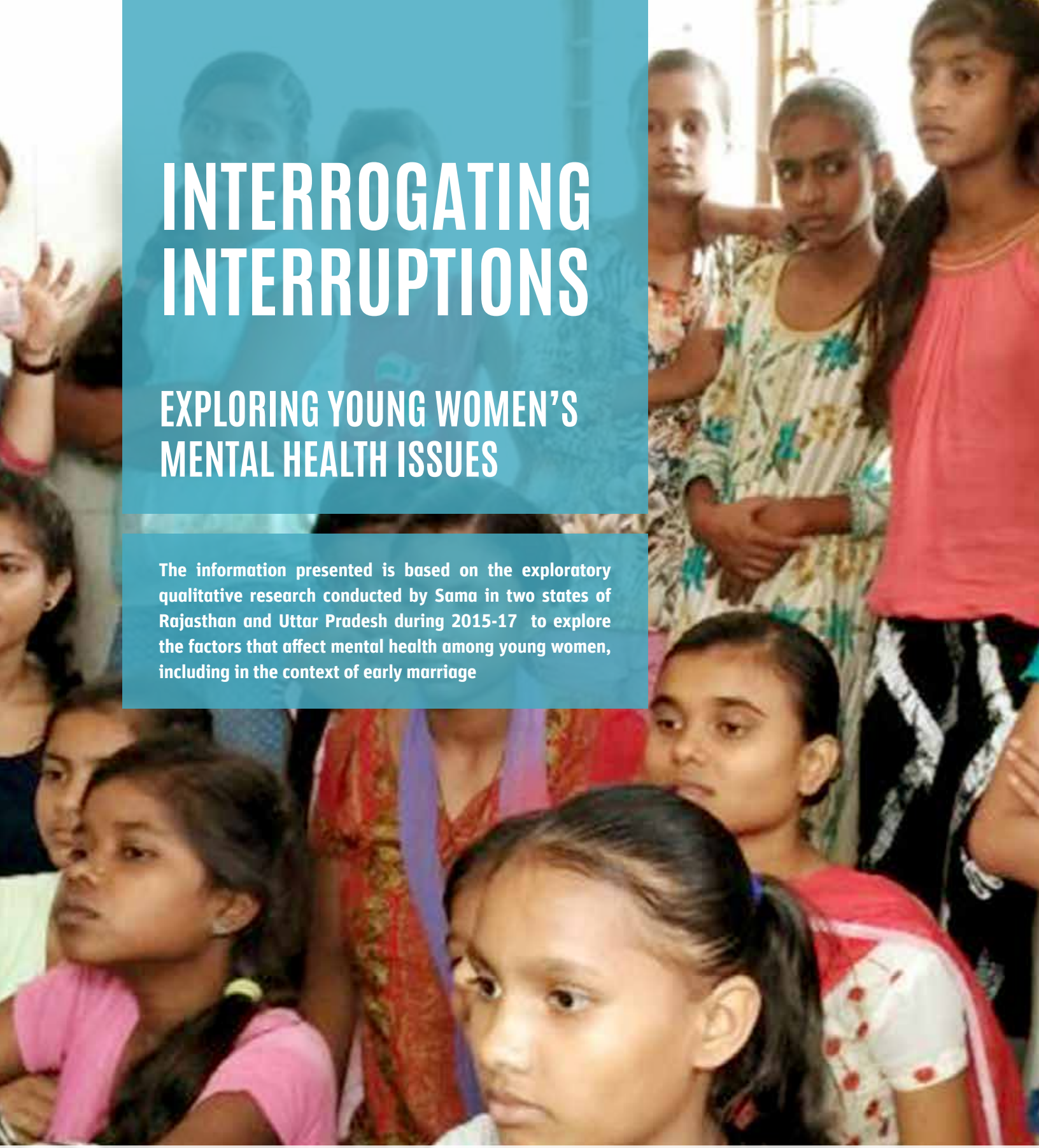

INTERROGATING INTERRUPTIONS

EXPLORING YOUNG WOMEN'S MENTAL HEALTH ISSUES

The information presented is based on the exploratory qualitative research conducted by Sama in two states of Rajasthan and Uttar Pradesh during 2015-17 to explore the factors that affect mental health among young women, including in the context of early marriage

Sama- Resource Group for Women & Health

American Jewish World Service (AJWS)

INTERROGATING INTERRUPTIONS
Exploring Young Women's Mental Health Issues

Feminists have for 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. This view remains largely absent in the dominant medicalized discourse on mental health which views it as merely an absence of disorder and locates women's mental health to disorders emerging in their bodies, ignoring the impact of socio-cultural, economic and political structures. While there is scholarship on women's experiences of mental health linked to their everyday experiences, the need for deeper inquiry into diverse aspects of these interlinkages is limited. Sama's research on exploring young women's mental health issues sought to gain insights into the contributing factors to mental health; mental health needs, healing, care and support amongst young women in rural areas, including those who were married 'early'.

* Not all images used in the document are from Sama's initiative on mental health.

**The cover page image was taken during a workshop on SRHR that Sama conducted at Adolescent Resource Centre, Matri Sudha, Delhi.

Research Objectives and Location

The specific objectives of the research were:

- **To understand the contributing factors to mental health including implications of early marriage among young women**
- **To assess the mental health issues, needs, health care and support of young women, including those in early marriages**

The qualitative, exploratory research was conducted in the states of Uttar Pradesh and Rajasthan, in Patti Block, Pratapgarh district and Railmagra Block, Rajsamand district respectively. The interviews with young women and group discussions took place in select villages at the block level. Interviews with healers, healthcare providers as well as other key informants were conducted at the village, block and district levels.

Women in the age group of 18-25 years were purposively selected for 42 in-depth interviews, of which 21 were from Uttar Pradesh (UP) and Rajasthan respectively. Of the total 42 women from both the states, 14 were never married, 18 were married at the time of the research (including three women whose *gaunas*[1] were yet to take place), and 10 were separated, divorced or whose husbands had died. Of the 28 women who were married, 12 were married between 18-21 years, while ten and six women were married below 18 and 10 years

KEY FINDINGS FROM THE RESEARCH

Perspectives and understanding of Mental Health

The understanding of mental health amongst young and other women from the communities was embedded in their socio-political realities and everyday experiences of poverty, caste, gender and sexuality. While the larger contexts of women were similar, not all of them experienced distress similarly. Their subjective social locations determined their vulnerability to mental distress, their coping and healing.

While the term 'mental health' (*maansik swasthya*) was unfamiliar to them, their conceptualisation and articulation of mental distress was through a range of expressions. The language used by women included anger (*gussa*), anxiety (*ghabrahat, chinta*), fear (*darr*), sadness (*dukh*), dizziness (*jee bhaari, jee ghabrana, matha ghumna, chakkar aana*), emptiness (*sunapan*), and even thoughts about ending their lives (*jee karta hai mar jayen*).

These expressions were used interchangeably, although apparently in some hierarchy of order of the intensity of their expression of mental health. For example, sad, emptiness and desire to die– with the latter seeming to reflect a higher degree of intensity compared to the former. The research reinforced the challenge of the measurement of mental health, which unlike other physical health issues that can be assessed by a diagnostic instrument, is different and subjective. It also raises fundamental questions around this 'measurement' and whether stratifying young women's experiences of mental distress should and can be done and is that not subsumed into the existent medical diagnostic categories?

Social labels of "mad" (*paagal*) were used for persons exhibiting 'different behavior' which included "abusing verbally" (*gaali dena*), "talking too much" (*jyada bolna*), "not eating" (*khana peena nahi*), or "running away from home" (*bhaag jana*). The label is also used for non-normative or non-conforming behavior by young women. For example, women who were being assertive, aspirational, talking loudly, refusing to do household work, etc., were labeled "mad".

SOCIO-ECONOMIC AND POLITICAL REALITIES

Intersections of poverty, gender and caste limited access of the young women to education, to livelihoods, to healthcare and enforced marriage to "unburden" their natal family, create a deep sense of anxiety, helplessness and hopelessness. For example, the reduced access to education, also impacted as access to a critical space for interaction, of mobility, of coping in situations of mental distress. Sexuality and gender norms for maintaining "sexual purity" penalized young women, and caused them to experience indignity, helplessness and discrimination, leading to severe mental distress.

EARLY MARRIAGE

The concept of "early" is extremely nebulous. Young women who were married were asked about their understanding of "early" and they explained "Early" marriage in negation to "not early" - as that which takes place following completion of their education (schooling), when they are able to be independent (*apne pairon par khade hoke*), especially financially independent. The choice of partner was also conditions that they believed were important to their decisions about marriage.

Poverty, illness of parent or grandparent and the need for family members to 'see them married' before their imminent death, or due to the death of a parent , the number of siblings in the family and physical appearance (young women who looked older or "more mature" than their age) – were some of the reasons cited by young women for marriage.

About three of the women who had married before they were 10 years old, talked about experiencing emotional conflicts as they grew older with regard to person they should have and had married. While the inevitability of patrilocality was true for all women, the younger the woman, the higher the mental distress experienced.

Mandatory patrilocality created fear, inhibition, anxiety given the new environment, relationships, burden of work, etc., for all women, the older women had possibly undergone a longer socialization of acceptance. The move to the husband's home also enforced breakdown of their known spaces for interaction, friendships that the young women had to forego. The prevalent institution of marriage and its imperative character caused anxiety and distress among young women. The women who were unmarried, cited a constant pressure on them – marriage never seemed too distant.

The inability to get married either due to poverty and incapability to arrange for dowry (seen in UP mainly) also led to a feeling of hopelessness among women. These pre-determined aspirations also flag the need for deeper understanding of women's relationships with their natal and marital homes, that move beyond the natal "versus" marital and can be seen more as a continuum.

RESTRICTIONS ON MOBILITY AND ABSENCE OF SAFE SPACES

The restrictions on mobility of young women were socially determined and reinforced by the women themselves. These restrictions and control over mobility were extremely deleterious for their mental health as they posed barriers to their access to information and knowledge to make informed decisions. For example, young women spoke about negative reproductive outcomes (miscarriages, unaware of being pregnant following abuse, etc.) but were unable to seek care and support for the outcomes as well as the mental distress resulting from them. The "newly married" women in both the states spoke about the restrictions on them - going out of the house even for agricultural work for a year following marriage was limited. Their social interactions were restricted and it created a sense of fear and anxiety in them to approach any person, other than those at home.

The young girls spoke of the constant surveillance over everything that they did – whether speaking on mobiles, of the household work, what they wore, how they conducted themselves outside their homes. The young women stated that this created tremendous pressure on them to "conduct" themselves in keeping with existing norms.

ABUSE AND VIOLENCE

Abuse and violence as well as the fear of violence in public spaces, was stated by at least 70 percent of the women. This impacted their mobility and independent access to public spaces. Abuse and violence by members of the family was also not uncommon. More than 80 percent of the women stated that domestic violence was prevalent in the community in both the states - in natal as well as in marital homes. The violence often led to mental distress, anxiety, fear, and in some instances, even suicidal ideation and attempts. A young woman from Rajasthan who had been kidnapped and sexually abused and held in captivity, shared about her experience of pregnancy following the assault. She was worried and anxious because she felt that there was something wrong with her body until she got to know at five months about the pregnancy. Distress and trauma experienced as a result of violence was exacerbated by the lack of knowledge pertaining to reproductive and sexual health.

YOUNG WOMEN'S AGENCY AND RESISTANCES

All the young women were seen resisting and negotiating spaces in their natal as well marital households constantly – for instance, women talked about refusing to have sexual relationships, refusing to go to their marital homes, or to talk to the husband and family, etc. The repercussions, however, of the resistance, caused further mental distress in some of the women – driving them to attempted suicide, illness resulting from mental distress, anxiety and fear. Women, however, who were able to seek the support of local organizations were able to mitigate the repercussions of resistance and were able to cope despite extremely adverse situations. For a couple of women, constant support from their mothers enabled them to resist and to diminish the resulting backlash and mental distress.

ACCESS TO HEALING, HEALTHCARE AND OTHER SUPPORT BY WOMEN

Care and Health seeking trajectories and decisions: The trajectory of care seeking among young women was pre-determined by existing pathways rather than by the needs of the women. Women and their families accessed healing and care that were proximally available and those that were affordable: local healers were perceived as more "socially accessible" compared with the "socially distant" diagnosis and treatment provided by medical practitioners. The healers and some of the local "Bengali" doctors were also willing

to provide care on credit and make visits to the households. Preferred healing and care was also determined by previous experiences of interface with the healthcare system for other health issues. The trajectory of healthcare was also determined by the decisions of family members – particularly so, given that they were young women. Parents, grandparents, older brothers were the decision makers in the case of unmarried women, or married women who had returned to their natal homes for the treatment. Decisions about healthcare for married women were generally made by husbands, parents in law, brothers and sisters in law.

Availability and access to healing and healthcare: Apart from family members, peers, friends and local organizations played important roles in providing psychosocial support. The support of specific members of natal and marital families was emphasised as foremost by the women, in the absence of which implications for coping and care were negative. However, "support" needs further understanding as families were also sources of mental distress; young women's dependence on their families was determined by control of mobility and resources.

The need for spaces that were safe and private where women could have access to information on a range of issues; spaces where they could meet with peers and be able to talk openly about their lives, participate in activities that could build their skills and resilience, seek counselling, etc., emerged very clearly from the research. While the community based organizations working in the area were trying to provide some support, they were also constrained by limited understanding, resources and non-availability of information as well as skilled human resources to facilitate access to mental healthcare and psychosocial services (support groups at community level, counselling, etc.) for young women.

The research flags some critical issues for mental health in the context of young women, particularly in rural locations. The evidence from the research substantiates the need for an understanding of mental health that is beyond the medical / psychiatric domains. While the latter cannot be completely dismissed as it maybe required in some situations, however, a psychiatry-centric response to young women's mental distress tends to suppress the realities that determine their mental health and thereby the strategies for care, healing and support. This understanding is critical to inform strategies for response, including existing and future policy and programmes for young people.

[1]*Gauna is a tradition practiced primarily in the northern states of India in which a young bride lives with her parents until another ceremony is performed, after which time the bride goes to live with her husband*

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