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The interplay of gender bias, self-efficacy, and mental health among rural women of Delhi

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Abstract

Empowering rural women of India naturally uplifts womanhood of the nation. The challenges they face are critical compared to urban women. Factors like inequality, opportunities and recognition play a vital role in women's mental health and their growth. This study investigated the potential associations between gender bias, self-efficacy, and mental health among rural women. This research included 150 women participants residing primarily in Bawana and Delhi NCR, aged between 15-30 years. This study used Convenience, Purposive and Snowball sampling to acquire responses and adopted a mixed-methods approach - both online surveys and personal interviews were conducted. Various psychological measures were employed to derive the correlation among gender bias, self-efficacy and mental health. Correlation coefficients and p-values were calculated, and Shapiro-Wilk tests were conducted to assess normality.

Correlational analyses revealed very weak positive correlations between the variables. These correlations were not statistically significant, indicating an absence of robust linear relationship. The lack of significant correlations emphasizes the need for a detailed exploration of multifaceted determinants beyond gender bias and self-efficacy to understand mental health outcomes in this demographic comprehensively.

Keywords: Gender bias, self-efficacy, rural woman, mental health

Introduction

The Interplay of Gender bias, Self-efficacy, and Mental Health among Rural Women

Indian culture follows many inbuilt constructs, which leads to various restrictions and biases in the society, hampering the life of women. But why always women? Half of the population in India consists of women and yet women are the ones whose situation keeps on getting worse. For many years, they have been deprived of opportunities for growth in the name of religion and socio-cultural practices. Women face discrimination, restrictions, gender bias, inappropriate treatment both at work and homes. This impacts not only their physical health but also their mental health.

A study named "Socio-economic status and prevalence of mental disorders in certain rural communities in India" found that there was no significant correlation between total morbidity and socioeconomic position. (Nandi *et al.*, 1979) ^[1]. The research paper (Anju *et al.*, 2022) ^[8], found that a considerable percentage of girls face challenges such as delayed health treatment, restrictions on mobility, and pressure to conform to traditional gender roles. The book "Mental Health and Illness in the Rural World" talks about the various challenges rural women face including gender disadvantage, poverty, poor physical health, roles of caregiving, and being women farmers. (Chandra *et al.*, 2020) ^[3].

This study sets out to explore the relationship of gender bias, socio-economics status, and self-efficacy with mental health of rural women. This study focuses the population residing in Delhi NCR and Bawana, the reason being rural women there are less privileged for freedom to express their views and opinions. They lack resources within their available limits, their mindset is conditioned in such a way that they never try to explore or look out for other options to tackle their problems, instead they decide to bear them. On the other hand if one has the availability of all the resources, they try to explore for options to tackle their problems.

Methods

Participants

The selection criteria included women residing in rural areas, aged between 15-30 years. There were 150 participants in the study. Data was collected using the personal interview and survey method. The participants primarily reside in Bawana and Delhi NCR. Convenience, Purposive, and Snowball sampling were employed. Convenience sampling was used because of the research's exposure in the rural setting and participants were voluntarily and readily available. But in order to get a variety of data from multiple places purposive sampling was employed to not have one demographic dominant over others. Previously employed participants were given the form link and were asked to circulate it among friends and family and if they knew of eligible women suitable for the study, the participants were asked to share their contact information if they felt comfortable.

Hypothesis

1. There is a significant negative correlation between gender bias experienced by rural women and their mental health, indicating that higher levels of gender bias are associated with lower mental health scores.
2. There is a significant positive correlation between self-efficacy levels of rural women and their mental health, suggesting that higher levels of self-efficacy are associated with higher mental health scores.

Tools

Mental Health Inventory (MHI) is a screening questionnaire for mental health. The first version of this instrument was a 38-item scale and measured psychological distress and wellbeing. (Veit and Ware, 1983) ^[5]. The MHI-18 is an abbreviated version of the 38-item Mental Health Inventory which was used for this study. The MHI has 4 subscales (Anxiety, Depression, Behavioral Control, and Positive Affect) and 1 total score. Positively worded items were reverse scored so that higher total MHI-18 scores indicated better mental health.

Scoring ranged from 1 (all of the time) to 6 (none of the time). Positively worded items were reverse scored so that higher total MHI-18 scores indicated better mental health. McHorney, Ware, Rogers, Raczek, and Lu (1992) ^[6] reported that the MHI-18 had a reliability of .96.

Gender Norms Attitude Scale (GNAS), constructed by Cynthia Waszak, Lawrence J Severy, Laila Kafafi and Isis Badawi in the year 2000 was employed to assess the extent of gender bias experienced by rural women in various aspects of their lives, including family, community, and workplace. Comprising 14 items categorized into two distinct subscales, this scale endeavors to capture attitudes related to equity for girls and women, as well as the perpetuation of rights and privileges for men. The scale demonstrates a satisfactory level of internal consistency, with estimated alphas of 0.70 for the subscale addressing men's privileges and .67 for the subscale exploring equity for girls. Predictive validity of the tool was tested by bivariate analysis and multivariate hierarchical regression. Higher scores on both scales indicated more egalitarian beliefs. (Waszak *et al.*, 2001) ^[4].

The General Self-Efficacy Scale (GSE) was developed by Ralf Schwarzer and Matthias Jerusalem in 1995. GSE measures participants' beliefs in their ability to overcome

challenges and achieve their goals, providing insights into their confidence levels. The GSE comprises 10 items. Respondents rate their agreement on a 4-point scale, requiring an average of four minutes for completion. The total composite score, ranging from 10 to 40, is derived by summing the responses across all 10 items without recoding. Reliability analyses, spanning 23 nations have showcased Cronbach's alphas ranging from .76 to .90,

Procedure and analysis

The research team conducted one-on-one sessions with potential participants, explaining the research's purpose, the data collection methods, and the protection of their privacy and confidentiality. Participants were given ample time to ask questions and clarify any doubts they had before voluntarily agreeing to participate. To introduce the research objectives and ensure that participants understood the significance of their involvement, sensitization workshops were organized.

Google Forms are employed to administer the scales, namely the Gender Bias Scale, Mental Health Inventory and Self-efficacy Scale. These Likert scale questionnaires are adapted for online administration. Incorporating personal interviews into the data collection process played a significant role in building rapport. The interviews were conducted in a non-judgmental manner, creating a safe space for participants to share their experiences, challenges, and aspirations.

Statistical software (e.g., SPSS) was used to analyze the collected data. Correlation coefficients and associated p-values were calculated to determine the strength and significance of relationships between variables. Shapiro-Wilk tests assessed the normality of the data distributions, crucial for understanding the statistical assumptions underlying the analyses.

Results

Table 1: Age of the sample

N	Mean	Standard Deviation	Minimum	Maximum	Range
150	22.47	4.91	15	30	15

Table 1 indicates descriptive statistics of the sample's age. The standard deviation is 4.91 which is lower than 1/3rd of the mean age which indicates that the data is not widely distributed. The mean, hence, is a reliable measure to describe the characteristics of the sample accurately.

Table 2: Descriptive Statistics of scores on MHI, GNAS, and GSE

	Mental health	Gender Bias	Self-efficacy
N	150	150	150
Mean	62.4	3.13	27.7
Median	62.5	3.00	27.0
Standard	9.08	1.82	5.40
Deviation			
Minimum	28.0	1.00	0.00
Maximum	99.0	8.00	40.0
Shapiro-Wilk			
W	0.975	0.893	0.931
Shapiro-Wilk (p)	0.007*	< .001*	< .001*

*Indicates $p < 0.05$

Table 2 denotes the descriptive statistics of the sample on three measures chosen. The Shapiro-Wilk normality test

indicates that the scores on mental health, gender bias, and self-efficacy are not normally distributed because the p

value is less than 0.05.

Table 3: Correlations between Mental Health Inventory, Gender bias and Self-Efficacy

Variable	Spearman's rho (Correlation coefficient)	Significance value
Mental Health and Gender Bias	0.043	0.603*
Mental Health Inventory and Self-Efficacy	0.058	0.479*

*indicates $p > 0.05$

Since the scores on Mental Health Inventory are not normally distributed, a non-parametric method like Spearman's rank correlation coefficient is used to determine correlation between the variables. The scores are denoted in Table 3.

Mental Health and Gender Bias

Table 3 denotes that the correlation coefficient between gender bias and mental health was found to be 0.04 with a p-value of 0.603. This indicates that there is no significant relationship between the extent of gender bias experienced by rural women and their mental health as the p value is greater than 0.05. In other words, the level of gender bias did not appear to have a direct and statistically significant impact on the mental health of the participants in our sample. Hence the hypothesis: There is a significant negative correlation between gender bias experienced by rural women and their mental health is rejected.

Mental Health and self-efficacy

Table 3 denotes that the correlation coefficient between self-efficacy and mental health was 0.058 with a p-value of 0.479. This suggests that self-efficacy levels among rural women were not significantly correlated with their mental health. Hence, the data did not support a statistically significant positive relationship between self-efficacy and mental health. In simple terms, higher levels of self-efficacy were not found to be associated with higher mental health scores in our sample. Hence the hypothesis: There is a significant positive correlation between self-efficacy levels of rural women and their mental health is rejected.

Discussion

The study aimed to explore potential associations between gender bias, self-efficacy, and mental health among rural women. The findings of the correlational analyses, however, revealed weak and statistically non-significant relationships between these variables in the sample of 150 rural women.

Mental Health and Gender bias

The correlation analysis between gender bias and mental health yielded a weak positive correlation ($r=0.04$) with a p-value of 0.603, indicating a lack of statistical significance. Despite the positive correlation, the insignificance of the relationship suggests that the extent of gender bias experienced by rural women in this study did not exert a direct and substantial impact on their mental health outcomes. While prior research has often highlighted the negative consequences of gender bias on women's well-being, this study suggests that the relationship might be more complex and influenced by various contextual factors. The lack of statistical significance emphasizes the need for a nuanced understanding of how gender bias interacts with other determinants to shape mental health outcomes in rural women.

Mental Health and Self efficacy

The correlation between self-efficacy and mental health also revealed a weak positive correlation ($r=0.058$) with a non-significant p-value of 0.479. This implies that the self-efficacy levels of rural women, as measured by the assessment tool, did not significantly influence their mental health outcomes in this specific sample. While self-efficacy is often considered a protective factor, the lack of a significant correlation in this study suggests that other factors may play a more prominent role in shaping the mental health of rural women. It is essential to explore additional aspects of the socio-cultural context and individual experiences that may contribute to mental health outcomes. The study suggests that the mental health of rural women may be influenced by a more complex interplay of factors beyond the direct effects of gender bias and self-efficacy, and it highlights the need for future research to explore the nuances of this relationship. The non-significant correlations between gender bias, self-efficacy, and mental health indicate that, in our study, there was no clear linear relationship between these variables among rural women.

Conclusion

Correlation coefficients between gender bias and mental health ($r = 0.04$, $p = 0.603$) and between self-efficacy and mental health ($r = 0.058$, $p = 0.479$) lacked statistical significance.

These results suggest that gender bias and self-efficacy among rural women did not have a statistically significant relationship with their mental health outcomes within this specific sample.

Limitations of the study: The study acknowledges the limitations of focusing solely on gender bias and self-efficacy and emphasizes the importance of considering a broader range of determinants. Further, it is limited in sample because of the location selected, that is Bawana in rural Delhi. The interplay of these factors may contribute to the intricate tapestry of mental health outcomes, and future research should adopt a more comprehensive approach to unravel the complexities involved.

Future direction

1. Future research should expand the scope by incorporating qualitative methods and exploring additional variables such as social support, community engagement, and access to mental health services
2. Longitudinal studies could provide insights into the dynamic nature of these relationships over time.
3. Cultural variations within rural populations should be considered to ensure the generalizability of the finding.

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