© Journal of the Indian Academy of Applied Psychology
January 2025, Vol.51, No.644-655

# Using an Intersectional Approach to Explore Mental Health Literacy, Help-Seeking Attitudes and Psychological Wellbeing of Women

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Women's mental health needs in Jammu and Kashmir remain understudied, despite potential heightened vulnerabilities. To explore the mental health needs of women in Jammu and Kashmir, focusing on mental health literacy, help-seeking attitudes, and their relationship to psychological well-being and depression. 179 women (Mean Age=29.15; SD=5.49) from J & K completed measures including the Mental Health Literacy Questionnaire (MLHq), Mental Help Seeking Attitude Scale (MHSAS), Psychological Well-being Scale (PWS), and Beck's Depression Inventory-II (BDI-II). Participants demonstrated average mental health literacy (M=119.95; SD=8.84), high help-seeking attitudes (M=5.24; SD=1.41), minimal depression (M=13.83; SD=11.33), and average psychological well-being (M=171.73; SD=29). Significant positive correlations were found between MLHq and PWS, MHSAS and PWS, and MLHq and MHSAS. A significant negative correlation was found between MLHq and BDI-II. MLHq emerged as the strongest predictor of PWS and BDI-II.

**Keywords**: mental health literacy, help-seeking attitudes, psychological well-being, depression, Jammu and Kashmir

Mental health is an integral component of overall well-being, yet it often receives less attention than physical health. According to the WHO (2004), mental health is defined as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." This definition emphasises the impact one's mental health can have on an individual's thoughts, feelings, behaviours, and overall quality of life.

Research suggests that ongoing conflicts have a huge impact on the communities' mental well-being. Thus, the prevalence of psychological distress is found to be high in politically turbulent regions such as that of Jammu and Kashmir which has seen conflict since the 1980s (De Jong, et al. 2008).

Several studies have examined the levels of psychological distress in the population of J&K with findings ranging from 33.3% (De Jong, et al., 2008) to 45% (Housen et al., 2017). For depression, the estimates go up to 55.72% (Amin & Khan, 2009). The reported prevalence of post-traumatic stress disorder (PTSD) varies from 15.9% (Margoob & Sheikh, 2006) to 19% (Housen, 2017), which is notably high compared to other

regions. Additionally, Housen et al. (2017) reported a probable prevalence of anxiety disorders at approximately 26%. These findings underscore the significant mental health challenges faced by the population of J&K.

Along with mental health challenges, gender inequality is also magnified in conflict, with women facing disproportionate disadvantages in terms of personal safety, access to resources, and human rights (Jansen, 2006). This inequitable impact is evident from significant gender differences found in various research studying mental health in Kashmir. Amin & Khan (2009) in their research on depression in Kashmir, found that females exhibited an overall prevalence of 60 per cent, compared to 51.34 per cent in males. Notably, being female in Kashmir was associated with higher rates of depression, anxiety, and post-traumatic stress disorder (PTSD) (Housen, et al. 2017). These findings highlight the gendered nature of mental health vulnerabilities in the region.

The degradation of the mental health of the population in J&K could be related to other factors as well. Studies have found that half widows have worse mental health than widows (Wani et al., 2016). Additionally, cannabis use in the region has been implicated in higher levels of anxiety, depression, loss of behavioural/emotional control, and lower levels of life satisfaction and mental health index scores (Wani et al., 2017). Institutional factors such as frequent internet and communication bans in conjunction with the recent COVID-19 pandemic have been implicated in aggravating mental health issues in the region (Naqshbandi et al., 2021).

To achieve mental well-being, it is imperative to empirically assess the community's existing knowledge of mental health. This allows for the formulation of effective awareness policies. Thus, exploring Mental Health Literacy as a framework may be beneficial.

*Mental Health Literacy* (MHL), refers to "*knowledge and beliefs about mental disorders which aid their recognition, management or prevention*" (Jorm, 1997). This concept includes the capacity to identify particular disorders, determine methods for obtaining information about mental health, understand risk factors and causes, be aware of self-treatment options and available professional assistance, as well as foster attitudes that encourage recognition and applicable help-seeking behavior (Jorm, 2000). Mental health literacy facilitates the early detection of mental illness, help-seeking behaviour, and better understanding and fostering of empathy towards those with mental disorders in the community (Ogorchukwu et al., 2016). Conversely, insufficient knowledge and stigma can significantly impede access to and utilization of mental health care and support services. A qualitative study by Housen, et al. (2019) indicated that the symptoms of psychological distress identified locally in Kashmir were analogous to those identified in the Hopkins Symptoms Checklist (HSCL-25) and the Harvard Trauma Questionnaire (HTQ). No other information regarding the mental health literacy of the population is available.

Mental health literacy also promotes 'help-seeking behaviour', a concept that enables the exploration of why and when people may or may not reach out for help (Salaheddin & Mason, 2016). It is considered to be a convoluted decision-making process instigated by a problem that impedes personal abilities (Cornally & McGarthy, 2011) i.e., problem-focused, planned behaviour, involving interpersonal interaction with selected healthcare professionals. It includes any act of actively seeking help from the health care services or trusted people in the community and consists of understanding, guidance, treatment and general support.

Without prior knowledge of an illness, it can be highly challenging to pursue help, thus mental health literacy seems like a precondition (Cornally & McGarthy, 2011).

To the authors' best knowledge, no information is available regarding the help-seeking attitudes and their relation to the mental health literacy of people in Jammu and Kashmir, highlighting the gaps in the literature. Therefore, the present research attempts to examine the status of mental health literacy, help-seeking attitudes and their relationship to mental health in the region. This study focuses exclusively on women in order to give impetus to achieving their long-ignored mental health needs.

An intersectional approach is essential to fully understand the complexities of mental health among women in Jammu and Kashmir. Intersectionality recognizes that people's experiences of mental health are shaped not just by gender but also by other intersecting social categorisations such as education level, employment status, etc (Crenshaw, 1989). Thus, we also aim to explore how various factors—such as marital status, employment status and acquaintance with people with mental health issues— shape women's mental health outcomes.

## Method

### Sample

The sample consisted of 179 women (Age range 20-50 years; Mean Age= 29.15 years, SD= 5.49) from urban areas of neighbourhoods of Jammu & Kashmir where access was safe for the researchers. The sample was predominantly educated with 96.1% with qualifications of undergraduate and above. The sample had equal distribution in terms of employment with 45.3% of the sample being employed and unemployed respectfully. Further, 64.8% of the sample were single, while 35.2% of the sample were married.

### Instruments

*The Mental Health Literacy Questionnaire* (MLHq), developed by Dias, Campos, Almeida & Palha in 2018, assesses a holistic perspective of mental health literacy instead of concentrating on a limited range of mental disorders or specific aspects. It has 29 items divided into four subscales or factors including, knowledge of mental health problems, erroneous beliefs/stereotypes, first aid skills and help-seeking behaviour, and self-help strategies. The construct validity, evaluated using exploratory factor analysis, indicated a four-dimensional factorial structure aligned with the multimodal perspective of MHL. The internal consistency evaluated using Cronbach's Alpha demonstrated acceptable reliability values for the overall score. (5ØüÞ=0.84).

*Mental Help Seeking Attitude Scale (MHSAS)*: It was developed by Hammer, Parent & Spiker (2018). This is a 9-item tool used to evaluate respondents' overall perception (unfavorable vs favorable) of obtaining assistance from a mental health expertl when facing mental health issues. Higher scores indicate a more positive attitude toward seeking help. The MHSAS demonstrates internal consistency (á = .93 to .94) and temporal stability (.76) over three weeks (Hammer et al., 2018). The feedback from experts and community adults signified the content validity, who rated the MHSAS instructions and items as clear, relevant, and representative of the intended construct.

*The psychological well-being scale* (42-item version) was developed by Ryff and colleagues in 2007. The scale measures six components of psychological well-being: environmental mastery, autonomy, positive relations with others, personal growth, purpose in life, and self-acceptance (Ryff et al., 2007). The five-point Likert scale ranges from strongly disagree to strongly agree. There are no specifically defined scores

indicating high or low psychological well-being and the distinction can be drawn out based on the distribution of the data. The internal consistency (á) between older and middle-aged groups are comparable with average alphas as .71, .78 respectively (Shryock & Meeks, 2018). The *priori six-factor* model has also been validated in multiple studies (eg, Abbott et al. 2006; Burns and Machin, 2009), however high inter-factor correlations have also been reported (Clarke et al. 2001).

*Beck's Depression Inventory-II (BDI-II)*: It is a self-report questionnaire developed by Beck, Steer, & Brown, (1996). It measures the severity of cognitive, affective, somatic, and vegetative symptoms of depression in clinical and normal patients. It has 21 items, with a 4-point Likert scale, ranging from 0 to 3. The raw scores range from 0 to 63, and higher scores depict greater symptom severity. Between clinical ratings of depression and the BDI for psychiatric and non-psychiatric populations, the mean correlation coefficient of 0.72 and 0.60 has been found (Beck, Steer, Garbin;1988). "High concurrent validities have been confirmed between the questionnaire and other measures of depression such as the Minnesota Multiphasic Personality Inventory-D, r = 0.77" (Beck, Steer, Garbin;1988). "Criterion validity of the BDI-II is positively correlated with the Hamilton Depression Rating Scale (r = 0.71) with a high 1-week test-retest reliability r = 0.93 and an internal consistency of á = 91" (Poole, Bramwell, Murphy; 2009). The scale is also considered to be highly reliable, as the alpha coefficient ranging from 70 to .89. was established from analysis of BDI-II total score and subscale scores, showing a moderate to high internal consistency (García. et. al.; 2018). Finally, it has also been standardized in India (eg., Basker et al, 2007).

## Results

Table 1. Mean and Standard Deviation for Scales and Subscales

| Variable | Range | Min | Max | Mean | SD | Skewness | | Kurtosis | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | SE | | SE |
| MLHq | 47 | 95 | 142 | 119.95 | 8.84 | .13 | .18 | -.24 | .36 |
| Factor 1(Knowledge of mental health problems) | 30 | 28 | 58 | 43.97 | 4.73 | .08 | .18 | .16 | .36 |
| Factor 2 (Erroneous beliefs/stereotypes) | 24 | 20 | 44 | 34.28 | 4.08 | -1.0 | .18 | 1.73 | .36 |
| Factor 3 (First aid skills and help-seeking behaviour) | 23 | 8 | 31 | 24.58 | 3.25 | -1.07 | .18 | 4.54 | .36 |
| Factor 4 (Self-help strategies) | 11 | 10 | 21 | 17.16 | 2.29 | -.79 | .18 | .41 | .36 |
| MHSAS | 5.67 | 1.33 | 7 | 5.24 | 1.41 | -.05 | .18 | -1.51 | .36 |
| PWS | 136 | 103 | 239 | 171.73 | 29 | .24 | .18 | -.77 | .36 |
| Autonomy | 31 | 11 | 42 | 26.68 | 6.09 | .24 | .18 | -.06 | .36 |
| Environmental Mastery | 31 | 10 | 41 | 27.10 | 6.07 | -.06 | .18 | -.14 | .36 |
| Personal Growth | 29 | 13 | 42 | 30.70 | 6.11 | -.38 | .18 | -.37 | .36 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Positive Relation | 29 | 13 | 42 | 29.62 | 5.89 | -.18 | .18 | -.27 | .36 |
| Purpose of life | 28 | 14 | 42 | 29.64 | 5.80 | -.07 | .18 | -.43 | .36 |
| Self Acceptance | 33 | 9 | 42 | 28.28 | 6.68 | -.15 | .18 | -.19 | .36 |
| BDI-II | 51 | 0 | 51 | 13.83 | 11.33 | .84 | .18 | .00 | .36 |

From Table 1, we can see the descriptive statistics for the major variables in the study. The data indicate moderate levels of mental health literacy, high help-seeking attitudes, and average psychological well-being among participants. Depressive symptoms were minimal. The relevant variables in the data were also subjected to a test of normality, the skewness and kurtosis values for scores of MLHq, MHSAS, and PWS were lower than +/-0.5 and +/-1.96 respectively, suggesting the distribution was fairly symmetrical and are suitable for further parametric analyses. The subscales of MLHq revealed varying levels of knowledge and beliefs in different aspects of mental health literacy, with "Knowledge of mental health problems" having the highest mean score relative to its range. These findings provide a foundation for examining relationships between the variables in subsequent analyses.

Table 2. Correlations Matrix of Main Variables

| Variable | | MLHq | MHSAS | PWS | BDI-II |
|---|---|---|---|---|---|
| MLHq | *Pearsons's r* | - | | | |
| | *P value* | - | | | |
| | *Cohen's d* | - | | | |
| MHSAS | *Pearsons's r* | .25*** | - | | |
| | *P value* | <.001 | - | | |
| | *Cohen's d* | .53 | - | | |
| PWS | *Pearsons's r* | .39*** | .24*** | - | |
| | *P value* | <.001 | <.001 | - | |
| | *Cohen's d* | .84 | .50 | - | |
| BDI-II | *Pearsons's r* | -.29*** | .06 | -.65*** | - |
| | *P value* | <.001 | .37 | <.001 | - |
| | *Cohen's d* | -.62 | .13 | -1.72 | - |

*P<.05, **P<.01, ***P<.001

Table 3. Correlations Matrix of Secondary Variables

| Variable | | MLHq | MHSAS | PWS | BDI-II |
|---|---|---|---|---|---|
| Factor 1 | *Pearsons's r* | .76*** | .14 | .28*** | -.20** |
| | *P value* | <.001 | .056 | <.001 | .006 |
| | *Cohen's d* | 2.34 | .28 | .58 | .41 |
| Factor 2 | *Pearsons's r* | .57*** | .18* | .12 | -.08 |
| | *P value* | <.001 | .016 | .095 | .24 |
| | *Cohen's d* | 1.38 | .36 | .24 | -.17 |
| Factor 3 | *Pearsons's r* | .59*** | .22** | .29*** | -.27*** |
| | *P value* | <.001 | .002 | <.001 | <.001 |
| | *Cohen's d* | 1.46 | .46 | .61 | -.56 |
| Factor 4 | *Pearsons's r* | .46*** | .03 | .30*** | -.19* |
| | *P value* | <.001 | .60 | <.001 | .01 |
| | *Cohen's d* | 1.03 | .07 | .63 | -.38 |
| Autonomy | | | | | |
| | *Pearsons's r* | .38*** | .26*** | .75*** | -.43*** |
| | *P value* | <.001 | <.001 | <.001 | <.001 |
| | *Cohen's d* | .82 | .60 | 2.28 | -.97 |
| Env Mastery | | | | | |
| | *Pearsons's r* | .24*** | -.04 | .80*** | -.66*** |
| | *P value* | <.001 | .58 | <.001 | <.001 |
| | *Cohen's d* | .51 | -.08 | 2.74 | -1.8 |
| Personal Growth | | | | | |
| | *Pearsons's r* | .35*** | .13 | .77*** | -.45*** |
| | *P value* | <.001 | .07 | <.001 | <.001 |
| | *Cohen's d* | .74 | .27 | 2.41 | -1.01 |
| Positive Relations | | | | | |
| | *Pearsons's r* | .35*** | .30*** | .80*** | -.54*** |
| | *P value* | <.001 | <.001 | <.001 | <.001 |
| | *Cohen's d* | .74 | .64 | 2.75 | -1.29 |

| | | | | |
|---|---|---|---|---|
| Purpose of Life | | | | |
| *Pearsons's r* | .40*** | .14* | .76*** | -.42*** |
| *P value* | <.001 | .04 | <.001 | <.001 |
| *Cohen's d* | .89 | .29 | 2.35 | -.93 |
| Self-Acceptance | | | | |
| *Pearsons's r* | 29*** | .22** | .85*** | -.61*** |
| *P value* | <.001 | .003 | <.001 | <.001 |
| *Cohen's d* | .60 | .45 | 3.26 | -1.54 |

*P<.05, **P<.01, ***P<.001

The correlations of various variables with each other are represented in Tables 2 and 3. The correlation between MLHq and MHSAS was significant and positive. This implies that an increase in MLHq will lead to more positive help-seeking attitudes. MLHq correlated positively with PWS and its subscales. Amongst the subscales, the correlation between MLHq and purpose of life was the strongest, followed by autonomy, positive relation, and personal growth. MLHq and BDI-II had a significant negative association. These correlations signify that an increase in mental health literacy is associated with better mental health outcomes. Help-seeking attitudes (MHSAS) showed significant positive correlations with PWS and several of its subscales, particularly Positive Relations and Autonomy. This implies that more positive help-seeking attitudes lead to more psychological well-being. There was not a significant correlation between MHSAS and BDI-II scores.

Table 4. Multiple regression with and MLHq, MHSAS, employment status, marital status, and acquaintance with mental health problems as predictors of PWS and BDI-II scores

| PWS | | | | | | | |
|---|---|---|---|---|---|---|---|
| Predictors | Unstandardised B | Std. Error | β | 95% CI | $r^2$ | $sr^2$ | p |
| MLHq | 1.14 | .22 | .34 | [.69, 1.58] | .15 | .12 | .000*** |
| MHSAS | 3.25 | 1.41 | .15 | [.45, 6.04] | .06 | .02 | .023* |
| Employment Status | 7.52 | 2.96 | .16 | [1.67, 13.37] | .03 | .03 | .012* |
| Marital Status | 8.98 | 4.08 | .14 | [.92, 17.03] | .03 | .02 | .029* |
| Acquaintance | 3.37 | 2.79 | .08 | [-2.14, 8.88] | .003 | .008 | .229 |

$R^2$= .24, Adjusted $R^2$= .22, F (5,173)=11.068, p <0.001, Durbin-Watson=1.850. $R^2$ proportion of outcome variable variance explained by predictors, $r^2$ proportion of variance explained by each predictor (including shared variance), $sr^2$ (semi-partial $r^2$) which is the proportion of unique variance attributable to the predictor. * symbolises p<.05, *** symbolises p<0.001.

| BDI-II | | | | | | | |
|---|---|---|---|---|---|---|---|
| Predictors | Unstandardised B | Std. Error | β | 95% CI | $r^2$ | $sr^2$ | p |
| MLHq | -.42 | .09 | -.32 | [-.60, -.23] | -.08 | -.104 | .000*** |
| MHSAS | 1.14 | .58 | .14 | [-.00, 2.29] | .004 | .02 | .05* |
| Employment Status | -2.01 | 1.21 | -.11 | [-4.42, .39] | -.01 | -.01 | .100 |
| Marital Status | -3.43 | 1.67 | -.14 | [-6.74, -.12] | -.04 | -.02 | .042* |
| Acquaintance | -1.76 | 1.14 | -.10 | [-4.03, .50] | -.008 | -.01 | .127 |

$R^2$= .161, Adjusted $R^2$= .137, F (5,173)= 6.641, p <0.001. Durbin-Watson=1.779; $R^2$ proportion of outcome variable variance explained by predictors, $r^2$ proportion of variance explained by each predictor (including shared variance), $sr^2$ (semi-partial $r^2$) which is the proportion of unique variance attributable to the predictor. * symbolises p<.05, *** symbolises p<0.001

Table 4 summarizes the multiple regression analyses for psychological well-being (PWS) and depressive symptoms (BDI-II) as outcome variables. MLHq, MHSAS, employment status, marital status, and acquaintance with mental health problems were the predictor variables. For PWS, the model explained 24.2% of the variance ($F(5,173) = 11.068$, $p < .001$). Mental health literacy (MLHq) turned out to be the strongest predictor ($\beta = .34$, $p < .001$), followed by employment status ($\beta = .16$, $p = .012$), help-seeking attitudes (MHSAS; $\beta = .15$, $p = .023$), and marital status ($\beta = .14$, $p = .029$). Acquaintance with mental health problems was not a significant predictor. For BDI-II scores, the regression model accounted for 16.1% of the variance ($F(5,173) = 6.641$, $p < .001$). MLHq again emerged as the strongest predictor ($\beta = -.32$, $p < .001$), followed by MHSAS ($\beta = .14$, $p = .05$) and marital status ($\beta = -.14$, $p = .042$). Here, employment status and acquaintance with mental health problems were not significant predictors of depressive symptoms. This analysis showcases the importance of mental health literacy as a predictor for both psychological well-being and depressive symptoms, with higher literacy associated with better mental health outcomes. Help-seeking attitudes and marital status were also significant factors in both models, while employment status (being employed) was only predictive of psychological well-being.

## Discussion

Research has consistently emphasized the importance of mental health literacy in the timely identification and management of mental illnesses (Dias et. al., 2018). The present study aimed to extend this line of inquiry to the understudied region of Jammu and Kashmir, where mental health needs are urgent. The study examines the mental health literacy and help-seeking attitudes of women in Jammu & Kashmir. It also further attempts to highlight the relationship of these variables with psychological well-being and experienced depression.

The data indicated that the sample's overall mental health literacy was average (Table 1), supporting Housen et al. (2019) conclusions that frequently acknowledged symptoms of mental health issues aligned with those in standardized checklists. This finding, however, contrasts with other studies in India, where mental health literacy has been found to be low (eg., Gaiha et al., 2014; Saraf et al., 2018; Ogorchukwu et al., 2016). This discrepancy may be attributed to our sample's composition. Various research has shown that young women have higher levels of MHL (e.g., Chandra, & Minkovitz, 2006; Cotton et al., 2006; Martínez-Zambrano et al., 2013). Since our sample was composed of educated women only, it might account for the findings.

Among the factors of MLHq, we found satisfactory knowledge of mental health problems (Factor 1), minimal false beliefs (Factor 2), and average first-aid skills and help-seeking behaviour (Factor 3). This shows more promising results as compared to other studies, where for instance, in Karnataka, depression was identified by 29.04% and schizophrenia/psychosis was recognised by only 1.31% of adolescents (Ogorchukwu et al., 2016). However, self-help strategies (Factor 4) scored lower than in Dias et al. (2018), highlighting a potential

area for improvement in mental health education in the region.

The MHSAS data suggest a significant inclination towards help-seeking, as seen in Table 1. This aligns with Housten et al. (2018) emphasis on people in the region often merging sociocultural and biomedical approaches for mental health support. Traditional healers, due to their cultural resonance and accessibility, are commonly favoured over medical services. The widespread practice of blending both traditions is colloquially called '*Dua Ti Dawa Ti*', meaning 'both prayer and medicine'. Although a psychiatric hospital is usually a last resort, it's clear that individuals are still actively pursuing help, often from traditional sources.

Interestingly, our sample demonstrated moderate levels of psychological well-being (PWS) and minimal BDI-II scores (Table 1), contrasting with previous research indicating high depression prevalence in the community (Housen et al., 2017; Amin & Khan, 2009). Additionally, the literature consistently links being female to increased depression rates (Housen et al., 2017; Amin & Khan, 2009; Wani et al., 2020). This disparity in our results can be attributed to our specific sample: educated urban women from upper-middle-class backgrounds with some mental health awareness. Past studies highlight that rural residency, younger age, and unemployment often correlate with heightened depression risks (Housen et al., 2017; Amin & Khan, 2009; Wani et al., 2020). It's worth noting that a higher socioeconomic status generally aligns with improved mental health outcomes (Steptoe et al., 2007). This also suggests that intersecting factors like education, socio-economic status, and urban residency may mitigate some of the mental health vulnerabilities associated with gender in this region.

The significant positive correlation between MLHq and MHSAS supports previous research (eg., Gorczynski et al., 2017; Smith & Shochet, 2011; Wright et al. (2007). Amongst the four factors of MLHq, Factor 3 (First aid skills and help-seeking behaviour), showed the strongest correlation with MHSAS ($r=0.226$ $p<0.002$). Research suggests that providing mental health literacy training leads to improvements in confidence in assisting a person with mental health issues and intentions to provide first aid (Morgan et al., 2018).

The results also revealed positive correlations between MLHq and PWS, alongside a negative association with BDI-II (Table 3). These findings correspond with other research suggesting a positive relationship between health literacy and beneficial mental health outcomes. Bjørnsen et al. (2019), investigated the correlation between positive mental health literacy and mental well-being and found that the regression model accounted for 41% of the variance in adolescents' mental well-being. Research indicates that higher health literacy is associated with higher psychological well-being and decreased risk of depressive symptoms (eg., Milner et al., 2019; Fiedler et al., 2018). Further, the psychological well-being and help-seeking attitudes showed a positive correlation. This further supports the potential benefits of informal help-seeking in reducing poor psychosocial outcomes (Heerde & Hemphill, 2018).

Regression analyses provided further insights into the predictive power of our variables. For PWS, the model explained 24.2% of the variance, with MLHq emerging as the primary significant predictor, followed by employment status, MHSAS, and marital status. In the case of BDI-II scores, the variance explained stood at 16.1%, with MLHq as the predominant predictor, succeeded by MHSAS and marital status (Table 4). Consistent with our findings, prior studies have suggested a predictive relationship between mental health literacy and mental

health (e.g., Bjørnsen et al., 2019). Previous research has also highlighted the positive impact of employment on psychological well-being (Waddell & Burton, 2006), and the role of positive help-seeking attitudes in reducing psychological distress (Rickwood et al., 2005). Conversely, reservations towards seeking help can impede timely assistance, exacerbating mental distress – a sentiment echoed by Vogel et al. (2007). Marital status, specifically being married, has also been associated with enhanced psychological well-being among women, especially in societies with pronounced gender roles (Simon et al., 2014). These findings also highlight how intersecting social factors like employment and marital status, combined with gender, influence mental health outcomes, reinforcing the need for an intersectional approach to understanding the complexities of women's mental health and systemic approaches for improving these outcomes.

However, it is crucial to acknowledge that the predictive power of these variables for psychological wellness and experienced depression is modest. Indeed, mental health is multifaceted and cannot be strictly determined by one's knowledge of mental health issues. It's influenced by a plethora of biological and psychological factors. Nonetheless, our findings underscore the potential benefits of enhancing mental health literacy and fostering positive help-seeking attitudes for overall mental health.

## Conclusion

With respect to limitations, a few must be mentioned. First, due to restrictions, the data collection was restricted to certain neighbourhoods of Kashmir and Jammu. Thus, the majority of participants included educated urban women from Kashmir and Jammu. Given that information about mental health issues and access to mental health professionals is better available to urban and educated classes, thus limiting the generalisability of these findings (eg, Suhail, 2005; Kermode et al., 2009). Secondly, even though the tools are statistically robust, their cultural validity has not been verified in this population.

In future studies, the limitations of the present study may be addressed, to produce more generalisable results. Researchers may develop standardised questionnaires catered to the present population or adapt available questionnaires for the same. Some other variables like the SES background could also be taken into consideration. Furthermore, future research must focus on formulating interventions aimed at enhancing mental health literacy. Adhering to guidelines provided by studies like Noar (2006), which emphasise the importance of preliminary audience research, targeted communication, and rigorous campaign evaluations, would be beneficial. There's much to glean from studies such as Evans-Lacko et al. (2010), which spotlight the transformative power of media campaigns in reshaping mental health narratives.

In conclusion, the study highlights the critical role of mental health literacy and help-seeking attitudes in promoting psychological well-being and mitigating depressive symptoms in Jammu and Kashmir. While the predictive power of these factors is modest, they offer tangible targets for intervention. Stakeholders should focus on developing and implementing culturally sensitive, gender-specific programs to enhance mental health literacy and promote positive help-seeking attitudes in the region.

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