exposure—participants who had contact with mental health professionals, NGOs, or personal experiences reported more accepting attitudes.

The urban-rural comparison highlights structural and systemic disparities. While urban respondents were more aware of formal services, they often cited issues like privacy and societal judgment as barriers. Rural respondents, meanwhile, faced infrastructural challenges such as the unavailability of trained professionals or digital access, which match the structural critiques reported in the NMHS [1] and recent evaluations of rural outreach efforts like SMART Mental Health [20].

Importantly, our study contributes to the small but growing set of research that centers the perspectives of community actors—caregivers, field workers, and even religious leaders—whose voices are often absent in mental health research [14,9]. Their narratives not only deepen our understanding of how stigma is perpetuated but also suggest pathways for change—from school-based awareness programs to community dialogue platforms.

In essence, while our findings confirm much of what is already known about mental health stigma in India, they also **extend the field** by offering comparative, grassroots-grounded insights that have been largely missing from the literature. The coexistence of biomedical and traditional worldviews, the gendered experience of stigma, and the voices of lay community members all offer new directions for both policy and future research.

5. Conclusion

This study set out to explore mental health stigma across urban and rural India—an issue that, while increasingly acknowledged, remains entangled in cultural, structural, and

perceptual barriers. Through a mixed-method approach combining over 760 survey responses and in-depth interviews, this research highlights how stigma is not simply a matter of ignorance but is rooted in longstanding social beliefs, unequal access to care, and institutional gaps.

The study confirms prior findings that stigma persists in both overt and subtle ways—from supernatural beliefs in rural areas to social distancing in urban ones. However, it also reveals lesser-documented nuances: the coexistence of traditional and biomedical models of mental illness, the differentiated impact of stigma on women and youth, and the silent but significant influence of community actors like NGO workers and family caregivers.

By offering a comparative lens, the research fills an important gap in Indian mental health literature—one that moves beyond isolated case studies to understand how stigma operates across regions, systems, and identities. It also strengthens the call for culturally grounded interventions that respect community belief systems while expanding access to quality care.

The findings point toward actionable paths forward:

- introducing mental health awareness programs in schools and colleges.
- Integrating culturally trained community health workers, and embedding anti-stigma education in both public campaigns and professional training.

Despite a growing policy focus, India's mental healthcare remains chronically underfunded—receiving less than 1% of the total health budget. Recent reports highlight a significant gap between projected mental health funding in national surveys and actual allocations at the state level [26]. Bridging this policy-practice divide is essential for translating public awareness into real, accessible care.

Addressing stigma in India requires more than just clinical solutions—it demands empathy, dialogue, and a systemic rethinking of how mental illness is perceived and supported.

In short, this study contributes to the evolving conversation around mental health in India—not by offering universal answers, but by grounding our understanding in the lived realities of those most affected.

6. Declaration

Conflict of Interest: The author declares no conflict of interest.

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Declaration of Originality: I hereby declare that this research paper is an original piece of work and has not been submitted or published elsewhere. All sources and references used have been duly acknowledged.

Conflict of Interest: The corresponding author, on behalf of second author, confirms that there are no conflicts of interest to disclose.

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Appendix

Appendix A: Quantitative Questionnaire: Mental Health Stigma in Urban and Rural India

Purpose: This questionnaire measures perceptions, beliefs, stigma, help-seeking behaviors, and care system access related to mental health among Indian populations in urban and rural settings. It is designed for quantitative data collection, with statements reflecting cultural nuances of India.

Instructions: Please read each statement carefully and indicate your level of agreement using the following scale:

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

Demographic Information:

• Age: _____

• Gender: Male / Female / Other

• Location: Urban / Rural / Semi-Urban

• Education Level: Below High School / High School / Graduate / Postgraduate / Other

• Religion: Hindu / Muslim / Christian / Sikh / Other

• Caste: General / OBC / SC / ST / Other

• Occupation: Student / Employed / Unemployed / Other

Section 1: Mental Health Stigma

This section assesses attitudes and stigma toward individuals with mental illness, reflecting Indian social norms and family concerns.

1. People with mental illness are dangerous and should be avoided in public places.

2. Having a mental illness in the family brings shame and affects marriage prospects.

3. Individuals with mental illness cannot hold responsible jobs like teaching or banking.

4. Mental illness is a sign of personal weakness and lack of self-control.

5. I would feel uncomfortable living next to someone with a mental illness.

6. Families should hide members with mental illness to protect their reputation.

7. People with mental illness are unpredictable and cannot be trusted in social settings.

Section 2: Perceptions about Mental Health

This section measures how mental health is viewed, including medical versus social perspectives common in India.

1. Mental illness is a medical condition that can be treated like diabetes or hypertension.

2. Mental health problems are caused by stress and can be managed with willpower.

3. Mental illness only affects people who are emotionally weak or unstable.

4. Depression is a common mental health issue that many people experience.

5. Mental health problems are less serious than physical illnesses like cancer.

6. Mental illness is often exaggerated and not a real health concern.

7. People with mental health issues can lead normal lives with proper support.

Section 3: Beliefs about Mental Health

This section captures cultural and spiritual beliefs about mental illness prevalent in India, such as supernatural causes.

1. Mental illness can be caused by evil spirits, black magic, or jinn possession.

2. Mental health problems are a result of bad karma from past actions.

3. Visiting temples or performing religious rituals can cure mental illness.

4. Mental illness is a punishment from God for sins committed.

5. Traditional healers (e.g., ojhas, pandits) can effectively treat mental health issues.

6. Mental illness is caused by a chemical imbalance in the brain.

7. Ancestral curses or family sins can lead to mental health problems.

Section 4: Help-Seeking Behaviors

This section evaluates preferences and barriers to seeking help for mental health issues, reflecting India's mix of medical and traditional options.

1. I would consult a psychiatrist if I experienced mental health problems.

2. Talking to family members is the best way to address mental health issues.

3. I would visit a faith healer or religious leader for mental health concerns.

4. I feel comfortable discussing mental health problems with friends or peers.

5. Seeking professional help for mental illness is a sign of weakness.

6. I would avoid seeking help for mental health to prevent social stigma.

7. Online mental health services (e.g., apps, teletherapy) are a good option for support.

Section 5: Care Systems

This section lightly assesses access to and perceptions of mental health care systems, focusing on barriers and awareness in India.

1. Mental health services are easily accessible in my community.

2. Hospitals in my area have qualified professionals to treat mental illness.

3. I know where to go for mental health support in my city or village.

4. Stigma from healthcare providers discourages people from seeking mental health care.

5. Mental health treatment is too expensive for most people in my community.

6. Government health programs adequately address mental health issues.

7. Community health workers (e.g., ASHA workers) are trained to support mental health needs.

Appendix B: Semi-Structured Interview Guide: Mental Health Stigma in Urban and Rural India.

Purpose: This interview guide is designed to collect qualitative, descriptive data on perceptions, beliefs, stigma, help-seeking behaviors, and care system access related to mental health among Indian populations in urban and rural settings. It targets mental health professionals, community members, and social service providers to capture diverse perspectives.

Instructions for Interviewer:

• Conduct interviews with 5–10 participants (e.g., 2–3 mental health professionals, 2–3 community members, 2–3 social service providers) to keep the scope feasible.

• Use open-ended questions to encourage detailed responses, probing for clarification (e.g., "Can you explain more?" or "Can you share an example?").

• Record interviews (with consent) or take detailed summary notes to avoid full transcription, using tools like Otter.ai for partial transcription if needed.

• Ensure interviews last 20–30 minutes to respect participants' time and your capacity for analysis.

• Adapt questions slightly based on the participant's role (e.g., professionals vs. community members) while maintaining consistency.

Demographic Information

• Age: _____

• Gender: Male / Female / Other

• Location: Urban / Rural / Semi-Urban

• Occupation/Role: (e.g., Psychiatrist, Community Member, Social Worker, ASHA Worker)

• Religion: Hindu / Muslim / Christian / Sikh / Other

• Caste: General / OBC / SC / ST / Other

• Years of Experience (for professionals/social service providers): _____

Section 1: Mental Health Stigma

This section explores attitudes and stigma toward mental illness, focusing on social and family dynamics in India.

1. How do people in your community view individuals with mental health issues, and what kind of stigma do they face?

2. In what ways does mental illness affect a family's reputation or social standing, such as marriage prospects or community acceptance?

3. Can you share an example of how stigma influences how people with mental illness are treated in your area?

4. What do you think drives stigma toward mental health in your community (e.g., lack of awareness, cultural norms, fear)?

Section 2: Perceptions about Mental Health

This section examines how mental health is understood, including medical, social, or personal perspectives.

1. How would you describe the general understanding of mental health issues in your community?

2. Do people in your area view mental health problems as medical conditions, personal weaknesses, or something else?

3. Can you share a story or observation about how someone's perception of mental health affected their response to it?

4. What factors (e.g., education, media, personal experience) shape how people in your community perceive mental health?

Section 3: Beliefs about Mental Health

This section captures cultural, spiritual, or traditional beliefs about mental illness prevalent in India.

1. What are some common beliefs in your community about what causes mental illness (e.g., supernatural, spiritual, or biological factors)?

2. How do religious or cultural practices influence how people view or address mental health issues?

3. Can you describe a situation where someone's belief in causes like karma or evil spirits affected their approach to mental illness?

4. How do these beliefs about mental health differ between older and younger generations, or between urban and rural areas in your area?

Section 4: Help-Seeking Behaviors

This section investigates preferences and barriers to seeking help, reflecting India's mix of medical, traditional, and modern options.

1. When people in your community experience mental health issues, who do they typically turn to for help, and why?

2. What prevents people from seeking professional mental health care, such as psychiatrists or counsellors?

3. Can you share an example of how someone's decision to seek help (or not) was influenced by mental health stigma or cultural beliefs?

4. How are newer help-seeking options, like online therapy or community support groups, perceived in your community?

Section 5: Care Systems

This section lightly explores access to and perceptions of mental health care systems, focusing on barriers and gaps.

1. What are the main challenges people in your community face in accessing mental health services?

2. How does stigma among healthcare providers or community members affect the use of mental health care services?

3. Can you describe the availability of mental health resources (e.g., professionals, clinics, or government programs) in your area?

4. What changes or improvements do you suggest to make mental health care more accessible in your community?