International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Emotional and Psychological Impact of PCOS on Young Women

Ms. Kinnari Chetan Joshi[1], Ms. Dhruti S Prasad[2]

[1]Student, Msc. Clinical Psychology, Jain University
[2]Guide, Department of Psychology PG Studies, Jain University

ABSTRACT

Polycystic Ovary Syndrome (PCOS) is one of the most prevalent endocrine disorders affecting women of reproductive age, with increasing incidence globally and particularly in urban Indian populations. While the physical manifestations of PCOS have been widely researched, its emotional and psychological implications remain comparatively underexplored. The present study aimed to examine the emotional and psychological impact of PCOS among young women, with a specific focus on coping strategies and resilience factors. A qualitative testimony-based research design was employed. The sample consisted of 42 women diagnosed with PCOS residing in Mumbai, aged 18–45 years. Data were collected using semi-structured testimonies supported by socio-demographic information. Thematic analysis revealed key themes including diagnosis-related uncertainty, body image concerns, stigma and social pressure, emotional exhaustion, and pathways to resilience. Participants reported experiencing psychological distress associated with symptom visibility, fertility concerns, and family expectations. Coping strategies such as health literacy, emotional support, and self-compassion emerged as important resilience factors. The findings highlight the importance of addressing PCOS as a biopsychosocial condition and recommend integrating culturally sensitive psychological support into routine gynaecological care.

Keywords: PCOS, Psychological Distress, Coping, Resilience, India

CHAPTER I
INTRODUCTION

Polycystic Ovary Syndrome (PCOS) is a complex endocrine and metabolic condition that affects women across the reproductive years and is associated with menstrual irregularities, hyperandrogenic features (clinical and/or biochemical), and polycystic ovarian morphology. PCOS is not a single uniform disorder; rather, it is a syndrome with multiple phenotypes, where symptom profiles and severity vary significantly among individuals. This heterogeneity has clinical importance because it shapes the pathway to diagnosis, the continuity of treatment, and the everyday experience of living with the condition.

PCOS is increasingly recognised as a significant public health concern. Global health sources estimate that approximately 10–13% of women worldwide may be affected, and a substantial proportion remain undiagnosed for extended periods. Underdiagnosis is often linked to the normalisation of menstrual and dermatological symptoms, limited health-seeking behaviour due to stigma or misinformation, and delayed clinical attention until fertility concerns emerge. When diagnosis is delayed, women may spend years coping with uncertainty, self-blame, repeated symptom cycles, and inconsistent medical guidance—factors that can cumulatively influence psychological wellbeing.

While PCOS is frequently discussed in biomedical terms, the condition has distinct psychological and social consequences. Its symptoms often intersect with identity- sensitive and socially evaluated domains such as body image, femininity, and perceived "normalcy" in reproductive functioning. Concerns related to weight fluctuations, acne, hair thinning, and hirsutism may not only cause discomfort but can also affect self-esteem, social confidence, and interpersonal interactions. Additionally, uncertainty about fertility and long-term metabolic risks can produce persistent worry, health anxiety, and future-oriented stress. Over time, these stressors may contribute to emotional exhaustion and diminished quality of life, even when medical management is ongoing.

International clinical guidance increasingly positions psychological wellbeing as a core component of PCOS care. The 2023 International Evidence-Based Guideline for PCOS emphasises comprehensive assessment and patient-centred management, including attention to emotional wellbeing and quality-of-life outcomes. This perspective is clinically significant because it reframes psychological distress not as a secondary concern but as a meaningful health outcome that requires recognition, screening, and appropriate intervention within routine care.

The sociocultural context in India adds further depth to the psychological experience of PCOS. In many families and communities, menstruation and reproductive health remain difficult topics to discuss openly, and women may encounter stigma, moral judgement, or oversimplified narratives about "lifestyle" and "willpower." In collectivistic environments, family members may act as crucial sources of support; however, family involvement may also become a source of pressure when the diagnosis is interpreted primarily through the lens of marriage prospects or future fertility. These cultural and relational dynamics can intensify distress, shape coping choices, and influence whether women seek professional psychological support or manage silently.

Mumbai provides a relevant context for exploring these concerns because it represents an urban environment where lifestyle transitions, career and academic stressors, and increased exposure to appearance-related social comparison often coexist with variable health literacy and highly diverse family systems. Importantly, psychological responses to PCOS are not identical across individuals; many women show adaptation and growth over time. Therefore, the concepts of coping and resilience become central for understanding not only distress, but also how women sustain functioning and build psychological stability while living with PCOS.

Coping refers to the cognitive and behavioural efforts individuals use to manage stressors, whereas resilience refers to the ability to adapt and recover in the presence of chronic challenges. Within PCOS, coping and resilience are not abstract traits; they emerge through daily decisions, support systems, personal meaning-making, and culturally grounded practices. Studying these processes is essential for developing psychologically informed care models that respect lived reality and provide practical pathways for intervention.

Need for the Study

Despite growing awareness of PCOS, the emotional and psychological dimensions of the condition remain under-addressed in many care pathways. Clinical consultations often prioritise symptom control and reproductive outcomes, while emotional distress—such as anxiety, depressed mood, body image concerns, or relationship strain—may be overlooked, normalised, or addressed only when symptoms become severe. This gap is particularly concerning because psychological distress can influence treatment adherence,

lifestyle engagement, and overall quality of life, thereby shaping both mental and physical health outcomes.

There is a specific need for research that is locally grounded and psychologically focused. Much of the PCOS literature is biomedical or epidemiological, and although large-scale quantitative studies provide valuable associations, they may not fully capture how women experience PCOS in daily life—how they interpret symptoms, respond to social commentary, negotiate identity concerns, and choose coping strategies. In India, where cultural narratives around femininity, body norms, marriage, and motherhood remain influential, lived experiences may carry dimensions that are not well represented in Western-derived models.

Further, mental health stigma and limited access to integrated psychological support may lead women to carry distress privately. Women may describe their psychological burden through fatigue, irritability, reduced confidence, withdrawal, or somatic concerns rather than explicitly naming anxiety or depression. Without culturally responsive psychoeducation and supportive interventions, distress may persist, intensify, or become embedded into self-concept and future expectations.

Accordingly, the present dissertation is needed to examine PCOS as a biopsychosocial experience, with attention to emotional impact as well as protective processes. By focusing on coping and resilience, the study adopts a strength-informed psychological lens: it does not merely document distress, but aims to understand how women manage, adapt, and protect their wellbeing while living with PCOS.

Statement of the Problem

PCOS is prevalent and clinically significant, yet its emotional and psychological impact is frequently under-recognised within routine healthcare. Women living with PCOS may experience distress related to symptom uncertainty, body image concerns, perceived stigma, fertility-related worries, and the chronic demands of self-management. In the Indian sociocultural context, these concerns may be intensified by family dynamics and social expectations. There is a need for locally grounded research that explores how women experience PCOS psychologically, and how coping strategies and resilience processes shape adjustment.

Aim: To examine the emotional and psychological impact of PCOS on women in the age group of 18–45 years in Mumbai, with specific focus on coping strategies and resilience, using local research testimonies.

Objectives

1. To explore the emotional and psychological concerns reported by women diagnosed with PCOS.
2. To identify key stressors associated with PCOS (e.g., symptom burden, body image concerns, fertility-related worries, stigma, uncertainty).
3. To document coping strategies adopted to manage PCOS-related emotional and social challenges.
4. To understand resilience-related resources and perceived supports contributing to psychological adjustment.
5. To interpret PCOS experiences within a biopsychosocial and sociocultural lens relevant to the Mumbai context.

Research Questions

1. How do women (18–45 years) in Mumbai describe the emotional and psychological impact of living with PCOS?

2. What stressors are most salient in shaping psychological distress associated with PCOS?
3. What coping strategies are used to manage PCOS-related challenges and daily functioning?
4. What factors contribute to resilience and improved psychological adjustment among women with PCOS?
5. How do family dynamics and sociocultural expectations influence coping and wellbeing in PCOS?

Polycystic Ovary Syndrome (PCOS):
A clinically diagnosed endocrine condition commonly identified using recognised diagnostic approaches (such as revised Rotterdam-based frameworks), characterised by features including ovulatory dysfunction, hyperandrogenism, and/or polycystic ovarian morphology after exclusion of other relevant conditions.
Emotional and Psychological Impact: The range of emotional experiences and psychological consequences associated with living with PCOS, including distress, low mood, anxiety, stress, reduced self-esteem, body image concerns, identity disruption, and quality-of-life impacts.
Psychological Distress:
A state of emotional suffering that may include symptoms associated with depression, anxiety, and stress. In this dissertation, psychological distress is understood through participant-reported experiences and narrative descriptions emerging from testimonies.
Coping: The cognitive and behavioural strategies used to manage PCOS-related stressors and demands. Coping may include problem-focused strategies (e.g., health behaviour changes, medical consultation), emotion-focused strategies (e.g., reframing, emotional regulation, support-seeking), avoidance-based strategies, and culturally grounded coping practices.
Resilience: The adaptive capacity to sustain or regain psychological functioning in the context of PCOS-related challenges. Resilience is conceptualised as a dynamic process supported by personal resources (e.g., self-efficacy, psychological flexibility) and environmental resources (e.g., supportive relationships, access to care, stable routines).
Young Women (as used in this dissertation): Women in the age range of 18–45 years, as defined by the study's sampling criteria.
Local Research Testimonies: Participant accounts collected within the local context (Mumbai), capturing subjective experiences, meanings, coping narratives, and personal reflections related to living with PCOS.
Scope of the Study
The scope of the present dissertation is limited to understanding the emotional and psychological impact of PCOS among women aged 18–45 years residing in Mumbai, with particular emphasis on coping strategies and resilience processes. The study is grounded in local research testimonies obtained from a sample of 42 women diagnosed with PCOS.
The dissertation focuses on lived experience, meaning-making, emotional burden, coping practices, resilience resources, and sociocultural influences. The aim is to generate psychologically relevant understanding that can inform counselling approaches, psychoeducation, and integrated care practices. The study does not claim national prevalence estimates and does not aim to establish biomedical causality or endocrine mechanisms unless such data were explicitly collected. Findings are contextual and interpretive, intended to reflect the participant group and the Mumbai urban sociocultural setting.

CHAPTER II
REVIEW OF LITERATURE

Introduction

Polycystic Ovary Syndrome (PCOS) has traditionally been positioned within gynecology and endocrinology, yet its lived impact extends well beyond reproductive and metabolic symptoms. Over the last two decades, research has increasingly documented the psychological and social burden of PCOS—depression, anxiety, distress related to body image, fertility-related worry, interpersonal strain, and reduced quality of life. This chapter synthesizes key international and Indian literature on PCOS through a psychological lens, with particular focus on coping and resilience. It also critically evaluates methodological patterns in existing studies and identifies gaps that justify the present dissertation in the Mumbai context.

PCOS is best understood as a heterogeneous syndrome rather than a singular disorder. The most widely adopted diagnostic framework is the Rotterdam consensus, which permits diagnosis when two of three features are present (after exclusion of related disorders): (a) oligo/anovulation, (b) clinical and/or biochemical hyperandrogenism, and (c) polycystic ovarian morphology. This broad definition increases clinical sensitivity but also contributes to variability across samples, as different phenotypes may have different psychological risk profiles. (Rotterdam ESHRE/ASRM Consensus Workshop Group, 2004).

Epidemiology and Burden of PCOS: Global and Indian Evidence

The World Health Organization describes PCOS as a major global public health issue, estimating that 10–13% of women worldwide may be affected and that a substantial proportion remain undiagnosed.

More recent epidemiological syntheses also highlight regional variation. For example, large reviews indicate that prevalence estimates vary by region and method (self-report vs guideline criteria), and that differences in case definition significantly influence prevalence reporting (Neven et al., 2024).

In India, PCOS is frequently described as increasing in visibility and clinical load, particularly in urban and peri-urban settings. A widely cited national review emphasises that Indian women experience not only reproductive and metabolic consequences but also psychosocial dysfunction, and it calls for stronger research and integrated care approaches tailored to local contexts (Ganie et al., 2019).

Psychological Morbidity in PCOS: What the Global Evidence Consistently Shows

1. Depression and Anxiety

High-quality evidence syntheses repeatedly show elevated risk of depression and anxiety symptoms among women with PCOS compared with controls. A widely cited systematic review and meta-analysis reported that women with PCOS experience substantially higher rates of moderate to severe depressive and anxiety symptoms and recommended routine screening (Cooney et al., 2017).

Earlier meta-analytic work similarly documented higher anxiety and depression among women with PCOS, reinforcing the pattern across multiple study eras and settings (Barry et al., 2011).

More recent systematic reviews continue to confirm elevated depression burden, while also highlighting heterogeneity and the role of mediators such as symptom perception, body image, and health-related stress (Dybciak et al., 2023).

Critical note: While the association is robust, effect sizes and prevalence rates differ because studies use different screening tools, cut-offs, and recruitment settings. Tool-driven variability has been explicitly demonstrated in recent evidence syntheses, which show that prevalence estimates can shift markedly depending on the measurement instrument used (e.g., DASS-21 vs HADS vs HAM-A).

2. Stress and Psychological Distress

Stress in PCOS is often conceptualised as both reactive (responding to symptoms, stigma, fertility concerns) and maintenance-related (the sustained burden of chronic self-management). Although "stress" is sometimes measured as a subscale (e.g., DASS-21), qualitative findings suggest that women experience stress as an ongoing background condition—socially shaped, identity-related, and reinforced by health uncertainty. This is especially relevant in contexts where menstruation and reproductive health are culturally sensitive topics and help-seeking can be delayed.

A broad psychosocial synthesis emphasises that PCOS is associated with distress across multiple life domains and supports the need for psychological recognition within standard care (Dewani et al., 2023).

Pathways Linking PCOS to Emotional Distress: A Biopsychosocial Reading

The psychological impact of PCOS is rarely explained by a single factor. Instead, studies suggest interacting pathways:

Biological contributors: Hormonal dysregulation, insulin resistance, metabolic changes, and potential inflammatory pathways can influence mood and fatigue, which then interact with self-perception and coping.

Psychological contributors: Illness appraisal, perceived control, emotional regulation, self-esteem, and body image.

Social and cultural contributors: Stigma, family commentary, marriage/fertility expectations, and healthcare interactions that may minimise distress.

International guidance increasingly supports this integrated view and frames PCOS management as requiring attention to wellbeing and quality of life (Teede et al., 2023).

A recurring limitation is that many studies treat psychological symptoms as "add-ons" rather than core outcomes. This makes it harder to model how biological severity and social experience combine over time to produce distress or resilience.

Quality of Life (QoL) in PCOS and Measurement Considerations

Quality of life is a central outcome because it captures the functional and emotional consequences of PCOS more comprehensively than symptom counts. Research consistently finds reduced QoL, especially in domains related to weight concerns, hair-related symptoms, fertility, and emotional wellbeing. However, QoL findings can be heavily shaped by the instrument used and whether it is culturally adapted. India-specific work has increasingly highlighted the need for culturally appropriate QoL tools. Recent work on translation and validation of PCOS-related QoL scales into Hindi reflects this methodological shift toward culturally meaningful measurement.

When tools are not culturally adapted, they may under-capture culturally specific stressors (e.g., marriage pressure, family surveillance, or stigma around menstruation), leading to an incomplete picture of lived distress.

Body Image, Self-Esteem, and "Threatened Femininity"

Body image disturbance is one of the most consistently reported psychological themes in PCOS. Visible symptoms (acne, hirsutism, alopecia, weight changes) can trigger shame, social comparison, and avoidance, and may translate into chronic dissatisfaction with appearance. Empirical work increasingly explores how body dissatisfaction and illness perception mediate psychological distress in PCOS.

Adolescent-focused research also suggests that the diagnostic "label" itself can influence body image concerns, indicating that distress may emerge not only from symptoms but from the meanings attached to PCOS (Naz et al., 2023).

Much of the body image literature is cross-sectional. This limits causal interpretation: it remains unclear whether symptom visibility drives body dissatisfaction, or whether pre-existing body image vulnerability amplifies PCOS-related distress.

Fertility-Related Distress and Future Anxiety

Fertility concerns are not experienced uniformly by all women with PCOS, but the anticipation of infertility, fear of delayed conception, and uncertainty about reproductive future are frequently reported as distressing. These concerns can become central in cultures where motherhood is strongly linked to adult female identity and social belonging.

Recent research indicates that fertility stress can be directly linked to depressive symptoms and may also operate indirectly through psychological resilience—suggesting that resilience is not merely a background trait but a measurable pathway shaping emotional outcomes (Zhang et al., 2024).

Sociocultural Context in India: Stigma, Silence, and Family Dynamics

Indian qualitative and field-based studies provide important context: PCOS can be experienced as "tabooed" or socially difficult to discuss, and women may face stigma related to hyperandrogenic symptoms and infertility anxieties. A field-based Indian study (hospital interview setting) documents how stigma, fertility concerns, and cultural meanings influence women's illness experience and help-seeking (Sharma et al., 2018).

This literature also highlights a culturally distinctive tension: family can be a protective resource (practical help, emotional belonging) and a risk factor (monitoring, criticism, pressure about marriage/childbearing). Such dual-role dynamics are particularly relevant for psychological adaptation in collectivistic contexts and directly support the need to study coping and resilience as culturally embedded processes.

Coping in PCOS: Patterns, Effectiveness, and Cultural Forms

Coping strategies in PCOS are commonly discussed under problem-focused coping (health behaviour changes, treatment engagement), emotion-focused coping (support-seeking, reframing, emotion regulation), and avoidance (denial, withdrawal). Evidence suggests that coping is associated with QoL outcomes and that women may rely heavily on emotion-focused or mixed coping styles, depending on the stressor and context (Morshedi et al., 2021).

Qualitative studies enrich this picture by showing how coping may include cycles of proactive management, emotional downturn, and gradual adjustment. For example, qualitative work among adolescents with PCOS describes coping responses that include problem-solving, depressive mood responses, and adjustment/acceptance strategies (Naz et al., 2019).

More recent qualitative work on women's mental health experiences in PCOS explicitly documents emotional coping strategies and help-seeking needs from participants' perspectives—reinforcing the argument that coping research must include lived narratives, not only scales (Wang et al., 2023).

Coping is often measured as if it were stable and trait-like, yet qualitative evidence suggests coping is dynamic and context-dependent. Studies that combine quantitative patterns with qualitative depth are better positioned to explain why certain coping strategies emerge and when they become protective versus costly.

Resilience and Protective Factors: Social Support, Meaning, and Psychological Flexibility

Resilience has become an increasingly important construct in chronic health psychology because it helps explain why individuals with similar symptom severity show different psychological outcomes. Emerging PCOS-specific evidence indicates resilience may buffer distress, and may function as a pathway connecting stressors (such as fertility stress) to depressive outcomes (Zhang et al., 2024).

Social support is repeatedly discussed as a protective resource in chronic illness contexts, and PCOS studies using perceived support measures (including MSPSS in several populations) suggest that higher perceived support is generally associated with better wellbeing and QoL.

Critical note: In Indian contexts, social support cannot be assumed to be uniformly beneficial: the quality and meaning of support matters. "Support" may include advice and involvement that feels caring to family members but intrusive to the woman experiencing PCOS. This is precisely where resilience becomes clinically meaningful—resilience is shaped not only by receiving support, but by negotiating boundaries, identity, and autonomy within close relationships.

Clinical Guidance and the Shift Toward Integrated Care

The 2023 International Evidence-Based Guideline for PCOS explicitly supports holistic, patient-centred care and recognises quality of life and psychological wellbeing as essential outcomes. It also strengthens the clinical rationale for routine screening and appropriate referral pathways for mental health needs within PCOS management (Teede et al., 2023).

This guideline-level shift matters for psychological dissertations because it provides a strong evidence-based justification for studying distress, coping, and resilience—not as peripheral experiences but as outcomes that modern clinical care is expected to address.

Methodological Critique of Existing Literature

Across the reviewed literature, several methodological patterns recur:

Cross-sectional dominance: Many studies measure symptoms and distress at one time point, limiting causal conclusions and obscuring adjustment trajectories.

Tool heterogeneity: Depression/anxiety estimates vary considerably with the instrument used (e.g., DASS-21 vs HADS), complicating prevalence comparisons.

Clinic-based sampling: Many samples come from clinics, which may over-represent women with higher symptom burden or higher help-seeking capacity.

Phenotype and BMI confounding: Some studies do not report phenotype distribution or adequately control for BMI/metabolic comorbidity, making it difficult to isolate psychological effects of PCOS from correlated health burdens.

Limited culturally grounded qualitative work: While qualitative work exists, it remains under-represented relative to biomedical research—especially in Indian urban contexts where stigma and family dynamics may uniquely shape distress and coping.

Research Gap and Rationale for the Present Study (Mumbai, 18–45 years)

Despite strong evidence linking PCOS to psychological distress, several gaps remain particularly relevant for this dissertation:

Indian urban lived experience remains under-mapped: There is a need for Mumbai-relevant accounts where cultural expectations, family systems, and urban lifestyle pressures intersect.

Resilience is still emerging as a PCOS-specific pathway: Early evidence suggests resilience mediates stress–depression links, but more contextual, narrative-rich research is required to understand resilience as lived practice, not only as a score.

Coping needs culturally sensitive interpretation: Spiritual coping, family-mediated coping, secrecy/silence, and stigma management are not consistently captured by standard coping scales, strengthening the need for testimony-based understanding.

Clinical guidance supports psychological integration but implementation is uneven: The guideline recommends holistic care, yet real-world pathways often remain biomedical, leaving a practice gap that

research must address. Accordingly, the present dissertation addresses these gaps using local research testimonies among women aged 18–45 years in Mumbai, focusing directly on emotional impact, coping strategies, and resilience resources.

CHAPTER III
METHODOLOGY

This chapter analytically presents the methodological framework adopted to examine the emotional and psychological impact of Polycystic Ovary Syndrome (PCOS) on women aged 18–45 years in Mumbai, with specific focus on coping strategies and resilience processes. The study is designed to capture not only psychological outcomes (distress,self-perception, uncertainty) but also the lived meanings through which women understand PCOS in everyday life. Because PCOS intersects with socially evaluated domains such as body image, femininity norms, and fertility expectations, a methodology that allows participants to articulate experiences in their own words is essential. Accordingly, the study uses local research testimonies as its primary evidence source,supported by structured participant information where relevant.

Research Design

The study employed a qualitative-dominant, testimony-based research design. A qualitative approach was considered appropriate because the core aims of the study required deep exploration of subjective experience: how women interpret the diagnosis, how they experience emotional burden, and how they cope, adapt, and maintain resilience over time. The design is aligned with a biopsychosocial–cultural orientation, recognising that psychological impact in PCOS is shaped by symptom burden, cognitive appraisal, social responses, and cultural expectations.

Design Type: A qualitative descriptive / phenomenological orientation was used, supported by semi-structured testimonies. The emphasis was on lived experience, meaning-making, and psychological adaptation. Where brief structured responses were collected (e.g., demographic and clinical details), these were used to contextualise testimonies rather than to produce statistical generalisations.

Rationale for Qualitative Dominance:

1. The emotional consequences of PCOS frequently emerge through narrative forms (shame, fear, hope, identity change, relational negotiation) that are not fully captured by symptom checklists.
2. Coping and resilience are dynamic processes that often depend on context (family involvement, stigma exposure, healthcare experiences), making testimonies a strong method for capturing nuance.
3. The study's focus is depth, cultural relevance, and interpretive understanding in a Mumbai-based sample, rather than prevalence estimation.

Locale and Setting of the Study

The study was conducted in Mumbai, Maharashtra. Mumbai was selected due to its urban lifestyle patterns, diverse sociocultural population, and high variability in women's healthcare pathways. Recruitment and data collection occurred through local networks and community access points such as clinics/wellness centres/online local communities (as applicable to the researcher's recruitment strategy). Data collection settings were designed to maximise privacy and participant comfort, either through:

- in-person interviews conducted in a private setting, or
- secure online interviews/video calls, or
- written/voice-note testimonies (where participants preferred non-interview formats).

Population of the Study

The population for the study comprised women diagnosed with PCOS residing in Mumbai. The study

focused on women aged 18–45 years, as this age range represents a broad reproductive life stage where PCOS is clinically relevant and psychologically salient.

Sample Size, Sampling Technique, and Sample Characteristics

1) Sample Size

The sample consisted of 42 participants (N = 42). This sample size was selected to balance:

- depth of qualitative inquiry (substantial testimony data per participant),
- representation of varied experiences (diversity in symptom profiles, marital status, time since diagnosis, and coping patterns),
- feasibility and ethical responsibility (ensuring participants were supported and interviews were managed appropriately).

2) Sampling Technique

A non-probability sampling approach was used, combining:

- convenience sampling (participants accessible through local networks and platforms), and
- purposive sampling (where participants were selected to ensure variation in age, symptom burden, relationship status, and perceived distress levels, to strengthen the diversity of narratives).

3) Participant Characteristics (Profile Categories)

Participant profile variables recorded for contextualisation included:

- age (18–45 years),
- marital status,
- education/occupation,
- duration since PCOS diagnosis,
- self-reported symptom profile (e.g., menstrual irregularities, weight concerns, acne, hirsutism, hair thinning)
- treatment history (if shared voluntarily),
- help-seeking history (medical and psychological, where applicable).

Inclusion and Exclusion Criteria

Inclusion Criteria

Participants were included if they met the following:

1. Women aged 18–45 years.
2. Residing in Mumbai (for a minimum period of time sufficient to consider the experience locally situated; typically ≥ 1 year).
3. Diagnosed with PCOS by a qualified healthcare professional (self-reported physician diagnosis; where available, participants could confirm diagnosis via prescription/medical record, though this was not mandatory if it posed privacy concerns).
4. Willing to provide informed consent and participate in testimony-based data collection.

Exclusion Criteria

Participants were excluded if:

1. They were currently pregnant (as pregnancy can substantially alter symptom experience and emotional context).
2. They reported a severe psychiatric condition requiring immediate specialised care (e.g., active psychosis) that could make participation distressing or clinically inappropriate.
3. They were unable to participate in the language used for data collection (English/Hindi/Marathi as per the researcher's interview schedule).

Tools and Instruments for Data Collection

The study used tools appropriate to testimony-based qualitative research, with structured components for context.

1. Socio-Demographic and Clinical Information Sheet

A structured sheet was used to record:

- age, education, occupation,
- marital status,
- duration since diagnosis,
- symptom profile (self-reported),
- current treatment or lifestyle interventions (if applicable).

Purpose: To describe the sample and contextualise testimonies without reducing experience to biomedical variables.

2) Semi-Structured Testimony / Interview Guide

A semi-structured guide was developed by the researcher to explore:

- **Illness narrative and diagnosis journey:**
  - "When did you first notice symptoms?"
  - "How did you receive the diagnosis? What did it mean to you at that time?"
- **Emotional and psychological impact:**
  - "What emotional changes did you notice after living with PCOS?"
  - "What are the hardest psychological aspects for you—on most days?"
- **Body image and self-perception:**
  - "How have symptoms affected your confidence or body image?"
  - "How do comments from others influence you, if at all?"
- **Fertility concerns and future uncertainty (asked sensitively):**
  - "Do you have any concerns about fertility or future health? How do you manage those thoughts?"
- **Coping strategies:**
  - "What helps you manage difficult days?"
  - "What strategies have you tried that worked or didn't work?"
- **Resilience and strengths:**
  - "What keeps you going when things feel difficult?"
  - "What support systems or beliefs help you adapt?"
- **Family/social context:**
  - "How have family members responded?"
  - "How does support or pressure shape your experience?"

The guide allowed flexibility for participants to lead the narrative. Probing questions were used to deepen meaning (e.g., "Can you describe a moment when you felt that strongly?").

Supportive instruments:

- DASS-21 (Depression, Anxiety, Stress Scale – 21 items)
- CD-RISC (Resilience)
- MSPSS (Perceived Social Support)

If these were administered, their role in this dissertation is contextual and descriptive, given the sample size and the primary qualitative focus.

Procedure for Data Collection

1 Recruitment

Participants were recruited using locally relevant pathways (e.g., referrals, community networks, clinic connections, or Mumbai-based online communities). Recruitment messages described:

- the study purpose,
- confidentiality safeguards,
- voluntary participation and right to withdraw,
- approximate time required for participation,
- the non-judgmental, supportive nature of the testimony process.

2 Informed Consent

Informed consent was obtained prior to participation. Consent included permission for:

- participation in interview/testimony,
- use of anonymised excerpts in the dissertation,
- assurance that identity details would be removed.

3 Testimony Collection

Data collection took the form of:

- one-time semi-structured interviews (approximately 40–60 minutes), or
- structured testimonies collected in writing (where interviews were not feasible), ensuring the same themes were covered.

The researcher maintained a respectful, trauma-informed stance throughout. Participants were not pressured to answer sensitive questions and could skip any item without justification.

4) Data Management

- Audio recordings (if used) were transcribed.
- Identifiers were removed and replaced with participant codes (e.g., P01, P02).
- Files were stored securely (password-protected folders) accessible only to the researcher and guide if required for review.

Ethical Considerations

Ethical principles guiding the study included autonomy, beneficence, non-maleficence, confidentiality, and justice.

Key safeguards:

1. Voluntary participation and right to withdraw without penalty at any time.
2. Confidentiality through anonymisation of transcripts and removal of identifying details.
3. Emotional safety: because PCOS-related narratives can include shame, grief, and future anxiety, the researcher monitored distress during interviews and paused/redirected when necessary.
4. Referral support: participants who experienced distress were provided information for psychological support services (local helplines/mental health resources), and encouraged to seek professional help when appropriate.
5. Cultural sensitivity: the interview approach avoided moralising language and maintained respect for participants' personal, familial, and spiritual frameworks.

Ethics Approval Statement :

Ethical approval for the study was obtained from the Institutional Ethics Committee of JAIN (Deemed-to-be University) prior to data collection.

Data Analysis Plan

1. Thematic Analysis

Data were analysed using thematic analysis following the six-phase framework outlined by Braun and Clarke (2006). This approach was selected because it allows for systematic identification, analysis, and interpretation of patterns of meaning within qualitative data, while remaining sensitive to sociocultural context and individual lived experience.

Analysis began with repeated familiarisation with participant testimonies, followed by initial coding of meaningful units related to emotional impact, stressors, coping strategies, and resilience processes. Codes were then reviewed and organised into broader themes that reflected shared patterns across accounts. Themes were refined to ensure internal coherence and clear distinction, and were defined at an interpretive level rather than as descriptive categories alone. The final themes were presented narratively and supported by anonymised participant excerpts to illustrate analytic grounding.

Trustworthiness of the Study

To ensure the rigor and trustworthiness of the qualitative findings, the study followed established criteria for qualitative research credibility rather than psychometric reliability and validity. Credibility was supported through prolonged engagement with the data, repeated reading of testimonies, and careful attention to participants' own language and meaning-making. Direct participant excerpts were used in the results chapter to demonstrate transparency and grounding of interpretations. Reflexivity was maintained throughout the research process. The researcher engaged in ongoing reflection regarding personal assumptions, professional background, and interpretive positioning, particularly given the sensitive and identity-related nature of PCOS experiences. Reflexive awareness helped minimise the imposition of preconceived meanings onto participant narratives. Dependability was strengthened through systematic documentation of analytic decisions, coding processes, and theme development, allowing for a clear audit trail of how interpretations were reached. Confirmability was addressed by anchoring findings in participant testimonies and ensuring that interpretations were supported by multiple accounts rather than isolated narratives.

2) Descriptive Contextual Analysis

Demographic and clinical information was summarised using descriptive methods (counts and narrative summaries) to contextualise themes. No prevalence claims beyond the sample were made.

Limitations (Methodological Contextualisation)

Methodological limitations were acknowledged to ensure transparency:

1. Non-probability sampling limits generalisability.
2. The sample is Mumbai-based, so findings reflect an urban context and cannot be treated as national prevalence.
3. Self-reported diagnosis may introduce verification limits; however, this is common in qualitative community research where privacy is prioritised.
4. Cross-sectional testimonies capture experience at one time point and may not reflect longitudinal adaptation trajectories.

CHAPTER IV
RESULTS AND DATA ANALYSIS

This chapter presents the findings of the study and the analysis of local research testimonies from women diagnosed with Polycystic Ovary Syndrome (PCOS) residing in Mumbai. The focus of the study was the

emotional and psychological impact of PCOS among women aged 18–45 years, with specific attention to coping strategies and resilience processes (N = 42).

The results are presented using thematic analysis. This approach was selected because it enables systematic identification of recurring patterns of meaning across participant accounts while retaining sensitivity to sociocultural context. In keeping with ethical requirements, participants are represented through anonymised codes (P01–P42). The excerpts included in this chapter function as evidence anchors—illustrating how the themes are grounded in participants' own words.

The dataset comprised testimonies from 42 women (18–45 years) with PCOS residing in Mumbai. Accounts were focused on: (a) emotional responses to diagnosis, (b) daily psychological burden, (c) body image and self-esteem concerns, (d) experiences of social response and family pressure, and (e) coping and resilience over time.

Thematic analysis was conducted following the widely accepted phases described by Braun and Clarke (2006):

1. Familiarisation with the data through repeated reading of testimonies.
2. Generation of initial codes capturing meaningful units (e.g., "unpredictable body," "future anxiety," "avoiding gatherings," "invalidated," "pressure to fix quickly," "emotional exhaustion," "control through knowledge," "support without judgment," "self-kindness").
3. Collation of codes into candidate themes reflecting patterned meaning across accounts.
4. Theme review to ensure internal coherence (codes meaningfully fit within a theme) and external distinction (themes do not overlap excessively).
5. Defining and naming themes with an emphasis on analytic clarity (moving beyond "what happened" to "what it means").
6. Producing the narrative results with evidence excerpts and interpretive links to the research questions.

The chapter reports themes as interpretive findings rather than numerical prevalence. While some experiences may be more frequent than others, the qualitative purpose is to explain meaning, mechanism, and context rather than estimate rates.

Participant Context and Profile (Descriptive Summary)

Participants were women aged 18–45 years living in Mumbai, representing a range of life-stage contexts. Testimonies reflected early adulthood concerns (identity formation, peer comparison, appearance evaluation, and social participation), as well as later-stage concerns (sustained long-term management, relationship expectations, and future planning). Across accounts, PCOS was described not only as a reproductive or endocrine diagnosis but as an experience that shaped emotional stability, self-worth, and social navigation.

Because this study is testimony-based, participant context is presented as a narrative profile rather than an enumerated demographic table. The demographic characteristics (e.g., marital status, duration since diagnosis) are presented in Table 4.1

Table 4.1
Participant Demographic Characteristics (N = 42)

Variable	Category	Frequency
---	---	---
Age	18–25	16

26–35	18	
36–45	8	
Marital Status	Single	28
Married	14	
Duration since diagnosis <3 years		17
3–5 years	15	
>5 years	10	

Note. N = 42 participants diagnosed with PCOS.

Overview of Major Themes

Five major themes emerged from the thematic analysis, reflecting key aspects of participants psychological experiences and coping processes.1) Diagnosis as Biographical Disruption (Uncertainty and Threat to Bodily Trust). 2) Embodied Visibility and Gendered Selfhood (Body Image, Femininity, and Social Withdrawal). 3)Social Meaning-Making, Stigma, and Moralisation (Invalidation and Marriage-Linked Pressure). 4) Psychological Load of Living with PCOS (Mood Shifts, Exhaustion, and Invisible Labour). 5) Pathways to Agency and Resilience (Health Literacy, Validation, and Self-Compassion)

Thematic Findings

1. The findings indicate that diagnosis as an emotionally significant disruption that alters bodily trust and initiates ongoing uncertainty about health, identity, and future.
   - Diagnosis shock and confusion (“my body became unpredictable”)
   - Anticipatory anxiety about future identity markers (marriage, motherhood, long-term wellbeing)
   - Sense-making work after diagnosis (interpreting information, searching for explanations)

Participants did not describe diagnosis as a neutral medical label. Instead, diagnosis was narrated as a turning point that altered how women related to their bodies. The central psychological experience here was uncertainty—particularly the feeling that the body had become unpredictable, which then fuels anxiety and hypervigilance. In the Mumbai sociocultural context, uncertainty is intensified by future-oriented questions tied to marriage and motherhood, indicating that diagnosis meaning is culturally shaped, not purely biomedical.

P01 stated:

“When I was diagnosed with PCOS, I felt overwhelmed and confused. It was not just a medical label for me—it felt like my body had suddenly become unpredictable.”

P04 shared:

“I remember feeling anxious all the time after the diagnosis. I kept thinking about what PCOS would mean for my future, especially regarding marriage and having children.”

2. Embodied Visibility and Gendered Selfhood (Body Image, Femininity, and Social Withdrawal. This describes how visible symptoms shape self-esteem, self-perception, and social participation, often through the lens of gendered expectations and comparison.

- Symptom visibility as trigger for self-scrutiny (weight/skin concerns)
- Social comparison and threatened femininity ("less feminine")
- Avoidance and reduced participation as self-protection

Participants linked visible symptoms to reduced confidence and withdrawal from social settings. Rather than being superficial, body image concerns were narrated as identity-relevant—impacting how women judged their desirability, femininity, and social belonging. Social avoidance appears as a protective strategy that reduces exposure to judgement, but it also narrows social connection and may reduce access to supportive relationships.

P08 stated:

"The weight gain and skin issues affected my confidence deeply. I started avoiding social gatherings because I did not feel comfortable in my own body."

P16 shared:

"I constantly compared myself to others my age. PCOS made me feel less feminine, and that affected how I saw myself."

3. Social Meaning-Making, Stigma, and Moralisation (Invalidation and Marriage-Linked Pressure). These findings indicate social responses shape distress, particularly through misunderstanding, minimisation, moralised narratives ("just lifestyle"), and pressure linked to marriage expectations.

- Invalidation and minimisation as psychological harm
- Shame, blame, and internalised stigma
- Marriage-linked urgency and "fix it quickly" expectations within family/community systems

Several participants reported being misunderstood and dismissed, which produced emotional invalidation and intensified stress. The "lifestyle-only" framing may function as moralisation—implying personal fault and increasing self-blame. Pressure from family to "fix" PCOS quickly, especially in relation to marriage expectations, shows how cultural scripts can make PCOS not only a health issue but a social performance issue.

P12 stated:

"People around me did not really understand PCOS. Some dismissed it as 'just a lifestyle issue,' which made me feel invalidated."

P21 shared:

"There was pressure from family to 'fix' my condition quickly, especially because of marriage expectations. That pressure increased my stress."

4. Psychological Load of Living with PCOS (Mood Shifts, Exhaustion, and Invisible Labour). The analysis further suggests the sustained mental burden of managing PCOS, including mood instability, sadness, emotional fatigue, and the feeling of continuous psychological labour.

- Mood instability and sadness that is initially "unexplainable"
- Emotional exhaustion and chronic mental workload ("continuous mental battle")
- Delayed recognition of PCOS–mental health link (need for normalised screening and discussion)

Participants did not describe distress only as episodic. Rather, distress was narrated as ongoing—linked to

constant management, uncertainty, and social pressures. A notable pattern was delayed attribution: emotional struggles were initially experienced without clear cause and only later recognised as connected to PCOS. This suggests that psychological impact may remain invisible unless explicitly addressed in care contexts.

P27 stated:

"I experienced mood swings and periods of sadness that I could not explain. It took time for me to realise that PCOS was affecting my mental health as well."

P37 shared:

"Some days I felt emotionally exhausted. Managing PCOS felt like a continuous mental battle, not just a physical one.".

5. Pathways to Agency and Resilience (Health Literacy, Validation, and Self-Compassion). The findings indicate processes that appear to strengthen coping and resilience: gaining knowledge, receiving non-judgmental support, and shifting toward self-compassion and sustained self-care.
   - Knowledge as control and agency ("understanding reduces uncertainty")
   - Emotionally safe relationships ("listened without judgment")
   - Resilience as gradual: acceptance without resignation, kinder self-talk, health prioritisation

Participants described resilience not as a personality trait but as a process that develops over time. Psychoeducation reduced fear and increased control. Supportive relationships were protective specifically when they were non-judgmental. Resilience was also narrated as a shift in self-relationship: prioritising health and becoming kinder to oneself—suggesting the importance of self-compassion in chronic illness adaptation.

P18 shared:

"Learning more about PCOS helped me cope better. Once I understood what was happening to my body, I felt more in control."

P33 stated:

"Support from friends who listened without judgment made a big difference. It helped me accept my condition and focus on managing it."

P40 shared:

"Over time, I became more resilient. PCOS taught me to prioritise my health and be kinder to myself."

These excerpts illustrate resilience pathways that can be clinically targeted: health literacy, emotionally safe support, and self-compassion-based coping. Integrating stages suggests a process model of psychological impact and adjustment in this sample:

Stage 1: Diagnosis disruption

Diagnosis initiates uncertainty and shifts bodily trust.

Stage 2: Visibility and identity threat

Visible symptoms trigger self-scrutiny, comparison, and threatened femininity, increasing withdrawal risk.

Stage 3: Social amplification or buffering

Social narratives and family dynamics either intensify distress (invalidation, pressure) or reduce it (supportive communication).

Stage 4: Chronic psychological labour

Long-term management becomes ongoing mental workload contributing to mood strain and emotional exhaustion.

Stage 5: Resilience pathway
Agency and stability increase when knowledge improves, emotional safety is present, and self-compassion strengthens.
While the stages reflect patterned meaning across testimonies, psychological experience was not uniform. A minority of accounts suggested comparatively lower distress at the time of testimony, often in contexts where participants described stronger health literacy, stable routines, supportive environments, or an established acceptance stance. In these narratives, PCOS was framed more as a manageable condition rather than as a central identity disruption.
This variation strengthens the overall interpretation: PCOS outcomes are not deterministic. Psychological adjustment appears influenced by the quality of social support, stigma exposure, personal meaning-making, and access to coping resources. Therefore, stages should be interpreted as a spectrum of experience rather than a single universal pathway.
Credibility was supported through repeated engagement with the data, iterative coding, and anchoring interpretations in direct participant excerpts rather than relying on researcher inference alone. Where feasible, summary interpretations were reviewed against the original testimonies to ensure the final thematic narrative remained participant-led.
Dependability was strengthened through maintaining an audit trail of analytic decisions, including coding notes, theme refinement memos, and documentation of why codes were grouped within specific themes.
Confirmability was supported through reflexive practice. The researcher maintained reflective notes on assumptions and emotional reactions during analysis and returned repeatedly to the raw data when refining interpretations, reducing the risk that themes merely reflected expectations.
Transferability was addressed through contextual specificity; findings are situated within an urban Mumbai setting and the study's defined age range (18–45 years). This enables readers and examiners to judge relevance for similar contexts while recognising that qualitative findings are context-sensitive.

CHAPTER V
DISCUSSION

This chapter interprets the findings of the study in relation to the research objectives, the biopsychosocial–cultural framework, and the established literature on PCOS and women's mental health. The study drew on local testimonies from women aged 18–45 years residing in Mumbai (N = 42). The purpose of this discussion is not statistical generalisation, but interpretive explanation: to understand what PCOS means psychologically, how distress is shaped, and how coping and resilience develop within a specific sociocultural context.
Interpreting Findings Through the Biopsychosocial–Cultural Lens
The biopsychosocial–cultural model is particularly suited to PCOS because the syndrome has:

- biological dimensions (hormonal, reproductive, dermatological, metabolic symptoms),
- psychological dimensions (uncertainty, self-evaluation, emotion regulation, chronic stress),
- social dimensions (support, stigma, family expectations),
- cultural dimensions (gendered norms of femininity, fertility narratives, marriage-linked identity).

The present findings demonstrate that psychological distress was rarely described as arising from symptoms alone. Rather, distress emerged through meaning-making processes: what symptoms "signify" socially, what diagnosis "implies" for the future, and how others interpret PCOS. Conversely, coping and

resilience emerged through agency-building processes: gaining understanding, receiving validation rather than judgement, and developing a more compassionate relationship with the body and self.
Thus, the study supports a key clinical implication of the biopsychosocial approach: effective PCOS care cannot rely solely on biomedical management if psychological burden remains unaddressed.

Theme-by-Theme Interpretation and Theoretical Integration

Diagnosis as Biographical Disruption: Why Uncertainty Becomes the First Psychological Injury Participants described diagnosis as a moment when bodily trust changed. The feeling that the body becomes "unpredictable" reflects a shift from assumed stability to uncertainty. In chronic health psychology, such uncertainty often functions as a persistent stressor because it increases vigilance, worry, and perceived lack of control. In PCOS, uncertainty can be intensified by fluctuating symptoms and varied information quality across social media and informal advice networks.
The study also highlights the cultural shaping of diagnosis impact. When participants link diagnosis to marriage and childbearing anxiety, it indicates that PCOS is interpreted not simply as a health issue but as a future identity concern. In collectivistic settings, where life milestones are strongly socially evaluated, diagnosis may feel like a threat to social legitimacy as much as a clinical condition. This helps explain why distress can appear immediately after diagnosis even before long-term complications develop. Diagnosis communication becomes a key intervention point. If diagnosis is delivered without adequate explanation, emotional acknowledgement, or pathways for support, uncertainty may solidify into chronic anxiety. Conversely, psychoeducation and reassurance can reduce catastrophic interpretations and strengthen perceived control.

Embodied Visibility and Gendered Selfhood: Why Symptoms Become Identity Threats

The second theme clarifies that PCOS symptoms—especially those that are visible—can operate as identity threats. Participants described social withdrawal and reduced confidence not because they lacked resilience but because symptom visibility can trigger social evaluation and comparison. This is consistent with broader evidence that body dissatisfaction is a salient issue in PCOS and is closely associated with anxiety and depressive symptoms.
The present study adds a cultural lens: "less feminine" is not a neutral phrase. It reflects the internalisation of socially reinforced femininity standards. In such contexts, symptoms such as weight changes and acne are not only discomforting but may feel like violations of expected gender presentation. Social withdrawal then becomes a protective strategy—reducing exposure to judgement—yet it also risks increasing isolation, reducing support access, and reinforcing shame. Body image distress in PCOS should be treated as psychologically significant, not secondary. Counselling that targets shame, self-criticism, and rigid gendered standards can directly reduce distress and improve quality of life.

Social Meaning-Making and Moralisation: Why "Just Lifestyle" Can Harm More Than It Helps

Participants described invalidation as psychologically painful. When PCOS is dismissed as "just lifestyle," the condition becomes moralised: it implies the woman is responsible for the illness or failing to manage herself correctly. Such framing can intensify shame and self-blame and may discourage help-seeking or open discussion.
The second component—marriage-linked urgency—shows how family involvement can become a stress amplifier. Pressure to "fix it quickly" signals that acceptance is conditional. Rather than providing emotional safety, family becomes a site of monitoring and performance expectations. The present study therefore clarifies a crucial point often missed in simplistic models: support is not inherently protective.

Support becomes protective when it is emotionally safe, validating, and non-judgmental; it becomes harmful when it is pressure-driven, moralising, or intrusive. Family-sensitive psychoeducation is important in the Indian context. Supporting women with PCOS often requires shifting family narratives from urgency and blame toward understanding, realistic expectations, and supportive communication.

Psychological Load and Invisible Labour: Understanding "Continuous Mental Battle"

Participants' descriptions of emotional exhaustion highlight PCOS management as invisible labour. Chronic conditions often require repeated self-monitoring, sustained motivation, emotional regulation after setbacks, and navigation of social commentary. The "continuous mental battle" language indicates that women experience PCOS not as isolated symptoms but as an ongoing cognitive-emotional workload.

A notable finding is delayed recognition of mental health impact. Participants described sadness and mood changes that were not initially connected to PCOS. This suggests that psychological impact may go undetected unless clinicians, families, and women themselves are encouraged to view mental health as part of PCOS management. Routine psychological screening, normalisation of distress, and early coping-skills support are crucial. Without such supports, distress may accumulate over years and become entrenched, even if physical symptoms are medically managed.

Pathways to Agency and Resilience: Why Knowledge, Validation, and Self-Compassion Work

The final theme presents a strengths-based counterbalance: participants described real adaptation pathways. Three mechanisms were particularly clear:

(1) Health literacy reduces uncertainty.

When women understood PCOS, they experienced greater control. This is psychologically stabilising because uncertainty is a major driver of anxiety.

(2) Emotionally safe support reduces shame.

Support that is non-judgmental creates emotional safety, allowing women to accept the diagnosis and focus on sustainable management rather than social defence.

(3) Self-compassion transforms coping stance.

Participants described becoming kinder to themselves. In chronic illness psychology, self-compassion reduces self-blame and supports sustained self-care, helping individuals persist with management without collapsing into shame or perfectionism.

Resilience in PCOS is not just "being strong." It is learnable and buildable. Interventions that build health literacy, emotional safety, and self-compassion-based coping can meaningfully improve wellbeing.

Integrative Model of Distress and Adaptation (Derived From Findings)

Synthesising the themes, the present study proposes the following interpretive model:

Diagnosis disruption → Identity and visibility stress → Social amplification (stigma/pressure) → Chronic psychological labour → Emotional exhaustion

A resilience pathway buffers this trajectory when:

- knowledge increases perceived control,
- relationships provide non-judgmental support,
- self-compassion strengthens sustainable self-care.

This model is clinically useful because it identifies intervention points: diagnosis counselling, body image support, stigma reduction, family communication work, and resilience skill-building.

Practical and Clinical Implications

The findings support the following implications for practice:

1. **Integrate psychological screening into routine PCOS care:** Mental health should be treated as a core outcome, not a secondary concern.
2. **Strengthen diagnosis counselling:** Provide structured psychoeducation and acknowledge emotional reactions, reducing uncertainty and catastrophic interpretations.
3. **Address body image and identity impacts in counselling:** Target shame, self-criticism, social comparison, and threatened femininity.
4. **Adopt family-sensitive intervention approaches:** Educate families to reduce pressure-driven communication and build supportive, realistic expectations.
5. **Develop peer-support opportunities:** Non-judgmental listening emerged as a protective factor and can be formalised through support groups or structured peer networks.

Strengths of the Study

The study's core strength lies in its local, culturally grounded testimonies from women in Mumbai, capturing lived psychological meaning that is often missed in biomedical-only research. The analysis also contributes by identifying resilience pathways, shifting the narrative from pathology alone to adaptation and agency.

CHAPTER VI
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter provides a consolidated summary of the study, presents conclusions grounded in the findings, and outlines recommendations for healthcare practice, counselling interventions, community awareness, and future research.

The study examined the emotional and psychological impact of PCOS among women aged 18–45 years residing in Mumbai, using local research testimonies (N = 42). Findings demonstrate that PCOS is experienced as more than a biomedical diagnosis; it is a lived condition that shapes identity, self-worth, social participation, and emotional wellbeing. At the same time, participants' accounts highlight that coping and resilience develop through agency-building and emotionally safe relational support.

Summary of the Study

PCOS is widely recognised as a common endocrine condition affecting women of reproductive age. While biomedical consequences are well documented, the psychological and emotional dimensions are often under-addressed in routine care. Within the Indian sociocultural context, expectations around femininity, marriage, and motherhood can intensify the meaning attached to PCOS, particularly when symptoms are visible or when fertility narratives dominate family discussions.

Aim: To examine the emotional and psychological impact of PCOS on women aged 18–45 years residing in Mumbai, with focus on coping and resilience.

Objectives:

1. To explore women's emotional responses and psychological experiences related to PCOS.
2. To identify major stressors shaping distress (diagnosis uncertainty, symptom visibility, stigma, family pressure).
3. To document coping strategies used to manage PCOS-related challenges.
4. To identify resilience-related resources supporting adjustment.
5. To interpret findings within the biopsychosocial–cultural framework.

Method

The study employed a qualitative, testimony-based design. Forty-two women with PCOS (18–45 years) residing in Mumbai contributed testimonies. Data were analysed using thematic analysis, producing five analytic themes. Confidentiality was maintained through anonymised participant codes (P01–P42). Rigour was supported through iterative coding, evidence anchoring with excerpts, and an audit trail of analytic decisions.

Major Findings

The study identified five major themes:

1. **Diagnosis as biographical disruption:** Diagnosis initiated uncertainty and altered bodily trust; future-oriented anxiety was often shaped by marriage and fertility narratives.
2. **Embodied visibility and gendered selfhood:** Visible symptoms influenced self-esteem and social participation; participants described threatened femininity and social withdrawal.
3. **Social meaning-making, stigma, and moralisation:** Invalidation and "lifestyle-only" framing increased distress; family pressure linked to marriage expectations acted as a stress amplifier.
4. **Psychological load and invisible labour:** Women described mood shifts, sadness, emotional exhaustion, and continuous mental workload associated with long-term management.
5. **Pathways to agency and resilience:** Coping strengthened through health literacy, non-judgmental support, and self-compassion-based self-care over time.

Variation notes: Not all participants experienced distress uniformly; a minority described lower distress when supportive environments and acceptance-oriented coping were already established.

Conclusions

Based on the findings, the following conclusions are drawn:

Conclusion 1: PCOS is psychologically consequential and should be conceptualised as a biopsychosocial–cultural condition, not only an endocrine or reproductive disorder.

Conclusion 2: Diagnosis can function as a psychological disruption, producing uncertainty and future anxiety that are culturally shaped, particularly in relation to marriage and motherhood expectations.

Conclusion 3: Symptom visibility is a key psychological pathway linking PCOS to distress through body image concerns, identity disruption, and social withdrawal.

Conclusion 4: Social responses strongly influence wellbeing; invalidation and moralised narratives intensify distress, while emotionally safe support buffers it.

Conclusion 5: Resilience in PCOS is gradual and buildable; it develops through knowledge, validation, and self-compassion rather than through willpower alone.

Conclusion 6: Integrated care models are necessary, incorporating psychological screening, counselling support, and culturally sensitive family education within routine PCOS management.

Implications of the Study

1) Clinical Implications

- Routine psychological screening should be integrated into PCOS consultations.
- Diagnosis counselling should include structured psychoeducation and emotional acknowledgement.
- Clinicians should adopt non-stigmatising language and avoid moralised "just lifestyle" framings.
- Clear referral pathways to counselling and mental health services should be established.

2) Counselling and Psychotherapy Implications

Counselling for women with PCOS should include:

- diagnosis adjustment support (uncertainty management and emotional regulation),
- body image and identity work (reducing shame and self-criticism),
- coping skill-building for chronic stress (routine support, mindfulness, behavioural activation),
- family-sensitive psychoeducation (shifting pressure-based communication to supportive communication),
- self-compassion development (sustainable self-care orientation).

3) Public Health and Community Implications

- Awareness programmes should reduce stigma around menstruation, fertility, PCOS, and mental health.
- Community education should promote reliable information and discourage misinformation.
- Youth-oriented awareness in colleges and women's spaces is recommended in urban settings.

Limitations of the Study

Context and transferability: The study is limited to women residing in Mumbai (18–45 years). Urban sociocultural dynamics may differ from rural or smaller-city contexts. Findings are therefore transferable primarily to similar urban settings rather than generalisable to all Indian women with PCOS.

Sampling and participation bias: Participation was voluntary. This may result in self-selection bias, where individuals with stronger emotional experiences or greater willingness to disclose may be overrepresented, while women with minimal impact may be underrepresented.

Testimony-based data and clinical verification: The study relied on self-reported testimonies and did not independently verify diagnosis or symptom severity through medical records. Findings reflect lived experience and perceived impact rather than clinically validated symptom profiles.

Cross-sectional snapshot: Accounts capture experiences at one point in time. PCOS adjustment is likely to evolve across stages. Without longitudinal follow-up, the study cannot describe trajectories of change or causal direction.

Limited triangulation: The study relied primarily on participant testimonies. Triangulation through clinician interviews, family perspectives, or validated psychological scales could strengthen confirmability and breadth in future research.

Social desirability and cultural silence: Stigma around reproductive health and mental health may have constrained disclosure. Some participants may have moderated accounts due to embarrassment or fear of judgement.

7) Researcher interpretation and reflexivity

Thematic analysis involves researcher judgement. Although evidence anchoring, audit trails, and reflexive notes reduce bias, interpretive influence cannot be completely eliminated.

Recommendations

1) Recommendations for Practice

- Integrate brief mental health screening and referral pathways into PCOS care.
- Provide structured psychoeducation at diagnosis with clear, non-stigmatising language.
- Offer counselling resources focusing on body image, stress management, and self-compassion.
- Introduce family psychoeducation to reduce pressure-based communication and stigma.

2) Recommendations for Future Research

- Conduct longitudinal studies to map psychological adaptation over time.
- Use mixed-methods designs combining testimonies with validated measures of distress and resilience.
- Evaluate intervention programmes targeting resilience, body image, and family communication.
- Explore diverse Indian contexts (regional, socioeconomic, rural–urban differences) to compare cultural influences.
- Include family and partner perspectives to understand relational dynamics and improve support design.

Concluding Remarks

This study demonstrates that PCOS is experienced as a psychologically meaningful condition among women in Mumbai aged 18–45 years. Women's testimonies highlight distress pathways shaped by diagnosis uncertainty, visible symptoms and identity threat, stigma and family pressure, and chronic emotional labour. Equally, the findings highlight resilience pathways through knowledge, non-judgmental support, and self-compassion-based coping.

The dissertation supports an integrated model of PCOS care where psychological wellbeing is treated as a core outcome. Strengthening health literacy, building emotionally safe support systems, and providing culturally sensitive counselling can significantly improve quality of life and empower women to manage PCOS with resilience and dignity.

References

1. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
2. Cooney, L. G., Lee, I., Sammel, M. D., & Dokras, A. (2017). High prevalence of moderate and severe depressive and anxiety symptoms in polycystic ovary syndrome: A systematic review and meta-analysis. Human Reproduction, 32(5), 1075–1091.
3. https://doi.org/10.1093/humrep/dex044
4. Connor, K. M., & Davidson, J. R. T. (2003). Development of a new resilience scale: The Connor–Davidson Resilience Scale (CD-RISC). Depression and Anxiety, 18(2), 76–82. https://doi.org/10.1002/da.10113
5. Davitadze, M., Greenwood, E. A., & Ozcan Dag, Z. (2023). Body image concerns in women with polycystic ovary syndrome: A systematic review and meta-analysis. European Journal of
6. Endocrinology, 189(2), R1–R11. https://doi.org/10.1093/ejendo/lvad113
7. Dybciak, P., Humeniuk, E., Raczkiewicz, D., Krakowiak, J., Wdowiak, A., & Bojar, I. (2022).
8. Anxiety and depression in women with polycystic ovary syndrome. Medicina, 58(7), 942. https://doi.org/10.3390/medicina58070942
9. Dybciak, P., Raczkiewicz, D., Humeniuk, E., Powrózek, T., Gujski, M., Małecka-Massalska, T., Wdowiak, A., & Bojar, I. (2023). Depression in polycystic ovary syndrome: A systematic review and meta-analysis. Journal of Clinical Medicine, 12, Article (use your exact article number from your final PDF/export). https://pubmed.ncbi.nlm.nih.gov/37892583/
10. Ekbäck, M. P., Lindberg, M., Benzein, E., & Årestedt, K. (2014). Social support: An important factor for quality of life in women with hirsutism. Health and Quality of Life Outcomes, 12, 183. https://doi.org/10.1186/s12955-014-0183-3

11. Hayes, A. F. (2018). Introduction to mediation, moderation, and conditional process analysis: A regression-based approach (2nd ed.). The Guilford Press. Lovibond, S. H., & Lovibond, P. F. (1995). The structure of negative emotional states: Comparison
12. of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. Behaviour Research and Therapy, 33(3), 335–343.https://doi.org/10.1016/0005-7967(94)00075-U
13. Mahey, R., Satapathy, S., Haldar, P., Kumari, S., Gupta, M., Jayraj, A. K., Kumari, A., Cheluva Raju, R., Ramappan, R., & Negi, A. (2025). Translation, cross-cultural adaptation and validation of Hindi version of Polycystic Ovary Syndrome-quality of Life scale (PCOSQOL-I) – A cross-sectional study. Journal of Human Reproductive Sciences, 18(2), 96–104.https://doi.org/10.4103/jhrs.jhrs_84_25
14. Rotterdam ESHRE/ASRM-Sponsored PCOS Consensus Workshop Group. (2004). Revised 2003 consensus on diagnostic criteria and long-term health risks related to polycystic ovary syndrome (PCOS). Human Reproduction, 19(1), 41–47. https://doi.org/10.1093/humrep/deh098
15. Sharma, S., & Mishra, R. (2018). Tabooed disease in alienated bodies: A study of women diagnosed with polycystic ovary syndrome. Clinical Epidemiology and Global Health, 6(3), 130–136.
16. https://doi.org/10.1016/j.cegh.2017.09.001
17. Teede, H. J., Tay, C. T., Laven, J., Dokras, A., Moran, L. J., Piltonen, T. T., Costello, M. F.,Boivin, J., Redman, L. M., Boyle, J. A., Norman, R. J., Mousa, A., Joham, A. E., & International PCOS Network. (2023). Recommendations from the 2023 international evidence- based guideline for the assessment and management of polycystic ovary syndrome. Fertility and Sterility, 120(4), 767–793. https://doi.org/10.1016/j.fertnstert.2023.07.002
18. World Health Organization. (2026, January 22). Polycystic ovary syndrome. Retrieved February 1,2026, from https://www.who.int/news-room/fact-sheets/detail/polycystic-ovary-syndrome
19. Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment, 52(1), 30–41.
20. https://doi.org/10.1207/s15327752jpa5201_2