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THE ROLE OF TRADITIONAL GENDER NORMS AND EMOTIONAL LABOUR IN SHAPING WOMEN'S MENTAL HEALTH, AUTONOMY AND SOCIAL POSITION IN UTTARAKHAND

Dr. Aaradhana Bandhani

Assistant Professor, Department of Sociology & Social Work H.N.B. Garhwal (Central) University, S.R.T. Campus, Badshahi Thaul Tehri Garhwal-249199, Uttarakhand, India

***Corresponding Author Email**-aaradhana10socio@gmail.com

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ABSTRACT

Traditional gender norms link socially constructed traits to biological sex, defining men as providers and women as nurturers. In Uttarakhand's villages, women face a "double burden" of farming and domestic duties as men migrate for work. This shift creates emotional challenges for families, leaving elderly parents experiencing loneliness and children lacking support. This silent strain on women's mental health is driven by deep isolation caused by male out-migration, the normalization of violence, patriarchal control, and overwhelming added responsibilities. A comprehensive analytical framework is required to fully understand the multifaceted nature of women's contributions to society. This paper adopts a comprehensive analytical framework to examine how diverse domestic, agricultural, and community responsibilities contribute to the unequal distribution of emotional labour. It further analyzes the impact of traditional gender roles and the burden of emotional labour on women's mental health, autonomy, and social standing in rural Uttarakhand. This paper employs a secondary data analysis approach, synthesizing findings from peer-reviewed studies, government reports, and empirical research conducted in Uttarakhand between 2017 and 2025. Key sources include Pande et al. (2017), Mathias et al. (2016), and Dumka (2020). Women face increased anxiety and chronic fatigue due to the burdens of visible and invisible care work, compounded by gendered expectations that limit their education, employment, and decision-making autonomy. This emotional labour perpetuates gender inequality, harming psychological well-being and independence. The relationship between gender and mental health is primarily social rather than biological, leading to cycles of suffering and marginalization. To improve women's mental health and autonomy, a fairer division of emotional labour and supportive policies are crucial. The paper advocates for gender-transformative mental health interventions that address these structural and psychosocial factors.

Keywords: Gender Norms, Emotional Labour, Women's Mental Health, Autonomy, Uttarakhand, Social Determinants of Health, Migration, Silent Mental Health Crisis.

INTRODUCTION

Traditional gender norms are socially constructed expectations tied to biological sex, labeling traits as "masculine" or "feminine." Masculine norms value assertiveness and independence, pressuring men to avoid vulnerability, while feminine norms emphasize empathy and nurturing, encouraging women to prioritize others' needs. Historically, this has reinforced a divide between the roles of "provider" (male) and "nurturer" (female), shaping social expectations within families and communities.

In the Himalayan villages of Uttarakhand, women are traditionally seen as homemakers and nurturers, playing a crucial yet often overlooked role in maintaining family health and well-being. From a young age, women are socialized as the primary emotional managers of the household—a burden that intensifies with male out-migration. While many men leave for urban centers to find work, women spend their days farming, caring for livestock, raising children, and managing homes.

This shift in labour is not merely an economic issue but reveals a deep psychological struggle in rural areas:

- Elderly parents experience loneliness and depression after their sons and daughters migrate.
- Children struggle with education and social development due to a lack of support.
- Women bear the heavy burden of caring for both the home and aging relatives, facing a "double burden" that leaves them physically exhausted and anxious.

Research indicates that women are approximately twice as likely as men to be diagnosed with anxiety and depression (WHO, 2021).

While this was previously explained primarily by biological factors such as hormones and genetics, emerging evidence suggests that social factors play a significant role (Riecher-Rossler, 2017). Women are not inherently more sensitive than men; rather, they contend with numerous chronic stressors arising from living in a patriarchal society.

This conceptual review seeks to integrate theoretical perspectives and empirical research to illuminate the psychosocial mechanisms linking gender and mental health outcomes. By examining how entrenched traditional gender roles, societal expectations, and the demands of emotional labour act as chronic, gendered stressors, we can better understand their profound impact on women's mental health, autonomy, and social standing.

METHODOLOGY

This paper is a conceptual review that synthesizes existing empirical findings from sociology, public health, gender studies, and cultural psychiatry. The review is structured thematically, examining three primary mechanisms: traditional gender roles, traditional gender norms, and emotional labour, followed by an integrative analysis of their combined impact on mental health, autonomy, and social position. The paper draws on quantitative and qualitative studies conducted in the Uttarakhand region, including works by Pande et al. (2017), Mathias et al. (2016), Das et al. (2018), Jain et al. (2021), and ethnographic research by Drew (2015).

Definitions of Core Concepts

- **Traditional Gender Roles:** Socially constructed expectations of how women and men should behave, rooted in patriarchal divisions of labour (e.g., the "caretaker" archetype for women).
- **Traditional Gender Norms:** The socially constructed rules, roles, behaviors, and expectations that a culture considers appropriate for men and women based on their biological sex.
- **Emotional Labour (Workplace):** The effort required to manage one's own emotions to display a feeling demanded by a job (Hochschild, 1983).
- **Emotional Labour (Relational):** The invisible work, performed primarily (but not exclusively) by women, involving managing emotional well-being, anticipating needs, resolving conflicts, and maintaining social bonds within families, friendships, and communities.

- **Mental Health:** A state of well-being where individuals recognize their abilities, effectively manage life's stresses, work efficiently, and contribute to their communities.
- **Autonomy:** The ability to self-govern and make informed decisions about one's own life and body, free from coercion.
- **Social Position:** An individual's standing or role within a social hierarchy, shaping their access to resources, power, and opportunities, which in turn affects key life outcomes, including physical and mental health.

THEMATIC ANALYSIS

Traditional Gender Roles: Pathways to Negative Mental Health Outcomes

In rural Uttarakhand, traditional gender roles create specific pathways that can lead to negative mental health outcomes.

- **The "Superwoman" Role:** This manifests acutely as women perform a "second shift" by managing household chores, childcare, animal husbandry, and demanding agricultural labour on steep, terraced fields, often while their husbands migrate for work. Ethnographic research by Drew (2015) in rural Garhwal reveals how gendered hardships, including water stress, heavy agricultural workloads, and inequitable access to resources, exacerbate women's daily struggles. Pande et al. (2017), in their foundational study of 250 women across three developmental blocks of Almora district, documented that rural hill women work 12–16 hours daily, confirming this chronic role overload. This overburden leads to burnout, elevated stress hormones, and hypertension (Taneja et al., 2024).
- **The "Selfless Caretaker" Role:** This leads women to prioritize the needs of others over their own, neglecting their own requirements for rest, nutrition, and medical care. This neglect can erode a woman's sense of identity and contribute to feelings of learned helplessness, low self-worth, and clinically significant depression (Kaur et al., 2021). Additionally, Jain et al. (2021) found that anxiety disorders affect over 13% of homemaking women in the Kumaon region. Furthermore, Pande et al. (2017) reported that 16.8% of women suffer from antepartum depression, while 7.6% experience postpartum depression.

Traditional Gender Norms: Societal Enforcement and Silenced Suffering

Unspoken gender norms function as powerful enforcement mechanisms shaping women's emotional lives and mental health outcomes, particularly within Pahari culture.

The "good girl" norm socializes women to avoid conflict, suppress anger, and prioritize others' comfort, making it difficult to set boundaries or articulate their own needs. This silent suffering leads to anger turned inward—a classic pathway to depression—while persistent people-pleasing breeds resentment and emotional exhaustion. Because societal norms typically frame anger as masculine, women learn to convert justified anger into self-blame and sadness, a process that can fuel major depression and increase anxiety.

Women in Pahari culture often face pressure to remain silent about their hardships. This culture expects them to endure suffering without expressing their feelings or making trouble. Since direct emotional expression is forbidden, psychological distress frequently manifests as somatisation: chronic headaches, gastric complaints, or unexplained body aches.

Research from Uttarakhand confirms how structural gender inequality and restrictive social norms impact women's mental health:

- A survey by Mathias et al. (2016) found that gender inequality and social exclusion significantly contribute to depression, with women from oppressed castes facing a two to three times higher risk.
- Chauhan (2025) examines harmful practices like Chhaupadi, which confine women to cowsheds and undermine their autonomy and dignity.

- In the Kumaon region, studies show that traditional gender norms expect ever-married women to endure the challenges of joint family life, economic instability, household substance abuse, and marital disputes without question or the option to leave.

These norms are socially enforced through family structures and community expectations, leaving women with little room to voice distress. As a result, their suffering becomes invisible—manifesting as depression, further deepened by parental anxiety over children's futures and a negative self-image imposed by patriarchal standards. Das et al. (2018) demonstrate that this silenced suffering is a direct consequence of entrenched gender inequalities, where women's mental health is systematically undermined while their pain remains unacknowledged.

Emotional Labour: Cognitive Overload, Burnout, and the Empathy Toll

In rural Uttarakhand, emotional labour profoundly shapes mental health through several interrelated pathways:

- **Chronic Cognitive Overload:** Arises from the constant monitoring of family members' needs, anticipating a husband's fatigue, regulating one's own distress, and silently managing scarce resources. This mental strain results in decision fatigue and elevated cortisol levels.
- **Emotional Dissonance and Burnout:** Occurs when women suppress exhaustion to perform cheerfulness during family or community gatherings. The gap between felt and performed emotion fosters depersonalization and burnout. Pandey, Singh, and Sohani (2018) conducted a ten-month study with 26 ASHA workers in rural India. They found that these women handle emotional work in two ways: "surface acting" (pretending to feel certain emotions) and "deep acting" (trying to genuinely feel those emotions). Deep acting in negative situations led to stress, decreased effectiveness, and spillover into personal life. A subsequent quantitative study by N. et al. (2024) of 467 ASHA workers confirmed that emotional labour in precarious work environments significantly affects organizational commitment and contributes to burnout.
- **The Empathy Toll:** Manifests as women constantly validating and soothing the anxieties of others without receiving reciprocal support, leading to empathy fatigue, secondary traumatic stress, and heightened anxiety.
- **The Thankless Factor:** Ensures that emotional labour remains invisible by design, with no one acknowledging the wife who manages children's tantrums or the one who remembers an in-law's health checkup. This invisibility breeds resentment, loneliness, and a profound sense of injustice—all strong predictors of depression. Pande et al. (2017) quantified this: 42.4% of rural women experienced stress from physical violence, and a majority exhibited poor mental health status.
- **Cultural Expression of Burden:** Varma's (2022) ethnographic research on the Gaddi community in the Himalayas provides valuable insights into the cultural expression of emotional burden. The term "kamzori" means weakness and is used by adult women to describe a state that includes physical, emotional, and relational aspects. Varma suggests that "kamzori" reflects not just aging but also a physical state that shows disrupted care relationships. This highlights the unreciprocated work and care that family members provide, offering a culturally relevant understanding of emotional burden amid structural changes like male out-migration.

The Silent Mental Health Crisis: Migration as an Amplifier

As noted by Dumka (2020), mass youth migration from Uttarakhand's hill districts creates an "invisible affliction" for those left behind. Women face a double burden: they must perform both their traditional domestic roles and the agricultural labour previously managed by migrating men.

Gurung (2007) argues that across the Himalayan region, male labour migration, while providing economic stability, increases women's workloads and leaves them to shoulder the mountain economy alone. This occurs alongside limited access to education, health facilities, and communication—reinforcing the feminization of poverty and psychological vulnerability. The people left behind experience loneliness and depression, while children face academic and social challenges. This migration-induced stress interacts with existing gender norms, amplifying the emotional labour and chronic anxiety already borne by rural women.

IMPACT ON AUTONOMY AND SOCIAL POSITION

Drawing from the preceding analyses, we can examine how these interlocking forces profoundly shape women's autonomy and social position.

Erosion of Autonomy

Autonomy—the capacity to make independent decisions about one's body, labour, finances, mobility, and healthcare—is systematically eroded. Research by Pande et al. (2017) found that chronic cognitive overload leaves little mental energy to assert preferences, reinforcing passive acceptance of male authority. This pattern indicates that women are entrusted with operational decisions related to their labour but excluded from strategic decisions about family finances, social alliances, and major purchases.

Concrete evidence of fragmented autonomy is provided by Tiwari and Kumar (2025), who document that in the Kumaon region, menstruating women are compelled to live in cowsheds for 5 to 7 days, denied access to home bathrooms and participation in socio-religious events. This practice directly compromises their autonomy, privacy, dignity, and human rights. Chauhan (2025) further examines how such traditional menstrual practices restrict women's social status and freedom.

Economic Constraints

Economic data from the Uttarakhand Economic Survey 2024–25 highlights the stark disparities that compound these autonomy restrictions:

Metric / Parameter	Rural / Hilly Area Status	Impact on Autonomy & Well-being
Wage Gap	Women in hilly areas earn 45% less than those in flat areas.	Severely restricts financial independence and domestic negotiating power.
Employment Type	68% of rural women work in low-paying agricultural jobs.	Hinders long-term earnings, growth opportunities, and increases physical fatigue.
Skill-to-Job Conversion	Only 26% of young women completing skill-training find stable jobs.	Disconnect between training and employment reduces confidence and sense of life control.

Social Subordination

Women's social position is equally constrained. They are valued not as individuals with rights but as gatekeepers of relationships and vessels of modesty. Their worth is measured by their ability to perform invisible emotional labour without complaint and to endure hardship stoically. As a result, they are praised for self-sacrifice but never for assertion, rendering them socially subordinate.

A large survey by Mathias et al. (2016) in Uttarakhand found that gender inequality and social exclusion significantly contribute to mental health problems. People from socially oppressed castes were two to three times more likely to experience depression. Even ASHA and Anganwadi workers are viewed as low-status because their roles are seen as extensions of caregiving rather than leadership. This internalization of norms causes women to reinforce patriarchal hierarchies among themselves.

DISCUSSION

The analysis confirms that in the hills of Uttarakhand, traditional gender norms and emotional labour do not merely affect mental health; they actively construct and reproduce women's diminished autonomy and subordinate social position. The mechanisms identified—role overload, silenced suffering, somatisation, cognitive overload, and the thankless factor—are not individual failings but structural and psychosocial determinants. Geographic isolation, out-migration of men, and the

additional "silent mental health crisis" described by Dumka amplify these burdens. The scarcity of mental health services and cultural prohibitions against expressing distress ensure that suffering remains invisible and untreated.

The concept of kamzori, as elaborated by Varma (2022), illuminates how Himalayan women process emotional distress. Rather than being recognized as psychological suffering requiring intervention, weakness is normalized as an expected consequence of female aging and labour. This cultural framing serves dual functions: it provides women with a legitimate vocabulary for expressing distress, but it also naturalizes suffering, reducing the perceived need for structural or policy responses.

Research conducted in the Kumaon region highlights a pressing issue regarding women's mental health. A study by Das et al. (2018) revealed that 18.8% of ever-married women experience clinically significant depression. The likelihood of depression is notably higher among women who live in joint families, face economic instability, or encounter family disputes, underscoring the impact of social and economic factors on women's mental well-being.

The consistent results observed across studies, including those by Pande et al. (2017), Mathias et al. (2016), and Jain et al. (2021), indicate that this issue is not an isolated incident but rather a broader systemic crisis. The literature review shows that gender norms in Uttarakhand are not static. They are shaped by a powerful interplay of patriarchal traditions, environmental changes leading to male migration, and emerging economic pressures. These social norms create a system where women's work, whether physical, household, or emotional, is often normalized, overlooked, and unpaid. This adds a significant burden on women, harming their mental and physical health and limiting their economic and social opportunities.

CONCLUSION

The higher rates of anxiety, depression, and burnout among women in rural Uttarakhand are not a product of biology but of deeply embedded social forces. Traditional gender roles, enforced by unspoken norms and performed through invisible emotional labour, create a chronic stress ecology that systematically undermines mental health, erodes autonomy, and entrenches subordinate social positions. The added dimension of mass youth migration intensifies this crisis, leaving women to shoulder impossible double burdens in geographic and social isolation.

Recognizing these mechanisms is the first step toward change. Policy and practice must move beyond individual clinical models toward structural interventions that redistribute domestic and emotional labour, challenge patriarchal norms, and amplify women's voices and agency. Only then can the cycle of silenced suffering and marginalization be broken.

LIMITATIONS AND FUTURE DIRECTIONS

- **Methodological Limitations:** This conceptual review is not based on primary empirical data collection but synthesizes existing secondary research.
- **Empirical Fieldwork Needed:** Future studies should conduct field interviews and structured observations with women in rural Uttarakhand to confirm and improve these findings. Surveys are required to evaluate how frequently these stressors occur and how they statistically correlate to clinical health outcomes.
- **Intervention Research:** Action-oriented research is urgently needed to test culturally adapted, gender-transformative programs that reduce emotional labour, challenge silencing norms, and promote women's autonomy and access to care.
- **Targeted Vulnerable Demographics:** Particular attention should be paid to the specific mental health needs of women explicitly left behind by migration, as this subgroup remains significantly understudied.

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