

Interrogating Interruptions

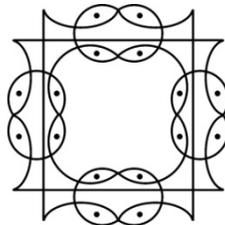
Exploring
Young Women's
Mental Health Issues



Sama- Resource Group for Women & Health

INTERROGATING INTERRUPTIONS

Exploring young women's mental health issues



Sama

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INTRODUCTION

The dominant medicalized discourse views mental health as an absence of disorder and continues to posit women's bodies as a source of ill health, including mental ill health. It ignores, however, how this process embodies and reifies latent social norms and mechanisms of patriarchal control (Davar, 2001; Vindhya, 2001). There have been some shifts in the discourse due to the growing understanding of mental well-being, which is perceived not merely as the absence of disorder but as a state of positive being, frequently affected by a spectrum of socio-political factors (WHO, 2014; WHO, 2001). Yet, mental health policies and approaches remain largely wanting in this domain.

In the area of research, for example, there is definite need for further examination of mental health issues; what has been done to date largely focused on prevalence, diagnosis, treatment of mental disorders and illnesses but inquired to a much lesser degree into the socioeconomic and political factors that determine mental health.

Feminists have long highlighted the importance of locating mental health in an understanding of women's experiences emerging from the inequities that they encounter due to their marginalized position in the patriarchal social structure. Despite the vast scholarship on women's experiences of mental health linked to their everyday experiences, the inquiry into diverse aspects of these linkages needs greater understanding. The history of women's mental health indicates the need to establish links between the biological, developmental and social variables of mental health (Chakraborty, 2001). Feminist scholarship highlights the need to include the politics of how the masculine and feminine stereotypes are valued differently, thus resulting in a gender bias in understanding women's mental health (Shah, 2001).

The mental health discourse emerged from concerns about deviant behaviour, termed as "madness" and considered an abnormality. This led to the socially acceptable and naturalized constructions of abnormality, which were labelled "mental illness" or "mental disorder" (Hedge, 2001; Vindhya 2001). Postmodernist¹ (Walker, 2006) critiques foregrounded multiple voices of opposition to the hegemony of such "scientific" discourse. Feminist and human rights movements challenged the so-called "rational" and "natural" division of "normal" and "abnormal". They argued that the body and mind cannot be de-contextualized from the economic and political structures and that, given all knowledge is socially constructed, it is imperative to research the domain of the experience of mental health, analysing lived suffering and distress rather than constructing labels (Addlakha, 2008; Fee, 2000).

The feminist and social constructionist paradigm² (Brown, 1995) highlights the manner in which the hegemony of science has led to the constructions of normality and abnormality and has validated the labelling of women's "culturally inappropriate" behaviour as mental illness (Vindhya, 2001). The pathologization and marginalization of women's experiences is challenged with the need for an appropriate observation model (Alldred et al., 2001) that went beyond what the "masculine milieu of psychiatric practices" called for. This model analysed the manner in which the subjugation of women in existent power structures labels their experiences as mental illness or disorder (Davar, 2001).

The links between gender inequality and women's mental health issues were established and found official recognition in the reports of the World Health Organization only in the 1990s and thereafter (WHO, 2001). This led to the understanding of the aetiology of psychosocial distress, which has been used by feminist activists to understand the nature and correlates of women's mental health (Davar, 2001).

A paradigm shift in the underlying thought of segregation of the mentally ill in institutions³ to initiating processes of their rehabilitation within the community marked a shift for women's mental health by attempting to incorporate a gendered lens and understanding of women's situations (Feldman, 2012). In countries like India, the concept of community mental health care, however, had existed in the form of community-level folk or faith healers and family support for the care of the mentally ill.

Health policies in India, guided by the dominant medical model, deem these indigenous practices as unscientific, despite their popularity. The lack of acknowledgment and integration of these healing practices, coupled with the pathologization of mental health issues, alongside inadequate skilled human resources in the public health system, have remained the bane of mental health care in India.

Continued disproportionate focus on serious mental disorders⁴ while side-lining mental distress that is a consequence of gender and other forms of social oppression is the norm (Davar, 2005). These other "non-serious mental disorders" or "common mental disorders" are trapped in categories and labels, flagging yet again the distant understanding of mental well-being without its pathologization. The disregard of a socio-political understanding and pathologization of women's mental health conditions has continued since the identification of "hysteria" as the first mental disorder attributable to women.

The "disease" was associated initially with sorcery, from a largely Catholic demonological perspective, which considered the female body as weak and prone to attacks by the devil. Later, the "scientific" explanation located the cause as a malfunctioning of the uterus, also called "uterine melancholia", or a case of "wandering wombs" (Tasca et al., 2012). This perception of "female madness" connected to the biological body, or specifically the reproductive body, has persisted. Even though "hysterical neurosis" was deleted in the 1980 *Diagnostic and Statistical Manual of Mental Disorders* (DSM III), such medical explanations for the mental health conditions of women continue to prevail in the form of premenstrual syndrome (PMS), post-partum depression and anorexia nervosa (Vindhya, 2001). Even the concept of hysteria arising from a lack of sexual attention remains a causal factor for women's mental health.

Young women's mental health in India

Young people in India constitute a large proportion of the population—young people aged 10–24 years account for around a third of the population and are projected as a demographic dividend for the country (Andrew, 2015). The evidence on young women's mental health suggests otherwise, though—poverty, caste and stringent gender and sexuality norms control and dictate young women's well-being and access to care. For example, around 15 per cent of maternal mortality occurs among females aged 15–24 years (among rural women), which may make this age group susceptible to mental health issues (Andrew, 2015). High rates of suicide (56 per cent) among young girls (15–29 years) is also a serious concern (Patel et al., 2012).

Social science research has provided ample evidence on how marginalized socioeconomic status, lack of decision-making power, vulnerability to rigid norms of sexuality and control, situations of early marriage, early conception, sexual harassment and violence adversely impact the health and well-being of young women (Speizer, 2011; Jarallah, 2010; Santhya et al., 2007). But few of these studies establish linkages with mental health. Conforming to the cultural perceptions of sexuality of women curtails the agency of young women. Along with conditions of increased household burden, confinement to home and socialization to become a "dutiful" wife and mother, young women also deal with their changing physicality (due to onset of puberty) as well as culturally propagated body image norms, leading to situations of conflict and mental distress. Even though young girls are lower down the power hierarchy,

they are the perceived bearers of family honour, which thus imposes immense burden of potentially jeopardizing the social position of the family. It is a contradiction that may adversely impact their mental health (Bhardwaj, 2001).

In situations of early marriage, these upheavals are accompanied by the additional burden of early childbearing and responsibility of care and the related risk of maternal and infant mortality and morbidity (Jejeebhoy, 1998), all of which impact their physical and mental well-being. Girls who marry are also stripped of their chance and right to an education, a healthy lifestyle and personal development and growth, which may create a sense of discontent leading to distress (Uecker, 2012; Jarallah, 2010). Although gender disparity as a risk factor for mental health has been established globally, early marriage, early conception and violence against young women have been recurrent factors in India (Petroni et al., 2015; Kermode et al., 2007; Patel et al., 2006; Nambi, 2005). Young women's narratives and voices, however, on mental health remain unexplored.

The research

Sama's previous research on the impact of early marriage on health found that the health impact of early marriage had been neglected at the policy level or remains restricted to its impact on the reproductive roles of women. The absence of age-disaggregated data in pan-Indian demographic surveys, like the National Family Health Survey (NFHS), makes it difficult to map how early marriage and other related factors are linked with health. The research also found that even when age- and marital status-disaggregated information were available, many significant indicators, such as related rates of nutrition and anaemia, access to and use of antenatal and postnatal care, knowledge of disease transmission and prevention and age at first birth, were absent. Although there was an acknowledgment in policy on the impact of early marriage on the mental health of young women, the nature and extent of the impact required deeper inquiry and understanding (Sama, 2015).

Within this research, Sama aimed to further the understanding of mental health, drawing on young women's perceptions and experiences. The research was designed to learn about the lived realities of young women, which may range from everyday stressors to suffering that negatively impacts their health and ability to work. The research explored the manner in which forced adherence to the complex network of sociocultural norms and societal position exposes young women to situations of mental distress.

The research built on existing scholarship, in particular the context of young women living in rural areas. It sought to gain insights into the contributing factors to mental health, mental health needs, healing, care and support among young women, including those who had married early. Most importantly, it proposed to explore the understanding of mental health beyond the paradigms of disorder and illness.

This report, *Interrogating Interruptions: Exploring Young Women's Mental Health Issues*, is based on that research. The following chapters discuss the methodology used, the findings from the research and the analysis of the findings and conclude with emerging issues for further discussion.

Endnotes

¹ Postmodernism asserted that there are no absolute truths, and, instead, there are only different interpretations formed in language. Pragmatism later added the requirement of utility to the mix. Postmodernism acknowledged how human relationships and communication create vocabularies that interpret our experience—that is, our realities are socially constructed (Walker, 2006, pp. 71–87).

² Social constructionism holds that individuals and groups produce their own conceptions of reality and that knowledge is the product of social dynamics. There is a distinction between the medical notion of disease and

the social constructionist concept of illness. For the medical profession, disease is a biological condition, universal and unchanging; social constructionists define illness as the social meaning of that condition and how class, gender, language, technology, culture and the political economy shape the knowledge and assumptions about incidence, treatment and even the naming of the disease (Brown, 1995, pp. 34–52).

³Institutional therapy and treatment through segregation in an institution, once called asylums and then mental hospitals, was the dominant mode of practice and cure for people suffering from mental illness or disorder.

⁴Mental health constitutes both common mental disorders, like depression, anxiety or obsessive-compulsive disorder, and severe mental illness, like psychoses, schizophrenia or bipolar disorder (Patel and Andrade, 2003; Patel and Kleinman, 2003).

METHODOLOGY

This chapter is organized in two sections, although both provide an overview of the research process. Section A presents the research objectives, research questions, ethical review process, criteria and selection of study sites and participants, data collection, data analysis and some challenges during the conduct of the research. Section B profiles the research sites and the research participants.

Section A: Research design and objectives

The current research is informed by Sama's long engagement with young women, their rights and their health, especially the need to understand and address their mental health. Findings from the preceding research on early marriage and health by Sama (2015) flagged several gaps in data, policies and programs as well as the understanding of early marriage and its links with health. One particularly significant area was mental health—the review and analysis of health and demographic surveys indicated a lack of data and analysis on the mental health of young women, including those in situations of early marriage.

The research also raised critical concerns about the continued implications of patriarchy, caste, poverty and other structural issues for the lives of women before as well as after marriage. The prevalent vulnerabilities of young women resulting from gendered norms and unequal power relationships along with the poor availability and access to information, health care and support were seen to deeply impact young women in and outside of early marriages.

The current research by Sama was premised on the existing scholarship (Davar and Ravindran, 2015; Addlakha, 2008; Davar, 1999; Patel et al., 1999), particularly in the context of young women living in rural areas. The research explored the mental health of young women from their perspectives and based on their lived realities. It aimed to build an understanding of mental health beyond the paradigms of disorder and illness.

Research objectives

The objectives of the research:

- Understand the contributing factors to mental (ill) health of young women, including the implications of early marriage.
- Assess the mental health issues, needs, health care and support available for young women in rural contexts, including those in early marriage.

Research questions

- How does the community perceive mental health, especially of young women?
- What are the contributing factors to mental health?
- What is the effect of early marriage on mental health?
- What are the current public health approaches and initiatives that address the mental health of young women?
- How do and to what extent do these approaches address mental health of young women in situations of early marriage and what are its limitations?

- What are the other support and services available to young women and communities to address mental health concerns?

Location of the research

The study was conducted in the states of Rajasthan and Uttar Pradesh from May 2015 to June 2017.

Selection of the research sites: The selection of Rajasthan and Uttar Pradesh states was based on data from the National Family Health Survey (NFHS) 3 (2005–06), wherein both states had a high prevalence of child marriage, with 58 per cent and 52 per cent of women, respectively, married before they were 18 years old. However, a considerable decline was seen in the NFHS 4 (2015–16) findings, with Rajasthan at 35 per cent and Uttar Pradesh at 21 per cent. Similarly, the national average on prevalence of child marriage also declined considerably, from 47.4 per cent (NFHS 3) to 26.8 per cent (NFHS 4).

Health indicators in the two states as per the NFHS 4 (table 1) outline the social status of women as well as health care access in these states.

Health indicators	India	Rajasthan	Uttar Pradesh
Sex ratio at birth for children born in the past five years (females per 1,000 males)	919	887	903
Women aged 15–49 years who are literate (%)	68.4	56.5	61
Women aged 20–24 years married before age 18 (%)	26.8	35.4	21.2
Women aged 15–19 years who were already mothers or pregnant at the time of the survey (%)	7.9	6.3	3.8
Institutional births (%)	78.9	84.0	67.8
Institutional births in a public facility (%)	52.1	63.5	44.5
Ever-married women aged 15–49 years who had ever experienced spousal violence (%)	28.8	25.1	36.7

Source: NFHS 4 (Ministry of Health and Family Welfare, 2016).

Selection of the districts and blocks: Within these states, two districts—Rajsamand in Rajasthan and Pratapgarh in Uttar Pradesh—were purposively selected using the following criteria (table 2):

- Percentage of adolescent and young population was above the state average.
- Percentage of women married before they were 18 years old was above the state average.
- Female literacy rate (literacy was taken as a proxy indicator to show the status of women in these areas) below the state average.
- Presence of partner organizations that Sama has worked with previously, which helped in facilitating interactions with the communities for the research.

Table 2
Status of adolescent and young women in Pratapgarh and Rajsamand districts

District	State	District	State	District
	Uttar Pradesh	Pratapgarh	Rajasthan	Rajsamand
Adolescent and young population (aged 18–24 years) %	46.54	50.17	47.11	48.60
Women married before they were 18 years old (%)	2.18	3.20	3.69	6.14
Female literacy rate (%)	59.30	58.45	52.7	47.95

Source: Census of India, 2011.

Research design

The design of the research was qualitative. The research explored perceptions of mental health by the community and young women, what factors impacted mental health and how women responded to them as well as their access to mental health care. It also explored how the health system addresses mental health care needs and mapped out the available pathways and services for care and support.

Data collection

Data was collected both from primary and secondary sources. Data collection was primarily done during December 2015 to June 2016, with follow-up interviews carried out until December 2016.

Research tools for primary data collection: The questions for in-depth interviews with the young women, for the interviews with the informants and guides for the focus group discussions were designed for eliciting responses that addressed the research objectives and questions. The research tools were prepared in consultation with the advisory board; they were pre-tested during the pilot phase to determine any gaps and subsequently modified. All the interviews were audio recorded during the course of the field research. Interviews and discussions were conducted in Hindi and its dialects, such as Awadhi and Bhojpuri in Pratapgarh (Uttar Pradesh) and in Rajasthani and Marwari in Rajsamand (Rajasthan), which were spoken by the young women and communities in the respective study sites.

Data sources

The secondary data sources were web-based and accessed through the search engines Google and Google Scholar. Statistical data on adolescents and young women were collected from the 2011 census findings, the NFHS 3 (2005–06) and 4 (2015–16) and the District-Level Household Survey 3 (2007–08) and 4 (2012–13).

Data from the National Crime Record Bureau for 2015 was also sourced for mental health problems, suicides and violence against women. Literature, including research publications focusing on early marriage, violence, sexuality and their impact on physical or mental health, were also reviewed.

Additionally, for the purpose of analysis, secondary review of literature was further carried out wherever appropriate. This enabled the analysis of the findings from a position of conceptual clarity and corroboration with related findings.

Primary data sources

The primary sources of data were the interviews and focus group discussions conducted with women (married and unmarried) at the village level as well as interviews with informants, such as healers, health care providers and school teachers at the village, block and district levels.

In-depth interviews with young women: The interviews with young women and the group discussion took place in select villages at the block level. In Railmagra Block, they were conducted in eight villages and in six villages in Patti Block. The villages were selected purposively but were in areas that the local organizations worked in.

The 42 in-depth interviews were with young women aged 18–25 years, both married and unmarried. The group discussions facilitated rapport with the women in the communities, which aided the selection of participants for the in-depth interviews. A few of the participants from the group discussion, who approached the research team and consented to participate in the research, were selected based on age and other criteria. Other participants were approached in the villages with the help of the informants from the community, such as schoolteachers, front-line health workers and local healers.

Multiple visits and meetings were carried out to facilitate the in-depth interviews. The interviews were conducted with the participants at a location of their choice, where they felt they could speak freely. Locations of the interviews included a participant's home, a neighbour's home, agricultural fields, school premises, *anganwadicentres*, the home of an accredited social health activist and the offices of the local organizations.

The interviews varied in length, from 60 to 90 minutes. A few respondents wanted their friends or family members, mainly sisters, to accompany them during the interview. In such situations, each participant's narrative and responses were documented as the primary interview; any information provided by the accompanying person was documented separately but not included in the analysis of the participants' narratives. Consent was taken from the participants before audio recording.

Key Informant interviews: In total, 39 interviews (table 3) were conducted with representatives of local organizations, schoolteachers, front-line health workers, doctors, psychiatrists and traditional healers in the community, block and district levels to get insights into the understanding of mental health of young women and their access as well as barriers to mental health care. Caregivers of two participants diagnosed with mental illness were also interviewed as key informants. Key informant interviews were carried out based on each person's availability and their willingness to participate in the discussion.

Table 3
Key informants interviewed

	Patti Block, Uttar Pradesh	Railmagra Block, Rajasthan
Health officials (CMO)	2	2
Front-line health workers (auxiliary nurses and midwives and accredited social health activists)	3	3
Government schoolteacher	1	2
Faith healers (<i>ojha, pandit, baoji</i>)	2	2
Local healers, or “Bengali doctors”	1	1
Doctors (general practitioners, psychiatrists, gynaecologist, ayurvedic practitioners)	6	3
Women and their caregivers who were suffering from high levels of mental distress	7	-
Dai, or midwife		1
Mahila Thana counsellors		2
Organization representatives	1	

Focused group discussions:Ten group discussions (table 4) were conducted to understand the perceptions regarding mental health prevalent at the community level. Separate group discussions were conducted with married and unmarried women of different age cohorts. Each group included approximately 12–15 women from a community. The participants were selected based on the following inclusion criteria: aged 18–25 years (young women), 26–35 years (older women), marital status (married or unmarried) and their willingness to participate in the discussions.

The discussions helped in understanding the gendered, social and economic contexts of the research areas, such as education level, livelihood opportunities, marriage norms, prevalence and forms of gender-based violence, and the social determinants of health, particularly mental health, as well as the formal and informal health care avenues available to them.

A guide with questions was developed to facilitate these discussions. The discussions were conducted with the support of the community-based organizations, front-line health workers and schoolteachers in the respective areas. The discussions took place in such locations as schools, *anganwadi* workers’ houses, *anganwadicentres*, offices of the local organizations and in the houses of the field workers of local organizations.

Table 4
Focus group discussions conducted in the two blocks

	Patti Block, Uttar Pradesh	Railmagra Block, Rajasthan
Unmarried women (aged 18–25 years)	3	-
Married women (aged 18–25 years)	2	3
Married women (aged 26–35 years)	1	1

Data analysis

Data was transcribed from the audio recordings of the interviews and group discussions. Codes were used for the in-depth interviews and for key informants. While this ensured confidentiality, respondents were identifiable by their profession (health worker or medical practitioner) along with the name of the state that they resided in. This enabled coherence in the recording of findings. The codes were replaced by pseudonyms in the report.

For the purpose of analysis, the fully documented interviews were then categorized into themes emerging from the narratives. The research team members initially worked independently to code the data and identify subcategories; subsequently, the subcategories were finalized collectively after discussions and data from the documented interviews were fed in. This broad categorization of data helped in organizing the data and its analysis.

Following the analysis, the writing of the report was initiated. The organization and drafts of the chapters underwent multiple revisions after peer reviews within Sama, followed by reviews by external reviewers. Regular meetings were organized to map the progress of the drafts as well as to discuss the emerging issues and questions from the study. This also enabled the researchers to draw from each other's work and avoid overlap.

Research advisory

A three-member research advisory group comprising Renu Addlakha,¹Deepika Nair² and Gracy Andrew,³ who combined have expertise in the areas of mental health, gender, disability and sexuality, was constituted to guide the study. Two formal meetings and interactions with the advisory members were carried out to discuss the study design, to sharpen the research tools and advise on the consent formats as well as to assess other aspects of the research, analysis and report writing.

Research team

The research team consisted of two coordinators and two associates. The team underwent orientations on the research through capacity-building sessions and regular mentoring. The initial orientations were conducted towards developing a conceptual understanding of the research objectives, along with an understanding of the timeframe for the activities. The orientations helped the team frame questions for the research schedules and draft and implement the consent processes to maintain an ethical and objective perspective while conducting interviews. Subsequent orientations also enabled the team to sharpen their interviewing skills and documentation.

Local non-government organizations

In each of the research sites, the team approached community-based organizations that had participated in Sama's prior initiatives on adolescent sexual and reproductive health and rights. Tarun Chetna was the local organization in Pratapgarh, and in Rajsamand, it was Jatan Sansthan. Tarun Chetna works at the state level and implements programs on women and child development, youth development, community mobilization and local governance. Jatan Sansthan is a grass-roots organization that works with the rural population in Rajasthan, with special emphasis on youth, women, girls and adolescents.

Through initial discussions with members of these organizations, the research team gained substantial clarity on the prevailing socioeconomic conditions of the respective areas, the communities and especially the situation of women. Interaction with the organizations also provided further information about the local systems of healing, care and other support services (formal and informal) that were accessible to the communities in general and to the women in particular. These discussions were also useful to gain an understanding of the locally prevalent expressions and practices with regard to mental health. The organizations also facilitated meetings with women from the communities that helped in locating participants for the research. Meetings were organized with the two organizations in the respective blocks, during which the research team shared the details of the research—its rationale, objectives and methodology.

Ethical issues

Considering the personal and sensitive nature of the subject under study, several ethical issues were implicated. Because socially taboo and impressionable topics, such as sexuality, gender norms, sexual and domestic violence and mental health, were probed, it was of the utmost importance to ensure participants' safety, welfare and comfort. The members of the advisory group reviewed all ethical aspects of the research as well as the consent forms for the participants. Prior to the interview, the researchers provided information about the study, its aims and objectives to the participants, provided assurance of confidentiality and anonymity, described the future use of the data being collected and explained the estimated duration of the interview to enable them to decide whether they would be willing and able to participate. A copy of the consent form signed by a member of the research team was provided to the respondents and to the informants. The consent forms were developed in English and Hindi.

Participation in the study was completely voluntary, and the participants were informed of their right to withdraw at any point during the interview. Participants (both women and service providers) were assured that their narratives and responses would be confidential, and anonymity and confidentiality were strictly respected and maintained. Anonymity was ensured by maintaining codes in data entry. The researchers were sensitive to the participants' situation, emotional state, dilemmas, inhibitions and practical difficulties and interacted with them in an understanding, respectful and encouraging manner. The researchers also sought prior consent for audio documentation of the interviews; recording was done only when the interviewer was permitted to do so.

Challenges in the data collection and analysis

- The sample for the study was limited to two blocks, one from each of the research states. Although the qualitative data provided critical insights, the sample size limits the extent of generalization of the research findings.

- For the in-depth interviews, willing participants aged 18–25 years, both married and unmarried women, were selected using purposive sampling. Information related to caste and religion of the participants was not taken into consideration while purposively selecting the respondents. Therefore, cross-state comparisons on caste implications on mental health could not be drawn substantively—a majority of the study respondents in Patti Block, for example, belonged to Scheduled Castes, whereas in Railmagra they were from Other Backward Classes.
- In some villages, the local dialects used, such as Rajasthani and Marwari in Rajsamand (Rajasthan) and Awadhi and Bhojpuri in Pratapgarh (Uttar Pradesh), were a challenge for the research team. This was managed to the extent possible with the help of the team members of the local organizations.

Section B: Profile of research districts and participants

Profile of research districts and blocks

During the initial field visits to the districts, it was observed that the research sites were primarily rural, with the economy organized mainly around agriculture. In both study blocks, the main source of employment was agriculture—the majority of the workers were either cultivators or agricultural labourers. The main food crops cultivated were maize, wheat, oil seeds, vegetables, etc. in Railmagra, while in Patti it was wheat, rice, potato, lentils and other cash crops; in the interim, peas, garlic, onions and mustard were grown.

In- and out-migration were observed in both the study districts. In Rajsamand District of Rajasthan, due to the presence of the marble mining industry, a lot of in-migration was occurring from other states, like Bihar and Uttar Pradesh. In Pratapgarh District of Uttar Pradesh, out-migration during the lean season was reported, where male members migrated to urban towns and cities to work as daily wage labourers and returned during the cropping season.

The Dalit communities, who are largely landless, are dependent on wage labour, like work in brick kilns, and migrated out of their villages for work. There were a few profession-based communities, like *darji*, *dhobi*, *kahar*, *kumhar* and *тели*, some of whom were Muslims. In Railmagra, Brahmin (Sharma) and Rajput (Singh) were the castes with landholdings; Other Backward Classes (Jats, Ahir, Yadav, Gadhri, Sisodia, Lohar, Goswami and Kumavats) also owned land and were the dominant castes; Scheduled Castes (Sargara, Salve, Khatik and Bagri) and Scheduled Tribes (Bhils) mainly worked as labourers in mines (the marble mining industry was seen to be a flourishing business on the outskirts of Rajsamand District), construction work or migrated out for work to other states, like Gujarat and Maharashtra.

Young women in both blocks were primarily involved in home-based work (cooking, cleaning, providing and caring for elders and children) and agriculture. However, in Railmagra, older women worked under the Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA). In Patti, too, women benefited from MNREGA entitlements, but work was available for an average of 28 days only. In Railmagra, women spoke about the social issues in the area, which mainly related to illiteracy, poverty, alcoholism and domestic violence. During the field visits, the team learned of the high prevalence of early and child marriages; girls as young as 3 years were married; sex selection, *atasatamarriage* (sister exchange), *nata pratha* (culturally approved cohabitation with another man post-marriage) were some other issues raised by women, which impacted their status and choices in marriage.

In Patti Block, early and child marriages were not the norm, but some of the young women had married early due to circumstances of poverty, illness of parent or grandparent, etc. Both married and

unmarried women were pursuing undergraduate studies in private colleges. Girls who had dropped out of school were enrolled or had completed vocational training in tailoring; this was seen to be financially lucrative for supporting themselves and their families. In Railmagra, most of the young women who were part of the research in the group discussions or interviews had discontinued their education after Class 12; a few of them were pursuing undergraduate studies, but there was much interest among them to undertake nursing courses.

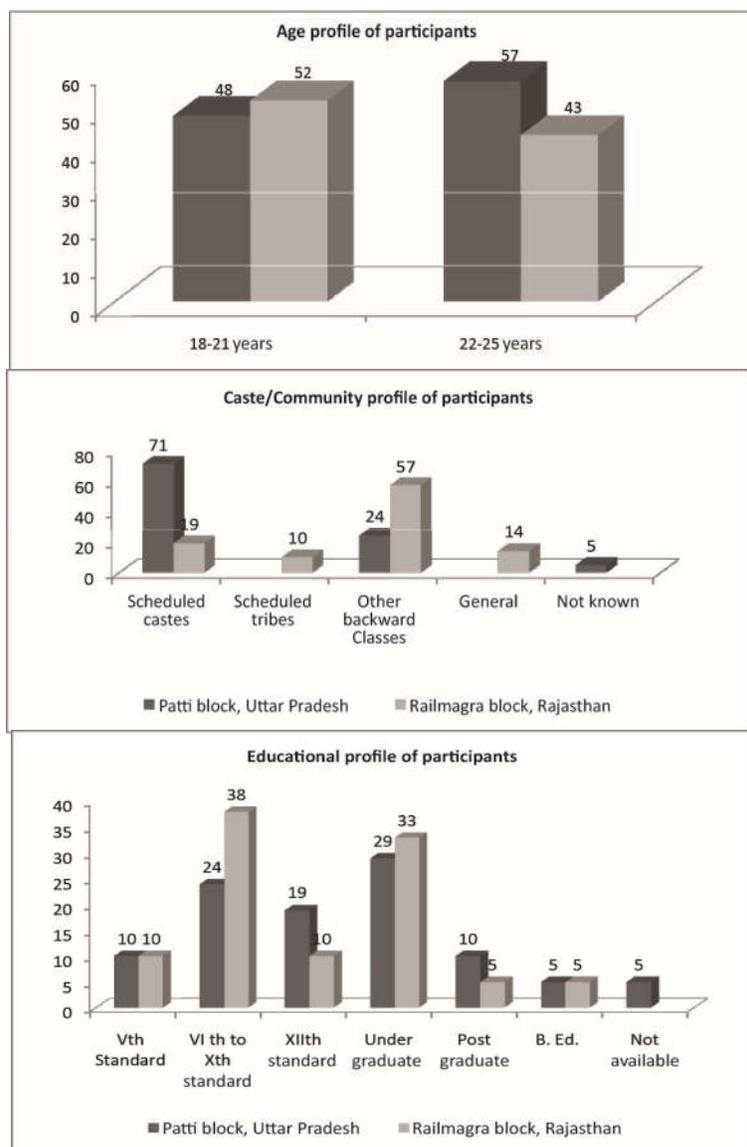
Apart from public health services, a host of private practitioners were also found to be providing mental health care services in the study areas. For example, in Pratapgarh District, a psychiatrist from Allahabad District was practicing on a weekly basis. Healing and care were also sought from local healers as well as from physicians (“Bengali doctors”, allopathic, homeopathic and ayurvedic) and psychiatrists—simultaneously or cyclically. The healers (*ojhas*, *baojis* and *pandits*) provided services in the villages also through house visits; they offered prayers and performed rituals for healing, such as offering incense, coconuts, flowers (*dhok dena*) as part of the ritual, accompanied by prayer.

Profile of research participants

The participants for the in-depth interviews were young women, both married and unmarried, aged 18–25 years who were purposively selected. The 42 persons who were interviewed were evenly divided between the two states. Of them, 22 were aged 18–21 years and the other 20 ranged from 22 to 25 years.

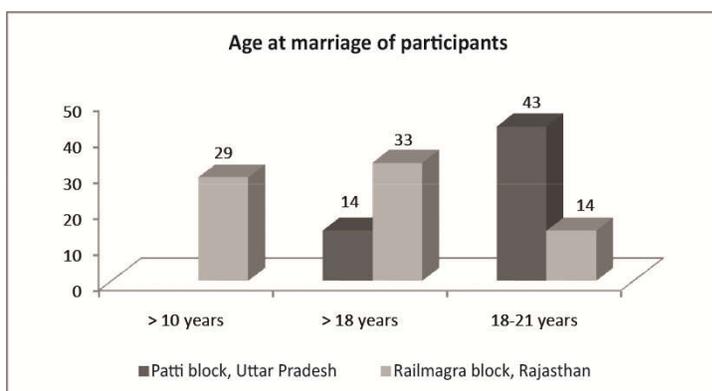
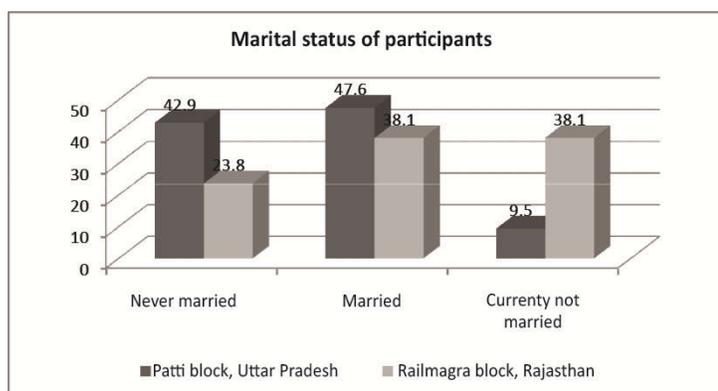
Forty-five percent (19) of them were from the Dalit or a Scheduled Caste community, and 4 per cent (2) were from tribal or a Scheduled Tribe community; the remaining 40 per cent (17) belonged to Other Backward Classes primarily, and 7 per cent (3) to the general category. Other Backward Classes included Jats, Ahir, Yadav, Gadhri, Sisodia, Lohar, Goswami, Kumavats in Railmagra and Yadavs and Patel in Patti. Scheduled Castes in the area were Sargara, Salve, Khatik and Bagri in Railmagra and Musahars in Patti; Scheduled Tribes included Bhils and Gamti. The “general” category participants were either Brahmin and Rajput. All but one of the participants for the in-depth interviews were Hindu; the one was from the Muslim community.

Eighteen (43 percent) of the 42 women⁴ were studying at the time of the research. Of them, 13 (31 percent) were pursuing an undergraduate degree; five were doing postgraduate studies, including Bachelor of Education degrees. Of the remaining 23 young women who had discontinued their education at varying levels, four had completed Class 5, 13 had completed between Class 6 and Class 10, and six had



completed Class 12.

Of the 42 women, 14 (33 per cent) had not married, while 18 (43 per cent) were married at the time of the research. This included three women whose *gauna* (moving from natal to marital home for consummation of their marriage) had yet to take place. Ten women (24 per cent) were separated, divorced or widowed. Of the 28 women who were married, 12 (29 per cent) had married when they were between 18 and 21 years old, while 10 (24 per cent) had married before they were 18, and 6 (14 per cent) had married before they were 10 years old.



Of the 28 married women, 18 (64 per cent) were staying in a joint family; of them, 12 (43 per cent) had children aged from 1 month to 11 years.

All the participants were from households whose socioeconomic status was poor; only about a half (22) of the participants lived in a *pucca* house (designed to be solid and permanent). They were largely financially dependent on their husband or other family members, such as father, elder brother, elder brother-in-law or grandparents, who were in such occupations as agricultural laborers (32 per cent), government service (7 per cent), daily wage work as migrants (17 per cent), self-employed (27 per cent) in such areas as masonry, small trades, basket making, carpentry) and others (15 per cent, such as working in mines, cement factory, drivers). One research participant was dependent on her mother who worked as a bangle hawker.

Of the total participants, eight young women (19 per cent) were employed—four each in Patti and Railmagra blocks and were working as domestic help, ward member, field resource person with local organization, in a beauty salon or were engaged in agricultural work.

The young women in the research sites, like in other rural areas in India, were responsible for multiple productive and reproductive work—household work, such as collecting firewood, fetching water, cooking, caregiving for children and older persons. If their families owned land, the young women worked as farmers, engaging in ploughing, weeding, seed preparation, planting, harvesting and processing of household crops. Those who did not own land worked as hired labour during sowing and harvesting seasons. At the community level, they were required to actively participate in religious and cultural ceremonies, such as family functions, marriages and funerals. With such competing demands at various levels, the young women said they were left with no time for themselves. Much of their work was unpaid and unacknowledged.

Table 5

Profile of work—main source of income

	Patti Block Uttar Pradesh	Railmagra Block Rajasthan	Total
Self-employed*	7 (35%)	4 (20%)	11 (28%)
Agriculturelabour	4 (20%)	9 (45%)	13 (33%)
Government service	2 (10%)	1 (5%)	3 (8%)
Wage work (migrant)	5 (24%)	2 (10%)	7 (18%)
Others**	2 (10%)	4 (20%)	6 (15%)

Note: N=20 in each block; one participant in each study area was dependent on her mother, who worked as a hawker selling bangles, whereas the other was working as a domestic help and providing for herself without any financial support from others.

* Self-employed includes fathers or brothers working as carpenters, masons, small traders, petty shops and cycle repairs, provision store, iron or steel fabricator).

** Others include people working as drivers and in mines and cement factory. Figures in parentheses are percentages.

Source: In-depth interviews.

Endnotes

¹Dr Renu Addlakha, Professor and Deputy Director at the Centre for Women's Development Studies, has been engaged in research on health, disability, gender and development. Her doctoral work focused on the psychiatric profession in India, with a particular emphasis on gender issues. She has trained in medical anthropology and her areas of specialization include mental illness and the psychiatric profession, public health systems, bioethics, gender and family.

²Ms Deepika Nair, Executive Director of Sathi All for Partnerships, a Delhi-based NGO working on issues of gender, women's access to resources, spaces, safety and mental wellness, is also associated with Kannur Dementia Care Society and Carers Worldwide. Her expertise is in human rights, social inclusion and issues around violence in schools, mental health and gender analysis.

³Ms Gracy Andrew, Country Director for CorStone India Foundation, is a clinical psychologist by profession. She has led several studies related to adolescent health, including a randomized control trial in 2013 among 400 girl students in Bihar, looking at the effectiveness of a resilience-based health program. Formerly, she was the Executive Director of Sangath, a Goa-based NGO. She has also been one of the national trainers of the program, Rashtriya Kishore Swasthya Karyakram of the Ministry of Health and Family Welfare, Government of India.

⁴The term "women" is used interchangeably with "young women".

FINDINGS

This chapter discusses the various aspects of mental health of the young women in the study through the analysis of their narratives. It is divided into three broad sections: Section A presents a map, of sorts, of community perceptions of mental health. Section B, with its various subsections, presents the analysis of the influence of certain structural factors, such as gender, caste and poverty, on the everyday lives of the young women and the manner in which they combine to determine mental health. Lastly, section C discusses women's resistance to the contexts that affect their mental health.

The biomedical discourse frequently ignores the socio-political, economic and cultural realities, such as poverty, sexuality and caste, that impact mental health. Critical realities of women's lives, such as access to education, mobility, ability to express their sexuality, decisions regarding marriage as well as their vulnerability to abuse and violence, are well established. The impact of these realities on mental health is illustrated by the narratives of the young women who were part of the study. The mental health issues experienced by the women were not merely issues of an individual but the result of the interactions between the individual and her social location.

Section A: Perceptions of mental health

Individual and community articulations of mental health

One of the main objectives of the study was to explore the participants' understanding and perceptions of mental health. Yet, the majority of the women who participated were unfamiliar with the term "mental health" (*maansik swasth*); it was not used by communities nor young women in their articulations of distress. Only about six women (Rajasthan-4; Uttar Pradesh-2), with whom interviews were conducted, said that they understood the term *maansik swasth* and responded to it. Some of those responses were as follows:

"There are many people in my village who are mentally unwell; people in the village say they have problem with their brain [*dimaag*]. Such people do not work or are not able to concentrate on work, they do not feel like talking to other people, they just keep sitting in sadness...they just eat and sleep."

"It [mental health] is, for example, a person who does not have any tension, a person who is free from any worries. Any person, if he or she is doing what makes them happy and they don't have any problems or worries that affect his or her life, that person is mentally healthy and has mental health."

"People who are hassled or upset, who talk to themselves....don't talk to others....who are too troubled because of pains and aches in hand and head...because of evil spirits...so all this is related to mental health."

"A person who is stressed...because of household issues, financial issues...who keeps thinking and worrying about the future—how things will work out."

Given the various terms used by women and the different articulations of mental health, the research team employed open-ended questions to explore and understand this extremely culturally nuanced issue and to prevent the use of jargon, which was far removed from the participants' everyday speech and understanding.

The research team used open-ended questions, such as: What, when and why do you feel sad, angry or happy? (*Kin cheezon se, kab, kyun dukh hota, rona aata, gussa aata hai? Kin cheezon ya baton se, kab, kyun khushi milti hai?*) These questions on feelings and emotions as tracers opened up an avenue of expressions. Women in both states used a range of expressions that articulated distress or compromised mental health. These were in local dialects of Hindi but were largely common across the study areas. Of the 42 young women, 15 (Rajasthan–5; Uttar Pradesh–10) expressed feeling anxiety (*pareshaani* or *ghabrahat*), tension (*tanaav*) and sadness (*mayusi*) at the time of the research. The remaining 27 young women had also been in situations of distress at different points in their life but believed that they were coping at the time of the research or had been able to overcome the distress.

Chinta = worry
Tanaav = tension
Sunapan = emptiness
Mayusi = sadness
Darr = fear
Dukh = sorrow
Pareshaani
Ghabrahat = anxiety
Gussa = anger
Udaas = woe, depression

“Mad” (*paagal*) or “something wrong with the brain” (*dimaag kharab hua*) were the commonly used terms for mental illness. These terms were also used colloquially for people who did not have any symptoms of malaise. The label of mad was also used for the non-normative or non-conforming behaviour of young women. For example, women who were being assertive, aspirational, talking loudly, refusing to do household work were labelled as mad.

Kanchan, 20, married and a member of an Other Backward Class community in Rajasthan whose *gauna* was yet to be performed and who was in another relationship, shared:

“They say that I am mad [pagal].... I tell them that I am not interested in conforming to the world [duniyadaari se koi matlab nahi hai]. I don’t agree with what they say, I am very different. Because I think freely, I am told that I am mad and that something is ‘wrong with my brain’ [dimaag kharab hai].”

While the contexts of the women who participated in the study were broadly similar, not all of them experienced distress similarly—their subjective social locations determined their vulnerability to mental distress, as well as their coping and healing. The language or terms for expressing the felt state of mental health were also subjective—for example, loneliness (*akelapan*) could indicate different characteristics and degrees of mental distress for different women.

These expressions were used interchangeably, although apparently in some hierarchy of the intensity of their expression of mental health. For example, sadness, emptiness and the desire to die were used to express distress, but the latter seemed to convey a higher degree of intensity of distress than the other two terms. Moreover, the women did not necessarily express themselves only in terms of emotions. Their expressions were deeply embedded in their gender, caste, through the work that they did, their expressions of sexuality, etc. Having discussions on the mental health of young women is thus complicated, especially because the expressions are not objective measures of mental health or distress.

These culturally diverse and subjective articulations of distress and mental health present complex variations that pose significant challenges to public health research, policy and interventions.

Awareness of the symptoms of mental health in the community was limited to those that manifested in the case of severe mental illness or in the later stages of an illness. For example, during the group discussions, women expressed that depression was associated with such symptoms or conditions as not

wanting to eat food or drink water, feeling like crying all the time, not being able to get out of bed, feeling sad, having disturbed sleep, remaining withdrawn, talking less, being irritable, having thoughts about ending their life and actual suicide attempts.

Some of the interviews and discussions reflected a gradual shift that has taken place in the language and understanding of mental health, with medicalized and psychiatric vocabulary permeating into the rural communities. For example, in Uttar Pradesh, some women in one of the villages used the term “hysteria”, which was explained as a condition in which a person who is or becomes a mental type (*jo mental type ho jaata hai*). The hysteria term seemed to have made its way into the community through interactions with a local electro-homeopath practitioner.¹⁴“Depression” was used by women in Rajasthan who had migrated from a city to one of the villages where the research was being conducted. During a group discussion with young married women in Rajasthan, four of the women, in response to what they understood as mental health, said it was “like when people who get depression” (*jaise ki logon ko depression ho jata hai*). Depression was understood as sadness, being quiet, non-interactive (*udaas, chhup baithe rehte hain, shunya mein takna*).

Community articulation of mental health has been documented often in the form of somatic manifestations. Women referred to the physiological consequences that, according to them, were closely linked to affected mental health: dizziness (*jee bhaari hona, jee ghabrana, matha ghumna, chakkar aana*), lack of sleep (*saari raat nahi sona*) and even thoughts about ending their life (*jee karta hai mar jayen*). The women also described it as not being able to get up from bed (*khaat se uth nahin paatey*), stiffening of the body (*badan akad jaana*) and backaches (*kamar dard karna*).

Nayar and Mehrotra (2015) highlighted, while reflecting on other literature, that such expressions point towards an affected state of mental health. The articulation of mental distress in terms of physical suffering was also critical in the context of care seeking because it was only when the distress was experienced in the form of physical suffering was care and support sought by the women and families. This was closely linked to women’s work within households. Although women’s burden of relentless work was a contributing factor to their distress, for families, women’s labour was indispensable and irreplaceable. Any barriers to women performing their work were thus addressed more promptly.

During the interviews, expressions used by the women, such as *asbhoot chadna, devi chadna, upari chakkar*, and *devi aana* (in Uttar Pradesh) and *baoji aana* (in Rajasthan), also emerged as explanations for mental distress that they had experienced. These were terms typically used by the community for behaviour perceived as unusual and not normal (for a particular person) or to describe possession, which was seen as a sign of mental health issues.

Possession and the practice of exorcism is more than just a perception based on superstition and folk lore. Belief in God or spirit possession is an ancient phenomenon, conferring either divine powers on the possessed individual or used as an explanation for illness and disorder. For example, *baoji aana* is possession in the affirmative, and any person who is thus possessed is to be listened to or heeded. Possession trance states have been seen to have distress-relieving, integrative or adaptive functions for the possessed individual (Wittkower, 1970). The predominance and susceptibility of women to such possession trance states may be seen as a response to their suppression and powerlessness in patriarchal societies and as a method of self-assertion (Bourguignon, 2004). Women suffer great mental distress because they are often rendered powerless and voiceless, and possession is a means to express protest and exercise resilience, which can be empowering and healing for the “possessed” woman.

Thus, mental health was perceived by the women as involving changes in thoughts, emotions, behaviours or all three, associated with distress and/or the inability to function “normally” within social, work or family settings. The local understanding of these “illnesses”, however, was based on different perceptions of normality. Shaped by a shared understanding of mental health within different communities, there was no singular term or cause that could explain mental health across the different communities.

Perceptions of mental health by local healers and health care providers

Perceptions regarding young women’s mental health among local healers and health care providers were largely informed by their level of acquaintance with the community and young women. The school teachers’ and community health workers’ understanding of young women’s mental health was also located in their sociocultural locations. They acknowledged the patriarchal control over young women, the constant surveillance as well as the lack of spaces to share their distress as determinants that affect mental health.

For instance, one auxiliary nurse and midwife in Rajasthan, who had 20 years of nursing experience and had had some training for counselling, explained:

“When there are tensions in the family, then it impacts women’s mental health negatively [ladies ka dimaag kharaab ho jata hai]. They often come to me and say, ‘Didi [older sister], this happened, we had a fight, they beat me up. I don’t get enough to eat, I don’t have any money of my own to spend. How should I deal with these problems? Now I think I should die.’ I take out 5–10 minutes for them. That is why they come to me so that they can hear some positive words [expressions of affirmation, support]. [Uske liye 5–10 minutes nikaal leti hoon. Is liye aate hain ki main uske liye kuch acche shabd bol doon.]”

The construct of mental health by doctors, including psychiatrists, inevitably reflected a focus on an individualized and de-contextualized approach to young women’s mental distress, ignoring their social contexts. They tended to focus on family medical history or an individual’s medical history to find links with mental distress, with complete disregard for their social location. There was a constant pathologization of these constructs of mental distress, using such expressions as irrational behaviour, hysteria and so on.

One psychiatrist from Uttar Pradesh, for example, noted:

“... [the] ones [young women] who have suicidal impulse are usually people who are dependent or immature. Maybe they have a family history of psychopathology. So, in such conditions, you will see cases of suicidal impulse.”

Other responses reflected the gendered perceptions of medical practitioners—that women use symptoms of mental distress, termed as hysteria, to gain attention or to shy away from their gender roles. Young women were accused of putting on a show (*natak*) or seeking attention to themselves to satisfy their sexual needs. A medical officer from Rajasthan, for example, remarked:

“At times, when marriage is delayed, women may become mentally disturbed. Because of that, she has hysteria-like symptoms. In our local language we call it putting up a show—dizziness, fainting spells—all these are attempts to seek attention as their physical needs increase.”

Such biased perspectives among medical practitioners, particularly in psychiatric practice, are well documented. The current research also evidenced the extremely biased diagnosis of mental health founded on gender, caste or class. The construction of mental health is solely viewed and responded to

as an illness that is located within the individual. This completely erases the sociocultural contexts that women’s mental distress may emerge from. Psychiatry, which is the dominant approach to mental health within the public health care system, has been known to individualize women’s expressions and experiences of mental distress. The research findings reflect these fundamental and persisting concerns about the understanding of mental health that physicians and psychiatrists have.

The subjective experiences of mental distress among young women must be central to any understanding of mental health. Thus, the need to deconstruct prevalent knowledge about mental health—its medicalized shifts and to create knowledge founded on young women’s experiences and expressions—becomes critical.

The following sections discuss in some detail situations of mental distress that young women experience and the links between experiences of mental distress and structural issues of poverty, gender and sexuality.

Section B: Structural factors influencing mental health



Intersection of gender, caste, sexuality and poverty

The understanding of mental health among women from the communities in the study areas was embedded in their social and economic realities and their everyday experiences of poverty, caste, gender and sexuality as well as the stress associated with adverse life events. The narratives of the women reflected the ways in which the complex intersections of gender, poverty, caste and sexuality determine mental health. These factors influence and interact with each other to contribute to an individual’s unique social and cultural location. The state of their mental health is, in turn, a product of the intersection between the individual’s unique sociocultural location and larger socioeconomic and political realities.

These intersections create consequences, such as limited access to education, livelihoods and health care, and often result in forced or early marriage to “unburden” their natal family, creating a deep sense of anxiety, helplessness and hopelessness. Apart from the denial of a young person’s right and their

chance to develop intellectually, reduced access to education, for example, often had a cascading effect: impacting access to a critical space for interaction, mobility and coping in situations of mental distress.

The findings resonate with other community-based studies in India that suggest that common mental disorders are associated with economic difficulties, limited agency and decision-making and low levels of family support (Patel et al., 1999). The findings from one such study (Patel, Flisher and Cohen, 2006) indicate that a complex web of factors contribute to and sustain young women's distress. These are often translated into symptoms of mental disorder, such as depressed mood, poor concentration, insomnia and fatigue associated with major depression.

The complex interplay of factors makes it challenging to segregate and study the impact of individual factors' impact on mental health. Qualitative studies produce rich narratives, which capture an individual's experiences of being young, poor, lower caste or a young bride; but it is precisely this existence of multiple elements in a single narrative that makes the isolating and studying of separate variables a challenging task. Although analysis of this study's research findings was made under distinct themes, overlaps inevitably persist and must be borne in mind when reviewing them.

Poverty and caste

"I belong to a lower caste. Other caste communities don't allow us to take up many jobs, like taking tuitions, even though I am educated. Because I can't get any other job during my holidays, I work in NREGA or make brooms at home. Earlier, I had taken up a teacher's job in a local organization, but the higher caste children's parents raised objections about a girl from a low caste teaching their children. So, the organization asked me to leave. They did not support me, what can I say. What has my caste to do with teaching children? My identity as a Dalit always haunts me, even if I am good at what I do. The discrimination always makes me feel sad and affects my mental health."

This narrative from Sunidhi, 19, not yet married and a member of the Dalit community in Rajasthan, illustrates the experience of caste discrimination, which conflicts with the young woman's self-perception of being equal and competent and produces a feeling of alienation, estrangement and despair.

It is well known that for a large majority of Dalits, whether in rural or in urban areas, whether educated or uneducated, managing and living with stigma and discrimination is a matter of perpetual struggle and mental distress. Dealing with the stigmatized identity and discrimination is a major health problem. Studies have established that caste, which often intersects with poverty, impinges on women's lives and their autonomy and impacts their mental health. Research has found similarities between the impact on mental health of sexual assault survivors and those who have experienced the trauma of racism: Both of them are an attack on the personhood and integrity of the person (Bryant-Davis and Ocampo, 2005).

Poverty is another factor that emerged repeatedly in the study for the impact it had on mental health. Tamanna, 25, who had married when she was 15 and is from an Other Backward Class community in Rajasthan, was diagnosed with cancer (also the indicated reason for her husband and marital family abandoning her) and was extremely worried about her health and the high cost of treatment: "Thousands of rupees were spent by my family on medicines and injections," which was unaffordable for a poor family like hers. For months she "cried all day" and stopped eating.

Poverty is strongly associated with mental health and in a way that complicates situations. Poverty creates vulnerability to hunger and violence and poor access to education and housing, all of which lead to the absence of robust social networks—factors that determine mental health. On the other hand, affected mental health can impact education, lead to high health care costs, irregular employment and poor social relationships, which may push individuals and families into deprivation and poverty.

Poverty and caste are also interrelated, with Dalit and tribal communities disenfranchised on most socioeconomic indicators, including ownership of productive resources, employment and health. Indebtedness caused by lack of livelihood options or out-of-pocket health care expenditures places a huge burden on individuals and families from these and other marginalized communities and are a cause of great distress. As Sunidhi's narrative illustrates, caste and gender discrimination cause even educated persons to experience unemployment, which has a severe impact on their self-esteem and mental health.

Early and forced marriages

This section highlights issues emerging from the normative structure of marriage, especially the impact of early and forced marriages, and how women experience the transition to the marital household.

Generally, the popular understanding of early marriage (*jaldi shaadi*) in all study areas related to age. "Women younger than 18 years" was the immediate response to the understanding of early marriage. But on being asked to explain which marriages were considered "early" or "not early", the respondents defined not-early marriages as those that take place following the completion of their school education and after young women become independent, especially financially independent.

Young unmarried women in Uttar Pradesh stated that there was no fixed age for marriage: "Some get married at 18, others at 20", said one participant. But there were some conditions that precipitated an early marriage (at an age younger than 18 years). For example, girls who looked older or more mature than their age were married early—"if a girl is 15–16 years but looks 25, then in such a situation the marriage takes place earlier", explained another young woman. Other reasons included the perceptions of the community or the family about the girl. According to Mansi, 18, not yet married and from a Scheduled Caste community in Uttar Pradesh:

"In villages, young women cannot stay unmarried for too long. They are married off early. Families and the community believe that otherwise the girls will run away or do something 'wrong'. That is why family members are afraid and hence get young women married off early."

Poverty was cited as another reason for early marriage. Ankita, 23, who was married when she was 14 and is from a Scheduled Caste community in Uttar Pradesh, reported:

"Cannot say no, cannot say yes. Just peacefully say it is okay, whatever has been done or decided. No issues... basically the problem is of money. If there is money, when we want it, whenever we need it and as much as is required, then we could do it [marriage] as we want to... but otherwise those who do not have the financial capacity think, 'Let's get her married now, there will be more [financial] problems in the future.'"

Many families married off their daughters at an early age in the absence of financial resources for continuing their education, for reducing marriage expenses, following the death of the primary wage earner in the family or the poor health condition of the patriarch—usually the grandfather or the father. Some of the young women in the study were also married early for emotional reasons, such as an aging family member's wish "to see them married" before their imminent demise or a marriage arranged by the family immediately following the death of a family member.

Almost all of the 12 married participants in Uttar Pradesh were from caste groups that were landless and dependent on daily wage labour. Some of them said that penury compelled them to marry to reduce the burden on their families. In Rajasthan, too, financial considerations were a significant underlying cause of early marriage, as articulated by 14 of the young women.

The young women in Rajasthan were married earlier than the women in Uttar Pradesh. Some of them had been married ritually even as early as 2 and a half years of age, especially if they had older sisters—“all sisters will get out in a single expense” (*ek kharchey mein sab behne nikal jayengi*). This was primarily to minimize expenses through a single marriage event.

The 28 young married women revealed that their families had made the decisions regarding the timing of their (early) marriage and who they married. This compulsion and pressure to marry, the lack of decision-making power and the inability to express their desires, according to the women, affected them mentally. As for their understanding of forced marriage, the young women articulated it as a marriage that they did not want for but were compelled to accept, regardless of when it took place. The narratives of the women brought out the extreme stress of their situations, their feelings of helplessness and struggles with the lack of control over their lives.

Kanchan, who was married at 16 and whose *gauna* had yet to be performed, expressed her frustration and anger at being made to marry a person against her will:

"I was emotionally pressured to marry the boy of my father's choice. I had told my mother, clearly, that I did not want to get married. I felt irritated and angry and wanted to run away. I had thought of becoming financially independent and then going ahead with marriage. I don't like my husband; he is not someone with whom I would like to spend my life. I don't like his lifestyle and the way he talks. He doesn't seem to be serious about his life nor does he have any aim in life."

She said that when she told her parents about being unhappy with the marriage and her desire to leave her marital home, she was physically and emotionally abused by her father. Her mother was supportive but was unable to do anything about it because Kanchan's father was intolerant of any support provided to her and used to abuse her mother for doing so. Kanchan had to relent and go to her matrimonial home to protect her mother, despite repeatedly returning to her natal home. Struggling with her situation as a result of her decision being side-lined and the loss of control over her life, she expressed the desire to join the police force because it would provide her power and authority.

Similarly, Raveena (from Rajasthan), who was 23 years old at the time of the interview, had been married at age 4. She expressed her frustration at not being able to choose her partner. She desired an understanding, trusting and “good” person as a partner. She disliked the person she was married to and said that he did not have the qualities she wanted in a partner. She was in a relationship with another man. She received no support from her natal family, with her father unwilling to listen to her concerns. She wanted to walk out of the marriage and be with the partner of her choice but was fearful of the repercussions, especially for her two sisters-in-law. She was worried that no one would be willing to marry them as a consequence of her decision. She was experiencing tremendous distress and had no one to guide or counsel her.

About 14 unmarried girls (Rajasthan–5; Uttar Pradesh–9) mentioned having to compromise between their own desires and the demands imposed by the family members. The pressure to uphold family honour, to avoid bringing a bad name to the family and to not cause pain or suffering to family

members led to tremendous stress. This was exacerbated in situations in which support was not adequate nor transformative so that they could assert their desires and decisions.

Most of the women across the study sites aspired for a partner “who is educated, trustworthy, will take care of them and has good habits”, as one of them explained. However, to assert their right to choice of partner or the timing of marriage was a path wrought with anxiety and distress. As previously noted, some of the young women who were married were trying to withdraw from their marital relationship but were challenged by the lack of support. Distress as a consequence of the lack of space to express their desire or to discontinue a relationship that they did not desire was common.

These situations and the absence of alternatives for redress or the anxiety that they would not be heard created a sense of helplessness and hopelessness among the young women. That the institution of marriage expected young women to be subservient and pliant acceptors of all that they were subjected to was a major concern for the women, who, whether or not themselves were married, were well acquainted with the largely restrictive and exploitive situations that marriage inflicted on young women.

Post-marriage patrilocality

One of the issues that emerged strongly as a concern related to marriage was the inevitability of patrilocality. This concern around patrilocality was true for all 42 women, whether they were married before 10 years of age, between 10 and 18 years or even for some who were not married. The women stated that having to shift to their marital home, away from the home that they considered theirs, created fear, inhibition and anxiety about the new environment, relationships and the burden of work. Neelima, 25, who had married when she was 17 and was from a Rajput community in Rajasthan, shared:

"After marriage, when I came to my marital home, initially I was fearful—what if I make some mistake or if I am not able to do my work properly? I do not know anyone here, everyone is new to me."

Ridhima, 24, (divorced and from a Scheduled Caste community in Rajasthan) said:

"My mother-in-law used to say, '...from where should we get soap and shampoo, they are costly. Who will bear the expenses?' So, they did not provide me with oil or soap. My mother-in-law used to taunt me saying, 'She lives like a queen. She is the cause of so much expenditure—she wants a different soap for bathing and washing—we cannot afford such expenses. 'She used to observe me closely and criticize my actions all the time."

Although the experience of distress with regard to patrilocality was true for all women, it seemed that the younger the women (aged 14–19 years) who had relocated to the marital household, the greater was their experience of mental distress. The older women (aged 20–25 years) had possibly undergone a longer socialization because they commented on the way other women around them—their sisters-in-law, their older married sisters, relatives, neighbours, etc.—behaved and were treated. They normalized or explained their own experiences as inevitable. The move to the marital household enforced a breakdown of their known kin networks, forcing the young women to forego friendships from their natal home and community. Sociocultural norms about marriage imposed the complete breaking of ties with the natal family in many respects. This transition to the marital household contributed to tension and stress for them because they were generally expected to adapt immediately to unfamiliar sociocultural expectations and work responsibilities. In a group discussion with married young women in Rajasthan, one participant explained:

"[The] marital home is not like our home where we can work if we wish to or not if we don't want to. Here [in our marital home], if we sit idle even for two minutes, our mothers-in-law will ask us to work. We have to work here because we are the daughters-in-law of the house."

As young daughters-in-law, many of the young women expressed that they were expected to be subservient and perform all the work that was asked of them, even if they were averse to it. During a group discussion, a woman member of the local council (ward *panch*) recalled her experience:

"Soon after marriage, in the marital household, I was asked to pick up dung, but I refused to do it. My father-in-law complained to my father. My father apologized to my father-in-law and told me that I had brought shame to the family. I felt very bad and cried a lot. I decided that [henceforth] whatever they tell me to do, I would do."

Although the work burden in natal households was also substantial, as the narratives of the women reflected, the surveillance and control in the marital households and the powerlessness of young daughters-in-law created a burden of silence and intolerance that was greater than in their natal home.

Nine women (Rajasthan—7; Uttar Pradesh—2) felt that they were constantly under surveillance and lived with the fear of being chastised, in case of any mistakes, which created a constant sense of anxiety and stress. Neelima, Karishma and Swati from Rajasthan and Megha from Uttar Pradesh (all currently married) said that they had been fearful of being under surveillance during the initial years of marriage. Others, such as Raveena, talked about how in-laws were always conscious of their actions. Sharda, Rachna and Kanchan (whose *gaunas* were not yet performed), were hesitant to go to their marital household due to the fear of the close watching and an overall hostile environment.

That the inability to perform any household chore reflected poorly on the quality of socialization and upbringing in their natal family was an additional burden for the young women. Even the most banal chores were linked with their natal family's honour. A number of women talked about the humiliation that they faced in the marital household that had deeply affected their self-esteem and had serious impact on their mental health.

Married but not relocated to marital home

As discussed earlier, three of the women from Rajasthan who were married—Sharda, Rachna and Kanchan—were staying in their natal household and continuing their education because their *gaunaw*s were not yet performed. They were married at age 6, 14 and 16 years, respectively; two of them were pursuing undergraduate studies and the third was in Class 11. They were from an Other Backward Class community, which was the dominant caste with agricultural landholdings in Railmagra Block. The women were expected to visit their marital households from time to time, but having to balance the two realities (perceived as different by them) of the natal and marital homes was extremely distressing for them. They narrated how they were expected to behave as "good" daughters-in-law in their marital household by wearing the saree and the veil (*ghoongat*) and performing household chores, such as cooking for the entire family and cleaning, some of which they also did in their natal household. However, they were perceived as different and that there was more space for negotiation in their natal home.

Kanchan's narrative highlights the challenging negotiations and struggles she experienced in both contexts—the natal and the marital homes. The ongoing tussle with her education, her desires and aspirations and the hostility of her father as well as her marital responsibilities worsened her distress. Her narrative also suggests that given that her *gauna* had not been performed and she was staying with

her natal family, the space for sharing such tensions was available, which helped her cope with the pressures and consequent distress.

Supportive marital families

Nine of the young women who were married said that their in-laws or husbands had been supportive and had permitted or encouraged them to continue their education or explore employment opportunities. They had also shared the burden of household work and often provided the young women a supportive space, which helped them in negotiating and overcoming stressful situations.

Nirmala, from a Rajput family in Rajasthan, was 17 years old when she married. Her marriage took place because her father had passed away and her grandfather, who was very old, insisted that she marry before anything happened to him. She had completed Class 5, and although it had been agreed that she would continue her education after marriage, she became pregnant soon after and did not get a chance to study. She was worried initially when she moved from her natal home to the marital household; she was anxious whether the people there would like her, whether she would be able to be a good daughter-in-law and speculated about what her marital family would say in case she made any mistakes.

Initially, after marrying, she felt lonely. But she found a supportive family environment—her mother-in-law helped her adjust in the family, her husband was caring and her younger sister-in-law became a good friend. Her in-laws wanted her to continue her studies further but after two children, she did not have any interest to do so.

Reema, 25, from Rajasthan, was ritually married when she was 2 and a half years old. She experienced severe distress and anxiety when her relationship with her husband was impacted due to her brother's untimely death. She was part of an *ata saata* (sister exchange) type of marriage. Following her brother's sudden death, she went back to her natal home and her sister-in-law (her brother's wife) returned to her natal (Reema's marital) household. A rift in her relationship with her husband during this time impacted her. Then her husband called her after a few months and asked her to return. Her in-laws also wanted their daughter-in-law back. Reema now refers to her mother-in-law as her best and closest friend because she shares all problems with her. Her mother-in-law supports her and helps her with the daily household chores and with childcare.

The research findings raise specific concerns regarding young women in a marriage. The imperative character of the latter, along with other social ideals of homemaker, daughter-in-law and mother, cause much anxiety. The unequal and normative relationships, pre-determined by the institution of marriage, were a significant cause of mental distress among the young women. The women who were unmarried also cited a constant pressure on them—marriage never seemed too distant. Some women were in a relationship but expressed concern about their family's acceptance of their chosen partner and when the question of marriage would be raised. For example, Priyanka, 18, from an extremely poor family in Uttar Pradesh, thought that she might be married off the following year. She had a boyfriend and was concerned about the family's reaction if and when they found out.

Madhavi, 18, who had not yet married and is from an Other Backward Class community in Uttar Pradesh, was experiencing extreme distress due to the non-acceptance of her choice of partner by her older brother. The lack of support from her brother, who washed himself in a love marriage, and the feeling of discrimination due to the patriarchal norms that allowed her brother to marry of his own choice while

she could not cause her much frustration and anxiety. This situation, coupled with an uncertain future, was adding to her distress.

The inevitable reality for all the young women was marriage at an opportune time and to the person decided by the family. Poverty, caste norms and sexual control formed a web of interlinked contexts that forced many young women to concede to this reality, with little or no choice in either timing or partner. All of the married young women in the research expressed how the coercion and their helplessness created serious concerns because of not wanting to marry at the time or did not want to marry the person selected by their parents or guardians.

For the study participants who had married at a very young age, late *gauna* posed additional problems. These young women lived in their natal home, were pursuing their studies and visited their marital home from time to time. This required them to balance the different realities of the natal and marital households. In the former, they had some space of negotiation and freedom and support, but in the latter, according to many of them, they had to comply with the roles and responsibilities of a young daughter-in-law.

Although some of the women managed the difficult transition to their marital household because of a supportive marital family, many struggled with the stringent norms of dressing, constant surveillance and the unmitigated burden of housework. The lack of support from the natal family exacerbated the distress. Natal family members suggested that they had to adjust, even if they faced oppression or violence in their marital family. Thus, in the absence of a support system, young women felt alienated and experienced severe anxiety. Only in extreme situations, such as desertion by the husband or in the case of critical illness, were natal families supportive of their daughter.

Given the socialization of young women that tells them marriage is inevitable and that it is their responsibility to sustain it, the women who had been separated or deserted experienced severe distress. Articulations by some of the women about returning to their husbands related to the stigma that surrounded those who were abandoned, precipitated by their devaluation, increased control of their autonomy and sexuality and curtailment in access to education and employment. All of that only reinforced and deepened the inequalities. In Rajasthan, where there was a societal sanction and acceptance of women leaving their husband to co-habit with another person through the process of *nata pratha*, (customary union presided by community elders or caste council) women who went through with a *nata* were viewed suspiciously. But *nata* did not give them any legal rights in the family, making their position extremely vulnerable.

Burden of productive and reproductive work

In a patriarchal society, a woman's ability to bear children is a sign of womanhood, and her contribution is evaluated in terms of her reproductive capability (Chodorow, 1999). As disclosed in this study, there was tremendous pressure exerted on the young women after marrying to prove their fertility—to prove their ability to have children, especially male children—within a year or two of marriage. The discussions in the study indicated that young women incapable of having children within a stipulated time after marriage were subjected to taunts and verbal abuse and even physical violence in some situations. This negatively impacted their mental health.

Young women who were unable to conceive sometimes faced eviction from the marital household. The research reinforced the gendered nature of infertility; young women were affected by their own socialization, which created a sense of guilt and failure. The socially constructed imperative of

motherhood affected young women's self-esteem and well-being. The women also talked about the pressures on them to have male children and the violence and distress that they often experienced due to prevalent notions of son preference.

For instance, Swati, 25, from an Other Backward Class community in Uttar Pradesh, highlighted how the effort to have children, the ongoing tension and sense of guilt at not having fulfilled the designated role of motherhood had created a situation in which she was always in a troubled state of mind, perpetually anxious. Swati was married for seven years and did not have any children. Although she felt no pressure from the family, she experienced guilt and poor self-worth because she was unable to have children. Her situation caused extreme angst. She had accessed medical intervention to conceive but had discontinued it when it was unsuccessful and expensive; instead, she continued to consult a faith healer.

Pregnancy and child care were each extremely stressful, as the discussions with the young women indicated. According to Reema, 25, who was married before she was 3 years old and from an Other Backward Class community in Rajasthan:

"At that time, I felt that it was better if I did not have children [laughs]...they don't let you sleep. I had to put him to sleep, change his clothes, change his diaper, bathe him, give him a massage."

Reema's experience during childbirth was terribly agonizing for her, and she had felt that she would not survive the process. But support from her husband and her mother's and mother-in-law's presence helped her cope with the agony caused by the physical suffering.

After childbirth, the young women were challenged by the multiple new roles and responsibilities that they had to carry out. They had to take care of the household work along with the added responsibility of caring for an infant. Some of the young women shared the stress that they faced as a result of the work burden in raising children as well as their household chores.

According to Megha, 20, who was married and from a Scheduled Caste community in Uttar Pradesh:

"My husband sometimes beats me when I am unable to do the work that he asks me to do. My husband's abuse continued even when I was unable to do any work due to my pregnancy or just after giving birth to the child. When I was pregnant, I suffered from nausea and vomiting for the first four months. After that, I got a skin allergy. In the ninth month, the problems increased, I could not do any work then. And after the child was born, then there were even more problems. I could not do any other work."

Women who were unable to productively carry out their household work due to an ailment or fatigue were often at the receiving end of abuse and even violence from their husband and in-laws regarding their inability to "take care" of the household. The young women's productive and reproductive roles within the household were crucial, and they were expected to get back to them at the earliest following childbirth or health ailments.

Sexuality and mobility

Social relations within patriarchy flourish through the subordination of women and a strict control over their sexuality. Families as well as communities impose restrictions on young women's mobility and behaviour. Relegated to the private sphere, sexuality was considered a taboo subject and met with silence during the study. This section highlights how control over young women's sexuality and the prevalent cultural and social silence around it in the context of sexual health impact mental health.

Restrictions on mobility

From birth, girls are socialized overtly and covertly to conform to the rules of how to “be” girls, which are primarily determined by their social and cultural settings. Although gender socialization starts at birth, it intensifies when girls reach puberty. Prevailing gender norms shape young women’s social behaviours—how they interact, form relationships, engage in sexual and reproductive practices, etc. Thus, they are constantly under pressure to conform to social expectations as well as to the patriarchal norms of female subordination that exist in society. This restricts their choices and opportunities and their social and sexual decision-making abilities.

During adolescence and thereafter, freedom of movement becomes increasingly constrained for girls and young women. They are expected to take on more household responsibilities and refrain from interacting with boys due to the growing concerns around their developing bodies and emerging sexuality. Getting them married is among the foremost priorities of their families. This social environment of increased restrictions and monitoring by their parents, family and the community limits their mobility and freedom and fosters low self-confidence.

Mobility restrictions are extremely deleterious for their mental health and have a direct impact on their ability to seek help from neighbours, friends and health care providers in situations of mental distress. Their access to knowledge and information is also severely curtailed, making it difficult for informed decisions about specific issues, like education, health and sexual and reproductive matters as well as their lives in general.

As already noted, the narratives of the young women revealed that families tended to control their mobility in terms of the people they interacted with, the clothes they wore, etc. Many young women reported that their family members were consumed by suspicion that they were secretly interacting with boys. Mrinalini, 21, who had married at 14 but was now divorced and from a Scheduled Tribe community in Rajasthan, expressed that such doubts arose even when a young woman interacted with male members of her own extended family because that, too, was seen as a threat to her “image”. Those who did not concede to the prescribed behaviours were branded as “bad girls”. Explained Mrinalini:

"Any family that has a 16- or 17-year-old daughter, family members torture her: 'Don't speak with boys, don't go out anywhere at night, don't wear short clothes or tight clothes like jeans.'"

Mansi, 18, who had not yet married and is from a Scheduled Caste community in Uttar Pradesh, echoed Mrinalini’s opinions:

"Those women who are haraami and badtameez [abusive terms] speak with boys. We don't. People are suspicious about you even if you speak to your relatives. So, we don't talk too much. In villages, young women can't stay unmarried for too long. They are married off early. The fear is that they may run away or do something 'wrong'. That's why girls are married off early."

Several narratives revealed that when a young woman tried to venture out of the village, she was subjected to extreme shaming. If the community branded the young woman as a “bad girl”, it had serious implications on the reputation of the family. In one of the group discussions, a young woman expressed that it was this fear of the family getting a bad name that drove them to impose so many mobility restrictions on young women.

Young women from Uttar Pradesh shared that they were married off early because their families were afraid that if they were left on their own for too long, they would start asserting themselves or make their own decisions about whom they wanted to marry, which was against the social and cultural norms and seen as tarnishing the honour of the family. As one unmarried woman said during a group discussion in Uttar Pradesh:

"If young women go out, people in the village start spreading rumours about them. The family members are worried that if people start talking about their daughter, the family's reputation will be at stake. That's why young girls in the village are not able to move forward in life."

This reveals that the consistent attempts at controlling and restricting women through various mechanisms may impinge on their perception of self and, in the long run, adversely impact their mental health. Studies have shown that the household is one of the primary sites of gendered practices that influence the mental and emotional well-being of both men and women. Ram et al. (2014) argued that stressors, such as an inhibition of independence, can create frustration and despair among young people. Barriers on mobility and self-expression also lead to health problems for both men and women, although women are far more disadvantaged in this regard.

According to Ram et al. (2014), young women in villages and small towns, as opposed to those who lived in cities, felt that their social mobility was more constrained because of the restrictions imposed on them by their family and the community. Some of them, however, believed that such controls were necessary so that young women do not "stray from the right path". Others expressed that such controls were their parents' way of ensuring that neighbours or others in the society did not malign the image of their daughters. That young women were perceived as the "bearers of the family honour" was implicit.

Gendered norms imposed an added burden on young women because they were forced to constantly question and monitor their own actions, just as their community did, so as to not bring a "bad name" to the family. Social pressures to conform and fear of violence were additional factors that loomed large in their minds almost all the time. Restricted mobility and minimal interaction with people—especially men—outside the immediate family were the dominant norms in the areas where the research was conducted. The study findings, however, revealed a process of constant negotiation with these dominant gendered norms. Young women spoke about "time-pass [temporary] relationships" before they were married to whomsoever was selected by the family. Some of the young women in Rajasthan also attributed relatively greater mobility to the presence of local organizations in the area and their consistent involvement with the community.

As discussed earlier, marriage did not result in a lessening of surveillance; instead, it brought with it more stringent surveillance and control on mobility. Raveena, 23, who was married when she was 4 and is from a Scheduled Caste community in Rajasthan, reported:

"The environment in their [in-laws] house is very oppressive. My husband doesn't let me go anywhere on my own. I noticed my father-in-law is also like this. He also doesn't let his wife go anywhere. Then there are all kinds of restrictions—don't sit here, don't sit there, don't talk to any stranger, don't look at anyone, only be inside the house."

Young women who were interviewed in Uttar Pradesh noted that, for a couple of years after marriage, they were not even allowed to go out and work in the fields. They were restricted to taking care of household work. Their social interactions were so limited that they often felt uncomfortable and anxious to approach anyone other than family members. They could not even express their distress and discomfort to anyone within the family due to the hierarchy within, wherein young daughters-in-law occupied the lowest position. The young women spoke of the constant watching over everything they

did—be it using a mobile phone, doing the household work, what they wore or how they conducted themselves outside their home. This created tremendous mental pressure on them all the time.

The gendered codes of conduct and mobility restrictions imposed on young married women who were deserted, divorced or widowed and were residing with their natal family seemed even more severe. Of the ten women who were “currently unmarried” at the time of study, four were deserted, three widowed and three divorced. All of them expressed that they felt dejected, humiliated and unworthy because of the constant monitoring and surveillance by the community of their everyday lives. Feelings of dejection and unworthiness had resulted in low self-esteem and anxiety. The narratives of the women deserted by their husband and/or their in-laws revealed that they faced a higher degree of surveillance by their natal family and community. Vineeta, 25, who had married at 16 and was now deserted and from a Scheduled Caste community in Uttar Pradesh, said that her brothers did not let her go out of the house. If she went out, even her neighbours perceived it as an “immoral” act:

“My brothers tell me, don’t go outside the house, the neighbours will slander and insult us; that’s what they say...because of this I am unable to go anywhere.”

According to Abida, 24, who is Muslim and had married at 20 but was now deserted by her husband:

“When a married woman starts staying in her natal home, she becomes a ‘bad woman’ in the eyes of the community. In your natal home, if you go anywhere, especially alone, they think you are indulging in some immoral act. But in your in-laws’ house, as long as you have your husband, nobody will say anything. You can go anywhere.”

Such heightened control on freedom and mobility caused significant helplessness. Along with the stress and humiliation caused by desertion, the women’s inability to go out and earn for their children added to their anxiety. Because they were from poor households, it was also challenging for their natal families to provide for them and their children. According to Vineeta, who was residing in her natal home in Uttar Pradesh with her two daughters following abandonment by her husband and his family:

“I think about it all the time, but what can I do? My brothers don’t let me do anything. I want to earn money for my children. I worry about their future. I want them to pursue their studies so that their lives are not like mine. These thoughts, and my inability to do anything, make me feel very depressed.”

A similar situation confronts young women who return to their natal family after the death of their husband. Gunjan, 20, from an Other Backward Class community in Rajasthan, was married when she was 6 years old and widowed at 17. She was a local council member (ward *panch*) at the time of the study and disclosed that the community talks unfavourably about her when she is seen with another man. Despite being an important public figure, she is constantly worried about being seen with someone. As a result, she is hesitant to speak with people, even though her job requires it. For two years after her husband’s death, she did not step outside the village, fearing that “something untoward would happen”.

Gunjan’s story resonated with those of other young women whose husbands had died. Their narratives highlight the severe impact on mental health that young women experience because of the stringent controls on their sexuality and mobility. This has systematically created a deafening silence around sexuality in the public sphere by making it a private affair. The resulting inhibition to engage in any open and healthy discourse about matters pertaining to sexuality severely affects the health of young women. Shame and secrecy associated with sexuality also hampers access to appropriate and adequate information around these issues, making the women vulnerable.

The following section highlights how such silence, shame and secrecy, which exists around sexuality and sexual health, impacts on the mental health of young women.

Silence around sexuality

Singh and Gopalkrishna (2014) argued that young people experience a significant amount of stress along with the biological changes that occur during puberty. This influences their relationships with their peers as well as with adults around them. Coupled with a lack of awareness about their body, this period can become extremely unsettling for many young women. For instance, accounts of many women from the research revealed that they did not have adequate knowledge about menstruation at the onset of menarche. This became a cause for stress and anxiety in the absence of a strong support system and adequate sources of information.

Further, the prevalence of sociocultural silences around sexuality discourage young women from inquiring about physical discomfort and pain. This includes body aches, abdominal pain and backaches experienced during menstruation or any sexual health-related issues, such as white discharge, itching, etc. Young women discussed feeling shame in talking about these issues. They also spoke about the tension associated with staining their clothes, in case they got their period while outside the house. With no one to discuss these worries with, they bore the physical suffering and discomfort silently, which affected their mental health.

Knowledge around intimacy and sexual relations among young women was also found to be limited. The little that they knew about sexual intercourse was from interacting with peers or through eavesdropping on older women's conversations. Such half-baked knowledge rendered these young women vulnerable to grappling with their initial sexual encounters (discussed later in the section on violence), also causing distress, fear and anxiety. The International Center for Research on Women (2017) argued that "inadequate access to sexuality education and appropriate sexual and reproductive health services, combined with a dearth of information about their own bodies and sexuality more generally, contributes to a lack of power in girls' relationships and puts them at an increased risk of unwanted and high-risk sexual encounters."

The comments from the young women in the study revealed that the secrecy and shame that shrouds discussions around sexual relations and sexual pleasure discouraged them from gaining information about these matters, leading to further confusion. Sharda, 23, for instance, who was married but had not yet initiated *hergauna* and is from an Other Backward Class community in Rajasthan, explained how sexual relations mystify her:

"I don't like all this...these sexual relationships, I don't like it...that's why I am calling it a useless affair.... We do it, but even when I think about it, I don't like it.... I tried understanding all this but couldn't understand, what it is, what it isn't."

This outlook reflects the lack of spaces to discuss matters pertaining to sexuality and sexual health. The young women indicated they were struggling to make sense of what sexual relations, intimacy and sexual pleasure were. Some of them echoed Sharda's anxiety and the need for information and understanding. This anxiety, at times, had physical manifestations, as described by Madhavi, 18, not yet married and from an Other Backward Class community in Uttar Pradesh:

"First, I was confused about why this happens. One or two years ago, once I had become mature, we were all sitting one day. We used to get only one channel on the TV—there was no electricity back then, so a TV show was coming that was called Nanhisi Kali, Meri Ladli (Little Bud, My Darling Daughter). When a kissing scene was shown in the show, I started vomiting.... I don't

understand why this happens. I am taking medication, but I still feel strange, my mood spoils. I don't vomit out now. I get goose bumps just like when you are feeling cold or when you get scared looking at something. I go into a state of shock."

Madhavi's story reflects the complexities generated by the silence around sexuality even when sexually explicit material, albeit limited, appears in popular media. Young women may have wanted to know and discuss what they were watching on television but were unable to do so, owing to the taboo of talking about sexuality. Madhavi's remark reflects the need for a process that would help her assess and address the reasons for her fear.

Women also talked about the distress caused by not having been aware of their pregnancy, for example, due to inadequate knowledge about reproductive health issues, their bodies, sexuality or because of the poor quality of health information and health care. As Swati, 25, married and from an Other Backward Class community in Uttar Pradesh, explained:

"They told me that miscarriage happened due to heat [and that] I had to get a vaccination done. But I didn't know. I checked using the pregnancy test card and it showed negative. They say that pregnancy test cards don't indicate incorrectly. The doctor told me that I had conceived but because I didn't get the vaccination, the miscarriage happened. How could I have got the vaccination done if I didn't know?"

Such experiences were also recounted by other women and that it had caused them sadness and anxiety due to the immense social and familial pressure on them to prove their fertility and produce children soon after marriage.

Patriarchal control over young women's sexuality, required for the establishment of private property and for the maintenance of caste purity (Chakravarti, 2018, 2006), constrains their social mobility and their freedom to choose a partner of their choice. Cultural and social norms around chastity place an added burden on young women. Sexuality and gender norms for maintaining "sexual purity" penalize young women and cause them to experience indignity, helplessness and discrimination. Further, social silence around sexuality has deep implications for the availability and accessibility of comprehensive information around sexuality and sexual health. There is a high prevalence of myths and misconceptions regarding reproductive and sexual health among young people (WHO, 2002). Incomplete knowledge around sexuality puts young women in vulnerable situations, which have implications for their health, both physical and mental. The interplay of these factors creates tremendous barriers for women in the assertion and fulfilment of their human rights and their autonomy, significantly affecting their access to healing, care and support.

Abuse and Violence

Violence against women and girls is defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (United Nations General Assembly, 1993). It manifests itself in various forms, such as domestic violence, intimate partner violence, honour killings, rape, sexual harassment, marital rape, trafficking and stalking.

It has also been recognized as a public health issue affecting women's physical, mental, reproductive and sexual health (Garcia-Moreno and Watts, 2011). The impact of various forms of gender-based violence on mental health are widely known and accepted within the public health discourse (Krug et

al., 2002). Violence, both in the private and public realm, has far-reaching consequences on the mental health of young women. Nor does it spare those who witness the violence.

Studies have found that gender, caste or racial violence has a traumatizing and devastating effect on anyone who witnesses it—be it the children or friends of women who are experiencing abuse and violence. Even those who hear about such incidents remain under constant fear (Ellsberg, 2006; Garcia-Moreno, 2005; Buzawa and Buzawa, 1996). Post-traumatic stress disorder, suicidal thoughts or attempts, withdrawal and isolation and overall loss of trust in people are the grave forms of psychological harms that have been observed in survivors of gender violence (Rajoura et al., 2012).

Young women who have experienced physical or sexual abuse are more likely to attempt, or at least think seriously about committing, suicide because of low self-esteem and hopelessness about the situation not changing. The World Health Organization's multi-country study of violence against women found that women who had ever experienced physical or sexual violence, or both, by a partner were significantly more likely to have ever contemplated suicide than other women. And among women who had ever contemplated suicide, those who had ever experienced physical or sexual violence, or both, were more likely to have ever attempted it. They were also more likely to report mental distress than women who had never experienced violence. Indeed, the study findings suggest that even violence in the past may be associated with current negative mental health outcomes (Garcia-Moreno, 2005).

Violence emerged as a significant factor affecting mental health in our study. The following section presents the different forms of violence that emerged from the data and analyses their links with mental health.

Prevalence of violence

About 70 percent, or 28 of the 42 women (Rajasthan–13; Uttar Pradesh–15) talked about how abuse and violence as well as the fear of violence affect their mental health, although not all the narratives pertained to their personal experiences. More than 80 per cent, or 34 of the women (Rajasthan–14; Uttar Pradesh–20), talked about domestic violence in their communities, both in the natal as well as in marital homes. Other forms of violence and abuse that the women had experienced were sexual harassment in public places, son preference, marital rape, abduction and sexual assault.

Eleven women (Rajasthan–7; Uttar Pradesh–4) shared their personal experiences of violence. Kritika, Tamanna, Kanchan and Raveena from Rajasthan and Abida, Vineeta, Megha and Swati from Uttar Pradesh disclosed their experiences of violence within their marital home. Rashi and Ridhima, also from Rajasthan (who had each separated from their spouse at the time of the study), and Sunidhi, also talked of the impact of the violence on their physical and mental well-being in their marital and natal homes, respectively.

The pervasiveness and normalization of violence against women and its employment as a tool of control were articulated by some of the other women. As Madhavi, 18, not yet married and from an Other Backward Class community in Uttar Pradesh, pointed out:

"Some people beat their wives.... She [the wife] takes her children and goes off to her natal home.... She stays there for a few days, and then she turns around and comes back. There is no other option."

According to Megha, 22, married and from a Scheduled Caste community in Uttar Pradesh:

"[Husbands] are violent against women only. For instances, they drink and come and are violent with women.... Some of it is to do with money. ...there is a lot of violence, this happens a lot. ... [the woman] does not raise her voice against her husband.... They continue to bear the beatings.... I am fearful of this."

Like Megha, other women talked about the fear and control that such violence exerted on them. This affected their access to education, employment and public spaces. Women also experienced and witnessed violence in a continuum, in multiple sites and times in their lifetime.

Perceived or real defiance of culturally expected behaviour by girls and women also led to the infliction of violence. Two women from Rajasthan, Sunidhi and Kanchan, talked about the abuse and violence in their natal home that caused them deep distress. Kanchan, 20, who was married at age 16 but her *gauna* had yet to be done and is from an Other Backward Class community in Rajasthan, spoke of violence in her natal and marital homes:

"Yes, my father beat me up—once, it was about my boyfriend, when I told my father that I want to marry him, and the second time it happened when I refused to go to my marital home. The same happened with my sister-in-law. She was seen talking to a boy; she was beaten very badly by a wooden block by my father-in-law.... She fainted, still they continued beating her. Her condition was pathetic, even my husband took turns in beating her up...."

Violence against women was an everyday reality that had a profound effect on women's mental health. Women's narratives explicitly talked about the normalization of violence; its prevalence and acceptance largely enforcing tolerance and silence around it. However, women expressed their anger and resistance to the violence while also articulating their frustration and helplessness at not being able to stop the violence against themselves or others.

Sexual harassment in public spaces

A study on the perception of girls' safety in public spaces in India revealed that one in three adolescent girls feared stalking or groping in public spaces, and one in four expressed their fear of being physically assaulted and/or raped (Save the Children, 2018). On the way to school, to the market, their workplace, in public transportation or in a public space, women and girls endure harassment and abuse, such as lewd comments, stalking, groping, exhibitionism and molestation.

The interviews with the study participants revealed that more than 80 per cent of them feared going alone to school or to other public spaces because of sexual harassment. They experienced verbal abuse and harassment in the form of "indecent" words or abuse, singing and whistling. They also mentioned being touched and having men rub themselves against their bodies. Women expressed fear and anxiety about sexual harassment in public spaces even when they had not personally experienced it themselves. This fear led to real consequences, such as dropping out of school and discontinuing their education.

According to Pallavi, 18, not yet married and from a Scheduled Caste community in Uttar Pradesh:

"When boys see girls alone, they pass remarks, whistle or, while passing, they rub against [her] body. It has not happened with my friends, but some girls have experienced it. That's why I am fearful. Boys also comment saying, 'How are you, where are you going?'"

And Neelima, 25, married and from Rajasthan, admitted:

"No, boys had not harassed me, but I still discontinued my education.... Other girls who go to school are harassed; I don't want any of this problem."

The community, in the name of protection and safety, acts as a watchdog of the movement of the young women. This sort of community surveillance also added to the fear, stress and low self-esteem of the young women.

In the discussions with the women, it also emerged that the fear of sexual harassment and/or experiences of harassment led to the social pressure in families to marry off their daughters early. Marriage is perceived as the protection against the risk of girls experiencing harassment in public spaces. However, community perceptions of women and sexual norms also determined marriageability. Far from receiving support and justice, the young women were instead blamed and held responsible for the harassment. Women who experience harassment are also perceived as "bad" and "loose", which impacts their social suitability as brides.

Violence within the home

As noted, some of the women in the study talked of experiencing violence in their marital home or relationship, as did others who were the children of survivors of violence (and had witnessed that violence). Although not many incidents were disclosed, this section presents the narratives that were revealed and draws on them to look more in-depth into the situations of the women experiencing violence and the impact on their mental health.

The incidence of physical violence by husbands, verbal abuse, the chronic nature of violence with repeated episodes and forced sexual relationships by husbands were some of the forms of violence that the women described. Some of the women who disclosed violence also resorted to self-blame or dismissed it as mere "quarrels", while others blamed it on alcoholism.

Rashi, 21, married and from a Scheduled Tribe community in Rajasthan, was living with her 4-year-old daughter at the time of the research. When she was 16, her parents had arranged for her marriage. Two weeks before the marriage, she was abducted by the neighbour's son. Rashi explained:

"When I woke up [she was likely drugged], I was in Goa. He married me in Goa. We were in Goa for three months—whenever he went out, he used to lock the room where we were from the outside so that I wouldn't go out. I was confined to just one room. I used to think about my parents—that they would be worried about me and also about what the community and [to be] in-laws would be thinking about me. I used to blame myself for bringing dishonour or bad name to the family. I had no control over my life, which made me anxious and stressed."

Rashi and her husband moved to Delhi after three months. She soon found out that she was pregnant. Her husband threatened to leave her if she had a baby girl. Rashi recounted feeling scared, helpless, anxious and unable to share her pain or seek help from anyone. She said that she was unwilling to go to her parents' house (in Rajasthan) because she feared they would blame her and would not believe her. She was, however, forced to go back to her parents' home after several months, after her husband did abandon her and when she was unable to take care of her child who had become very ill:

"When I came back home, my parents' behaviour was fine with me, and they wanted me to move ahead in life. But they wanted me to let go of my daughter. I told my mother, 'When you can't leave your daughter, then how can I let go of her?' I had nowhere to go. I was sad and anxious. I used to cry alone being with my daughter; she was my only hope. [Several months later], one night my husband came drunk, and again started abusing and beating me. And in his anger, he snatched

my daughter and poured kerosene on me and started searching for match sticks. I immediately ran out of the main door and hid. He was shouting and searching for me, and at the same time, I could hear my daughter cry. But I was helpless. Nobody came to help me from the neighbourhood. I remained out the entire night and took a bath in the morning. For three days, I smelled kerosene on my body. I tolerated all this and did not tell anyone because of the fear of the fact that people will judge me, and I will be held responsible for all this violence. In our society, even if the girl has done no wrong, she is blamed for all the negative events taking place in her life."

Rashi's maternal uncle took her to a local organization for support. The organization helped her to file a case against her husband and also provided her shelter at an NGO-run home. She stayed there for a year and had to leave after she turned 18 years old. "I fear for my daughter's future and don't want her to suffer the way I am suffering," she explained. "After all that has happened to me, I feel numb and traumatized, I don't feel happy or sad." She said that she felt unable to trust anyone and had thought of ending her life many times. She blamed herself for what she had gone through.

Rashi's narrative exemplifies the toxic impact that violence has on mental health in the immediate as well as in the long term. She was subjected to abduction, sexual assault, unplanned pregnancy, domestic violence and abandonment. Her statements indicate that the years of severe abuse and powerlessness had made her feel withdrawn, numb, depressed and anxious. She felt guilty and blamed herself for all that she had experienced.

Tamanna, who was suffering from blood cancer (explained previously), experienced repeated episodes of verbal abuse and physical assault by her husband, which caused her immense mental distress. Her husband threatened to leave her for another woman, and her in-laws also abused her mentally and verbally. Her parents, instead of offering support, were of the opinion that the violence was justified because she was "diseased". She received no support from the natal family, and the cancer was perceived as a disabling disease—a factor that posed a barrier in her fulfilling her responsibilities as a wife and daughter-in-law. Her husband eventually left her at her parents' house. She then registered a case of domestic violence against him. Yet, despite suffering violence and neglect, she was contemplating going back to her marital home because of the immense fear of social stigma associated with staying in her natal home.

The narratives from the research also flagged other forms of violence within the home—sexual assault and rape within marriage. Marital rape in India is a well-known reality based on a growing body of evidence. A 2012 study with young women pointed to a prevalence of forced sexual experience within marriage in India ranging from 10 per cent to 30 per cent (Acharya, Sabarwal and Jejeebhoy, 2012).

Ridhima, 24, who had married at 17 but was now divorced and from Rajasthan, talked of the forced sex in her first marriage. She described being filled with anxiety, fear and lack of control over what was happening to her. Thereafter, she tried to avoid situations in which she would be left alone with her husband, but her elder sister told her that all married couples had to be intimate and that she should do the same. Ridhima experienced extreme anxiety and distress following one rape by her husband:

"That night, he locked the room from inside and hid the keys. After that, he held me and had intercourse against my wish. I don't know what happened following that, I recall that there was blood. Then he tried to make me understand that I should not be scared.... My throat had gone dry, and I was unable to speak. I wondered what would happen to me; something wrong had happened with my body...this is how uncomfortable I felt."

Ridhima did not refer to this abuse in the context of violence nor articulate that she experienced rape—she expressed the lack of control she felt over what happened to her and the subsequent fear and anxiety. It is an important narrative because it highlights the subordinate position of women, the prevalent hetero-normative sexuality norms and the unequal, coercive, non-consensual relationships.

Other narratives revealed how the young women had experienced violence in their natal home. Kanchan was forced to marry a boy because her father had already arranged her marriage to his friend's son. She was allowed no say in the decision made by her father. This situation made her unhappy because she was already in a relationship with another boy and wanted to marry him. When she went to her marital home, she witnessed violence perpetrated against her husband's sister (described previously). She expressed shock over the manner in which the sister-in-law was beaten for expressing her refusal to marry the boy who was chosen by the family and for asserting her wish to marry another boy whom she was interested in. The two experiences of use of force with regard to marriage added to Kanchan's anxiety and feeling of resentment and apprehension of any future violence that may happen to her.

Violence in communities

Being compelled to follow certain oppressive patriarchal cultural practices was another form of violence that women experienced. Sunidhi, 19, not yet married and from a Dalit community in Rajasthan, disclosed that in her community, girls who were suspected of having a boyfriend or of having an extramarital relationship, were forced to undergo a test to prove their innocence: During the festival of Navratra, girls were made to dip their hands into a vat of boiling oil in front of a statue of the deity and pick up fried fritters with their bare hands. If they were able to pick up the fritters without burning their hand, they were considered pure and innocent. Sunidhi had been made to undergo the test twice already. She had sustained burns but was unable to say anything or seek help for fear of being labelled and "losing" her honour. She said that practices such as this caused her extreme tension, and she felt that it was the reason for her memory loss.

Virginity or chastity tests are prevalent in some parts of India. For example, in the Kanjarbhat community, a de-notified tribe in Maharashtra and Gujarat, women are forced to undergo a virginity test on their wedding night. The newly married couple is expected to consummate their marriage on a white sheet, and the presence of blood stains on the sheet is supposed to be proof of the bride's virginity. If the woman does not bleed, she is assumed to have had premarital sex, and the marriage can be annulled on these grounds. She may also be beaten up, her family may face ostracism and social boycott and be forced to pay large sums of money as punishment to the caste *panchayat*. Women subjected to the test have said that they found the test terrifying. In another case from Madhya Pradesh, a woman was forced to prove her chastity before her husband and in-laws by holding hot iron rods in her palms. The now-banned "two-finger test" performed by health workers on rape victims is yet another type of virginity test that purports to test the victim's chastity and character. Such cultural and patriarchal practices are extremely degrading and humiliating for women. They violate the victim's dignity and physical integrity and are extremely traumatic.

Gendered norms and societal attitudes of blaming the women inhibits them from disclosing their fears or any incident that they might have encountered within their home, family or public space.

Violence against women and girls is a tool of controlling the expressions and lives of women and girls, and one of the ways through which it happens is by attaching stigma and shame to the girl or woman

who experiences violence. Indeed, many young women not only spoke of the fear of violence but additionally their concern around the “shame” and “bad name” it brings for their family; both fears deter their speaking about what happens to them and contribute to their anxiety and distress over it. As Manasi, 18, not yet married and from a Scheduled Caste community in Uttar Pradesh, explained:

"We never disclose [the violence]. We are scared, people in the village are very suspicious; they feel the girl must have said something to provoke the boys. So, we do not share this at home. We share among ourselves. If my mother was around, I would have told her. I am not so sure about sharing with my sister-in-law—what if she shares with my brother [her husband]? I cannot talk to my brother about this, so I don't tell her [sister-in-law]. We tell our friends if something happens, that a boy said this...."

Anxiety and fear were commonly experienced by the young women who were interviewed. Some of them reported that not only was it a threat to their safety but blaming the women for the abuse and violence that they experience only further aggravates the feelings of shame and humiliation. Most significantly, the lack of any supportive space to discuss this issue reinforces the silence about the violence. Moreover, the breakdown of trusted relationships that were perceived as safe and supportive has created a huge sense of hopelessness and loss among the young women.

Education

Twenty-four (Rajasthan–11; Uttar Pradesh–13) women had discontinued their formal education for various reasons. Poverty, gendered norms and marriage were deeply intertwined in the decisions that led to the discontinuation of their schooling. However, in most instances, these decisions were made by fathers, brothers or other family members and were frequently contrary to what the young women wanted. Sunidhi, 19, not yet married and from a Dalit community in Rajasthan, explained her situation:

"I am currently in the first year of a BA at a government college. Because my college is far away from home, I stay in a government hostel, which is close to the college. My father is an alcoholic, he doesn't do any work; he often beats my mother when he loses his senses. My mother does different things to run the household. Sometimes, she works in NREGA or takes up some other work. There is no permanent source of income. There is so much tension at home, I don't even feel like eating. But I can't speak about these things to anyone.

"My brother and his wife are totally against my education. They say that I am old enough to get married, but my mother says there is nothing more important than education. She even gives me money for it. I wish to finish studying and become someone in life. I, too, have a life, I want to work and earn and show my parents what I can do. So, I have to constantly fight against everyone. In fact, sometimes I feel like committing suicide because of this constant bickering and lack of support.

"This is true of most girls. They get no support from their home, and the community is always prying, badmouthing them if they want to study or be independent. If they want to go out for anything, work or study, they [family or community] always suspect that there must be something 'wrong' going on here and create a situation to stop her. Nowadays, there are schools in the village. If parents want, they can educate their girls. But all they can think of is when to get them married. The community also pressures the family, saying, 'Even if she is educated and starts earning, she will earn for her in-laws, not for you. So, you should just get her married. 'Then they force the girls to do housework. If she wants to study, she will be told, 'You can study later; first finish the household work.' But for the boys, they will say, 'You just do your studies, you need not

think about anything else.' In my family, my brothers have not studied much. Only one of my brothers has studied till Class 7. But they are educating their children."

The husband of Ankita, 23, who was married to him at 14 and from a Scheduled Caste community in Uttar Pradesh, did not allow her to pursue her studies after marriage. Hence, she had to discontinue after Class 10. The sister-in-law of Kavita, 20 (not yet married and from a Scheduled Caste community in Uttar Pradesh), who is a teacher, asked her to discontinue her studies after Class 12 and help with caring for her nieces and nephews at home. She promised Kavita that she would help her continue her education later. Ridhima, 24, who had married at 17 but was divorced and from a Scheduled Caste community in Rajasthan, discontinued her education after Class 9 due to poverty and started working as a labourer. And Raveena, 23, who had married at age 4 years and from a Scheduled Caste community in Rajasthan, had to give up her studies after Class 10 because of her *gauna*; her in-laws did not allow her to study further.

Pursuing their education was fraught with challenges. It was an ongoing tussle in which the young women had to balance the burden of daily housework with going to school and negotiate the control over their mobility. Schooling up to a certain level was common among the study participants, irrespective of their family's economic condition; but thereafter, when they had reached a certain age, generally around puberty, gender norms were enforced more stringently. This implied that housework, for young women, was prioritized over schooling, and the values and benefits of their education were constantly judged and doubted. This made education an almost impossible achievement for the young women. Continuing education was never a given, but dependent on parental acceptance, adequate finances and a constant evaluation of its utility—in relation to marriage. This gendered perception did not create similar obstacles for the men, as pointed out by the participants, who reiterated that even in difficult family situations, their brothers continued their education while the women had to forgo theirs.

Of the 13 women in Uttar Pradesh who had discontinued their education, a majority stopped at the undergraduate level (either stopping after Class 12 or dropping out after starting college). However, the 11 women in Rajasthan who had discontinued their education had only a few years of schooling. Most of them were pursuing vocational training or were already engaged in some vocational activity to earn money. One of the participants, Nandita, 21, from an Other Backward Class community in Uttar Pradesh, remarked:

"I wanted to do a master's degree, but could not as my family had financial constraints. But I was working as a tailor to support my brother's coaching classes in Allahabad."

Such discrimination was upsetting to the young women because they were unable to fulfil their aspirations by pursuing higher education or improve their capacity to be independent and earning members in their family. However, not all women in the study felt upset about discontinuing their studies. For instance, Nandita, 21, not yet married and from an Other Backward Class community in Uttar Pradesh, felt a sense of self-worth and pride in being able to use her tailoring skills to support her brother's education. There was also a small number of women in the study who did not want to continue in formal education.

The discontinuation of schooling or college also led to a loss of space for the young women to interact socially with peers and even share their issues and concerns. Some of the women who had discontinued schooling indicated that the school was a place that they had liked, although not everyone expressed a positive experience. They fondly remembered their school and missed their friends. This loss of a safe space and a peer group was articulated by Sanjana, 18, not yet married and from a Scheduled Caste community in Uttar Pradesh, who had to discontinue her education after Class 12:

"After I discontinued schooling, there was no opportunity for me to meet and interact with my friends, as they all live far away from my village."

In the context of mental health, the discontinuation of education led to the loss of social networks and coping mechanisms in situations of mental distress. Among the small number of participants who were continuing their education in Rajasthan and Uttar Pradesh (16 women were pursuing an education), only five young women (Rajasthan–4; Uttar Pradesh–1) were attending an educational institution. While reasons for this would need further probing and analysis, the narratives reflect mobility, affordability, availability and responsibility of household work as some of the motives. The rest were pursuing "private" courses, which meant that they were not going to an institution. They felt that they were missing a social space where they could freely interact with other students and be themselves. As Sunidhi, 19, not yet married and who lived away from her family in a hostel close to her college, explained:

"Going to college, living away from my family, helps me get away from the various kinds of tensions at home. My father is an alcoholic and is always beating up my mother. Except for my mother, all in the family are dead against my studies. My hostel and college provide me a space that is free from all these tensions."

In some cases, women found support for the continuation of their higher education from their family. According to Mrinalini, 23, who had married at 14 but was divorced at the time of the study, from a Scheduled Tribe community in Rajasthan and pursuing an undergraduate degree:

"My mother is very supportive. She says, 'You continue your education, complete your graduation, then we will think about your marriage.' My elder brother also tells me, 'You concentrate on your studies. Once you are ready for marriage, we will arrange your marriage with a boy who is also educated.'"

Similarly, Preeti, 19, who had not yet married, was from a Brahmin community in Rajasthan and was pursuing a nursing degree, reported:

"My father says, 'First complete your education, and then we will look for a boy.' I want to complete my nursing course and work as a nursing tutor or in a hospital. Because I want to continue working after marriage, my father supports me by saying that he will look for a boy and a family that will allow me to work after marriage."

Usually such a situation arises only in rare situations in which the patriarch of the family is willing to support the education of the daughter. In most cases, pursuing education in opposition to the family, community or caste usually leads to sanctions being imposed on young women for transgressing the entrenched gendered norms.

Section C: Young women's resistance and agency

The previous sections highlighted how intersections of poverty, caste, gender and sexuality lead to experiences of mental distress among young women. Amid these situations, in which women were being subjected to patriarchal control, violence, early marriage, etc., the narratives also reflected that women were constantly resisting and negotiating spaces in their natal as well as marital households.

While all the women were trying to carve out spaces for themselves in their family and community, there were some women who were asserting themselves, expressing their views and decisions overtly.

At least 16 women from both states had expressed disagreement about decisions or factors affecting their life, within the home where they lived.

Both the married and unmarried women were doing this in multiple ways: such as refusing to have a sexual relationship with the husband, refusing to go to their marital home, refusing to engage in a conversation with their parents, supporting their own education in the absence of family support and working outside the home despite resistance from family members. Two women (one each from Rajasthan and Uttar Pradesh) had filed a legal case against their husband seeking maintenance support after being abandoned. Rashi, whose narrative was discussed in the previous section, had filed a case under the Protection of Children from Sexual Offences Act against her husband.

Abida, as previously featured, had faced unrelenting demands for dowry and accompanying violence. Her husband remarried when she was at her natal home during their child's birth. Abida's health was severely impacted by this trauma. She was hospitalized after repeated episodes of fainting. She described feeling extremely tense, sad and sorrowful, unable to eat food and worried about her son's future. While she said she would be glad to return to her marital home if they would take her back, she was also resisting control over her life and trying to claim her rights. She sought the intervention of the police and *panchayat* to stop the marriage, although it was unsuccessful. She was resisting the constant monitoring of her actions by the community and the stigma constructed around her continuing to stay in her natal home. She was asserting her agency by going out of the home to do agricultural work to make ends meet. Abida's narrative highlights the constant struggle and negotiation that she and other young women were grappling with in making decisions in their lives. She was also fighting a legal case for financial support from her husband.

But there is a backlash experienced when women attempt to assert themselves, and this often further exacerbates their mental distress. For example, in Abida's situation, she was trying to negotiate her space within her natal house, where she resides, and in the community by making efforts to earn for herself and her child. The constant surveillance and the comments about her further added to the stress that she was already experiencing.

This backlash was common. Other women in the study from Rajasthan and Uttar Pradesh, who were resisting or asserting themselves, had similar experiences. The repercussions that followed an act of assertion in the absence of any support network, such as local groups or peers or family members, can lead to further mental distress—sometimes even pushing women to contemplate or attempt suicide. Vineeta, 25, who was residing in her natal home in Uttar Pradesh with her two daughters following abandonment by her husband and his family, had similar experiences as Abida; her family expressed displeasure regarding her going out of the house to earn money for herself and her children. Vineeta's situation, in which she had no support network around, pushed her to contemplate suicide:

"Once when I was coming home with my daughters, a vehicle was coming towards us. I told my daughter Ruchi, a vehicle is coming towards us, I will go and get hit by the vehicle and die. Ruchi held me and said, 'If you die, then I will also die.' I started crying. Then I told her, taking both my daughters in my arms, that I will never do it."

In Rajasthan, three women had been married but had each divorced her husband, with the support from her natal family. These women had exercised their agency to escape an unfulfilling relationship and marital alliance. The narratives from two of them revealed that they had experienced violence in their marriage, which had had a deep impact on their mental health. They eventually chose to leave the relationship. One of the women, Ridhima, reported how she had refused to have any intimate relations with her husband, expressing different reasons for doing so:

"He used to force himself on me, but I used to clearly tell him no. I told him, 'I am yours and will remain yours. When you start earning decently, then I will come to you.'"

Women who were able to seek the support of a local organization were able to mitigate the repercussions of resistance and to cope relatively better, despite extremely adverse situations. Support from the local organization in the form of financial aid to pursue education, legal assistance, etc. was seen to placate some of the mental distress. Above all, the local organizations provided spaces for women where they could come together and interact with peers to share their experiences and distress. For a couple of the women, the constant support from their mothers also enabled them to resist and to diminish the resulting backlash and mental distress.

Social and peer networks can have a significant role in providing support to young women, particularly in situations in which women are trying to negotiate a space within their household and community. Young women's resistance and coping requires sustained support. Even where there are organizations, which were perceived as a critical resource by the women in this study, their capacities and resources to be supportive over a period of time, as long as the women need it, is typically limited. This is discussed further in the following sections.

Endnotes

¹This is a system of medicine based on the principle of: "The human organization is entirely composed of two elementary liquids, lymph and blood, and the health and diseases depend on the such liquids." The electricity has been observed in all the living beings, including plants. it is proved that no cell, no tissue, no organ and /or a body could possibly manifest its legitimate function without electrical energy. it is a fundamental and basic principle of the science that the manufacture, transmission, utilization and discharge of electrical energy of living cells is responsible for metabolism of the body and also give us a rational explanation for all the phenomena of life, health, diseases and therapeutics (see Electrohomeopathy Medical Council, n.d., available at: <http://ehmchr.com/>).

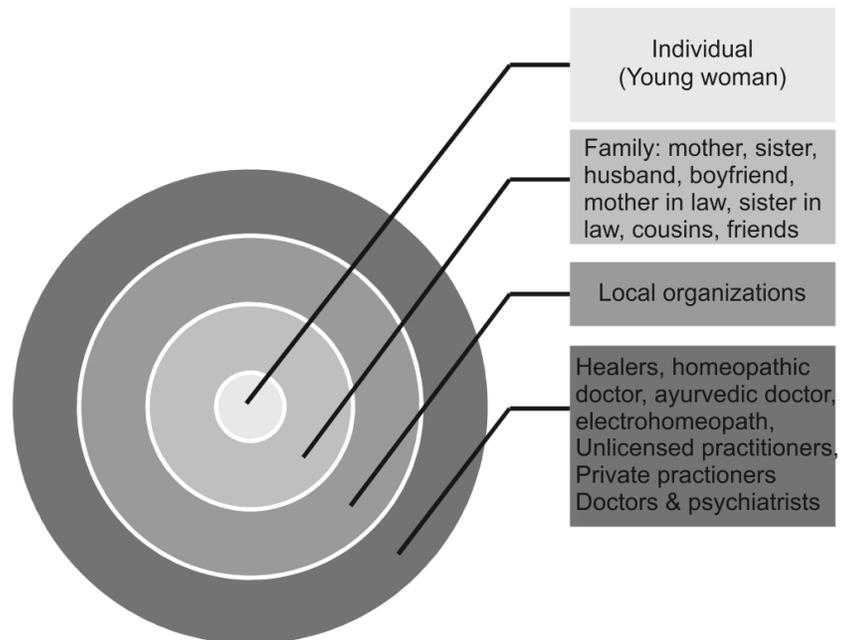
SUPPORT, HEALING AND HEALTH CARE

This chapter looks at the support, healing and health care that were available to the young women in the study in situations of mental distress. As discussed in the previous sections, the nature of mental health issues experienced by the young women were varied and based on a complex interplay of factors. While the social locations, perspectives and previous experiences of care accessed by the women and their families determined their pathways to mental health care and support, the healers and health care providers also definitively influenced their decisions, steering them to these pathways through referrals.

The chapter is divided into two sections: Section A discusses the different sources of care and support available in the rural communities in the study areas. Section B discusses mental health care and healing in the context of the health system: the practitioners who were accessed for mental health care, pathways of care and the implementation of public health programs for mental health.

Section A: Sources of care and support

The participants of the study emphasized the support of specific members of their natal and marital families as foremost, in the absence of which implications for their coping with mental distress and subsequent care were negative. Apart from this, friends and local organizations were important in providing psychosocial support. Although a few women mentioned the support of organizations, they had limited presence as well as capacities to respond to the mental health needs of the young women in the study areas.



Emotional and psychosocial support: Family members, friends, organizations

A majority (39) of the respondents said that they generally reached out to members of their natal or marital family when they experienced any mental distress. They reached out to mothers, mothers-in-law, siblings, husbands, cousins and others in their family. For instance, Mrinalini,²¹ divorced, from a Scheduled Tribe community in Rajasthan, reported:

"I was married at the age of 14 years when I was in Class 9. As my father had cancer, I was married off early. I had to leave my studies for a year. Then my in-laws insisted that I should discontinue my studies and stay at my marital home. However, my father died soon after and my mother decided that I should continue to study and not go to my marital home at all. Not many girls from our community [Bhil] have the opportunities for higher levels of education. After marriage, I went to my marital home only once. The divorce took place three years ago. I am presently staying with my two brothers and their families, after my mother died."

For married women, support from their partner made all the difference and, in a few instances, other family members were also perceived as supportive, enabling the young women to negotiate their space within the marital home. These supportive relationships helped them feel less isolated in situations of distress and to take care of some of their needs. According to Neelima, 25, married and from a Rajput community in Rajasthan:

"I speak to my mother-in-law when something is bothering me...she is my friend ...she keeps me very well and manages everything. If there are any issues, she empathizes with me and I feel better. For any issue, for example, even things related to my menstruation, I speak to her and resolve it. If my husband had treated me badly, I would not have stayed...even today, he treats me affectionately. My in-laws are also like that."

Of the 15 women who expressed experiencing distress at the time of the study, 11 turned to members of their family for support. This included mothers, aunts, older brothers, sisters, cousins as well as husbands in the case of women who were married. According to the participants, having supportive family members enabled them to discuss their feelings and emotions, which in turn helped them access advice, encouragement, etc. Members of the family provided emotional support and even helped the young women in a few instances in asserting their decisions, even when they were contrary to the views, or *diktats*, of the family. Family members also provided financial support, facilitated access to shelter and health care and tried to address other immediate and practical needs of the young women. In some cases, family members were also involved in caregiving in times of distress.

Three of the respondents said they shared their anxieties and problems with friends and sought their advice. The support of friends was particularly sought when family members were absent. Manasi, 18, not yet married and from a Scheduled Caste community in Uttar Pradesh, was distressed due to multiple issues at home—poverty and concerns over continuing her education, a violent brother who abused his wife and her father's illness—all of which were believed to have been prevailing due to an evil spell (*jadutona*):

"I cry, I talk to my friends and cry...that I am very alone. These are the many problems in my home.... I go through so much tension, and most of all I am tense about my father; he has not been keeping well at all."

While the support from family members and friends was enabling and helped the young women cope with stressors, it did not always facilitate action or decisions to alleviate them. Families—both natal and marital—being bound by the complex interplay of gender, caste and other socioeconomic factors, were often the very institution of oppression and the root cause of the stress. Decisions regarding various aspects of the women's lives were invariably steered by others—grandparents, parents, parents-in-law, older brothers—who were perceived as their "guardians". The lines between a supportive family member and decision-maker were not always distinct. Thus, support by members of the family was often coloured by the power hierarchy within them and guided by the prevalent gender, sexuality and other social norms.

This was also true about the support that the women received from friends, who were invariably peers who featured extremely low in the social power hierarchies and had their own limited space for negotiation and decision-making within their family and community. Friends were often restricted by the norm of non-interference in "private family" matters; mental health needs and issues were extremely stigmatized, and therefore attempts at trying to even talk about them were generally discouraged.

Similarly, while members of the family were obvious choices of support, given their proximity and their close relationships with the young women, the extent that support was, in most instances, unable to address the root cause of the distress. Moreover, the repercussions on those providing the support were a matter of considerable concern for the young women.

The young women understood and articulated diverse forms of support, as mentioned earlier. The nature and levels of support were also dependent on these dynamics. Undoubtedly, supportive family members and friends were extremely critical for the young women in their process of coping, healing and also access to health care and other mental health needs. Ultimately, the young women did receive whatever support was possible or available in the given circumstance, even though it did not necessarily coincide with their needs. Building these alliances, networks, their perspectives and capacities is important for young women in rural contexts. Hence, the potential ways in which the support of family members and friends can be consolidated by extended networks need to be comprehended and developed further.

Community-level support networks

Kanchan, 20, who was married at 16 and from an Other Backward Class community in Rajasthan, was receiving assistance from an organization to continue her education. Although it could have provided her the space to discuss some of the issues that were causing her anxiety, especially because she had no support within the family, her narrative indicates that she had not approached the organization for help in terminating her marriage. This was likely because of concerns around confidentiality and judgment about her decisions and relationships. Her narrative, nevertheless, suggests that support networks beyond family members and friends are important:

"My mother has always supported me, so I don't want her to suffer. Although my father knows that I dislike my husband, he still forces me to show my respect towards him and maintain this relationship. I want a divorce, but I don't know what to do. No one seems to want to pay heed to my feelings that I don't like my husband. I have even told him [husband]. ...I was married about two years ago when I was 16 years old because of my father. My father and my husband's father are friends, and my father is against my studying. The gauna following my marriage is yet to be performed.... I now have a boyfriend with whom I want to settle down. I am sexually and emotionally involved with this friend...."

Four of the young women said they had reached out to a local organization for help when they were unable to find it from their family or friends or to fulfil requirements that were beyond the capacity of their families, such as financial assistance for pursuing education and facilitating divorce proceedings or other legal action. This assistance was regarded as critical by the young women, especially in situations in which the family was the source of their mental distress or was reluctant to provide any support or did not have the ability to do so. The fear of repercussions on family members or friends who were providing support, especially when it was perceived as challenging a norm, was very real for the women. Due to the general perceptions about many of the situations as private family matters and off limits to any external interference, community-based organizations often found it difficult to take the onus in providing the kind of support that was needed for young women experiencing mental distress.

Thus, the mere presence of organizations was not adequate in situations of mental distress. Organization staff also were challenged by their lack of understanding of mental health issues and necessary skills to deal with them, which staff with two community-based organizations in the study areas in both states admitted. Training in the area of mental health, gender-based violence and sexual and reproductive health rights were perceived as needed to enable them to strengthen their

organizational strategies. Organizations were also concerned about the possible backlash from the communities if their interventions were perceived as going against the culture and norms. For example, in the research area in Rajasthan, girls and women were not allowed to participate in community meetings organized in the villages; practices such as child marriage persist and are deeply rooted not only in the community but among some of the organization's staff as well.

In another instance, an organization encouraged a young woman from a tribal community to take up teaching children who had dropped out of school, which in turn was helping her overcome her mental distress. However, the organization, under pressure from some of the villagers who were against a young tribal woman teaching their children, was forced to withdraw this support and ask her to discontinue.

A community support network or support group is an important concept and an urgent need for young women's mental health. However, this necessitates a cohesive process involving multiple persons from the community, including family members, friends and others, who can offer a supportive role collectively. Given the constraints on young women's mobility, issues of access and affordability, especially for marginalized rural communities, support networks at the community levels are extremely critical. Although these are informal networks, intersections with education, healing and health systems may also be possible.

Pathways of healing and health care

The discussions with the young women as well as community members revealed that the trajectory of health care for all health problems, including mental health issues, was largely determined by the beliefs and decisions of family members, particularly for young women. The decisions regarding the treatment to be sought or the health care provider to be accessed were also informed by the nature and extent of the health problem and the financial resources available, including systems of credit and payment. This was particularly pertinent for a majority of the study participants because they were living in situations of extreme poverty. For example, in the context of mental health care, the local healers were perceived as more acceptable and less stigmatizing, accessible and affordable.

However, health care was also sought from physicians ("Bengali doctors", allopathic, homeopathic and ayurvedic) as well as from psychiatrists, simultaneously or cyclically. According to one woman in a group discussion in Rajasthan:

"Whatever be it [the health issue], those who believe in these healing practices, will go to the baoji [local healer] only—for anything from pain in their feet to any other complication.... If someone is very unwell in our home, we take them to the doctor. But if there is no respite, then the Baoji comes by.... In the government [health centre], there is only a sister [midwife/ ANM]. There is not a single lady doctor in the entire block."

According to Samira, 22, married and from an Other Backward Class community in Uttar Pradesh who had suffered from mental health issues in the past:

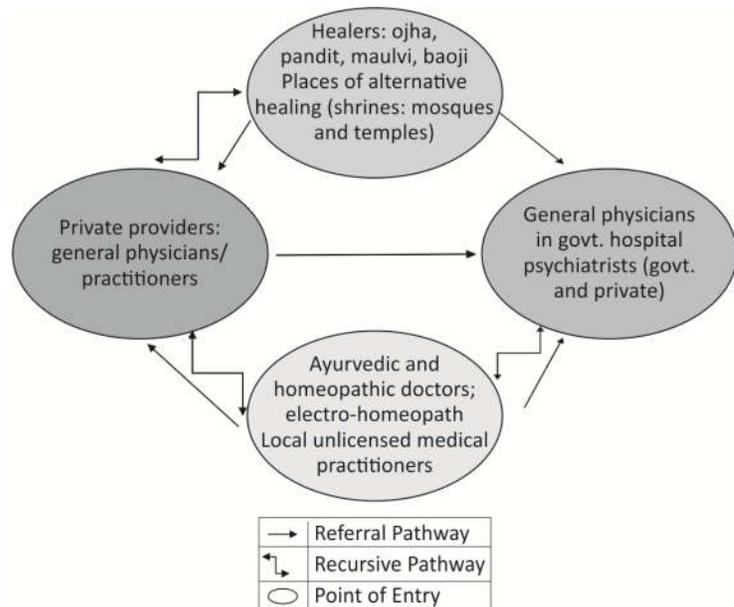
"I was taking medication after consulting a doctor in Pratapgarh and later another doctor in Sultanpur. Before this, I had consulted a faith healer [ojha], and then I consulted a lot of doctors.... I went for faith healing first—only later I took medication."

The trajectory of care seeking for mental distress by the young women was thus predetermined by pathways rather than by the needs of the women. Parents, grandparents and older brothers were the decision-makers in the case of unmarried women or married women who had returned to their natal

home for the treatment. Decisions about health care for married women were generally made by husbands, parents-in-law, brothers and sisters-in-law.

The choice of care stream was often determined by primary and secondary caregivers through referrals across the healing and health care systems. The pathways were complex, guided by multiple factors of belief and faith, previous experience of quality, their availability, affordability and accessibility. Further, healing and care for mental distress was often only sought when it affected the young women physically or when their capacity to carry out household or other economic activities was impacted. Care was invariably sought first from local healers and practitioners available and accessible at the primary and secondary levels in and close to communities, given the absence of comprehensive information and services for mental health needs in rural community contexts.

The discussions with community members, the young women and care providers also reflected the complex canvas of mental health care. A discourse, albeit marginal, was emerging on the “modern” versus the “traditional”, in which the preference of some of the young women for psychiatry or allopathic interventions was perceived as modern. At least four of the women—Ridhima, Gunjan and Tripti from Rajasthan and Abida from Uttar Pradesh—mentioned what they perceived as the gendered dichotomy of care; according to them, for most health issues, girls and women were initially taken to local healers while boys and men were invariably taken to the “doctor”. This was perceived as discriminatory by some of them. Some among the married women were sent to their natal home to seek treatment, only to return to their marital home after they had recovered.



Although these perceptions of care were extremely relevant and resonated with the evidence of gendered access to health care even in the context of mental health, they need to be understood further in the contexts of the young women. These perceptions may also have implications for preferred pathways of care and healing and thus for the conceptualization and implementation of mental health care.

Healing and health care largely for physical symptoms

Five of the young women experiencing mental distress had been taken to healers and the public health system when physical symptoms manifested. Two more women had accessed the public health system for other issues (violence and infertility, which were closely linked to their mental distress); they received some treatment for their other health issues but no counselling or care was provided for their mental health needs. According to Abida, 24, a Muslim who was deserted by her husband in Uttar Pradesh:

"I have cried for months. I did not eat any food for a month and used to cry all day. I was admitted in a hospital and tens of thousands of rupees were spent by my family on medicines and injections. When this problem began, sadness and anxiety made me sick. I was admitted to a government hospital in Patti Block. They gave me 6–7 bottles of glucose [IV]—it was all because of the grief about losing my husband; what other illness did I have? I used to starve the whole day. When I stopped eating and drinking water, there was obviously no strength left in my body. The doctor said it was related to the tension and grief. He said if I got rid of the tension from my head, I would be okay. This was not some illness or disease. He also said that I should try and eat normally.

"I could not sleep night after night because of the anxiety. Even now, I feel very tense at night. I feel no hunger and no thirst. This condition continues. When I was in the hospital—it was a private hospital—no one from there [the marital home] called; neither did my husband.

"I had also gone to the healer [maulvi] in Pratapgarh. There was some improvement, but he said, '... if you forget him, only then will the tension in you reduce. Unless you forget him, you can go wherever [for treatment]—Allahabad, Delhi, Lucknow—but you won't get better. 'Once I was admitted for a week, another time for four days, and so on. Now, after two or three years, slowly I have begun to think of my child. My son is now two and a half years old. As a mother, it is my responsibility to take care of him."

Abida's narrative presents a situation of serious mental distress, whereby she was in need of immediate care and psychosocial support. In the narrative, Abida had several interactions with the health system, where she was taken for "treatment". Although the care providers—both the doctor and the healer (*maulvi*)—diagnosed her condition as a consequence of the situation with her husband, the doctor provided some treatment for her weakness, which merely addressed some of the physical symptoms. She had to be admitted to the hospital repeatedly because of her inability to reconcile with her situation, the consequent grief and the physical and psychological consequences of starving and going without water. Despite this situation lasting for a substantial period, the absence of psychosocial counselling, care and support to discuss the root cause of the issue was palpable. Her vulnerability, despite her articulation of feeling better, necessitates sustained care and support.

Another narrative, from Tamanna,²⁵ and from another Backward Class community in Rajasthan who also was deserted by her husband, emphasizes the inseparable relationship between physical, mental and social health:

"I got married 10 years ago when I was 18. I knew nothing about marriage, but my parents got me married. At the time, they [in-laws] used to treat me well, talk to me nicely... Then the two children were born. The younger one was about 1 and a half years old when I fell ill—that is when the problems began. There was a tumour in the stomach... I went to the hospital where tests were done and the illness diagnosed.

"When this illness [cancer] was diagnosed two years ago, they [in-laws] stopped talking to me. They did not want us to live together. He [husband] also stopped talking to me, and his parents asked him to take another [wife]. They did not want to have anything to do with me. Before that, there were no issues in the marriage. [After] it was diagnosed the doctor gave me one tablet to have every day. I would have to have this for as long as I live. He [husband] began to tell me that he wanted to get another woman [wife]. He used to trouble me every day. He used to beat me [koot-ta tha], verbally abuse me [gaaliyan nikalta] for everything. His parents used to also say, 'We don't want this one, we want another. 'Everyone used to say this—all their family members. He used to say, 'I will also get your disease.' One day, there was no one else at home—just my

children—we had a huge fight. He said that he would bring another wife and even beat me up. When this happened, my husband said, 'You are troubling me no end.... I will fill you in a sack and get rid of you.'

"One day I drank something like phenyl and also gave it to the children. He took the children to the hospital but did not take me. That same evening, he brought me to my father's place in a bus. This was about 1 and a half years ago. This boy [her son] is 3 years old now and the older one is 9 years old—he is in Surat at my in-laws. They don't let him come here. My father-in-law, mother-in-law, sister-in-law and the 'other woman' [new wife] live there. My older son remembers me and comes to meet when they come here. They wanted to take this [younger] boy, too, but he would not go without me."

The diagnosis of cancer in the young woman and the consequent social repercussions, ranging from violence and abuse by her husband and in-laws, desertion and remarrying by her husband and taking away custody of her older child, had a deleterious effect on her mental well-being, evident from her attempted suicide. Although, Tamannahad several interactions with the health system, the response was limited to providing treatment for the cancer alone.

Swati, 25, married and from an Other Backward Class community in Uttar Pradesh, was unable to conceive after a substantial period of time (seven years). She talked of the inadequacy of the health system to respond to mental health needs, in addition to the ailment for which she sought care. That a number of women expect support from the health system to address their mental distress but are unable to get any is real and unfortunate.

The practice of consulting healers or health care providers only when a young woman's physical health had deteriorated and/or she was unable to perform household or other work results in delays in seeking care for mental distress. While the reasons for the delay may have been manifold—ranging from the lack of awareness on the issue or the inability to seek care due to financial constraints—the stigma associated with mental health is often a deterrent to talking about it and accessing care without delay. In the absence of "visible" signs, mental health issues remain unrecognized and are ignored by women as well as their family.

That a large number of persons with mental distress accessed health care for their physical symptoms also emerged in the NMHS 2015–16 findings. Mental health issues, such as depression and anxiety, were often missed in the diagnoses at different levels of the health care system. Evidence indicates that diagnosis and treatment are largely limited to physical ailments, which leads to symptomatic treatment and frequently results in sustained distress (Wittchen et al., 2000; Greenberg et al., 1999). The discussions with the healthcare providers also indicated that they were largely consulted by women for physical symptoms—headache, stomachache, backache, sleeplessness, weakness, dizziness—that they were suffering from. According to an ayurvedic practitioner in Uttar Pradesh:

"They [women] don't say they have a mental health issue. They talk about the pain that they have, that the pain extends from the neck to the back, pain everywhere, etc., which means there isn't any real pain, it's only psychological—this is what happens."

A medical officer from a community health centre in Rajsamand (Rajasthan) had a similar observation:

"They come for mental health problems, but the complaints they have are physiological. For example, 'I am not able to sleep, not able to stand, feel weak'—this is the problem. These are the kinds of complaints they come with—don't feel hungry, feel dizzy or have stomach pain."

Some of the health care providers in Pratapgarh District (Uttar Pradesh) believed that there was increasing awareness among communities regarding mental “illnesses”. However, most of this was related to persons suffering from serious mental health issues. Families of patients suffering from mental illness, according to the health care providers, sought out a psychiatrist after hearing about one from a neighbour or a family member who had experienced similar “symptoms”. While this may be so, enabling processes and the skills of health care providers to understand and respond to young women’s articulations of mental distress are necessary. Evidence from this study points to several gaps in healing and care for mental health needs, including the lack of adequately skilled human resources that can respond to the needs of young women.

Section B: Availability of mental health care services

Discussions were carried out with 19 public and private health care providers, indigenous healers and local unlicensed practitioners in the course of the study. These discussions indicated that health care providers, including general practitioners (allopathic, homeopathic and ayurvedic) as well as psychiatrists were accessed by the communities in the study areas for a range of issues pertaining to mental health. According to the health care providers and communities, indigenous healing systems, such as the *ojhai*, were sought out alongside homeopathic, ayurvedic and allopathic treatments. For mental distress, in both states, care was sought from a variety of care providers—healers, practitioners of Ayurveda, homeopathy and allopathy, in private as well as in government institutions.

This section gives an overview of the available healing and mental health care options that emerged through the discussions with community members and with diverse health care providers and other informants.

Healers at the village and block levels

Healers were consulted by the families of young women suffering from mental health distress and “disorders”. The discussions with the young women revealed that the communities in both states had immense faith in such healing practices and they regularly visited faith healers—*ojha*, *baojis* and *pandit*—as well as healing spaces, like temples, *dargahs* and other shrines. This was also reflected in the narratives of care providers who engaged with these healing practices. According to an *ojha* in Pratapgarh District (Uttar Pradesh), who provided care for persons with mental health issues:

"In a situation where there is too much tension, there is mental imbalance; in such a condition, villagers don't take such a person to hospital. Hindus will take the person to a temple, Muslims will go to the masjid or else they will go to an ojha or sokha[healers]."

Three healers were interviewed as part of the study. The healers (*ojhas*, *baojis*) provided services in the villages and visited homes of anyone requiring healing. They offered prayers and performed rituals for the young women who were brought to them. They offered incense, coconuts and flowers (*dhokdena*) as part of the ritual, accompanied by prayer. They talked to the young women and their family members and followed up regularly with them. One of the *ojhas* from Pratapgarh was a headmaster at the local college and also practiced healing:

"My practice includes providing herbal medicines [jhadibooti], which I source from Haridwar, and offering prayers [pooja] for people. If people get better, faith is established. Once the problem has been identified but doesn't get better, I refer the patient. I tell them to offer prayers for their inner peace [aatmshanti]. Offering prayers, worship, visits to temples and mosques is fine, but the truth is that the patient may get better only with medicine. So, I tell them after the ritual [jharwa] and

incense that the spirit has been removed. Now go and get medicines, I tell them. I refer them to an allopath or to a psychiatrist who comes from Lucknow to the block headquarters once a week."

Another healer, who was a priest in a temple (*pandit*), referred to his practice as *ojhai* therapy. He perceived his healing as therapy that he offered to all who went to him, including young women with mental health issues. He, like other healers, only performed rituals and thereafter referred people to private or government health care providers in the city of Allahabad.

Community-level public health care providers

Additionally, the young women said they approached the government appointed community health workers, the accredited social health activists (ASHAs) and the auxiliary nurses and midwives (ANMs), when they experienced mental distress. Although the ASHAs and ANMs were not skilled in counselling, they provided some emotional support and advised the young women regarding their problems. The ASHAs live in villages, while the ANMs are usually available at a sub-centre, though they also visit villages under their jurisdiction. The ASHAs and ANMs who were interviewed said that young women approached them whenever required, as did family members of the young women. They were frequently called upon to advise on treatment and referrals for mental health needs. Young women also requested them sometimes to speak with their parents in case there was a conflict at home. Some of the mothers of the young women asked the ASHA or ANM to counsel their daughter in case of any distress. As one of the ANM in Rajasthan reported:

"For instance, there is a 17- or 18-year-old girl in this village who has mental health issues. They are doing [jhaadphook], treatment[davaa sui], etc., but she is not getting better. Sometimes, she talks strangely and sometimes she is fine. This has been happening for four to five years. She had fever and after that she was unwell. Her family says that someone has done black magic on her [bhoot woot kardiye hain]. I told them that this is not black magic—show her to the doctor. Until proper treatment is done for this, she is not likely to feel better. They did some treatment for some time, then they discontinued; it goes on like that. It is obviously not black magic; the girl has lost her mental balance."

According to another ANM from Rajasthan:

"...when there are tensions in the family, it impacts the women's mental health negatively. They often come to me and say, 'Didi this happened: We had a fight, they beat me up, I don't get enough to eat, I don't have any money of my own to spend, how should I deal with these problems? I feel like ending it all, like dying.'"

While community health care workers are in a critical position to provide assistance for women experiencing mental distress and psychosocial support and referrals, their skill sets and capacities are extremely limited.

However, none of the young women respondents in the study said that they had approached an ASHA or ANM. Concerns around stigma and discrimination as well as confidentiality posed barriers to women wanting to confide in community health care providers.

Mental health services in the private and public sectors at the block and district levels

Local (private) practitioners, including the “Bengali doctors” as well as allopathy, Ayurveda and homeopathy practitioners, were available at the block and district headquarters in both states. They were consulted for physical ailments and for anxiety, depression and other mental health issues. Three general practitioners, two from Uttar Pradesh (one allopath, one Ayurveda), one from Rajasthan (an electro-homeopath) and one visiting psychiatrist in Uttar Pradesh were interviewed. The electro-homeopath applied different forms of medicine—he prescribed herbal medicines and conducted rituals that were typically practiced by indigenous healers. He also claimed to provide allopathic medication, if required. He had a clinic at the block headquarters but also made home visits in the villages.

The Ayurveda practitioner stated that patients with mental health issues were usually referred to him by the *ojhas* in the area. He provided medication for any physical symptom, but if it recurred over a long period or if he thought that the issue required more specialist intervention, he referred the patient to a psychiatrist in Allahabad. According to him:

“Many a times, there is need for counselling. Nothing is available nearby [in the block]. At the district level, in Pratapgarh, I heard that psychiatrists [now] come once a week from Allahabad and Lucknow.”

The private general physician practicing allopathy in Rajsamand (Rajasthan) said that he provided basic treatment for mental health issues and referred patients. He did not provide any services for mental health problems specifically. According to him:

“With regard to mental health-related problems, usually these cases do not come early, they come to me only at later stages. I refer such cases to a [private] medical college and hospital or the district hospital in Udaipur.”

One of the visiting psychiatrists in Pratapgarh (Uttar Pradesh), who was also a sex therapist, ran a private clinic for a few hours once a week in the district headquarters. He provided counselling in addition to prescribing medication. According to him:

“Psychiatry has been shifting away from hospitalization to community-based care. Mental health information and services are supposed to be available at the primary level—but this is only on paper. Quality of care is a huge issue, even where the necessary infrastructure is in place.”

The psychiatrist reiterated that people and communities were increasingly aware and cognizant of the need for specialized care for mental health. They were increasingly consulting psychiatrists directly. Information about healthcare providers was available to communities usually by word of mouth. He stated that many of his new patients come to him based on recommendations by other patients.

Public mental health services in the public sector at the block and district levels

At the Patti Block, interviews were conducted with health care providers at the community health centre as well as at the district hospital. According to the general physician at the health centre:

“[At the centre], those seeking care are placed under observation. Examination is carried out to check vitals, responses, etc. Medicines are provided for general symptoms, and if thereafter required, placebo treatment is provided. We also sometimes give IV fluids—the patient feels that some treatment is taking place. This is important for the family who accompanies her. They see that she may have fainted, that she was unwell and that medicines and IV fluids are given, etc., [thus] maybe they will allow her to get some rest for a few days.”

However, no health care for mental health issues was available at the community health centre or district hospital. If the health centre was unable to handle serious cases, referrals were made to a psychiatrist in a private hospital in the block.

The district hospital was accessed by women with depression, who, according to the doctor, usually come to the outpatient department as general patients. They invariably do not identify themselves as a person with a mental health issue. After an initial screening, these patients are referred to other facilities if they require specific care. The physician at a district hospital who was interviewed remarked that young women in the area experience mental distress owing to issues like forced discontinuation of their education, forced or early marriage and because of the poor social and economic situations (immediate surroundings) that they live in.

The need for services at the district level for mental health problems was perceived as critical. Because there were no specialized facilities available, young women were referred to the Allahabad District Hospital. The Allahabad District Hospital (about 85 km, or a three-hour journey, from Patti Block) has a separate department for mental illness (*maansik rog*). According to the psychiatrist working there:

"Mostly medication is given to the patients. Treatment through psychotherapy (counselling) is not possible at a government hospital since it requires spending time with the patient, and there is a lot of rush at any point in time. Patients from across socioeconomic backgrounds access services, but since it is a government hospital that provides services free of cost, many people, particularly from the lower socioeconomic class, come here. More men than women come; ...women usually go to local doctors or healers.

"Younger girls are suffering from anxiety disorder, exam pressure, while middle-aged women face interpersonal issues, marital crises; elderly women suffer from chronic illnesses. Young women in the age group of 18–25 years face issues like anxiety, depression, conflict between family values and individual aspirations, substance abuse, relationship issues, obsessive compulsive disorder, and issues pertaining to body image. Married women suffer more from interpersonal issues with husbands and in-laws. Anger and violence can be seen as core psychiatric issues.

"Some of these psychological issues are experienced in the form of physical discomfort (somatization of psychological issues), like palpitation, tingling and anxiety [ghabrahat]. It is mostly through word of mouth that these patients get to know of the department. In terms of the stage in the illness at which the person decides to see the doctor, there is definitely a delay in accessing treatment. Seeking alternative treatments, like going to the mazaar or rojha, is very common in the region; there is, in fact, a very famous mazaar in Allahabad, which is visited by people with mental health issues."

Referrals

Patients requiring referrals for mental health issues were sent to the district health centres in both states, often accompanied by an ASHA or ANM. Although neither of the districts had any specialized mental health services at the community health centre levels, the physicians there provided some treatment based on the physical symptoms. The physicians also stated that they spoke to the patients and counselled them and their families on a range of issues. Any issue or situation that seemed to be beyond their understanding or skills was referred to psychiatrists in private as well as public hospitals at the block or district level. There was no formal or systematic protocol for referral, and it was based on available human resources in the community health centres and the financial resources of the families.

Referrals to physicians and psychiatrists were also done by healers—*ojhas*, *baojis*, etc. They referred those who were in a serious condition to doctors, including psychiatrists. The referrals by healers were largely unidirectional—to an allopath, in the private as well as in the public sectors.

Young women and their families also sought care and healing directly, following the referral advice by neighbours and extended family members. The availability of information on mental health care was abysmal in both the study areas.

Mental health policy and programs

The National Mental Health Program (NMHP) 1982 was expanded to integrate mental health into the primary health services with the introduction of the District Mental Health Program (DMHP) in 1996–97. Evaluation evidence of the DMHP, however, indicate poor implementation of the program, findings that were echoed with the findings from this study.

The 12th Five-Year Plan (2013–17) proposed to appoint community mental health workers (community counsellors) at the primary health centre level to detect mental illnesses and provide a range of psychosocial treatments. However, no such provision was in existence in the study areas. In Rajasthan, according to the health officials, training of the ASHAs and ANMs in counselling was being carried out. However, the ASHAs and ANMs who were part of the discussions in the study were not aware of such trainings. Although there are commitments to improve integration of mental health services at the policy level, including enhanced funding to the DMHP (Roy and Rasheed, 2015), its translation into implementation on the ground seemed extremely limited. According to the district health officials in Rajsamand (Rajasthan):

"Some activities have been started on mental health under the initiative on 'noncommunicable diseases'. The Department conducts mental health camps at the block level every two to three months under the National Rural Health Mission. The camp usually gets two to three patients with mental disorders, but most importantly, a large number of women suffering from stress-related problems, such as insomnia, anxiety and eating disorders, visit these camps for treatment. In the department block meetings, ANMs and ASHAs have been oriented to provide counselling services to the people who are in need of such services."

The Health Department, according to the official household surveys, which are conducted routinely, incorporates two components on disability and mental health. Data about persons with disabilities and people suffering from mental health issues were to be collected from April 2016 and appointments at the district and block levels for counselling services were planned. Actual implementation needs to be assessed through follow-up visits in the state and especially in the study areas.

Under the National Urban Health Mission, the community health centres, or *Ujala* clinics, are part of the Rashtriya Kishor Swasthya Karyakaram (the National Adolescent Health Strategy) program and are expected to cater to the reproductive and sexual health needs of young people. One medical officer is appointed at the *Ujala* clinic and at the primary health centre level, a medical officer is designated and provides weekly consultation. During the study period, *ujala* clinics were functioning in four community health centres and eight primary health centres in the four blocks of Rajsamand District (in Deogarh, Bhim, Railmagra and Rajsamand). However, there were no skilled specialists, such as counsellors, psychologists and psychiatrists, available at the time of the study.

In Uttar Pradesh, doctors from government hospitals who were interviewed said that although each district hospital is expected to have psychiatric services, this was not the case. As per the District Mental Health Program, at least one doctor who is trained to address mental health issues should be available, even if they are not a psychiatrist. The district program was poorly implemented and, even the district hospitals did not have services for mental health because of interrupted or lack of funds or absence of counsellors and psychiatrists. According to the State Nodal Officer for Mental Health during a meeting (August 2017), the District Mental Health program in Uttar Pradesh was going to be revived in 24 districts, although Pratapgarh was not among them. By December 2017, about 45 districts were expected to be implementing the district program, which would include visits every month to block headquarters with a team of counsellors, a psychiatrist, a psychiatric social worker and nurses to initiate camps. Mobilizing people from adjoining areas would be done with the help of the community, especially the members of the *panchayati raj* institutions, so that anyone with a mental health issue could visit the camps for consultation, treatment and counselling. This was not being implemented in Pratapgarh.

India's law and policy architecture on mental health is primarily constructed around the Mental Health Care Act, 2017, the National Mental Health Program and the District Mental Health Program. The national program was launched in 1982, and the district program was introduced in 1996. The district program is now implemented in 517 districts.¹ The National and the District Mental Health Programs are based on a community model for delivery of services. The programs emphasize decentralization of services, accessibility, integration of mental health services in general health care and rehabilitation of persons with mental illnesses in the community.

When launched, the national program represented a conscious shift from the colonial-era institutionalization and custodial care of persons with mental illness to a community-based model. The shift came about due to several factors, including the increasingly accepted knowledge that treatment and long-term hospitalization of patients with mental health issues was counterproductive and led to difficulties with their reintegration into society; the difficulty of providing treatment through centralized programs in a resource-poor setting like India; and evidence that para-professionals could provide adequate treatment with adequate training (Kumar, 2013).

The National Mental Health Program was launched to make minimum mental health care available and accessible to all, with particular focus on the most vulnerable and marginalized sections of the society; to integrate mental health knowledge with general healthcare and in social development; and to encourage community development and self-help in the mental health service delivery. The district program, along with these objectives, aims to develop human resources and infrastructure for detection and treatment of mental illnesses, reduce the burden of mental health hospitals, reduce the stigma and change the public attitude towards mental illness.

Aid has been provided for setting up 24 Centres of Excellence and establishing or strengthening 46 post-graduate departments in mental health specialties in the country.² Some of the problems associated with the implementation of the national and the district programs are non-availability of trained mental health professionals, such as psychiatrists, clinical psychologists and psychiatric social workers, and low involvement of the community in the programs (Sinha and Kaur, 2011).

According to Ministry of Health and Family Welfare data, the estimated availability relative to the requirement (as of January 2015) of mental health professionals was: 3,827 of 13,500 needed psychiatrists, 898 of 20,250 needed clinical psychologists, 850 of 37,000 needed psychiatric social workers and 1,500 of 3,000 needed psychiatric nurses.³ India clearly has a critical shortfall in the required

number of trained mental health staff. Moreover, as the NMHS 2015–16 findings show, there is delayed and little use of mental health treatment. The time lapse between the onset of symptoms and seeking of care varied from 2.5 months for depressive disorder to 12 months for epilepsy. The treatment gap for bipolar affective disorder, schizophrenia, neurosis and depressive disorder was more than 70 per cent. The first and most common source of health care for a person with mental illness was the local faith healer, and when this did not result in a cure, the local doctor and later a psychiatrist were approached (MOHFW and NIMHANS, 2015–16).

The NMHA and the National Health Policy (2017) have indicated some changes, with the former having incorporated provisions for a rights-based approach towards mental health care, espousing provisions like advance directives and setting up of committees to review and protect the rights of people suffering from mental health issues. The various advances proposed would require significant investment in developing and training human resources, especially to run the Mental Health Review Board that will look into judicial aspects of mental healthcare for maintaining a minimum standard of care.

The National Health Policy aims to improve public mental health service provision. Similar to the 12th Five-Year Plan, it aims to increase the number of specialists and then networks of community members to provide psychosocial support and to strengthen mental health services at primary-level facilities. In addition, it also aims to leverage digital technology in a context in which access to qualified psychiatrists is difficult and proposes to strengthen mental health services in the country through a collaborative approach by involving non-government agencies and the private sector towards mental health.

Despite the National and District Mental Health Programs' goals, evidence from the current study as well as from others, including the NMHS 2015–16 suggests huge gaps in availability of public mental health care that has extremely harmful implications for persons with such issues, particularly young women. A large number of people require psychosocial support and treatment for their mental health needs. The health system has been unable to implement limited programs even in select areas. Public mental health care should ensure integration with other health programs, such as adolescent and child health programs, programs for maternal health, geriatric care, programs for non-communicable diseases and other national disease control programs. Undoubtedly, the availability of skilled human resources is central to public mental health care; psychosocial counselling and support is particularly critical, along with necessary medicines for treatment.

Strengthening community-based models for care, including psychosocial counselling and support, building awareness towards strengthened peer and community support and referrals are necessary to manage mental health issues and prevent any negative outcomes. Substantial care can be provided at the community and primary health care levels through well-designed and effectively implemented outreach programs, along with specialized care for mental health issues, that are made available in proximity to secondary-level facilities for those who need it.

Local healers and caregivers have an important role in providing care for mental health issues in communities; programs to address mental health should attempt to incorporate plural pathways of care and assess modalities for different care systems, working in tandem for a comprehensive approach to mental health and its care and treatment. Mental health programs must be designed so that the associated stigma and discrimination are not exacerbated; the evidence on the preference for healers is because of the concern of being labelled as "mentally ill", that the practice of psychiatry reinforces.

The understanding of the local contexts in the process of healing is crucial; they also include the family and community in the process of healing to a far greater extent than psychiatry does. Moreover, psychiatry pathologizes and medicalizes sources of women's mental health that are often embedded in women's social oppression, as the narratives reveal. Therefore, any treatment for mental health merely based on management through medication alone is irrational. If psychiatry remains central to the public mental health program, with all other approaches marginalized, it is inevitable that women's experiences will be "invisibilized".

Endnotes

¹Lok Sabha Unstarred Question No. 1719.

²Lok Sabha Unstarred Question No. 2339 (March 2018).

³Lok Sabha Unstarred Question No. 2339 (March 2018).

EMERGING ISSUES

Mental health and mental well-being: Strengthening concepts and identifying gaps

The young women's articulation about their mental health suggests that they understand their suffering not merely as a consequence of their biological and psychological selves but largely as a result of structural inequalities and the violation of their rights. Their understanding of mental distress was embedded in their socioeconomic and political oppression and everyday experiences of poverty, caste, gender, sexuality, etc. That these oppressions controlled and determined decisions and consequences around education, employment, marriage, social relationships, care and other aspects of their lives was articulated throughout the research.

The concept of mental well-being is deeply connected with social well-being. It is understood as more than the mere absence of mental illness or disorder and also represents the enhancement of opportunities and capabilities to thus have healthy and fulfilling relationships and lives. However, the notion of well-being is not singular, hence a definition is complicated and guided by the social location—gender, caste, class, race, sexuality, etc. of a person as well as by their cognition, which, in turn, is constructed by these social and normative structures. Can mental well-being, therefore, also be understood as possible for persons diagnosed with mental illness or disorder?

The recognition of the social, economic and political determinants of young women's mental well-being, not limited to an understanding of symptoms that require "fixing" by psycho-pharmaceutical approaches and systems, is critical. This resonates with feminist scholarship from India as well as globally. However, the concept of well-being seems to be more individual and incorporates relatively more subjectivities. "Mental health" is also gradually being understood and articulated in the context of the links with socioeconomic and political determinants and finds many overlaps with mental "well-being". Thus, can mental health be possible, for example, in a context of socioeconomic and political inequalities?

In terms of mental distress, the understanding of what most of the young women were experiencing was distinct from mental illness; the stigma associated with the latter was perceived as higher than with what they were experiencing. The absence of the labels for mental distress, as contrasting from mental illness was also recognized by the young women, as was the temporality of distress, like mental illness. Mental distress was invariably a description of life processes or events that were affected—these were, however, not understood as symptoms and blended with young women's emotions, relationships and socioeconomic contexts, along with physical discomfort, pain, spasms, fatigue, sleeplessness, fits, immobility, weakness, etc.

The understanding of mental health presented deep contrasts between the young women, healers and health care providers. Nevertheless, these were not disparate and may not be categorized distinctly across the participants. Several healers as well as government and private health care providers from different health care systems at varied levels of the health system seemed to suggest that the aetiology of young women's mental distress is a result of their social location. Yet, their understanding and management of these cases were also guided by the hegemonic social ideologies of caste, class, gender, religion, etc. As a result, the mental health needs of young women are pathologized or located in the sphere of spirituality and faith, which are largely inadequate. Such a de-contextualized approach to care and treatment obfuscates any need to address the social, economic and political causes of mental distress articulated by the young women in this study.

Gradual shifts in language, articulation and understanding have implications for healing and care for young women. These shifts were observable, some of it learned from social peers and guardians as well from interaction with healers and health care providers.

Articulation and understanding of mental distress, especially by the young women, seemed intuitive, reflecting close connections with social oppressions and realities. Although social labels of “mad” are used to refer to persons exhibiting different or non-conforming behaviour, with references to possession used by young women and communities to explain them, they are often reinforced by local healers and community health care practitioners.

The hegemony of the biomedical understanding that categorizes mental distress into disorders or illness and permeates the understanding and articulation of mental health or distress is palpable. This is apparent through language, such as the depression or hysteria terms being used by some of the young women as well as by local healers and local non-allopathic health care practitioners. The referral networks in the study areas also reflect this—some of the healers were regularly referring young women to psychiatrists for intervention and “medication” for their mental health issues. While referral networks are important, the rationale for the same are critical—the understanding of the psychiatric-centred system as “superior” to others may have deleterious consequences for young women with mental distress.

Evidence points to young women and communities, in general, accessing multiple systems of healing and care and often simultaneously, preferring local healers because of their belief systems and social and economic accessibility. Healers in the study areas are beginning to use terms such as hysteria and depression’ to diagnose young women with mental distress. One of the *ojhas* referred to his practice as “*ojhai* therapy” and likened it to the biomedical approach. Dichotomous articulations by a few young women of the traditional and modern care systems, with indigenous practitioners perceived as the former and the psychiatric-centric mental health care as more modern, also flag significant issues. These were posited as oppositional, with suggested preference for the modern; a few of the women also perceived the decisions regarding modern and traditional care as gendered—with boys and men accessing the modern, or the doctor, while girls and women were taken to the local healers for general health issues, including for mental distress.

This raises concerns regarding spaces for alternative discourses on mental health that are not limited to a biomedical or psychiatric-centred approach. Shifts and permeation of the hegemonic psychiatric-centric understanding of mental health needs to be further studied to understand their implications for healing and care, especially for women and marginalized communities.

Stratifying and categorizing mental distress: Implications for coping, care and healing

The discourse on mental health categorizes mental distress as “common mental disorders”, and the evidence globally and from India shows that it is most commonly used in relation to women, including young women. This categorization of “common mental disorders”—depression, neurosis, anxiety, etc.—creates restricted contours of understanding of mental distress. The young women used a range of expressions to narrate their experiences of mental distress—from “feeling sad” to “wanting to kill themselves” with terms varying with cultural contexts. Women’s use of the same terms to communicate diverse levels and experiences of their distress suggest the need for reconstructing the manner in which mental distress—its nature, levels and potential consequences, etc.—are understood. Women’s mental health needs, especially young women’s, are not captured in the current biomedical-

focused understanding of mental health—violations and vulnerabilities need to be recognized as potential triggers that may be precursors to mental health problems.

Instead, psychiatric-centric care and others have focused on fitting experiences of women into limited available categories that inevitably also predicated the levels of distress and their corresponding management largely through drugs and psychotherapy. But how and at what point does sadness, misery, anger, for example, become a category?

The approach of mandatory categorization of mental distress that employs diagnostic manuals and tools, de-contextualized from young women's realities, experiences and articulations, gives precedence to stratified definitions of extremely subjective and diverse experiences of women. The social locations and contexts of the young women were largely similar, but they had not experienced distress similarly.

While understanding the nature of young women's mental distress is a definite need for health care providers, the assumption and approach to it through pre-existing medicalized categorization, needs to be urgently transformed. Women's own articulations of distress need to be heeded.

Because experiences of mental distress are subjective, do universal diagnostic guides and tools identify and categorize mental distress appropriately? Is there even a need to do so? What alternative forms of care and skilled healers or practitioners can be envisaged to facilitate coping, care and healing? Creation of safe, transformative spaces at the community-level for young women to share their mental distress with skilled psychosocial care workers may be possible without the pathologizing and categorization of distress. This flags a need for a transformative shift away from the current paradigm of mental health care in the public health system, which is biomedical and psycho-pharmaceutical centred, to a community-centred one.

Safe spaces in communities

Silence (*chuppi, kuch nahi bolna*) was referenced repeatedly by women throughout the research. The implications of silence are extremely serious for women's health in general and particularly for their mental health. In the context of young women from rural, marginalized communities, creation of such spaces that are nearby, safe, accessible and private is necessary. For example, how do young women connect with safe spaces where they can break the silence without fear or judgment? Can there be spaces within communities where their experiences are not trivialized or pathologized? Are such supportive spaces possible?

While family members, friends and local organizations were perceived by young women as their support networks and were significant in helping them cope with their distress, there was a disjuncture between the needs of the young women and the nature of the support that was available to them. In a context in which gender, sexuality, poverty, caste and other structural factors are the determining factors of their mental health, family members, friends, community health workers and even organizations are often bound by their inability to challenge these extremely deep-seated structural factors and biases. Those who were supportive were also reined in by structural contexts, such as poverty, gender, caste inequalities and other normative ideologies that restricted the extent of support they were able to extend to the young women. The resistance was shaped by the contours of the social (gender, caste, sexuality and other) norms.

Moreover, concerns about repercussions for those who were supportive caused the young women to remain silent and suffer longer, despite the distress.

Families and communities are often the sites of oppression in which women, particularly young women, literally have no voice. Young women in the study, for example, said they hesitate to talk about incidents of sexual harassment in public spaces out of fear that their mobility would be curtailed.

This is an extremely challenging issue; in the absence of safe and confidential supportive spaces and people, silence and status quo often prevail, causing mental distress to prolong.

The concept of a space is thus beyond the physical—most importantly, what will these spaces do, who will be a part of it and how will they ensure safe and confidential interactions and support? How can such a space ensure safety and support in the face of backlash from families and communities? Would an organizational or an institutional space, such as that of the Adolescent-Friendly Health Clinic, be an appropriate space? Would young married women who experience high levels of surveillance and mobility control benefit from it?

Conversations with young women must continue to find possible ways of creating such spaces. Lessons from the experiences of communities and organizations that have created such spaces would be useful. While such initiatives will have to be context specific, exploring and documenting diverse methods and models would be extremely useful.

Early marriage

The research findings raise specific concerns that may affect younger women in situations of marriage; however, it seems that the institution of marriage and its imperative character cause anxiety and distress. The unequal and normative relationships pre-determined by the institution of marriage are a significant cause of mental distress among women. The women who were unmarried in the study cited a constant pressure on them—marriage never seemed too distant.

On the other hand, the inability to get married either due to poverty or incapability to arrange for dowry (in Uttar Pradesh mainly) also led to a feeling of hopelessness among women. These predetermined aspirations raise the need for a deeper understanding of women's relationships with their natal and marital homes and that move beyond the "natal vs marital" perspective to one that regards it as a continuum.

Young girls in married situations (in the case of the study—early or non-self-choice marriage) have greater vulnerability to poor mental health. In situations of marriages that occurred very early in life, women articulated feeling angered and sad as they grew up with the knowledge of being in an imposed relationship built upon the thwarting of their aspirations and emotions. Relationships and marriages decided by young women is extremely critical. The study findings flag that they, too, often mirror the prevalent understanding of relationships, reinforcing gender, sexuality norms, etc. Any discussion on mental health must therefore challenge and build an alternative discourse to the existing institution of marriage, with emphasis on equal, respectful relationships.

Policies and programs

The mental health of young women has increasingly been recognized as an area that needs attention. For example, the Rashtriya Kishor Swasthya Karyakaram program includes a mandate for mental health, however limited it may be. The study reinforces the urgent need for information, services and support for rural young women to address and mitigate their mental health concerns and needs. Although there are relevant services, such as the Rashtriya Kishor Swasthya Karyakaram as well as the National and District Mental Health Programs, their implementation was near invisible in the study areas. Can public health programs respond to mental health needs or distress that are largely emerging from young women's social, economic and cultural milieus without their pathologization?

The pathways of mental health care are plural, involving multiple systems of care and healing. Indigenous healers—*ojhas*, *baojis*, *dargahs*—are perceived as more “socially accessible” when compared with the “socially distant” diagnosis and treatment provided by physicians and psychiatrists. The former also claim to be connected to the wider belief systems that are integral to the lives of young girls and women and the communities they belong to. The pathways of mental health care are also determined by the resources at hand, the availability of credit (financial) and social and geographical access. Can the plural systems that are currently involved in providing mental health care be optimized to respond specifically to the mental health needs of young women, or would this require a system that is differently oriented?

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ANNEX

Profile of participants

UTTAR PRADESH

S. No.	Pseudonym	Current age (years)	Marital status	Age at marriage (years)	Education	Religion	Caste	Family type (members)	Type of house	Income source of chief wage earner	No. of children
1	Sanjana	18	Never married	-	Class 12	Hindu	Vishwakarma (Scheduled Caste)	Nuclear	Kuccha	Father is a carpenter	-
2	Kavita	20	Never married	-	Class 12	Hindu	Gautum (Scheduled Caste)	Joint	Pucca	Farming; elder brother is a driver in Mumbai	-
3	Mansi	18	Never married	-	Class 12	Hindu	Gautum (Scheduled Caste)	Joint	Kuccha	Brother is a construction labourer	-
4	Pallavi	18	Never married	-	Class 12	Hindu	Gautum (Scheduled Caste)	NA	Kuccha	Father repairs cycles	-
5	Nandita	21	Never married	-	Undergraduate	Hindu	Yadav (Other Backward Class)	Nuclear	Pucca	Agriculture, farming on own land	-
6	Komal	19	Never married	-	Undergraduate	Hindu	Yadav (Other Backward Class)	Joint	Pucca	Father makes iron gates	-
7	Madhavi	18	Never married	-	Undergraduate	Hindu	Patel (Other Backward Class)	Nuclear	Pucca	Father is government school teacher	-
8	Sonal	19	Never married	-	Undergraduate	Hindu	Gautum (Scheduled Caste)	NA	Pucca		-
9	Menaka	18	Never married	-	Class 8	Hindu	Gautum (Scheduled Caste)	Nuclear	Pucca	Father's a mistri	-
10	Swati	25	Married	18	Class 10	Hindu	Patel (Other Backward Class)	Joint	Kuccha	Elder brother-in-law migrant labourer in Delhi	None
11	Ankita	23	Married	14	Class 10	Hindu	Saroj (Scheduled Caste)	Nuclear	Kuccha	Husband is a driver	2
12	Ritu	24	Married	19	Class 10	Hindu	Gautum (Scheduled Caste)	Joint	Pucca	Husband works in a hotel in Bangalore	1
13	Urvashi	25	Married	21	Postgraduate	Hindu	Gautum	Joint	Pucca	Husband is a migrant	None

					ate		(Scheduled Caste)			labourer in Saudi Arabia	
14	Rupali	24	Married	17	Undergraduate	Hindu	Gautum (Scheduled Caste)	Nuclear	Pucca	Husband is a construction supervisor	3
15	Samira	22	Married	18	Undergraduate	Hindu	Yadav (Other Backward Class)	Joint	Pucca	Husband works in Health Department (government job)	1
16	Megha	22	Married	20	Class 5	Hindu	Gautum (Scheduled Caste)	Joint	Kuccha	Husband is a labourer in construction	1
17	Priyanka	19	Married	18	Class 12	Hindu	Gautum (Scheduled Caste)	Joint	Kuccha		None
18	Sukanya	24	Married	21	B.Ed.	Hindu	Saroj (Scheduled Caste)	Joint	Kuccha	Family has a small shop	None
19	Varsha	25	Married	22	Graduate	Hindu	Gautum (Scheduled Caste)	Joint	Pucca	Husband makes gates, construction labour	None
20	Abida	24	Separated/divorced	20	Class 8	Muslim	NA	Joint	Kuccha	Mother's a hawker	1
21	Vineeta	25	Separated/divorced	16	Class 5	Hindu	Gautum (Scheduled Caste)	Joint	Kuccha	NA	2

RAJASTHAN

S. No	Pseudonym	Current age (years)	Marital status	Age at marriage	Education status	Religion	Caste	Family type	Type of house	Income source of chief wage earner	Children
1	Reema	25	Married	2.5	Class 6	Hindu	Gadrhri (Other Backward Class)	Joint	Pucca	Husband has agriculture land	2
2	Malika	20	Married	20	Class 12	Hindu	Sisodia (Other Backward Class)	Joint	Kuchha	Father-in-law works in cement factory	-
3	Rachna	18	Married but <i>gauna</i> not performed	14	Class 11	Hindu	Lohar (Other Backward Class)	Joint	Pucca	Brother owns agriculture land	-
4	Raveena	23	Married	4	Class 10	Hindu	Saragra (Scheduled Caste)	Joint	Pucca	Husband works in a shop	-
5	Kanchan	20	Married but <i>gauna</i> not performed	16	Undergraduate	Hindu	Kumavat (Other Backward Class)	Nuclear	Pucca	Has a shop	-
6	Shraddha	23	Married	6	Undergraduate	Hindu	Kumavat (Other Backward Class)	Joint	Pucca	Husband has agriculture land	None

7	Neelima	25	Married	17	Class 5	Hindu	Singh (Rajput)	Nuclear	Pucca	Husband has taxi business	2
8	Karishma	22	Married	19	Class 10	Hindu	Singh (Rajput)	Joint	Pucca	Husband works in mines	2
9	Ridhima	24	Divorced	17	Class 9	Hindu	Salve (Scheduled Caste)	Nuclear	Pucca	Father is a mistri	-
10	Rashi	20	Separated	16	Class 9	Hindu	Ghamti (Scheduled Tribe)	Nuclear	Pucca	Works as domestic help	1
11	Gunjan	20	Widowed	6	Class 5	Hindu	Gadrhri (Other Backward Class)	Joint	Pucca	Father has agriculture land	-
12	Mrinalini	21	Divorced	14	Undergraduate	Hindu	Bhil (Scheduled Tribe)	Nuclear	Pucca	Agriculture labourer	-
13	Tripti	18	Widowed	10	Class 10	Hindu	Goswami (Other Backward Class)	Joint	Pucca	Has a shop	-
14	Deepika	18	Widowed	8	Class 8	Hindu	Kumavat (Other Backward Class)	Nuclear	Pucca	Agriculture labourer	-
15	Kritika	22	Divorced	18	Class 8	Hindu	Kumavat (Other Backward Class)	Nuclear	Pucca	Father has agriculture land	-
16	Tammana	25	Married	15	Class 6	Hindu	Kumavat (Other Backward Class)	Nuclear	Pucca	Father has agriculture land	2
17	Lalita	20	Never married	-	Postgraduate	Hindu	Khatik (Scheduled Caste)	Joint	Pucca	Has a shop	-
18	Preeti	19	Never married	Na	Undergraduate	Hindu	Sharma (Brahmin)	Nuclear	Pucca	Father has a shop	-
19	Sunidhi	19	Never married	-	B. Ed	Hindu	Bagri (Scheduled Caste)	Nuclear	Kuchha	Elder brother makes bamboo baskets	-
20	Nikita	18	Never married	-	Undergraduate	Hindu	Kumavat (Other Backward Class)	Joint	Pucca	Father has agriculture land	-
21	Juhi	22	Never married	-	Undergraduate	Hindu	Kumavat (Other Backward Class)	Joint	Pucca	Father has agriculture land	-

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