



**DEGREE OF MENTAL HEALTH AND PSYCHOSOCIAL ADJUSTMENT OF UNMARRIED
PREGNANT WOMEN IN RURAL AREA OF CHHATRAPATI SAMBHAJINAGAR,
MAHARASHTRA, INDIA**

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Abstract

Unmarried pregnancy remains a deeply stigmatized phenomenon in rural India, frequently resulting in severe psychological distress and social alienation. This study investigates the degree of mental health and psychosocial adjustment among unmarried pregnant women (N = 148) in rural areas of Chhatrapati Sambhajanagar, Maharashtra. Utilizing a descriptive, cross-sectional survey design, the study assesses psychological vulnerabilities—specifically depression, anxiety, stigma, suicidal ideation, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD)—alongside adaptive psychological resources, namely self-efficacy and resilience. Standardized psychometric instruments, including the Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), and the Connor-Davidson Resilience Scale (CD-RISC-10), were utilized for data collection. Quantitative analysis revealed alarming rates of severe depression (42.6%) and clinically significant anxiety (51.3%). Perceived social stigma was universally high, displaying a strong positive correlation with suicidal ideation ($r = 0.58, p < 0.001$) and PTSD symptomatology ($r = 0.44, p < 0.001$). Conversely, self-efficacy and resilience emerged as critical buffers, showing robust negative correlations with distress indicators. Based on these descriptive findings, this paper outlines targeted recommendations. These include implementing decentralized, stigma-free community mental health frameworks, integrating psychiatric screenings into rural antenatal care (ANC), and establishing community-led psychosocial support networks to safeguard this highly vulnerable demographic.

Keywords: Unmarried Pregnancy, Mental Health, Psychosocial Adjustment, Rural Maharashtra, Stigma, Resilience.

Introduction

In the socio-cultural landscape of rural India, traditional norms governing family structures, gender roles, and sexuality exert profound control over individual lives. Within this context, unmarried pregnancy constitutes a severe breach of deeply ingrained social codes, frequently resulting in extreme ostracization,



familial honor conflicts, and structural discrimination (Das & Kumar, 2021). While maternal healthcare policies in India have evolved considerably through frameworks like the Pradhan Mantri Surakshit Matritva Ab (PMSMA), the core focus remains overwhelmingly fixed on the physical and medical parameters of married pregnant women. The psychological landscape of unmarried pregnant women—particularly those navigating the structural and social constraints of rural environments—remains critically under-researched and underserved.

The district of Chhatrapati Sambhajnagar (formerly Aurangabad) in the Marathwada region of Maharashtra features a stark developmental contrast between its urban centers and agrarian rural periphery. Rural communities in this region are characterized by rigid caste dynamics, low female literacy rates, and patriarchal family systems. When an unmarried woman becomes pregnant in this environment, she faces an immediate, compounding crisis. The intersection of gender, unmarried status, and rural poverty subjects these women to intense psychological trauma.

Psychosocial adjustment during pregnancy requires a supportive ecosystem. For unmarried rural women, this ecosystem is replaced by an environment of hostility, shame, and isolation. This paper explores the multidimensionality of their psychological distress by evaluating a comprehensive matrix of clinical variables: depression, anxiety, social stigma, suicidal ideation, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD). Simultaneously, it evaluates their internal psychological resources—self-efficacy and resilience—to understand how these women cope with acute adversity. Through a rigorous descriptive analysis, this study intends to fill a crucial gap in empirical literature, offering actionable, localized structural recommendations for public health practitioners, policymakers, and civil society organizations.

Literature Review

The Burden of Stigma, Depression, and Anxiety

Societal stigma acts as the foundational driver of psychological morbidity among unmarried pregnant women in rural spaces. Erving Goffman's classic conceptualization of stigma describes it as an "undesired differentness" that reduces an individual from a whole, usual person to a tainted, discounted one. In rural Maharashtra, this "taint" extends beyond the individual to compromise the entire family's social and marital standing (Patil & Thorat, 2022). Extensive global and regional literature confirms that high levels of perceived stigma directly precipitate severe depressive episodes and generalized anxiety disorders. According to Mishra and Sharma (2023), pregnant women lacking marital validation exhibit a fourfold increase in the incidence of major depressive disorders compared to their married peers. Anxiety is further exacerbated by systemic uncertainties, including fear of violence, forced expulsion from the home, and economic dependency.



Suicidal Ideation and Trauma Pathways (PTSD & OCD)

The psychological distress experienced by these women often escalates to cognitive states of hopelessness, culminating in suicidal ideation. In India, suicide remains one of the leading causes of death among young women, with interpersonal conflict, unwanted pregnancies, and social shame acting as primary triggers (National Crime Records Bureau [NCRB], 2024).

Furthermore, the onset of an unplanned, socially forbidden pregnancy frequently follows structural or interpersonal trauma, such as sexual coercion, non-consensual relationships, or systemic exploitation. This positions Post-Traumatic Stress Disorder (PTSD) as a highly prevalent yet largely undiagnosed condition in this cohort (Deshmukh et al., 2022). The constant, intrusive worry regarding social exposure and the biological changes of pregnancy can also manifest as or exacerbate Obsessive-Compulsive Disorder (OCD) symptomatology, where compulsive checking, hyper-vigilance, and obsessive ruminations regarding contamination or moral failure become maladaptive coping mechanisms (Subramanian & Rao, 2023).

Resilience and Self-Efficacy as Coping Buffers

Despite severe external pressures, individuals possess varying degrees of internal psychological resources that mitigate distress. Self-efficacy—an individual's belief in their capability to execute behaviors necessary to produce specific performance attainments—plays a pivotal role in how a pregnant woman navigates healthcare systems and handles interpersonal conflict (Bandura, 1997).

Concurrently, resilience represents the dynamic process of positive adaptation within the context of significant adversity (Luthar et al., 2000). In rural settings, women who maintain higher levels of baseline resilience and self-efficacy are significantly better equipped to utilize available, albeit limited, resources, seek clandestine medical help, and resist internalizing the destructive narratives imposed upon them by their communities (Jadhav & Wagh, 2021).

Methodology

This study utilized a descriptive, cross-sectional survey design to quantitatively assess the mental health profiles and psychosocial adjustment levels of the target population. The study was conducted across rural primary health centers (PHCs), sub-centers, and non-governmental organization (NGO) safe houses located within the rural blocks of Chhatrapati Sambhajnagar district, Maharashtra (including blocks such as Gangapur, Vaijapur, Kannad, and Sillod) over a twelve-month period. A sample of N = 148 unmarried pregnant women was recruited using a combination of purposive and snowball sampling techniques. Given the hidden and highly sensitive nature of the population, researchers closely collaborated with grassroots Accredited Social Health Activists (ASHA workers), rural auxiliary nurse midwives (ANMs), and local community trusts to build trust and ensure safe, confidential access.



Inclusion Criteria: Unmarried legal status (single, widowed, or abandoned/divorced prior to pregnancy); currently pregnant; residing in a rural area of Chhatrapati Sambhajinagar for at least six months; aged 18 to 35 years.

Exclusion Criteria: Pre-existing, documented major psychotic disorders (e.g., schizophrenia or bipolar disorder with psychotic features) prior to pregnancy, to isolate the specific psychosocial impact of the current pregnancy crisis.

Instruments and Data Collection Tools

The survey instrument comprised a demographic profile sheet alongside seven standardized, validated psychometric scales translated and back-translated into Marathi: Depression: Patient Health Questionnaire-9 (PHQ-9); scores ≥ 10 indicate moderate-to-severe depression. Anxiety: Generalized Anxiety Disorder-7 (GAD-7); scores ≥ 10 indicate clinically significant anxiety. Social Stigma: Discrimination Devaluation Scale (DDS), adapted to measure perceived pregnancy stigma. Suicidal Ideation: Item 9 of the PHQ-9 and the Columbia-Suicide Severity Rating Scale (C-SSRS) Screen. OCD Symptomatology: Yale-Brown Obsessive Compulsive Scale (Y-BOCS) Self-Report checklist. PTSD Symptoms: PTSD Checklist for DSM-5 (PCL-5). Self-Efficacy: General Self-Efficacy Scale (GSE). Resilience: Connor-Davidson Resilience Scale (CD-RISC-10).

Ethical Considerations

Ethical clearance was obtained from the Institutional Ethics Committee. Written or thumb-print informed consent was secured from every participant. Complete anonymity was maintained by utilizing numerical coding rather than personal identifiers. Interviews were conducted in private, secure spaces. A strict distress-protocol was established: any participant demonstrating active suicidal intent or profound psychiatric crisis was immediately connected to a clinical psychologist or psychiatrist at the nearest tertiary care facility (e.g., Government Medical College and Hospital, Chhatrapati Sambhajinagar).

Results and Analysis

Research Question1: What are the Demographic and Descriptive Profile of Prevalence of Mental Health Vulnerabilities



Table 1: The demographic analysis highlights the heightened vulnerability of the sample. The mean age of the participants was 21.4 years (SD = 3.2), reflecting a predominantly young cohort.

Demographic Variable Category		Frequency (n)	Percentage (%)
Age Group	18–21 years	84	56.8%
	22–25 years	41	27.7%
	26+ years	23	15.5%
Education Level	Illiterate / No formal schooling	39	26.4%
	Primary Education (Grades 1–7)	68	45.9%
	Secondary Education and above	41	27.7%
Familial Support	Unaware of pregnancy	76	51.4%
	Aware, unsupportive/hostile	54	36.5%
	Aware and fully supportive	18	12.1%

Descriptive quantitative analysis of the psychometric scores revealed severe psychological distress across the sample. The mean score on the PHQ-9 was 14.8 (SD = 4.1), indicating moderate-to-severe clinical depression. For the GAD-7, the mean score was 12.6 (SD = 3.5), crossing the threshold for clinical anxiety.

Research Question 2: What are the mental Health sub-scale severity prevalence?

Table 2: Mental Health Sub-Scale Severity Prevalence (N = 148)

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Severe Depression (PHQ-9 $\geq$ 15)	42.6%
Clinically Significant	51.3%
High Perceived Stigma	82.4%
Active/Passive Suicidal Ideation	31.8%
Severe PTSD Symptoms (PCL-5 $\geq$ 33)	27.0%
Elevated OCD Ruminations	14.2%
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Social Stigma: An overwhelming 82.4% (n = 122) of participants reported high to extreme perceived social stigma, noting pervasive fears of community expulsion, verbal abuse, and physical harm.



Suicidal Ideation: Active or passive suicidal ideation within the past two weeks was reported by 31.8% (n = 47) of the cohort, illustrating the critical nature of their psychological distress.

PTSD and OCD: Clinical thresholds for PTSD were met by 27.0% (n = 40) of participants, strongly associated with past relationship trauma or the acute shock of discovery. Elevated OCD patterns (mostly centered on obsessive fears of discovery and compulsive hygiene/concealment rituals) were observed in 14.2% (n = 21) of cases.

Research Question 3: What are the Psychosocial Adjustment Matrices: The Role of Resources?

Table 3: Summary of psychosocial adjustment, correlation matrices computed between distress indicators and adaptive traits (Self-Efficacy and Resilience)

Variable	Perceived Stigma	Depression	Anxiety	Self-Efficacy	Resilience
Perceived Stigma	1.00				
Depression	0.52*	1.00			
Anxiety	0.49*	0.68*	1.00		
Self-Efficacy	-0.34*	-0.41*	-0.38*	1.00	
Resilience	-0.45*	-0.55*	-0.51*	0.62*	1.00

**Correlation is significant at the 0.01 level (2-tailed).*

The statistical data demonstrates that resilience and self-efficacy are significantly and negatively correlated with depression and anxiety. Women who scored higher on the CD-RISC-10 scale exhibited enhanced capacities for psychosocial adjustment, even when navigating environments with high perceived stigma.

Discussion of Findings

The descriptive findings paint a clear picture of the psychological vulnerabilities characterizing unmarried pregnant women in rural Chhatrapati Sambhajinagar. The exceptionally high prevalence of depression (42.6%) and anxiety (51.3%) stands in sharp contrast to the baseline mental health data for married pregnant women within Maharashtra, where prenatal depression typically ranges between 12% and 18% (Kulkarni & Shinde, 2023). This difference highlights the substantial impact of social invalidation. The strong relationship between perceived stigma and suicidal ideation underscores the life-threatening nature of this social issue. In a rural environment, honor is tied closely to ancestral land, family reputation, and caste standing. The body of the unmarried pregnant woman becomes a site of perceived familial dishonor, exposing her to unique psychological stressors.

The prevalence of PTSD symptoms (27.0%) suggests that these women experience pregnancy not as a normative biological transition, but as an ongoing chronic traumatic event. This trauma is compounded



by the lack of an institutional safety net. Fear of hostile exposure prevents these women from seeking standard prenatal services at local PHCs, leaving them physically vulnerable to complications and psychologically isolated.

Conversely, the data concerning self-efficacy and resilience offers an empirical foundation for strengths-based interventions. The inverse relationship between resilience and depression proves that internal psychological resources remain functional even under severe external stress. However, relying entirely on individual resilience is neither ethical nor sustainable. Internal strength must be supported by external, structural frameworks. Psychosocial adjustment is not merely an internal cognitive state; it is a relational process. If the community offers nothing but stigma, the individual's psychological resources will eventually deplete, leading to severe psychiatric crises or suicide.

Conclusion

This study establishes that unmarried pregnant women in rural Chhatrapati Sambhajnagar experience exceptionally high rates of psychiatric distress, driven by widespread social stigma and a lack of systemic support. The high rates of depression, anxiety, and suicidal ideation documented here demand immediate, targeted public health interventions.

While internal factors like self-efficacy and resilience help mitigate these psychological challenges, individual coping mechanisms must be backed by institutional support. Addressing this crisis requires moving beyond traditional maternal healthcare models to build a stigma-free, integrated system that treats mental well-being as a fundamental human right. Implementing these structural changes can help shift rural Maharashtra from a culture of punitive exclusion to a supportive framework of medical security, psychological recovery, and social dignity.

Recommendations

Based on the quantitative and descriptive insights gathered during this study, the following structural, clinical, and community-level recommendations are proposed:

1. Integration of Mental Health Screenings into Rural Antenatal Care (ANC)
2. Public health mandates must require all rural health sub-centers and PHCs across Chhatrapati Sambhajnagar to integrate brief, culturally adapted mental health screeners (such as the PHQ-2 and GAD-2) into routine maternal check-ups.
3. Given the intense fear of exposure, healthcare records for unmarried pregnant women must be managed with absolute privacy safeguards to protect them from local community surveillance.
4. Capacity Building for Grassroots Health Workers (ASHA and ANMs)



5. Stigma Reduction Training: ASHA workers and ANMs must undergo systematic, continuous sensitization training to eliminate moral judgments and bias when dealing with unmarried pregnant clients.
6. Frontline workers should be equipped with Psychological First Aid skills to identify early warning signs of suicidal ideation, complex trauma, or OCD rituals, allowing for immediate referral to district psychiatric facilities.
7. Decentralized Counseling Infrastructure and Safe Spaces Tele-Mental Health Sub-Hubs: Leveraging the national Tele-MANAS network, specialized confidential helplines in conversational Marathi should be launched, targeting young rural women experiencing reproductive or interpersonal crises.

References

- Bandura, A. (1997). Self-efficacy: The exercise of control. W. H. Freeman and Company.
- Das, S., & Kumar, P. (2021). Socio-cultural determinants of maternal health among marginalized populations in rural India. *Journal of Health and Social Sciences*, 6(2), 189–204.
- Deshmukh, R., Kamble, S., & Joshi, A. (2022). Unseen trauma: Assessing PTSD and anxiety disorders among unwed mothers in Western India. *Indian Journal of Psychiatry*, 64(4), 372–379.
- Jadhav, M., & Wagh, S. (2021). Resilience as a buffer against social isolation: A study of rural women in Marathwada. *Maharashtra Psychological Review*, 9(1), 45–56.
- Kulkarni, V., & Shinde, M. (2023). Maternal mental health in Maharashtra: Regional disparities and systemic gaps. *The National Medical Journal of India*, 36(3), 142–149.
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3), 543–562.
- Mishra, N., & Sharma, R. (2023). Psychosocial correlates of unplanned and out-of-wedlock pregnancies in rural spaces. *Asian Journal of Social Psychiatry*, 18(2), 112–126.
- National Crime Records Bureau [NCRB]. (2024). *Accidental deaths & suicides in India 2022*. Ministry of Home Affairs, Government of India.
- Patil, B., & Thorat, Y. (2022). Honor, shame, and the female body: Patriarchal structures in rural Marathwada. *Indian Journal of Gender Studies*, 29(2), 211–230.
- Subramanian, K., & Rao, M. (2023). Obsessive-compulsive symptoms and hyper-vigilance among vulnerable pregnant cohorts. *Journal of Clinical and Diagnostic Research*, 17(5), VC01–VC06.