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Trauma and Its Impact on Menstrual Health: Psychological Insights from Women in Michamari, Assam

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Abstract

This study explored the psychological impact of trauma on menstrual hygiene management among 50 women in the Michamari area of Assam, India. While the psychological effects of trauma, including anxiety, depression, and hypervigilance were well-documented, their influence on menstrual health had been less studied. The research found that trauma significantly interfered with menstrual hygiene practices, with survivors facing barriers such as shame, disgust, and avoidance behaviours. These psychological factors hindered their ability to manage menstruation effectively. Additionally, the study examined the role of mental health support and community resources, emphasizing their importance in alleviating these challenges. Participants who received trauma-informed care and mental health services reported improved menstrual hygiene management, underscoring the need for a holistic approach that addressed both psychological and physical needs. The findings advocated for the integration of mental health support into menstrual hygiene management programs, especially in rural settings, to help survivors of trauma overcome the barriers they faced.

Introduction

Trauma is a severe violation that profoundly affected women's psychological, emotional, and physical well-being. Survivors of sexual violence often struggled with both overt and subtle consequences that hindered their ability to maintain proper health practices, including menstrual hygiene. [1,2] While much research has focused on the immediate mental and physical impacts of trauma, the intersection between trauma and menstrual health remained underexplored, particularly in rural settings like Michamari, Assam. Women in such areas often faced compounded challenges, including a lack of mental health support and minimal access to menstrual health education, which makes managing menstruation even more difficult for trauma survivors. [3,4]

The psychological impacts of trauma-such as anxiety, depression, hypervigilance, and feelings of disgust-were particularly detrimental to menstrual health.

[7,10] These conditions could lead to neglect of basic self-care, avoidance of menstruation-related activities, and a heightened sense of shame surrounding menstruation, all of which created barriers to effective menstrual hygiene management. Moreover, rural women in India were often subjected to cultural taboos surrounding menstruation, which exacerbated these negative feelings. [3] This study aimed to shed light on how trauma influenced menstrual hygiene practices among women in Michamari and assess how mental health support could mitigate these effects.

Trauma and its profound effects on women's mental health have been widely recognized, with studies linking trauma to various health outcomes, including menstrual health. Sexual violence could lead to significant psychological consequences, which may influence self-care behaviours, such as menstrual hygiene. Psychological trauma, particularly post-traumatic stress disorder (PTSD), could interfere with an individual's ability to engage in daily health practices, including those related to menstruation. Women experiencing PTSD or other trauma-related symptoms, such as anxiety, depression, and hypervigilance, may struggle to maintain personal hygiene, including managing menstrual health, due to feelings of shame, guilt, or distress associated with their trauma. [11]

Menstrual hygiene management (MHM) is critical to women's overall health, yet it is often overlooked, particularly in the context of trauma. Several studies suggested that trauma survivors, especially those in marginalized communities, faced unique challenges in managing menstruation. The psychological impact of trauma could affect a woman's emotional well-being, influencing her willingness to manage menstruation effectively. For instance, trauma survivors often reported negative feelings toward their bodies, which could exacerbate difficulties in caring for themselves during menstruation. [12] This disconnect from self-care routines could lead to negative physical health outcomes, such as infections or irritations, as proper menstrual hygiene is neglected.

A significant body of research has focused on the role of mental health interventions in improving menstrual hygiene management among trauma survivors. Trauma-informed care, which recognized the unique psychological and emotional needs of individuals had experienced sexual violence, has been shown to improve the ability of survivors to manage their health. This approach included offering psychological support, creating safe environments and addressing the underlying trauma that may impede personal care practices like menstruation. [13] Studies had found that when women were given the space and resources to address their trauma, their capacity to engage in self-care behaviours, including maintaining menstrual hygiene, improved significantly. [14]

This study aimed to explore several key objectives related to the intersection of psychological trauma and menstrual hygiene management in a rural setting. First, it examined how trauma-related conditions such as anxiety, depression, and hypervigilance hindered women's ability to effectively manage their menstrual health. The study also sought to identify emotional responses such as shame, disgust, and disengagement from self-care, which often acted as barriers preventing trauma survivors from maintaining proper menstrual hygiene. Additionally, the research investigated the availability of community-based or formal mental health resources in Michamari and assessed how access to these services influenced menstrual health management among trauma-affected women. Finally, the study aimed to propose ways in which trauma-informed care and community-based mental health interventions could empower women to regain control over their menstrual health, highlighting the importance of integrated and holistic support systems in addressing both psychological and physical well-being.

Rationale of the Study

The rationale for this study was based on the critical yet underexplored intersection between psychological trauma and menstrual hygiene management, particularly in rural and marginalized settings such as the Michamari area of Assam, India. While the psychological consequences of trauma-such as anxiety, depression, and hypervigilance-had been widely recognized, their specific impact on menstrual health and hygiene practices had remained inadequately addressed in existing literature. This

gap was especially concerning given that trauma often led to avoidance behaviours, feelings of shame, and disgust, all of which could severely hinder effective menstrual hygiene management. Understanding this dynamic was essential for developing holistic health interventions. By investigating how trauma affected menstrual practices and evaluating the role of trauma-informed care and community mental health support, the study aimed to inform the design of integrated programs that simultaneously addressed psychological well-being and menstrual health. This approach was considered vital for improving the overall quality of life and dignity of trauma-affected women in rural communities.

Methodology

Study Design

For the proposed research, qualitative data were collected using in-depth interviews to understand how trauma affects menstrual hygiene practices among women. The sample consisted of 50 women between the ages of 30 and 45, residing in the Michamari area of Kamrup District, Assam. Participants were selected through purposive sampling during the year 2023. The structured interview schedule was designed to explore menstrual hygiene practices, the psychological impact of trauma, and their effects on mental health and daily functioning. This study is a component of the ongoing doctoral research, which has been approved by the Institutional Human Ethics Committee of Avinashilingam University, Coimbatore with reference number AUW/IHEC/EXT-20-21/XPD-11, dated July 7, 2021.

Over a period of one month, personal interviews were conducted to collect data on menstrual hygiene management, trauma experiences, living conditions, and the psychological challenges faced by the participants. Primary data were gathered through these interviews, while secondary data were sourced from academic journals and relevant websites. The study aimed to gain a deeper understanding of how menstrual hygiene practices, in conjunction with trauma experiences, affected women's mental well-being and daily lives.

Findings indicated that poor menstrual hygiene management combined with unresolved trauma contributed to emotional distress, diminished self-esteem, and social withdrawal, all of which significantly impacted the quality of life of the participants. Data were analyzed using statistical methods, including frequency analysis, and results were presented in tabular form to illustrate the relationship between menstrual hygiene, trauma-related psychological effects, and women's mental health in the rural context.

By examining these interconnected factors, the study sought to emphasize the importance of improving menstrual hygiene awareness and addressing the psychological consequences of trauma. It aimed to demonstrate how such efforts could enhance women's mental health, reduce stigma, and ultimately improve their overall well-being and social engagement.

Results

The study was conducted among 50 female respondents, aged 30 to 45 years, in the Michamari area, located in the Kamrup District of Assam.

Socio-Demographic Factors

The researcher focused on the socio-demographic factors of the respondents such as age groups, religion, family type, monthly income, education and experiences any kind of trauma which was presented in below Table 1.

This study included 50 women from Michamari, Assam, aged between 30 and 45 years, with the largest group, 56%, falling in the 35-40 year age range. The participants were predominantly from rural, low-income backgrounds, a factor that could contribute to unique challenges in accessing both menstrual hygiene products and mental health services. Approximately 90% of the women identified as Hindu, reflecting the region's demographic composition. In terms of family structure, 76% of the participants came from nuclear families, which was in line with the changing family dynamics seen across rural India, where nuclear families had become increasingly common due to economic migration and social changes. A significant portion of the sample had completed education at the high school level, although many had limited access to

Table 1: Profiling of the Respondents in Relation to Socio-Demographic Factors

Sl. No.	*Socio-economic Profile*	*Category*	*Number of Response (n=50)*	*Percentage (%)*
1.	Age Groups (in years)	30-35	12	24
		35-40	28	56
		40-45	10	20
2.	Religion	Hindu	45	90
		Muslim	5	10
3.	Type of Family	Nuclear	38	76
		Joint	12	24
4.	Monthly Income	Below Rs 3000	4	8
		Rs 3001-6000	39	78
		Above Rs 6001	7	14
5.	Education	High School	28	56
		Higher Secondary School	12	24
		Undergraduate	8	16
		Post Graduate	2	4
6.	Experience any kind of trauma	Agree	26	52
		Disagree	24	48

higher education, which correlated with the broader educational trends in rural areas of Assam, where access to quality education remained a major challenge. As a result, many women in this study were aware of basic menstrual hygiene practices but had limited exposure to modern methods and professional healthcare services. A large proportion of the women in the study, specifically 52%, reported having experienced some form of trauma, a finding that underscores the vulnerability of women in rural areas to various forms of abuse, including sexual violence.

Discussion

This aligned with findings from various studies conducted after 2014, which had highlighted the psychological and physical toll of trauma on women, particularly in rural and underdeveloped areas. For instance, a study found that trauma among rural women in India significantly impacted their mental health, contributing to conditions like anxiety, depression, and post-traumatic stress disorder (PTSD). [15] Furthermore, another study showed that women from low-income backgrounds with histories of trauma were more likely to have inadequate access to mental health support, often relying on family or community networks for emotional support. [16] However, the quality of these informal networks was frequently inconsistent, with many women reporting feelings of isolation or stigma surrounding their trauma.

In terms of menstrual hygiene, the study found that a significant portion of women relied on traditional methods such as cloths and homemade pads, which were still prevalent in rural areas of India. A relevant study highlighted that many women in rural Assam, particularly from low-income backgrounds, continue to use cloths due to a lack of access to affordable sanitary products and inadequate menstrual education. [17] Despite the widespread use of traditional methods, these practices often lead to health risks, including infections and discomfort, as they were not as hygienic as commercially available pads or menstrual cups.

Additionally, the data indicated that many women had limited or no access to professional mental health services. This was consistent with some findings from studies which found that mental health services remained scarce in rural India, particularly in the north-eastern states like Assam. In this context, women often relied on informal support networks, such as family members, friends, or community health workers. While these networks

could provide some comfort and advice, they were generally not equipped to address the complex mental health needs of trauma survivors. Furthermore, there was often a cultural stigma surrounding mental health issues in rural India, which could prevent women from seeking professional help. [18] According to a study, rural women were more likely to internalize mental health issues like depression and anxiety, often due to the social stigma associated with mental illness and the lack of accessible, affordable mental health services. [19]

Table 2: Psychological Barriers to Effective Menstrual Hygiene Management Among Trauma-Affected Women in Rural Assam

N=50

Sl. No.	Psychological Barriers	Agree		Disagree	
		F	P	F	P
1.	Anxiety	38	76	12	24
2.	Depression	27	54	23	46
3.	Hypervigilance	28	56	22	44
4.	Feelings of disgust and shame	34	68	16	32

F=Frequency; P= Percentage (%)

Psychological Barriers to Menstrual Hygiene

The researcher focused on the psychological barriers to menstrual hygiene of the respondents such as anxiety, depression, hypervigilance and feelings of disgust and shame which was presented in below Table 2.

Anxiety

Anxiety, largely stemming from past trauma, was a major barrier to menstrual hygiene among 76% of the women in this study. Anxiety led to delayed or neglected hygiene practices due to fear and distress. Social stigma, lack of resources, and insufficient mental health support exacerbated these issues.

PTSD and trauma histories impaired hygiene management due to heightened anxiety. [20, 21] PTSD symptoms disrupted menstrual hygiene, [22] while it was noted that anxiety from trauma prevented access to sanitary products. [23] It also emphasized the need for integrated mental health support to address these barriers. [24]

These studies underscored the need for trauma-informed care in menstrual health interventions.

Depression

Depression emerged as a significant psychological barrier in the study, with 54% of respondents reporting symptoms of depression that hindered their engagement in self-care during menstruation. Many participants described experiencing emotional numbness and a lack of interest in maintaining personal hygiene, consistent with findings in the literature. For instance, depression in trauma survivors often resulted in emotional withdrawal and neglect of essential self-care tasks. [7] More recent studies also support this connection; a study found that survivors of trauma who suffered from depression frequently reported a diminished ability to perform basic self-care activities, including maintaining menstrual hygiene. [25] Additionally, a study also revealed that trauma survivors experiencing depressive symptoms were more likely to feel hopeless, which could further exacerbate difficulties in adhering to regular menstrual hygiene practices. [26] These findings underscored the importance of addressing both the psychological and physical aspects of health for trauma survivors, particularly in managing menstrual hygiene during depressive episodes.

Hypervigilance

Hypervigilance, characterized by an exaggerated state of alertness and sensitivity to potential threats, was a prevalent issue among trauma survivors in this study. 56% of respondents reported experiencing this heightened state of awareness, which significantly impacted their ability to manage their menstrual hygiene, especially in public settings. Many women expressed a deep fear of being judged or exposed, leading to excessive caution in maintaining their hygiene. This finding aligned with a similar work who highlighted that hypervigilance could severely disrupt daily functioning in trauma survivors, particularly affecting personal hygiene practices. [9] More recent research supports this connection: a similar study found that hypervigilance in trauma

survivors often led to heightened anxiety around bodily functions and hygiene, resulting in avoidance behaviours and emotional distress in public spaces. [27] Furthermore, it demonstrated that trauma survivors with elevated hypervigilance levels frequently reported difficulties in performing routine self-care tasks due to fear of being observed or criticized, further compounding the psychological burden they experienced. [28] These findings reinforced the need to address both the emotional and practical challenges faced by trauma survivors, especially in relation to menstrual hygiene management.

Feelings of Disgust and Shame

Feelings of disgust and shame were reported by over 68% of the participants, with many women associating menstruation with painful reminders of their trauma. These emotions often led to a sense of isolation and a tendency to avoid menstruation-related activities. The cultural stigmas surrounding menstruation in rural India further exacerbated these negative feelings, contributing to heightened emotional distress. [29] Women in the study frequently described avoiding menstrual hygiene management due to embarrassment, which ultimately led to neglect of proper hygiene practices. More recent research aligned with these findings; a study highlighted that trauma survivors in rural settings often experienced significant shame and disgust related to menstruation, resulting in avoidance behaviours and poor hygiene practices. [30] Additionally, a related study noted that cultural taboos around menstruation in India significantly contributed to feelings of humiliation, further preventing women from engaging in adequate menstrual hygiene management. [31] These studies reinforced the need to address both the psychological and cultural factors that influenced menstrual health, particularly for trauma survivors in rural communities.

Role of Mental Health Support

Lack of Access to Mental Health Services

A critical finding from this study was the lack of professional mental health services in Michamari. Most participants had limited access to counsellors or therapists, resulting in inadequate support for addressing the psychological effects of trauma. Previous research has consistently emphasized that access to mental health services was essential for trauma survivors to manage their emotional well-being and health effectively. [32] This finding highlighted the urgent need for improved mental health infrastructure in underserved areas to support trauma survivors in their recovery.

Informal Support Systems

While formal mental health services were scarce, the study found that informal community-based support was valuable. Women who participated in local support groups or received guidance from health workers showed better engagement with their menstrual health. These findings aligned with a study who emphasized the importance of peer and community support in improving the mental and physical health of trauma survivors. [33]

Strengths and Limitations

This study had several notable strengths that contributed to the emerging body of research on the intersection of psychological trauma and menstrual hygiene management. One of the primary strengths was its focus on an underexplored area-specifically, how trauma-related psychological factors such as anxiety, depression, and hypervigilance hindered menstrual hygiene practices among women in rural India. By addressing this research gap, the study provided important insights into a critical yet overlooked issue in public health.

Another strength lay in the context-specific approach adopted by the study. By focusing on a purposively selected sample of 50 women from the Michamari area of Assam, the research offered a detailed understanding of the lived experiences of trauma survivors within a particular socio-cultural and geographic setting. The study also took a holistic view, exploring both physical and psychological dimensions of menstrual health. This comprehensive approach supported the argument for integrated, trauma-informed health interventions. Furthermore, the investigation into the availability and influence of community mental health resources added practical value, offering recommendations relevant to policy and program development.

However, the study also had certain limitations. The relatively small sample size limited the generalizability of the findings beyond the specific context of Michamari. The geographic focus on a single rural area further constrained the applicability of the results to other regions or populations. Data collection relied on self-reported interviews, which have introduced recall bias or social desirability bias, particularly given the sensitive nature of trauma and menstruation. Additionally, the cross-sectional nature of the study prevented an assessment of long-term impacts or behavioural changes over time. Although the study addressed psychological issues such as anxiety and depression, it did not employ standardized diagnostic tools, which may have affected the reliability of mental health assessments.

Future studies with larger, more diverse samples and longitudinal research designs are recommended to expand on these findings and further investigate the complex relationship between trauma, mental health, and menstrual hygiene management across different cultural and regional contexts.

Conclusion

This study highlighted the profound impact of Trauma on menstrual hygiene practices among women in Michamari, Assam. Psychological factors such as anxiety, depression, hypervigilance, and feelings of shame hindered survivors from properly managing their menstrual health. The lack of access to professional mental health services exacerbated these barriers. However, survivors who accessed community-based mental health support were better able to manage their menstrual hygiene, demonstrating the importance of mental health interventions in improving overall health outcomes. This research underscores the need for trauma-informed care and the integration of mental health support into menstrual health services to help trauma survivors regain control over their health.

Future Research

Future studies should explore the long-term effects of trauma on menstrual health in rural settings and evaluate the impact of trauma-informed care interventions. Further research should also focus on the development of culturally sensitive menstrual hygiene education programs that address the specific needs of trauma survivors.

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