MENTAL HEALTH STATUS OF WOMEN IN KERALA

Thesis submitted to
University of Calicut in partial fulfilment for
the award of the Degree of

DOCTOR OF PHILOSOPHY IN WOMEN'S STUDIES

By

JIJILA M. K.

Under the Guidance of

Dr. Moly Kuruvilla
Senior Professor
Department of Women's Studies
University of Calicut

DEPARTMENT OF WOMEN'S STUDIES
UNIVERSITY OF CALICUT
2024

DECLARATION

I, **Jijila. M.K**., hereby declare that the thesis entitled **"Mental Health Status of Women in Kerala"** submitted to the University of Calicut for the award of the Degree of Doctor of Philosophy in Women's Studies is an original work done by me under the supervision of **Dr. Moly Kuruvilla**, Senior Professor, Department of Women's Studies, University of Calicut. The thesis has not been previously submitted by me or any other person elsewhere for the award of any Degree/Diploma/ Certificate. In all cases, where it is relevant, material from the work of others has been acknowledged, given credit to and referred.

Calicut University
Date:

Jijila. M.K
Research Scholar

DEPARTMENT OF WOMEN'S STUDIES

UNIVERSITY OF CALICUT

Dr. Moly Kuruvilla

Senior Professor (Retd.)

Department of Women's Studies — Mobile No: 9567164007

University of Calicut — Email Id: molykuruvilla14@gmail.com

CERTIFICATE

This is to certify that the suggestions recommended by the adjudicators have been incorporated in the thesis entitled **"Mental Health Status of Women in Kerala"** prepared by **Ms. Jijila. M.K** under my guidance and supervision.

Place: University of Calicut — **Dr. Moly Kuruvilla**

Date: — Supervising Teacher

DEPARTMENT OF WOMEN'S STUDIES

UNIVERSITY OF CALICUT

Dr. Moly Kuruvilla

Senior Professor (Retd.).

Department of Women's Studies

University of Calicut

Mobile No: 9567164007

Email Id: molykuruvilla14@gmail.com

CERTIFICATE

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The suggestions recommended by the examiners have been incorporated in the thesis. The soft copy attached is the same as that of the resubmitted copy.

Place: University of Calicut

Date:

Dr. Moly Kuruvilla

Supervising Teacher

DEPARTMENT OF WOMEN'S STUDIES
UNIVERSITY OF CALICUT

Dr. Moly Kuruvilla
Senior Professor
Department of Women's Studies

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Calicut University
Date:

Dr. Moly Kuruvilla
Supervising Teacher

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University of Calicut
Date: ***Jijila. M.K***

ABSTRACT

This study delves into the paradox of women's mental health in Kerala, a state where women enjoy high societal status as indicated by literacy rate, Infant Mortality Rate (IMR), and Maternal Mortality Rate (MMR), yet suffer from low mental health profiles. Despite the high development indicators, Kerala's women have the highest rates of suicide and antidepressant consumption in India, as reported by the Indian Psychological Association. The research aims to understand the factors contributing to this low mental health status among Kerala's women, using a gender lens and focusing on personal experiences and subjective feelings. It evaluates the mental health landscape of Keralite women and identifies the influencing factors. The research design is both descriptive and exploratory, employing a mixed-method approach for reliable and valid data. A quantitative survey using questionnaire among a sample of 300 married women from three districts of Kerala namely Malappuram, Kollam, and Ernakulam was conducted to assess the mental health status of women. Unstructured interviews with 50 study participants, 25 each from the High and Low Mental Health groups drawn from the initial sample of 300 women, followed by thematic analysis served to identify the factors affecting their mental health. The research strictly adhered to ethical guidelines and pandemic protocols during data collection.

The study reveals that despite a higher proportion of women exhibiting high mental health, a significant number still have low mental health. The mean mental health score level of the sample is comparatively low, just above 50% of the total score. In a state with high education standards and other women's development indicators, a significant proportion of women having low mental health is a matter that needs special attention. Religion and income levels do not significantly impact women's mental health, but a significant difference was found in the mental health of women belonging to different castes and employment status. The research identifies eight major factors to affect the mental health of the study participants. They are gender-based violence, unfulfilled aspirations, lack of economic independence, adjustment issues with husband and in-laws, alcoholism of husband, lack of support

from natal home, lack of confiding relationships and conflicts with patriarchal norms. These sociocultural factors apply to women in both High and Low Mental Health groups, but their frequency and severity differ among the study participants belonging to the two groups. Women with high mental health were also found to adopt a differential approach to distressing incidents in their lives, either accepting them as natural or as societal norms or having an indifferent attitude. Issues like postpartum depression and infertility were found to impact women's mental health at specific periods in their lifetime. Role conflict and ruminating tendencies were also found to be higher among the women with low mental health.

സംഗ്രഹം

ശാരീരികാരോഗ്യം പോലെ തന്നെ പ്രധാനമാണ് മാനസികാരോഗ്യവും. വികസന സൂചികകളായ സാക്ഷരത നിരക്ക്, ശിശു മരണ നിരക്ക്, മാതൃ മരണ നിരക്ക് എന്നിവയിലെല്ലാം സ്ത്രീകൾക്ക് ഉയർന്ന സാമൂഹിക പദവിയാണ് ഉള്ളത്. എന്നാൽ ഇന്ത്യൻ സൈക്കോളജിക്കൽ അസോസിയേഷന്റെ റിപ്പോർട്ട് പ്രകാരം ആത്മഹത്യയുടെയും ആന്റിടിപ്രസ്സെൻറ്കളുടെ ഉപയോഗത്തിന്റെയും ഉയർന്ന നിരക്ക് കേരളത്തിലെ സ്ത്രീകളിലാണ് കണ്ടു വരുന്നത്. വികസന സൂചികയിൽ ഉയർന്ന പദവി ഉണ്ടായിരുന്നിട്ടും കേരളത്തിലെ സ്ത്രീകളുടെ മാനസികാരോഗ്യത്തെ പ്രതികൂലമായി ബാധിക്കുന്ന സാഹചര്യങ്ങളെ പഠനവിധേയമാക്കാനാണ് ഈ പ്രബന്ധത്തിലൂടെ ശ്രമിക്കുന്നത്. കേരളത്തിലെ സ്ത്രീകളുടെ താഴ്ന്ന മാനസികാരോഗ്യത്തിന് കാരണമാകുന്ന ഘടകങ്ങൾ ലിംഗ ലെൻസിലൂടെ, വ്യക്തിപരമായ അനുഭങ്ങളുടെ വെളിച്ചതിലൂടെയും ആത്മനിഷ്ടമായ വികാരങ്ങളിലൂടെയും കണ്ടെത്താനാണ് ഗവേഷണം ലക്ഷ്യമിടുന്നത്. ഇതിലൂടെ സ്ത്രീകളുടെ മാനസികാരോഗ്യത്തെ സ്വാധീനിക്കുന്ന ഘടകങ്ങളെ വിലയിരുത്തുകയും ചെയ്യുന്നു. വിവരണാത്മകവും പര്യവേഷണപരവുമായ രീതിയിലാണ് ഗവേഷണത്തെ രൂപകല്പന ചെയ്തിരിക്കുന്നത്. വിശ്വസനീയവും സാധുതയുള്ളതുമായ വിവര ശേഖരണത്തിനായി സമ്മിശ്ര രീതിയാണ് ഉപയോഗിച്ചിട്ടുള്ളത്. സ്ത്രീകളുടെ മാനസികാരോഗ്യ നില വിലയിരുത്തുന്നതിനായി ക്വാണ്ടിറ്റേറ്റീവ് ചോദ്യാവലി ഉപയോഗിച്ച് സർവേ നടത്തുകയും തുടർന്ന് അവരുടെ മാനസികാരോഗ്യത്തെ ബാധിക്കുന്ന ഘടകങ്ങൾ തിരിച്ചറിയുന്നതിനായി ഘടനരഹിത അഭിമുഖങ്ങൾ നടത്തുകയും ചെയ്തു. ഈ അഭിമുഖത്തിലൂടെ ലഭിച്ച വിവരങ്ങളെ വ്യാഖ്യനിക്കാൻ തീമാറ്റിക് വിശകലന രീതിയാണ് ഉപയോഗിച്ചിട്ടുള്ളത്. കേരളത്തിലെ മലപ്പുറം, കൊല്ലം, എറണാകുളം എന്നീ ജില്ലകളിൽ നിന്നായി 300 വിവാഹിതരായ സ്ത്രീകളെയാണ് പഠനത്തിൽ ഉൾപ്പെടുത്തിയിരിക്കുന്നത്. വിവരശേഖരണ സമയത്ത് ഗവേഷണ നൈതികമായ മാർഗനിർദേശങ്ങളും കോവിഡ് നിയമാവലികളും കർശനമായി പാലിച്ചിരുന്നു.

സ്ത്രീകൾ ഉയർന്ന മാനസികാരോഗ്യം പ്രകടിപ്പിക്കുന്നുണ്ടെങ്കിലും അതിൽ വലിയൊരു വിഭാഗം ഇപ്പോഴും താഴ്ന്ന മാനസികാരോഗ്യ നിലയിൽ തുടരുന്നുണ്ടെന്ന് ഈ പഠനം വെളിപ്പെടുത്തുന്നു. ഈ പഠനത്തിൽ സ്ത്രീകളുടെ ശരാശരി മാനസികാരോഗ്യ

നിലയുടെ സ്കോർ താരതമ്യേനെ കുറവാണ്. അതിനാൽ തന്നെ വിദ്യാഭ്യാസ നിലവാരത്തിലും മറ്റു വികസന സൂചികകളിലും ഉയർന്ന നിലയിൽ തുടരുന്ന ഒരു സംസ്ഥാനത്തിൽ സ്ത്രീകളുടെ ഗണ്യമായ അനുപാതം കുറഞ്ഞ മാനസികാരോഗ്യ നിലക്ക് പ്രത്യേക ശ്രദ്ധ നൽകേണ്ടതുണ്ട്. മതവും കുടുംബത്തിന്റെ വരുമാന നിലയും സ്ത്രീകളുടെ മാനസികാരോഗ്യ നിലയെ ബാധിക്കുന്നില്ല എന്ന് പഠനത്തിൽ കണ്ടെത്തി. എന്നാൽ ജാതിയും സ്ത്രീകളുടെ ജോലിയും മാനസികാരോഗ്യത്തെ ബാധിക്കുന്നതായും പഠനം കണ്ടെത്തി. ലിംഗാധിഷ്ഠിത അക്രമം, പൂർത്തീകരിക്കാനാവാത്ത അഭിലാഷങ്ങൾ, സാമ്പത്തിക സ്വാതന്ത്ര്യം ഇല്ലായ്മ, അമ്മായിഅമ്മമാരുമായുള്ള പൊരുത്തക്കേടുകൾ, പങ്കാളിയുടെ മദ്യപാനം, ജന്മഗൃഹത്തിൽ നിന്നുള്ള പിന്തുണയുടെ അഭാവം, വിശ്വസനീയമായ സുഹൃത്ത് ബന്ധങ്ങളുടെ അഭാവം, പുരുഷാധിപത്യ മാനദണ്ഡങ്ങളുമായുള്ള വൈരുദ്ധ്യങ്ങൾ എന്നിവയെല്ലാം കേരളത്തിലെ സ്ത്രീകളുടെ മാനസികാരോഗ്യത്തെ സാരമായി ബാധിക്കുന്ന ഘടകങ്ങളാണെന്ന് ഗവേഷണത്തിലൂടെ തിരിച്ചറിയുന്നു. ഈ സാമൂഹ്യ സാംസ്കാരിക ഘടകങ്ങൾ ഉയർന്നതും താഴ്ന്നതുമായ മാനസികാരോഗ്യ നിലയിൽ ഉള്ളവർക്കും ബാധകമാണ്. എന്നാൽ അവർ അനുഭവിക്കുന്ന പ്രശ്നങ്ങളുടെ ആവൃത്തിയും തീവ്രതയും വ്യത്യസ്തമാണ്. ഉയർന്ന മാനസിക നിലയുള്ള സ്ത്രീകൾ അവരുടെ ജീവിതത്തിലെ വിഷമകരമായ സംഭവങ്ങളോട് വ്യത്യസ്തമായ സമീപനമാണ് സ്വീകരിക്കുന്നത്. ഒന്നുകിൽ പ്രശ്നങ്ങളെ സ്വാഭാവികമോ സാമൂഹികമോ ആയ മാനദണ്ഡങ്ങളായി അംഗീകരിക്കാൻ ശ്രമിക്കുകയോ അല്ലെങ്കിൽ ഉദാസീനമായ മനോഭാവം സ്വീകരിക്കുകയോ ചെയ്യുന്നു. കൂടാതെ പ്രസവാനന്തര വിഷാദം, വന്ധ്യത, റോൾ കോൺഫ്ലിക്ട്, റൂമിനേഷൻ പ്രവണത തുടങ്ങിയ ഘടകങ്ങളും സ്ത്രീകളുടെ മാനസികാരോഗ്യത്തെ വിപരീതമായി ബാധിക്കുന്നുണ്ടെന്ന് ഗവേഷണം ചൂണ്ടികാണിക്കുന്നു.

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ABBREVIATIONS

MH	-	Mental Health
High MH	-	High Mental Health
Low MH	-	Low Mental Health
GBV	-	Gender-Based Violence
VAW	-	Violence Against Women
SRH	-	Sexual and Reproductive Health
SRHR	-	Sexual and Reproductive Health Rights
DV	-	Domestic Violence
FGM	-	Female Gentile Mutilation
PPD	-	Postpartum Depression
IPV	-	Intimate Partner Violence

Chapter I
INTRODUCTION

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In every country, women represent the cornerstone of the overall health of a family with a widespread perception that women can improve the health of children and other family members. Women's health and access to healthcare on the other hand are significantly influenced by social, economic, and political variables, which make gender one of the key socioeconomic determinants of health. As a result, the high level of gender disparity in developing nations like India severely impacts women's health. The 2030 Agenda recognizes the intricate relationship and interdependence between sustainable development and good health. Ensuring healthy lives and promoting well-being for all people of all ages is the goal of SDG 3. It considers growing economic and social disparities, accelerating urbanisation, environmental and climate change risks, the ongoing prevalence of HIV and other infectious diseases, and new issues such as non-communicable diseases. The attainment of SDG 3, which aims to eradicate poverty and reduce inequality, will need universal health care. However, the world is not on track to meet the SDGs relating to health. Both within and between the countries, there has been unequal progress. The countries with the shortest and longest life spans differ by 31 years in terms of life expectancy. Furthermore, national averages conceal the fact that many nations are falling behind, even while some have made remarkable progress. Approaches that are multisectoral, rights-based, and gender-sensitive are necessary to address disparities and promote everyone's health (UNDP, 2021).

The Global Gender Gap Report (2023) reveals that India is ranked 127 out of 146 nations in terms of gender parity. A lopsided sex ratio at birth, according to the report explains India's relatively poor overall score on the health and survival subindex at 142nd position. In 2022, India was the worst performer in the world in the health and survival index with 146th position out of 146 countries. Anyhow these rankings reveal the poor condition of India’s health system. The significance of mental health in this context is yet another reality. Every human being needs to be in good

health and the importance of mental health is therefore equal to that of physical health. If a person is happier, the more his/her body experiences that happiness. Even minor physical difficulties might leave one psychologically worn out. Therefore, a person can only be considered healthy if he/she has both good mental and physical health. It is a scientifically proven fact that when a person has good mental health, she/he feels good about her/himself will be comfortable around other people, and will also take charge of her/his life to meet its demands. According to WHO (2014), mental health is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community". Mental health is a positive concept linked to the individual's social, emotional, and psychological well-being. The concept of mental health is culturally defined but generally relates to the enjoyment of life, the capacity to cope with sorrows and sadness, the fulfilment of goals and potentials, and a sense of connection to others (UN, Nd.). Therefore, mental health is an important aspect of an individual's as well as social well-being.

1.1.History of Women's Mental Health

Throughout history, women have been considered more susceptible to mental illness or emotional breakdowns than men. Existing stereotypes in families and the patriarchal societal norms have contributed to the perception that women are more fragile and mentally weaker. Prior to the mid-nineteenth century, women who suffered from depression or mental illness were thought to have a disease in their soul or a form of evil for which there was no cure. These women were dragged to insane asylums and frequently treated worse than animals, being kept in cages and filth, given a limited amount of food, and often having little or no human contact (Dix, 1843). Finally, reforms came and attitudes toward mental illness began to shift gradually. Those suffering from severe depression or other forms of mental illness were no longer thought to be suffering simply because God had ordered it, but as a result of a diseased brain that could often be cured or at least treated. Hysteria, anorexia nervosa, and neurasthenia were among the new diagnoses, almost all of which were exclusively attributed to women. In the psychiatrists' eyes none of these were treated equally.

Nervosa anorexia was considered a more self-sacrificing and feminine disease, whereas hysteria was frequently regarded as selfish and destructive, a form of rebellion that doctors did not approve of (Showalter, 1985). However, female doctors were not permitted to practice until 1847 when Elizabeth Blackwell turned up to be the first woman to graduate from medical school and enter the profession. As a result, women were treated exclusively by men, as in the first half of the century. Even after this, the psychiatry profession was completely male-dominated until 1894, and they did not allow female doctors to join the Medico-Psychological Association (Srinivasa et al., 2015).

New approaches to women's psychological health have emerged in the wake of the revitalised women's movement. Since 1970, there has been a public recognition of a separate force that impacts women and men in Western societies. National and international organisations were formed to address inequalities in the treatment of women's physical and psychological problems and to effect radical change.

Emergent client populations were discovered in areas where problems were previously invisible and were not thought to exist. The difficulties encountered by these new client populations prompted the development of theories, research, and procedures to address their concerns. A group of women, both in the lay and professional communities, have worked together to create new agendas for treating and promoting women's mental health. The foundation for these agendas is rooted in the history and expansion of feminism.

1.2.Changing Perspectives on Mental Health

Once the shift began with feminist activism, women who had formerly been confined to cages in mental asylums and treated worse than animals started being well-fed, given shoes and clothing, and finally, removed from their chains. The mid-nineteenth century saw a rush of doctors studying mental health issues and experimenting on mentally ill patients. Doctors of this era believed women were likely to develop mental illness more, especially if they attempted to improve their situation by seeking education or engaging in "too many activities". Should a woman, during the Victorian era, have an outburst due to repression, sheer unhappiness, or discontent,

she was labelled "mad." Women who expressed any type of opinion outside the normal role of women at the time were believed to have hysteria and were put on bed rest, seclusion, a diet of bland food, and were ordered to refrain from mental activities such as reading. This solitary confinement frequently pushed the woman, who was merely irritated, to the point where she could be considered mentally ill. In short, women's "mental illness" during this period was regarded as an empowerment expression of men who were afraid of intellectual women. Women were constantly pressured to conform to the stereotype of the passive housewife, and those who resisted or questioned it were labelled hysterical or insane and sent to an asylum.

In the field of mental health, the consideration of sex, gender, and cultural diversity in the prevalence, aetiology, diagnosis, and treatment of a range of human problems was conspicuously absent until recently. A report on psychosocial factors and mental health of women, published by the WHO in 1992, explained in depth, the link between the increased prevalence of mental health issues in women and their vulnerable location in a patriarchal society. Two epidemiological surveys of community samples sponsored by the National Institute of Mental Health (NIMH, 2011) in the United States revealed that a high proportion of individuals with signs of depression, anxiety, panic, simple phobia, and agoraphobia are women, whereas men are overrepresented in the categories of substance abuse and antisocial behaviour. According to this survey (NIMH), the overall health and community mental health utilization values are higher for women than men in the United States.

New scholarship and research on the psychology of women in the past few decades have introduced the 'second sex' into the medical and psychological literature and brought the life span issue of women into sharper focus. The social construction of gender relocated the problem of women from individual to societal and external. The feminist construction of gender redefines the nature of the relationship between women and men in terms of expression and the maintenance of power. The multicultural construction of gender identified the intersection of gender, ethnicity, socioeconomic class, and sexual orientation that shapes personal and social identities.

The changes that have transpired in the past many years hold enormous implications for the ways in which psychological interventions with women take place.

Today, women's depression is frequently portrayed as a reflection of the overall meaning of their lives. Although women are diagnosed with depression nearly twice as often as men, it is generally considered as a by-product of low social status, the legal and economic discrimination of women, and traditional role expectations. The question of women has proved that biological, developmental, and social variables are not independent. Between distress and disease, there is a threshold area, not just a thin line.

1.3. Gender Difference in Mental Health

Gender is a critical determinant of mental health and mental illness. The morbidity linked to mental illness has garnered far more attention than the mechanisms and variables that are distinctive to a person's gender and that support and safeguard mental health. The socioeconomic factors that affect women's and men's mental health and well-being, as well as their social standing, treatment in society, and vulnerability to certain mental health hazards, are determined by their gender. Gender disparities are especially noticeable in the prevalence of common mental illnesses such as anxiety, depression, and physical ailments. Gender disparities are especially noticeable in the prevalence of common mental illnesses such as anxiety, depression, and physical ailments. Roughly one in three members of the population is impacted by these disorders, which are mostly affecting women, and they represent a significant public health issue (Malhotra & Shah, 2015). Women are twice as likely as males to experience unipolar depression, which is expected to be the second largest source of disability burden worldwide. As WHO (2000) has observed, depression is not only the most prevalent mental health issue in women, but it may also persist longer in them than in males.

Women are more affected than men are by depression, anxiety, psychological discomfort, sexual and domestic violence, and rising rates of substance abuse in different nations and contexts. Women's low mental health is partly explained by the pressures imposed by their many duties, gender discrimination, and related problems

such as poverty, hunger, malnutrition, overwork, DV, and sexual abuse. The prevalence and severity of mental health issues in women are positively correlated with the presence of these social factors. Depressive symptoms can also be predicted by traumatic life events that leave a person feeling helpless, inferior, humiliated, or entrapped. Hence, gender differences exist in patterns of extended psychological disorder (Kuruvilla, 2021). Women are more likely to ask for help from primary health care and disclose mental health problems to their primary healthcare physician, while men are more likely to seek MH specialists and are the main users of inpatient care (Doherty &O'Doherty, 2010).

A gender-sensitised approach to health entails identifying biological and social variables, examining how they interact, and paying attention to the ways in which gender inequality impacts health outcomes. It also offers direction for determining the proper reactions from public policy and the mental health care system. Even in areas with a less pronounced socioeconomic gradient, gender disparities are evident. Gender analysis raises the possibility of increased public involvement in health care by improving knowledge of the epidemiology of mental health issues, decisions, and treatments of these problems among underreported populations (Afifi, 2007). Like other stratifiers, gender is not an independent construct. It interacts additively or multiplicatively with racial and class markers, among other social markers (Vlassoff & Moreno, 2002). It seems that gender preconceptions about the likelihood that women will experience emotional difficulties and males will experience drinking problems limit people's ability to seek treatment in a traditional way and perpetuate societal stigma. They act as an obstacle to correctly diagnosing and treating psychological problems (WHO, 2006). When considering mental health from a gender perspective, action must be taken to increase women's access to, affordability of, and suitability of health treatments.

1.4.Gender Difference in Factors Affecting Mental Health

The literature review reveals several factors influencing the mental health of girls and women which are not applicable in the case of boys and men. The majority of these factors are sociological while only a few of them are biological. Sociocultural

factors include restricted mobility (Adeel, 2016; Carpio-Arias, 2022; Pennington et al., 2018; Rask et al., 2015), unfulfilled aspirations (Johnstone & Lucke, 2022; King, 2014; Sendroiu et al., 2021), lack of decision-making power even in personal matters (Ahinkorah et al., 2018; Ghaffari, 2019; Neil & Domingo, 2015), lack of self-esteem (Gebauer et al., 2013; Gold, 2016; Murti, 2020; Orth & Robins, 2014; Rosenberg & Owen, 2001), gender division of labour (Cohen, 2004; Drake, 2022; Ervin, 2022; Hyde, 2020; Suero, 2023; Seedat & Rondon, 2021; Xue & McMunn, 2021), gender based violence (Hossain et al., 2020; Sewalem & Molla, 2022; The World Bank, 2019; UNFPA, 2017), not being able to open up feelings and nobody to rely upon (Mushtaq et al., 2014; Ortiz-Ospina, 2020), alcoholism of husbands (Dostanic et al., 2022; Jeyaseelan et al., 2007; Satyanarayana et al., 2010; Sharma et al., 2016; UN Women, 2020), etc. Intimate partner violence (Kamimura, 2014; Mukhopadhyay, 2007; Nayak et al., 2010; WHO, 2022; WHO, 2021), marital rape (Agarwal et al., 2022; ETV Bharat National, 2020; Gahleitner, 2015; Thakur & Rangaswamy, 2019), economic dependency (Dhungel et al., 2017; Mehta et al., 2016; Villa, 2017; Yadavar, 2018), etc. are also quoted by authors worldwide as factors affecting the mental health of women. Postpartum depression (Arora & Bhan 2016; Bara, 2021; Joseph et al., 2016; Patel, 2012; The Times of India, 2020;**),** infertility (Akyuz et al., 2010; Cousineau & Domar, 2007; Damti et al., 2008; Gulseren et al., 2006; Rasool, 2015) and menopause (Bromberger et al., 2011; Freeman, 2010; Harvard Health Publishing, 2020; Peisley, 2017; Woods et al., 2008) are found to be the biological factors affecting mental health of women.

1.5.Approaches to Mental Health in India

In 1975, India launched an initiative to integrate mental health with general health services. The Ministry of Health, Government of India formulated the National Mental Health Programme (NMHP) in 1982. The same was reviewed in 1995, and the District Mental Health Program (DMHP) was launched in 1996, with the goal of integrating mental health care with public health care. This model has been implemented in all states, and currently, there are 692 DMHP sites in India. Mental health care services have been integrated into general health care services like

National Health Mission, PMSSY, Rashtriya Kishore Swasthya Karyakram, AYUSHMAN Bharat, PMJAY, etc. (Ministry of Health and Family Welfare, 2021).

Women in India lead their lives in a patriarchal societal setting. There are so many dos and don'ts in society, especially for women, that restrict them at every stage of their life (Roy, 2022) These patriarchal restrictions affect women's mental health, and many women have started questioning the underlying culture and practices (Gupta et al., 2023). There are many women who have no proper education, employment, mobility, or economic independence. Many Indian women have no right to express their opinions even in their homes. Still, men are the decision-makers in almost every family in India except female-headed households, especially in rural areas. Starting at puberty, young women are at the greatest risk for major depression and mental disorders globally (Whiteford et al., 2016). Married women in India are at an increased risk for depression, and it is important to identify factors that explain the experiences of the mental health of women folk (Steelman, 2007). In this context, it is to be noted that around two-thirds of married women in India are victims of DV (UNFPA, 2017). Girls from nuclear families and women who are married at a very young age have a higher risk of suicide and self-harm (Malhotra & Shah, 2015). But still, the mental health of women is an ignored topic, and the mental health issues among women are often normalized.

In April 2017, the Mental Health Care Act was passed in India, which brought in some revolutionary changes in society. Persons suffering from mental health issues have been afforded freedom and rights to choose the type of medical treatment, where they would like to be treated, and the duration of their treatment. They now also have the right to stay in the community instead of being confined to an establishment, to hold a job, to health insurance, and to live with dignity. This is a commendable attempt to reduce the stigma related to mental health. Affording equal rights to the mentally ill, irrespective of their gender, class, religion, region, and even sexual orientation, is another step in the right direction. Even though some sections of the act have been criticized, it is still more humane and appropriate in the current scenario. Perhaps,

with future amendments in some necessary areas, this act can prove to be a blessing to the mental health care system (Jagadhish et al., 2019).

1.6.Mental Health of Women: The Global Scenario

Women's mental health is a serious unconcerned issue worldwide. There are so many psychological problems that affect the lives of people, and their impacts vary by place, culture, lifestyle, etc. The UN has included mental health in its SDGs as depression is one of the major global health problems today. Around 280 million individuals in the world are reported to have depression. It is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. Especially when recurrent and with moderate or severe intensity, depression may become a serious health condition. It can cause the person to be in pain greatly and function badly at work, school, and in the family. At its worst, depression can lead a person to suicide. Over 700,000 people die due to suicide every year. Suicide is the fourth leading reason of death in 15–29-year-olds (WHO, 2021). In accordance with a new estimate, the COVID-19 pandemic drastically increased the prevalence of depression and anxiety disorders globally in 2020. An extra 53.2 million and 76.2 million instances of anxiety and major depressive disorders, respectively, were added to the overall increase in mental disorders (COVID-19 Mental Disorders Collaborators, 2021). In addition, depression is currently the third most common disease in the world and is expected to overtake all other diseases by 2030 (UN, Nd). However, more women than men have mental illnesses (Saloni et al., 2023). Over the course of their lives, women are nearly 50% more likely than males to experience depressive and anxiety disorders, whereas men are more likely to develop a substance use disorder overall, almost more women than males live with a mental problem since depressive and anxiety disorders make up the majority of instances of mental distresses (Pan American Health Organisation, 2019).

The COVID-19 pandemic was factored into the Global Burden of Disease 2020 estimations, which took into consideration many of the limitations surrounding epidemiological estimates of mental disorders in significant events. While international organisations are also becoming more and more interested in mental

health, they have also played an important role in raising awareness of it as a pertinent issue, particularly through their flagship publications like UNICEF's report on mental health for the 2021 State of the World's Children (UNICEF, 2021). Before the pandemic, 298 million individuals in 2020 were predicted to have anxiety disorders and 193 million people to have serious depressive disorders. Initial projections reveal an increase to 246 million for major depressive disorders and 374 million for anxiety disorders after accounting for the COVID-19 pandemic (COVID-19 Mental Disorders Collaborators, 2021). Another study observes that in both situations, the countries that were hit hardest by the pandemic had the greatest increase in disorder prevalence. All over the world, there was a greater increase in disorder prevalence among females than among males, likely because females were more likely to be affected by the social and economic consequences of the pandemic. Globally there was also a greater change in prevalence among younger age groups than older ones, potentially reflecting the deep impact of school closures and social restrictions on youth mental health (Health World, 2022). The global threats to mental health are major structural stressors with the potential to slow worldwide progress toward improved well-being. They affect whole populations and so can undermine the mental health of huge numbers of people. The key threats include economic downturns and social polarization, public health emergencies, widespread humanitarian emergencies, forced displacement, and the growing climate crisis (Pan American Health Organization, 2019). The historic conventions and global goals, such as the Convention on the Rights of Persons with Disabilities (UN, 2022), The SDGs, and Universal Health Coverage (WHO, 2021), have given countries, further critical impetus to transform and improve mental health. However, with regard to physical health, mental health is influenced by a wide range of social, political, and economic factors. These include social and economic disadvantage and deprivation, low levels of education, unemployment or insecure employment, discrimination, and violence (Roberts, 2018).

Mental health issues in turn impact other issues such as alcohol and substance misuse, abuse, and gender-based violence. Failure to address mental health issues, therefore, has consequences for society as a whole. The measures of body image, role performance, discrimination, and social class position are related to mental health

status. Women of lower social classes are especially at risk for low mental health outcomes. Having low educational attainment, low personal income, and less prestigious occupations are associated with a poor self-concept (self-esteem and self-efficacy). Women with low self-concepts, in turn, report low mental health globally. Researchers argue that African American women face multi-layered realities that may compromise their ability to handle the stresses of everyday life (Jackson & Mustillo, 2001). Low mental health in women has a number of causes. These include the sociocultural notions of women as the weaker sex (Ahmad, 2020; Kuruvilla, 2020; Zoellner & Hedlund, 2010) hormonal imbalances (Bansal, 2022; Basile, 2022; Borst, 2022; Mahindra, 2022; Spizeman, 2020), gender-based violence (Hossain et al., 2020; Sewalem & Molla, 2022; The World Bank, 2019), abuse (Office on Women's Health, 2021; Plumptre, 2021) and poverty (Cardoso et al., 2021, Pryor et al., 2016; Smith & Mazure, 2021). The most common forms of violence against women are domestic abuse and sexual violence. Victimization is associated with a high risk of mental disorders worldwide. Despite clinical guidance on the role of mental health professionals in identifying violence against women and responding appropriately, poor identification persists and can lead to non-engagement with services and poor response to treatment. However mental health services could perform a major role in the primary and secondary prevention of violence against women.

Violence can also happen within the family and because of the family members. Though serious depression episodes and suicidal thoughts are more common in Brazilian women. They experience greater violence from friends or family, which partially mediates this link. Intimate partner violence is associated with depression, but it is also associated with self-harm, which is a group that mainly consists of suicide deaths. Intimate partner violence accounts for 23 percent of depression in women aged 30 to 35. Another major risk factor for depression in women is childhood sexual abuse. Overall, childhood sexual abuse accounted for approximately six percent of the total female burden of depression in 2010, and an estimated seven percent of the burden among 15-19-year-old women (WHO, 2013).

Mental health problems are repeatedly under-recognized and stigmatized but tackling them is essential for improving the lives of women worldwide. In almost every country, both men and women can suffer from mental health and drug use disorders; nevertheless, when examining specific disorders related to these conditions, gender patterns are rather consistent. Women are more likely than men to suffer from the majority of mental illnesses, such as eating disorders, anxiety, bipolar disorder, and depression. It seems that most of the countries follow this pattern. The estimated ratio of male to female depression patients indicates that women are thought to have a higher prevalence of depression than men. Eating disorders, bipolar disorders, and anxiety disorders all fall under this category.

1.7.Mental Health of Women: The Indian Context

In a country like India, where patriarchal norms are immensely visible in many forms, customs and rituals have an influence on the mental health of women, who are always in a secondary status. The most interesting thing is that the studies related to the mental health of women in India are comparatively fewer and ignore the gender dimensions, focusing only on the psychological aspects. According to WHO research for the NCMH (National Care of Medical Health), there are no appreciable differences between urban and rural settings in the prevalence of major mental disorders in India, which stands at least 6.5% of the population. Despite the availability of efficient interventions and therapies, mental health professionals such as psychologists, psychiatrists, and physicians are in severe shortage. According to a 2014 estimate, it was as low as "one in 100,000 people." In India, the average suicide rate is 10.9 per 1 lakh individuals, with most suicide victims being younger than 44 (India Today, 2018). Although whenever the health needs of women are addressed in society, it is confined to physical and, at the most, reproductive health. Women's ability to perform their gender roles and duties is central to their familial and social construction of health. The concept of health for women is functional, while the concept of illness is substantive. However, women talk about health as a condition in which they can do their work well. For women, illness means when they have to meet a doctor. In these

circumstances, health is social while illness is physical. It was observed that the health needs of women in India have a history of negligence.

Due to their constant subordination, Indian women have a tendency to disregard their physical and emotional well-being. Reproductive health is always brought up when discussing health issues. The requirements of Indian women in terms of mental health have received very little attention. In accordance with estimations from the World Health Organisation (2004), by 2020, women's mental health issues particularly in the Indian context will account for the second-highest share of the global disease burden. Given that one in three women globally suffers from common mental illnesses like depression, women's mental health is undoubtedly a major concern. Understanding how deeply ingrained mental health is in a person's social and economic ties is realized by examining the psychological construct of mental health. Since gender-based discrimination affects women everywhere at every stage of their life, there is a significant worry for their psychological health. Given the seriousness of the situation, immediate corrective action, including identifying the root causes of psychological disorders in women, implementing a gender-sensitive strategy, promoting women's empowerment, and developing women-friendly health policies, could significantly improve the mental health of Indian women.

Unlike in the West, in India, family is the key resource for good mental health. In India, overwhelmingly, families adhere to a patriarchal ideology, follow the patrilineal rule of descent, are patrilocal, have family value orientations, and endorse traditional gender role preferences. Women are required to practice greater formalities in the constrictive joint family setting. The family's requirement that everyone submit to the elder's authority causes interpersonal maladjustment. The various gender roles that a girl or woman plays in society affect her mental health differently. In India, rather than going to doctors, those who suffer from serious mental health issues frequently turn to temples and shrines (Hussain, 2021). In rural places, there is a severe problem with mental health where many people think that spirits, devils, and ghosts are to blame for their mental illness symptoms. Consequently, it is believed that religious, magical, and other traditional methods by God, men, and traditional

healers can elevate the symptoms. The basis of these structures has to be examined in the context of the oppressive social structures in which there is widespread illiteracy and ignorance (Vajpayee &Makkar, 2016). India has a lot of false religious beliefs and superstitions, and the religious people strictly follow these kinds of traditional activities in their lives.

However, in the light of United Nations research from 2005, two-thirds of married women in India are victims of domestic violence, and one instance of violence costs a woman seven working days in the nation. Additionally, rapes, beatings, and forced sex are reported to have occurred in 70% of married women between the ages of 15 and 49. Indian women are frequently victims of sexual trafficking, mental and physical abuse, dowry death or harassment, female feticide, domestic violence, and public humiliation. Women's reproductive duties, including the pressure to have children, the effects of infertility, and the inability to have a male child, have been connected to suicides in women and wife battering (Malhotra & Shah, 2015). Domestic violence is a prominent factor in the low mental health status of women in India (Sharma et al., 2019). However, widowhood brings high mental issues in Indian women. They are forced to discontinue eating with others in the family and indulge in increased religious activities. Even though in all societal settings, widows were battered and abused, the prevalence was especially high in urban settings. The majority of widows were denied the decision-making role within the family settings. Some of them complained about the lack of property rights. Even though most of the widows who attended any social or family functions, suffered discrimination. The younger widows protect themselves against their sexuality and social misrepresentation or abuse of it. They engaged themselves in greater isolation in religious activities (Sandhya, 1994).

Across the world, studies in India have shown usual mental disorders like depression and anxiety are strongly associated with female gender and poverty. Women are two - to three times more likely than men to be affected by ordinary mental disorders (Malhotra & Shah, 2015). Women may be more susceptible to depression due in large part to hormones associated with the reproductive cycle. Indicators of

gender disadvantage are variables that are independently linked to the risk of common mental diseases. Among these are heavy drinking by partners, physical or sexual abuse by the partner, being divorced or widowed, having little control over decisions, and receiving little support from relatives (Nayak et al., 2010). In fact, mental health issues are highly visible in every stage of the lives of women in India, but they do not talk about mental health as an issue related to wellness. However, Common Mental Disorders (CMDs) such as somatization and anxiety are prevalent in general practice. These are twice as common among women in Kerala (Babu et al., 2019). The status of being single, adverse life circumstances, diabetes, sleep problems, and a history of drug use are reported to be independent determinants of anxiety (Babu et al., 2019).

1.8.Need and Significance of the Study

Women in Kerala enjoy high status as per the development indicators such as literacy rate, IMR (Infant Mortality Rate), MMR (Maternal Mortality Rate), etc., but their mental health status is comparatively low. As reported by Suchitra (2004), Kerala women suffer from mental disorders mainly due to social, economic, cultural, and gender-related stresses (Damodaran, 2016; Eapen, 2002; Joseph et al., 2021; Kodoth & Eapen, 2005; Kumar & Devi, 2010; National Mental Health Survey, 2017; Suchitra, 2004). There is a visible increase in the number of women going to psychiatrists with depression and other psychic disorders caused by social and economic reasons (Mohammed et al., 2002). A field survey of stress among Keralites in 2002 shows that 69.19 per cent of stress arises from financial problems, which ranks first, followed by anxiety-related issues and health problems. To overcome mental disorders, mental empowerment is needed for depressed persons. The proportion of the elderly population in India is increasing and is the highest in Kerala. In an effort to review and modify the existing old age policy, the state government deliberated on the need for elderly-centered research. Depression, anxiety, insomnia, somatization, and dementia are the commonly reported mental health issues in elderly people, especially those who are institutionalized (Indu et al., 2018; Joseph, 2021). Loneliness, isolation, neglect, and elder abuse were the major psychosocial issues identified (Linshi & Kuruvilla, 2015). Poor social activities, lack of interactions, and poor utilization of

mental health services were also observed. The caregiver burden was found to be high and the available family support services were reported to be inadequate. (Indu et al., 2018). There is a need to improve the accessibility, availability, and standard of mental health services and family support services for the elderly.

A broad review of the related literature shows that a lot of studies have been conducted in the area of mental health. More studies are from a general perspective or a psychological perspective. According to the survey on mental health conducted by the Institute of Social Studies (2002), women in Kerala experience higher degrees of mental stress and anxiety and lower mental well-being compared to men. The findings of the survey also indicate that the level of psychological well-being declines as people grow older, for both males and females. The difference in mental well-being between men and women is marked in the age groups of 25–34 and 55+. Every study consciously ignores the actual situation of the mental health of women, whereby they conclude it is on par with men. The Kerala State Mental Health Authority draws a poignant picture of the state, which has an increasing trend in suicides among females between the ages of 15–29 years (KSMHA, 2009). In order to comprehend the increasing mental torment among women in Kerala, Eapen, (2002) has attempted to investigate the social reasons, which are predominantly expressed in the oppressive gender roles and authorities, the structures that perpetuate subjugation of women. In conclusion, there is a need to investigate Keralite women's mental health issues due to the growing inconsistencies in social development between the state of women's physical health, which is very high, and the alarming rise in female suicides, which is a sign of severe mental distress.

In a survey on mental health in Kerala (KMHS, 2002), what comes out strongly from the data is that the level of mental distress is high in Kerala for both men and women and that it is consistently higher for women as different to men. The women in the sample also appeared to subscribe to patriarchal ideology to a greater extent than men. The most interesting is the result that subscribing to a patriarchal gender ideology is a much more potent (statistically significant) explanation for mental stress in women than in men (Mukhopadhyay, 2007). The results of the

multiple regression analysis reported by Mukhopadhyay (2007) also referred to stable statistical associations between a patriarchal gender ideology and higher levels of mental stress and anxiety in women. The low work participation rate among women despite their higher education standards and the higher alcohol consumption rate among men in Kerala (Varma, 2017) coupled with the lack of decision-making power of women, are potential factors likely to contribute to the low mental health profiles of women in the state (Kermode et al., 2007).

According to the KSMH Survey Report (2017), about 14.4 per cent of the population aged 18 and above in Kerala have suffered from a psychic disorder once in their lifetime. The survey was conducted by IMHANS under the guidance of experts from the National Institute for Mental Health and Neurosciences (NIMHANS), the key player in the national survey. Though Kerala has a better health care system, about 11.36 per cent of the total population is affected by mental disorders, including schizophrenia and other depressive disorders. As per the report, the prevalence of serious mental disorders in the state is 0.44 per cent. A threatening result of the report is that the suicide risk in the state has reached 12.6 per cent, which requires urgent attention. The double-digit status is almost double the national figure of six per cent. The report observes that though the state has a mental health policy, it does not have an action plan. Also, the report highlights the poor ratio of the available number of psychiatrists to patients. According to the report, there are only 1.2 psychiatrists for every one lakh patients in the state. The availability of clinical psychologists is 0.62 and psychiatric social workers is 0.04, for one lakh patients. In-depth studies are required in this regard to form valid conclusions regarding the mental health status of women in Kerala and the factors contributing to it.

1.9. Statement of the Problem

The present investigation is an attempt to assess the mental health status of Kerala women and identify the various factors contributing to it. Various factors, like domestic violence, intimate partner violence, alcoholism of husbands, economic dependency, unfulfilled aspirations, lack of decision-making power, infertility, postpartum depression, menopause, etc., affect the mental health of women in general.

How far these findings are applicable in the case of Keralite women has to be examined. An effort was also made to compare the mental health status of women belonging to different groups based on classificatory variables like religion, income level, caste, and employment status. A review of the related literature shows that a lot of studies have been done in the area of mental health, either from a general perspective or a psychological perspective. Studies with a gender perspective are very limited in the area of mental health. The state of Kerala has a high status with regard to women's development indicators compared to their counterparts elsewhere in the country. However, the Indian Psychological Association has been warning against the low mental health profiles of women in Kerala with high suicidal rates and consumption of antidepressants. So, the reasons for the low mental health status of Kerala women is a matter that demands immediate exploratory research.

1.10. The Research Questions

The present study was taken up to answer the following research questions:

- What will be the present mental health status of women in Kerala?
- Will there be a significant difference in the mental health status of women belonging to different sub-samples formed on the basis of classificatory variables like religion, income level, caste and employment status?
- Will paid employment and economic independence improve the mental health of women?
- Is alcohol dependency of men a significant factor that adversely affects the mental health of women?
- Whether domestic violence has a toll on the mental health of women?
- What are the major factors that affect the mental health of women in Kerala?

1.11. Objectives of the Study

The objectives of the present study are the following:

- To assess the mental health status of women in Kerala for the total sample and the sub-samples formed on the basis of classificatory variables like religion, income level, caste and employment status.
- To compare the mental health of women in Kerala belonging to different groups formed on the basis of the classificatory variables.
- To explore the factors affecting the mental health status of women in Kerala.
- To suggest measures that would enhance the mental health of women in Kerala.

1.12. Methodology

The study is designed as both descriptive and exploratory. A mixed method was followed to get valid and reliable data and results.

Sample

The population for the study consists of all married women in Kerala. The sample consists of 300 married women from three districts of Kerala namely Malappuram, Ernakulam and Kollam within the age group of 25 to 45. Single women and aged women were not included in the present study to focus more on the classificatory variables and their impact on the mental health of women in reproductively active age groups. The literature review revealed that married women have more responsibilities at home and require more adjustment with their husbands and in-laws than single women (Malhotra & Shah, 2015). Hence, the present study focused only on the mental health status of married women.

Tools Used

The data necessary for the study was collected from both primary and secondary sources. The primary data was collected using the WHO Ten Wellbeing

Index, a mental health scale. The factors contributing to mental health were collected from interviews with 25 women each, belonging to each subgroup formed on the basis of the classificatory variables studied (religion, income level, caste, and employment status). Secondary data was collected from published journals, reports, books, and statistics.

Analysis Techniques Employed

The data collected according to the above-mentioned methods was analyzed both qualitatively and quantitatively. The first part of the study was to analyze the mental health status of women. Statistical techniques were used to analyze the mental health status of the total sample and the sub-samples formed based on the classificatory variables. The investigator used qualitative techniques to identify the factors affecting the mental health of women in Kerala.

1.13. Scope and Limitations of the Study

Scope of the Study

Everyone's mental health is vital, but for women, gender has a significant role in defining that health. Women have historically been treated as inferiors and as the main homemakers in their families. Women experience mental health problems significantly more frequently than men across the world. Numerous psychological researches have been conducted in this context, but there is very little focus on the sociocultural factors that have an impact on women's mental health. In a state like Kerala, where development metrics are consistently high, the mental health profiles for women remain low which needs serious attention and focus. There have been very few studies in the field of mental health done with a gender lens. The study also examines the factors influencing women's mental health in Kerala. This report is expected to spark an additional investigation on the topic and provide insights into how the government should formulate its policies.

Limitations Identified

This study was limited to only three districts, due to the COVID-19 situation. Moreover, only married women in the reproductively active age group were included in the study as the focus was on exploring the factors affecting the mental health of women in married relations and that too living together with the husband and in-laws. The interpersonal relations and support extended by husbands needed to be examined. Those with young children face challenges related to childcare and upbringing where the sharing of house chores and equal parenting become inevitable for individual and familial wellbeing. Thus, single, divorced, deserted and women whose husbands have migrated were not included in the study. Elderly women who face lots of mental health issues were also not included.

1.14. Chapterisation of the Report

The whole study report is presented in five chapters.

Chapter 1 – Introduction: This chapter discusses in detail the rationale for undertaking the study. It also discusses the global scenario and Indian context of women's mental health, a statement of the problem, the research questions, and objectives of the study, a brief description of the methodology, the scope and limitations of the study and the chapterisation of the thesis.

Chapter 2 – Review of Literature: This chapter includes two parts; A theoretical overview of the topic as well as a review of previous studies conducted in the global and national contexts. The theoretical section offers the necessary theoretical information. This aids in gaining a greater comprehension of the arguments developed from the body of existing literature.

Chapter 3- Methodology: This chapter provides the methods employed throughout the thesis. It discusses the choice of the research approach, the profile of the area of the study, a detailed description of the sample, the tool, the data collection procedure, analysis techniques used, and ethical considerations. Laying the foundation for the thesis provides a greater understanding of the research activity.

Chapter 4- Analysis I- Mental Health Status of Women in Kerala: This chapter constitutes a detailed analysis of the quantitative data and the integrated empirical findings of the study.

Chapter 5- Analysis II-Factors Affecting the Mental Health of Women: This chapter constitutes a detailed thematic analysis of the qualitative data and the factors contributing to the mental health of women.

Chapter 6- Conclusion and Suggestions: The thesis is concluded in this chapter by creating a summary of all the information from the preceding chapters. Based on the study's findings, recommendations for future investigations and suggestions for improving the mental health of women are presented in this chapter.

Chapter 2
REVIEW OF RELATED LITERATURE

CHAPTER II
REVIEW OF RELATED LITERATURE

This chapter is designed to provide an overview of the sources that have been explored while researching the topic. Researchers from all over the world have recently done a number of studies on the status of women's mental health and the associated factors influencing it. Yet there are only too few studies on the particular problems with women's mental health conducted from a gender perspective. Theoretical explanations of women's mental health, factors influencing women's mental health status, and the status of women's mental health in the context of the global, national, and regional levels of society are also covered in this chapter.

2.1. Theoretical Overview on Mental Health

2.1.1. Concept of Mental Health

Mental health as the ability that helps us to seek adjustment in the difficult situations of life (Cutts & Moslay, 1941). However, Menninger (1945) defines "mental health as the adjustment of human beings to the world and each other with-a maximum of effectiveness and happiness. It is the ability to maintain an even temper, an alert intelligence, socially considerate behavior, and a happy disposition (Menninger, 1945, p.3)." Here, Hadfield (1950) defines mental health as the full and harmonious functioning of the whole personality while Jahoda (1958) has highlighted the adjustment component of human beings to the world and to each other with a maximum of fruitfulness and happiness for mental health. Not just efficiency, or just contentment, or the ease of obeying the rules of the game happily. It is all of these together and it is the capacity to manage temper, alert intelligence, socially considerate behavior, and a happy disposition. Carter et al. (1959) defined mental health as the absence of mental disease, and as a state of wellbeing that includes the biological, psychological, or social factors that contribute to an individual's mental state and ability to function within the environment. Murphy (1978) argues that culture has a clear influence on mental health which takes different meanings depending on the

setting, culture, socioeconomic, and political influences. In Waterman's (1993) definition, the emphasis is on the sense of mastery over one's environment. Then, Keyes (2006) distinguished emotional, psychological, and social well-being as the three pillars of mental health. Happiness, interest in life, and contentment are examples of emotional well-being; liking most of one's personality, handling daily obligations effectively, fostering positive relationships with others, and feeling content with one's own life are examples of psychological well-being. The Mental Health Foundation, (2008) notes that mental health is determined by how individuals think and feel about themselves and their lives and how an individual copes and manages in times of adversity. In tune with this, as defined by the American Psychological Association (2008) mental health is a condition of mind marked by emotional stability, appropriate behavioral adjustment, a lack of anxiety and other incapacitating symptoms, the ability to build positive relationships, and the ability to handle daily demands and stressors. From the positive psychology point of view, mental health may include an individual's capacity to enjoy life and make a stability between activities in life and endeavors to achieve psychological resilience.

Another definition from Snyder et al. (2011) indicates mental health to include an individual's ability to enjoy life and to create a balance between life activities and efforts to achieve psychological resilience from the perspectives of positive psychology or holism. However, Thirunavurakasu (2011) describes the utilitarian concept as the conceptualization of the biological entity whose health is called mental health. That entity has been called "manas," to willfully avoid the historic and archaic misconceptions attached to the word "mind," which are surprisingly imbibed in the contemporary teaching and practice of psychiatry and its allied sciences. The current conceptualization of the mind and mental health are plagued by the current Cartesian system of medicine, which considers the "mind" as an entity that interacts with the "body." According to the World Health Organization, (2014) mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." However, constructive functioning is referred to as social well-being, and it includes feeling like a member of a community, having

something constructive to contribute to society, and thinking that society is improving and that everyone should understand how it functions (Keyes, 2014). Galderisi et al. (2015) have proposed a more comprehensive definition:

> "Mental health is a dynamic state of inner stability which enables persons to use their abilities in harmony with universal values of society. Basic cognitive and social skills; the ability to recognize, express, and regulate one's own emotions as well as empathize with others; flexibility and ability to cope with sorrows and function in social roles; and a good relationship between body and mind are all important components of mental health that contribute to the state of inner stability to varying degrees (Galderisi et al., 2015, p.408)."

Mental health is seen as affecting one's ability to function and make the most of the opportunities that are available to them, and to participate fully in family, workplace, community, and peer relationships. There is a close link between physical and mental health, as they affect each other directly and indirectly (Ohrnberger et al., 2017). However, good mental health is related to mental and psychological well-being (WHO, 2019).

Components of Mental Health

According to the World Psychological Association (2008), mental health has six components as follows:

1) Positive Self-Evaluation: It includes self-confidence, self-acceptance, self-identified feeling of worthiness, realization of one's potentialities, etc.

2) Perception of Reality: It is related to how the individual perceives oneself as free from need distortion, absence of excessive fantasy, and a broad perspective of the world.

3) Integration of Personality: It indicates a balance of psychic forces in the individual and includes the capacity to understand and to share other individuals' emotions, the capacity to concentrate at work, and having an interest in various activities.

4) Autonomy: It includes a fixed set of internal standards for one's action, dependence for own personal development upon own potential rather than dependence on other individuals.

5) Group Oriented Attitude: It is associated with the capacity to get along with others, potential to work with others, and ability to find a entertainment.

6) Environmental Competence: It includes capacity in meeting situational necessities, the ability to work and enjoy, the capacity to take responsibilities, and the ability for adjustment.

In brief, mental health is a condition that permits the optimum development of physical, intellectual, and emotional states of a person so that one can contribute to the wellness of society and can also realize his/her thoughts and aims in life. Human beings, from birth to death, remain in close association with society. It is the proper interaction of a person with society that brings out the complete and harmonious development of one's personality. Health is the most precious asset that is sought by all human beings. Health as a state of psychosomatic well-being of an individual plays a vital role in the whole process of development of an individual. When we think of health, we normally associate it with physical health because without a healthy body, we cannot perform actions properly or experience life well. A sound mind lies in a sound body whereby good health depends on the state of both the body and the mind. In very simple and general terms, mental health denotes the emotional stability and social and intellectual efficiency of a person (Heinz & Kluge, 2010). It is an idea that indicates the extent to which an individual has been able to reach environmental demands. In general, when a person gets trapped in an unfair situation where he/she does not have strategies to deal with it, the person becomes mentally strained.

2.1.2. Theoretical Underpinnings of the Study

The present study is not based on a single theory. It draws inputs from various feminist and psycho-social theories. A number of sociocultural factors are found to have an overarching impact on women’s mental health. But while discussing the way they indirectly contribute to personal development and affect individual attitudes and

approaches to challenges in life, theories on psycho-social development find applicable. But the psychological theories lack a feminist/gender perspective. Hence the study draws lot more underpinnings from the feminist theories.

2.1.2.1. Psychosocial Theories on Mental Health

Various psychological theories that are closely related to mental health conditions are discussed here.

A. Abraham Maslow's Hierarchy of Needs

Abraham Maslow studied people's needs and motivations. In 1943, he created the hierarchy of requirements, which he used to arrange and illustrate the basic impulses or wants that shape human behavior in the form of a pyramid.

- The most basic needs are those for food, drink, shelter, sexual expression, and pain relief.
- The second level covers needs for safety and security, which include freedom from harm or imminent deprivation, protection, and security.
- The third level covers needs for love and belonging, which include enduring intimacy, friendship, and acceptance.
- The fourth level covers esteem needs, which include the need for self-respect and the respect of others.
- The greatest level is self-actualization, or the longing for truth, justice, and beauty.

In the context of the present study, whether women's needs remain satisfied or unmet can have its effect on their mental health. When women struggle through poverty and violence, lack safety and respect from others, the hierarchical needs are challenged which keep them passive and submissive. The question of esteem needs does not arise in the lives of majority of women, and they remain even

unaware of it. All these lead to the development of improper self-esteem whereby their contributions to individual and societal development remain abysmally low.

B. Erikson's Theory of Psychosocial Development

Building on Freud's theories of lifelong personality development, Erik Erikson (1950) gave more weight to social and psychological development during the course of a person's life. He proposed that a person's personality development does not stop during the first five years of life. Erikson maintains that a person's ability to successfully navigate existential issues like trust, autonomy, intimacy, individuality, integrity, and identity have a major impact on how one's personality develops. According to his theory, psychosocial growth happens in a sequence of phases that build on one another and need the accomplishment of particular life goals at each stage. Every stage presents a challenge that people must overcome in order to maintain their overall wellness and mental health. Eight stages make up Erikson's theory of development: Trust vs. Mistrust, Autonomy vs. Shame and Doubt, Initiative vs. Guilt, Industry vs. Inferiority, Identity vs. Role Confusion, Intimacy vs. Isolation, Generativity vs. Stagnation, and Integrity vs. Despair.

In the study context, women's secondary position within family and society and the nature of socialization that they generally receive from the various agencies like family, educational institutions, religion, media etc. affect their psychosocial development. For example, the mistrust they develop from negative life experiences, the shame, guilt and inferiority that they may develop due to various forms of discrimination, role confusions arising out of traditional gender role perceptions, and the subsequent stagnation and despair due to gender division of labour are all inevitable stages in the lives of majority of women in patriarchal societies. A woman who is considered as "other" often remains confused about her identity which is dependent on the man's role at the specific stage of her life. Erikson proposes that lack of proper accomplishment at each stage of life in turn will have negative implications on the mental health of individuals.

C. Moral Development Theory (Kohlberg, 1958)

This theory explores how people make decisions when faced with moral and ethical dilemmas. While moral and cognitive growth have some similarities, they are essentially different. This viewpoint holds that decision-making starts with an emphasis on problem-solving and self-interest before moving towards more altruistic and principle-oriented methods in the end. When these theories are applied to women, men or other cultural groups, there is found to be a range of interpretations.

The process of gender socialization has the power to influence moral values. According to Carol Gilligan (1996), socialization has distinct effects on how men and women develop their moral cognitive processes. Furthermore, one's moral development is highly influenced by the family environment. Youngsters who grow up in homes that support gender equality are more likely to follow these principles themselves. Another important factor influencing moral growth is culture. In addition to establishing social norms for appropriate behavior and attire, it influences how one perceives the consequences of one's choices and actions. Immoral behavior can bring guilt to the entire family in some cultures. Conversely, in cultures where individualism is valued more, persons' decisions are viewed as more indicative of themselves than their family. Religious and spiritual beliefs also mold conceptions of good and bad. Personal and societal value systems are frequently influenced by the limitations found in religious traditions (Gilligan, 1996).

In the present study gender discriminatory norms in the culture that dictate morality, and the religious traditions especially the rituals imposed more upon women can have implications on women's mental wellbeing and happiness.

D. Learned Helplessness Theory

Lenore Walker, a psychologist in the United States, studied the behavior of women who stayed in abusive relationships and developed the notion of learned helplessness in 1977. Walker hypothesized that continuous abuse might weaken a woman's desire to leave the relationship and force her to stay. This notion, however, conflicts with the reality that many women in violent marriages make multiple

attempts to escape and frequently take intentional steps to lessen the abuse they receive and protect their children. Some women nevertheless make the decision to stay with their violent relationships.

In the present study context in a patriarchal society like that of Kerala, women tend to stay back in abusive relationships due to several reasons like lack of economic independence, having no other place to go and stay and so on. But Walker's theory of learned helplessness seems applicable for women who are subjected to abuse on a repetitive basis by their intimate partners.

E. Nolen-Hoeksema's Theory of Ruminating Tendency (RST)

According to Nolen-Hoeksema's (1991) research, women experience depression at higher rates than men, and it also lasts longer and recurs more frequently. In accordance with her Response Styles Theory (RST), rumination—the tendency to ponder the significance, causes, and consequences of depressive symptoms repeatedly and willingly has an important role in this phenomenon. Lyubomirsky et al. (2015) noted that although ruminating does not have a bigger influence on depressive episodes in women than in males, women are more prone to participate in rumination, which increases their susceptibility to first depressive episodes.

Rumination and depression are related, and RST sheds light on this relationship, highlighting the ways in which rumination can amplify unpleasant emotions and either initiate or extend depressive episodes. Instead of actively seeking solutions to alleviate distressing circumstances surrounding depressive symptoms, individuals who ruminate tend to focus on these symptoms in a maladaptive manner. The theory's emphasis on rumination as a strong predictor of the onset and duration of depression has spurred further research in this field, contributing to a rich body of literature exploring rumination, its effects and associations, and its role in depression.

2.1.2.2. Feminist Perspectives on Mental Health

The awareness on gender bias in mental health started in the early centuries and many feminist authors have cited their perspectives on women's mental health. The early feminists strongly opposed the thoughts or arguments of men that 'women

are hysterical in nature, that's why they behave like abnormal. Friedan (1963) pointed out that women have many problems like menstrual difficulties, sexual frigidity, pregnancy fear, childbirth depression, and the high incidence of emotional breakdowns and suicides in their twenties and thirties. Women's inner voice that declares, "I want something more than my husband, my children, and my home" is something we can no longer ignore." The problem that has no name (Friedan, 1963, p. 412). In Feminine Mystique, Friedan argues that women in her times suffered as a result of a sexist and oppressive culture. She argues that women's limited roles resulted in widespread identity and mental health crises among women. It refers to the expectations and restrictions imposed on women by society in the 1950s and 1960s. It required that women prioritize their looks in order to attract husbands, and that women were defined by their sexual roles. After being married, they were supposed to stay at home with their kids and spouse and take care of them. The term is closely related to systemic or institutional sexism. On the other hand, Wolf (1929) exhorted that every woman has to create her own space in the home. Every woman needs a room of her own and also has to make her own area in the domestic setting (p. 91).

Chandra and Satyanarayana's (2010) research in the area of gender and mental health indicates that women are disproportionately affected by Common Mental Disorders (CMDs) as well as co-morbid mental disorders. However, the concept of gender disadvantage, its correlates, and mental health outcomes have received relatively less research attention. Jahanbakhsh et al. (2015) suggest that gender roles may influence women's self-confidence differently; in other words, women's self-confidence may be predicted by their gender roles. According to the investigation, 22% of the participants had female sexual roles and 21% had male sexual roles, with 30% of the subjects being androgynous and 26.9% being non-distinct. Accordingly, the study shows that, in comparison to other women, those in the androgyny sex-roles do not have the highest degree of self-confidence. In fact, the level of self-confidence in androgynous women are lower than that of those with female sex roles and non-distinct, and only slightly higher than those who had male sex roles.

Barnes (2020) reviews the various issues of occupational stressors and mental health status from a gender perspective. In the past few decades, owing to the women's movement of the 1960s and 1970s, there has been a marked change in the behavioral options available for men and women, in their roles, attitudes, and behaviors. All along, gender differentiation was well differentiated and articulated in terms of psychological variables in all cultures. Gender differentiation has served as a model of mental health, with any deviation considered pathological. Secondly, male traits also became the parameters to define mental health. However, the recent attitudinal shift has postulated that a healthy combination of male and female traits is essential for healthy adjustments. This has been called "androgyny," which has given a new gender identity to the present generation in some cultures.

Feminist perspectives on women's mental health question the traditional notions of considering biological factors as major determinants of mental wellbeing of women. It emphasizes how the social positioning of women as the "other" or with a secondary status can lead to the evolution of multiple factors detrimental to both physical and mental health of women. Gender socialization leads women to deny their health needs by themselves, and they are often not ready to go to the hospital either. The majority of them prefer home remedies for their illnesses. In fact, in the case of mental health, they also prefer praying to God and seek other cultural remedies.

Several studies have highlighted how poverty, violence especially intimate partner violence, lack of decision-making power, lack of control over resources and economic dependency impact upon women's peace and happiness. The constant threat of violence from within families and outside affects a woman's sense of security which is an important component of mental health. The complex network of socio-cultural factors acts through gender division of labour and the subsequent traditional gender roles of women where they engage in monotonous repetitive activities with minimal interactions with external world. The unpaid domestic labour adds to her economic dependency and lack of decision-making power. Even when women take up paid employment, they are often under employed and under paid. Lack of control over earnings in a male hegemonic system further violates her economic freedom. All these interconnected factors that are socio-cultural and socioeconomic result from the secondary position of women in society.

As proposed by radical feminists, the family serves as a site of women's oppression wherein the hierarchical power relations pull down women to the lowest rungs. Discrimination within the family system end up in unfulfilled aspirations for several women. Their spaces get confined, and voices remain unheard whereby women have to struggle a lot for their basic human rights. This constant struggle and associated frustrations will have serious implications on the mental health of women in a patriarchal society. Radical feminists believe that the main source of oppression for women in the family is patriarchy itself. Accordingly, to free women from exploitation and oppression, the entire patriarchal system must be eliminated. It is usually the first area where children are socialized into patriarchal ideology, whereby they believe that men are superior to women. As part of this ideology, they are taught to accept the division and distinction between the genders whereby girls and women accept their secondary position in society. This indicates that they will probably maintain patriarchal beliefs and behaviors. Women are objectified; they are viewed as nothing more than sexual objects prior to marriage and as housewives and moms after marriage. This objectification in turn encourages abuse of women in the home (including physical and sexual violence) at the hands of men. The perpetrators in most domestic violence cases are men. Men take advantage of women's bodies by using them for both reproduction and sexual pleasure, often resulting in sexual assault.

While discussing how unfulfilled aspirations and restrictions faced by women within families affect their mental health, the need for individual autonomy and individual self-fulfillment highlighted by liberal feminist theory find application. But when looking into the gender inequalities and power dynamics within families, this study draws inputs from the radical feminist theory as radical feminists expose how family becomes a site of women's oppression and end up in various forms of discrimination, gender-based violence, denial of SRHR and so on which affect women's mental health.

2.2. Studies on Gender and Mental Health

A study by Mitchel and Abbott (1987) found significant differences in the responses of men and women with women reporting more depression symptoms than

men. Another study by Maffeo et al. (1990) extends the literature on sex differences in depression to an employment setting. In contrast to previous findings, no gender differences remained on any of the measures after the effects of salary, age, education, and job classification had been taken into account. The findings replicate previous results showing that depressed males have difficulty with concentration and motivation than depressed females. In another study by Young et al. (1990), gender differences in the presence or absence and the severity of forty-seven clinician-rated features of depression were examined, controlling for the sex of the rater. Significant differences were found only for appetite and weight. There were no differences observed in endogenous symptoms, global severity of depression, or impairment in functioning. The results indicate that, although the rate of major depressive disorder is greater in women, its symptomatology is relatively homogeneous with regard to gender.

A study by Ernst and Angst (1992) found both males and females to be equally affected by repetitive depressions with work pressure. When syndromes or diagnoses were controlled, women and men suffered at an equal rate from subjective impairment at work. Women's syndromes were more repetitive. Among women, a diagnosis of depression was more often connected with trouble of appetite and with phobias than among men. Dennerstein et al. (1993) opine that the gender approach to mental health offers direction for determining suitable responses from public policy and the mental healthcare system. Even in situations where there may not be a significant socioeconomic gradient, gender inequalities are evident. Compared to women in the same marital status groups, men who have never married and separated or divorced have greater overall admission rates to mental health facilities. On the other hand, married women had high admittance rates than married men. Similar to other stratifiers, gender is not a standalone construct. It interacts with other social indicators such as race and class in an additive or multiplicative manner.

Williams et al. (1995) determined gender differences in the frequency and manifestation of depression in primary care. More women than men were diagnosed as having a mood disorder and an antidepressant was newly prescribed only for women. There were no gender differences in physician ratings of patients' health, but women rated their health significantly more poorly than did men. Similarly, functional impairment scores were significantly lower in women than in men. Women are much

more likely than men to have depressive disorders and, when these disorders are diagnosed, to receive a prescription for antidepressant medication. A study by Weissman et al. (1996) observe that the lifetime rates for major depression vary widely across countries. In every country, the rates of major depression were higher for women than for men. By contrast, the lifetime rates of bipolar disorder are more consistent across countries (0.3/100 in Taiwan to 1.5/100 in New Zealand), the sex ratios are nearly equal, and the age at first onset is earlier (average, 6 years) than the onset of major depression. Insomnia and loss of energy occurred in most people with major depression at each site. People with major depression were also at an increased risk for comorbidity with substance abuse and anxiety disorders at all sites. Persons who were separated or divorced had significantly higher rates of major depression than married persons in most countries, and the risk was somewhat greater for divorced or separated men than women in most countries. With regard to gender difference in mental health, Hoeksema et al. (1999) found that chronic strain, low mastery, and rumination were each more common in women than in men and mediated the gender difference in depressive symptoms. Rumination amplified the effects of mastery and, to some extent, the chronic strain on depressive symptoms. In addition, chronic strain and rumination had reciprocal effects on each other over time, and low mastery also contributed to more rumination. Finally, depressive symptoms contributed to more rumination and less mastery over time.

Piccinelli and Wilkinson (2000) also pointed out in their study that the prevalence, incidence, and morbidity risk of depressive disorders to be higher in females than in males, beginning at mid-puberty and persisting through adult life. According to them adverse experiences in childhood, depression and anxiety disorders in childhood and adolescence, sociocultural roles with related adverse experiences, and psychological attributes related to vulnerability to life events and coping skills are likely to be involved. At the same time, they proposed that genetic and biological factors and poor social support, however, have few or no effects on the emergence of gender differences. Simonds and Whiffen (2003) also found that women are more likely than men to be diagnosed with either one disorder alone or comorbidity. Furthermore, the ratio of women to men who experience anxiety alone or anxiety in combination with depression tends to be higher than the ratio of women to men who experience depression alone. Therefore, they concluded that attempts to explain the

gender difference in rates of depression would benefit from the understanding that women are more likely to experience anxiety. Somatic depression, which is associated with high rates of anxiety disorders, is much higher among women than in men. However, Bogner and Gallo (2004) reported no significant gender difference in the self-reported depression symptoms, even considering the higher level of depressive symptoms of women and the influence of other covariates. For example, women were no more likely to endorse sadness than men, as evidenced by a direct effect coefficient that was not significantly different from the null, adjusted estimated direct effect of gender on the report of sadness at 95% confidence interval. Men and women in this community sample reported similar patterns of depressive symptoms. No evidence that the presentation of depressive symptoms differs by gender was found. In a study, Winkler et al. (2004) investigated sex differences in the symptom presentation in an inpatient population. At admission into the hospital, women tended to show more affective liability, whereas men had higher scores in affective rigidity, blunted affect, decreased libido, hypochondriasis, and hypochondriac delusions. At discharge from the hospital, women had significantly higher scores in dysphoria, while men were more prone to having compulsive impulses. Although the results were obtained in a selected sample of inpatients at a university hospital, they are indicative of psychopathological differences between men and women in the core symptoms of depression. These differences may influence diagnostic practice and gender-specific treatment of depression.

Sloan and Sandt (2006) opine that depression is the leading mental health concern worldwide. Although depression is highly prevalent in both women and men, women are twice as likely to experience depression than men. This increased prevalence rate for women emerges around the age of 13 years and it continues throughout their life. The factors that affect the increased rate of depression in women are the incidence of stressful life events, a greater reporting depression symptom, a higher likelihood of presenting for treatment, and a gender diagnostic bias. Moreover, depressed women are more likely than depressed men to present with mental health problems (e.g., anxiety and eating disorders) and medical comorbidities. Such comorbidities negatively influence the course of depression and treatment, although the negative effects are comparable for both men and women. Given the high prevalence of depression in both men and women, it increased mortality rates in

depressed patients who have a comorbid medical condition. Women are more likely to suffer a higher number of stressful life events when compared with men, although no gender difference has been found to explain the genetic vulnerability. In another study Dalgard et al. (2006), concluded that the higher rate of depression in women is not explained by gender differences in negative life events, social support, or vulnerability. Chronic strain, low mastery, and rumination were each more common in women than in men and mediated the gender difference in depressive symptoms. However, women with no social support and who are exposed to life events, are more vulnerable than men without support.

Patel et al. (2006) analyzed the prevalence of common mental disorders, as 6.6% of the population (95% confidence interval). The mixed anxiety-depressive disorder was the most common diagnosis (64.8%). Among the factors independently associated with the risk of common mental disorders were gender disadvantage factors, particularly sexual violence by the husband, being widowed or separated, having low autonomy in decision making and having low levels of support from one's family. There was no association between biological indicators (anemia and reproductive tract infections) and common mental disorders. They also proposed that the clinical assessment of common mental disorders in women must include an exploration of violence and gender disadvantage. Gynecological symptoms may be somatic equivalents of common mental disorders in women in Asian cultures. In this context, Afifi (2007) observes that effective solutions for reducing mental health threat factors cannot be gender-neutral, because women's position and life prospects are still weak globally and the problems are gender-specific.

Eaton et al. (2012) in their epidemiological studies of categorical mental disorders consistently report gender differences in many disorders' prevalence rates and found that disorders are often comorbid. Gender differences in prevalence were systematic, such that women showed higher rates of mood and anxiety disorders, and men showed higher rates of antisocial, and substance use disorders. In the study, they investigated patterns of disorder comorbidity and found that a dimensional internalizing (mood and anxiety) and externalizing (antisocial and substance use) liability model fit the data well. This model was gender invariant, indicating that observed gender differences in prevalence rates originate from women's and men's different average standings on latent internalizing and externalizing liability

dimensions. Another study by Mezo and Baker (2012) discovered that both stress and rumination scores were found to account for a large proportion of variance in depressive symptom scores. The interaction of stress and rumination also accounted for a significant proportion of this variance, suggesting a significant moderating effect of stress on the rumination-depressive symptom relationship in women and men. Moreover, women and men with the highest degrees of stress demonstrated the strongest rumination-depressive symptom relationship. However, low-stress women and low-stress men demonstrated divergent patterns of relationships. The alternative model of rumination as a moderator of the stress-depression relationship likewise supported divergent relationships between low-rumination women and low-rumination men in the relationship between stress and depression.

Rao and Tandon (2015) discovered that schizophrenia has approximately equal incidence in both genders. Females, on the other hand, have a better course and outcome. Schizophrenia hits females in their reproductive years, having a very significant impact on the whole family. Being a female with severe mental illness is like a two-edged sword, putting them at a double disadvantage. Bipolar disorder has equal incidence in both sexes; however, females experience more depressive episodes and bipolar disorder more often than men. Mixed episodes and rapid cycling are more often seen in women. Substance use disorders in women have been steadily increasing. However, our culture is gender biased on substance use acceptability, and hence, substance use disorders are more often seen in men. Eating disorders, once believed to be diagnoses of the West, have a consistent presence in developing countries also. Kuehner (2017) also pointed out that women are about twice as likely as men to develop depression during their lifetime. This study summarizes evidence regarding the epidemiology of gender differences in prevalence, incidence, and course of depression, and factors possibly explaining the gender gap. Gender-related subtypes of depression are suggested to exist, of which the developmental subtype has the strongest potential to contribute to the gender gap. Limited evidence exists for risk factors to be specifically linked to depression. An integration of the Research Domain Criteria framework will allow the examination of gender differences in core psychological functions within the context of developmental transitions and environmental settings. Monitoring of changing socioeconomic and cultural trends in factors contributing to the gender gap will be important, as will the influence of these

trends on changes in symptom expression across psychopathologies in men and women.

2.3. Factors Affecting Mental Health of Women

There are several studies that discuss the factors affecting mental health of girls and women that are not applicable in the case of boys and men. While majority of these are inter-related and interdependent network of cultural, social and economic factors, a few may be listed as biological.

2.3.1. Cultural Factors

Studies in this respect cover areas like restricted mobility, gender division of labour, unpaid domestic work and so on. The studies related to these factors are detailed in the following sections:

- **Restricted mobility**

Restrictions on women's freedom of movement are prevalent in several countries and especially throughout India. India's National Family Health Survey found that "only one-third of women aged 15–49 are allowed to go alone to the market, to the health center, and outside the community" (Kishor & Gupta, 2004). Another study found that 71% of Indian women have to ask for permission to leave the home (Mistry et al., 2009). Parker and Brotchie (2010) found that mental health symptoms increased with mobility limitations, particularly in women. While, in the US, African Americans with severe depressive symptoms have been reported to have higher odds of mobility limitation than those without severe depressive symptoms (Thorpre et al., 2011). Another study by Rask et al. (2015) also found that mental health symptoms are significantly associated with mobility limitation both in the studied migrant populations and in the general Finnish population. However, mobility, for women, is an arena marked by the constitution, insecurity, and limited accessibility. Academic studies define mobility not only in terms of the actual physical usage of modes of transportation but also as the construction of potential opportunities for access and action for women. Women's mobility in our country is disproportionately more restricted than men's. It is a determinant of women's access to the most basic human

rights. Freedom of movement is, in fact, recognized, under the constitution and international instruments, as an essential human right (Adeel, 2016). A systematic review in low and middle-income countries ascertains that low levels of autonomy for women, including freedom of movement, were associated with poorer mental and physical health (Pennington et al., 2018).

- **Gender division of labor and Unpaid domestic work**

Division of labour on the basis of sex has been a universal feature of human society. Women and men have been assigned different tasks and responsibilities everywhere. The gender division of labor in which men tend to specialize more in paid work within the market and women tend to specialize more in unpaid work within the home, is a feature even in modern society.

A study from Krause and Markides (1985) found that husbands' involvement in housework was a better predictor of women's well-being than their involvement in child-care tasks. Moreover, Benin and Agostinelli (1988) found that women are more likely to be looking for assistance from their husbands with traditionally female rather than male tasks. However, Rosenfield (1989) found that housewives were typically more depressed than employed women, with one exception, housewives were less depressed than the most overloaded employed women (full-time working mothers who received little help with housework and childcare from their spouses). Robinson and Spitze (1992) propose that women's perceptions of the division of labor, as opposed to the actual division of labor, may be related to their mental health, above and beyond the proportion of family work they do. Perceived unfairness has been found to predict distress for women only. Another study found that performing larger numbers of traditionally female tasks is associated with more depression in women and sometimes in men (Fujimoto, 1994). In a review analysis study, Shelton and John (1996) examined the consequences of the division of household labor, focusing on those studies that examine its impact on labour force participation and wages, marital and family satisfaction, psychological well-being, and perceptions of fairness. Another study revealed that men's lower contributions to household labour explains part of the gender difference in depression. Inequity in the division of

household labour has a greater impact on distress than does the amount of household labour (Bird, 1999).

Research by Bianchi et al. (2000) indicates that one of the most important factors affecting women's mental health in dual-earner couples is the division of labor. The division of labour is a particularly important issue among working couples with children, especially infants, as these couples must negotiate not only the division of household tasks such as cleaning, cooking, and repairs but also child-care tasks such as feeding, diapering, and dressing. The transition to parenthood has been recognized as a critical time for examining the effects of multiple roles on men's and women's mental health, as couples renegotiate and widen their repertoire of roles to make room for a new person in their lives. While measures of both household and child-care task involvement have found evidence that these two domains may have different implications for women's mental health (Coltrane, 2000). Research indicates that even among couples in which spouses work an equal number of hours, women typically perform two to three times more of the daily, repetitive, and necessary household labour than men. In most traditional societies, child rearing and home maintenance are normally regarded as women's tasks, while hunting and fighting are always reserved for men (Cohen, 2004). Another study by Goldberg and Jenkins (2004) suggests that the division of child care is more salient in predicting distress than the division of housework for working-class women.

Recent research shows time poverty contributes to declines in mental health and also makes it harder to do things that improve health, like exercising, sleeping, or nurturing friendships (Hyde et al., 2020). However, gendered social norms construct women as caregivers and providers, and the unpaid work is clearly associated with poorer mental health for women (Seedat & Rondon, 2021). Another finding indicates that, among employed adults, unpaid labour is negatively associated with women's mental health, with effects less apparent for men. Globally, women spend a greater number of hours on unpaid labour; this review suggests that inequities in the division of unpaid labour expose women to a greater risk of poorer mental health than men (Ervin, 2022). The 2021 US Bureau of Labor Statistics data shows that both spouses

were employed in 46.8% of married couple families with 59% of women reporting as doing more household work than their partners. Over the last several decades, gender roles have evolved and changed to reflect shifting societal norms. Yet, despite these changes, unpaid household labor disparities still exist between partnered men and women worldwide. Women report taking on more unpaid work regardless of geographical location and time setting and this added burden is associated with poorer mental health in women. However, the impact on men was less clear (Drake, 2022).

- **Role conflict and mental health**

A study from Oster and Scannell (1999) concludes that measuring experienced role conflict and change in role perception should be taken into account in any consideration of women's psychological health. The study posits that changes in role perception after the birth of children influence psychological health directly or indirectly through role conflict. Studies by Geurts et al. (2003) and Zhang et al. (2017) reveal individuals with high levels of work-family conflict to have reported more depressive symptoms. Role conflict decreases both sexes' job satisfaction and men's marital satisfaction and increases women's psychophysical symptoms. Role overload does not affect role satisfaction or stress for either sex. It is concluded that perceived role conflict decreases women's psychological health, but role overload does not. While another study by Zhou et al. (2018) found that women's perceptions of both work-to-family conflict and family-to-work conflict were significantly negatively related to mental health. The results showed that negative affect and perceived stress were negatively correlated with mental health. The findings suggest that work-family conflicts affected the level of self-reported mental health, and this relationship functioned through the two sequential mediators of negative affect and perceived stress.

2.3.2. Social Factors

Literature in this aspect covers factors like alcoholism of husband, socialization practices, violence against women etc.

- **Alcoholism of husbands**

Alcoholism is a universal phenomenon. Through the centuries, numberless women across the globe have been coping with husbands who come home drunk, bash their wives and children, and make everyone's life miserable. However, surprisingly, most women timidly adjust to their husbands' ways rather than raise their voices in protest. The consumption rates of alcohol are so high in India that it has been identified as the third largest market for alcoholic beverages in the world. A study by Flanzer (1993) points out that alcohol operates as a situational factor, increasing the likelihood of violence by reducing inhibitions, clouding judgment and impairing an individual's ability to interpret cues. Other morbidities, such as bipolar disorder, paranoid schizophrenia, and delusional and antisocial personality disorder, increase the man's proclivity to commit sexual crimes. There is evidence from many forensic cases, such as that of Bobbit, Manu Sharma, Nirbhaya, etc., that alcohol was the common denominator in violence against women. Another study by McCauley et al. (1995) conclude that alcohol has consistently emerged as a risk marker for partner violence that is especially consistent across a range of settings. It causes serious mental illness in women. However, Jeyaseelan et al. (2007) also found that regular consumption of alcohol by the husband has been strongly associated with the poor mental health of women.

The problem of alcoholism, though defined in the context of an individual, affects the family as a whole. When one member of the family abuses alcohol, it causes disruption and disharmony within the family, and thus, every member suffers. The impact of alcoholism on the family is so great that it leads to the absolute breakdown of the family as an entity. The family members of alcoholics often report various negative emotional states ranging from guilt, shame, anger, fear, grief, and isolation. Among all members, the wives of alcoholics are most adversely affected as they undergo intense trauma and stress in their domestic environment, which brings about major psychological problems in them. The high levels of anxiety, depression, neuroticism, and poor self-esteem are a few of the symptoms on the slope. Domestic violence, emotional violence, and financial violence are some of the most frequently

occurring and well-recognized problems faced by the wives of alcoholics. Moreover, the alcoholic is so obsessed with drinking that he ignores the needs and situations of other family members and is unable to take up his expected roles and responsibilities. In such a scenario, the functions that are normally carried by husbands often fall on the wives, further adding to their burden and suffering (Satyanarayana et al., 2010).

Another study revealed that the problems faced by alcoholics' wives were in multiple domains like physical, psychological, and social. While most highly reported were the emotional problems, the least reported were the problems of physical violence (Sharma et al., 2016). The COVID-19 pandemic situation, which requires an extended stay at home atmosphere, trigger increased alcohol consumption among men, with rising tension that is leading to the use of violence, which has been already reported based on an average one-third increase in calls to helplines (UN Women, 2020). Dostanic (2022) concludes that the mental health of women whose partners have alcohol dependence is significantly threatened and should be considered, especially when it is associated with exposure to spousal violence.

- **Socialization practices**

Socialization is the process of internalising the norms and ideologies of society and encompasses both learning and teaching and is how social and cultural continuity is attained. It is strongly connected to developmental psychology. Humans need social experiences to learn their culture and to survive. It represents the whole process of learning throughout the life course and is a central influence on the behaviours, beliefs, and actions of adults as well as children. Socialization is the act of adapting behaviour to the norms of a culture or society. Different socialisation practices will elicit different responses in individuals experiencing the socialisation (Karen & Epstein, 1983). Evidence linking gender socialisation to mental health problems among youth is sorely lacking. In fact, there are only a few studies that evaluate the links between gender socialisation and mental health. According to Busfield (1988), feminists have been suggesting that the higher level of mental illness observed in women is a consequence of the oppression they face which may drive them into madness and mental disorder, and that the concept of mental illness is a social

construct inappropriately and incorrectly applied to women by a patriarchal order as a means of social control.

Glendinning (1998) opines, that "links between perceived family life and self-esteem and health behaviour are felt quite separately from each other. However, the impact that young people's feelings about their home life have on their self-esteem does help to explain links between family practices and health, particularly mental health in youth (p.61)." Another study by Moss (2002) found that higher the level of household gender discriminatory practices, the lower is the number of mental health problems in male youth. In contrast, females reported higher mental health problems as the number of gender-discriminatory practices in their households increased. However, Pearlin (2010) postulates that chronic strains and stressful life events threaten an individual's adaptive capacity. Stress process theory provides a useful conceptual framework for linking patterns of gender socialisation to the mental health of male and female youth in India.

A study by Ram et al. (2014) describes:

> "The gendered nature of socialisation experiences show that male and female youth inhabit different social worlds. Female youth expressed more gender egalitarian attitudes than male youth but reported greater restrictions on their independence than male youth. Poisson models revealed that female youth experienced more mental health problems when their households engaged in practices that favoured males over females, even as these same practices were associated with fewer mental health problems among male youth. Family violence and restrictions on independence were associated with mental health problems for both male and female youth. When males and females engaged in behaviours contravening sex-specific gender norms, there were corresponding increases in mental health problems for both sexes (p.215)."

The household environment emerges as a key setting in which gender inequality becomes insinuated into the fabric of social life, with corresponding influences on mental health and well-being.

- **Violence against women and mental health**

Violence against women is a prominent public mental health problem and a violation of human rights. Victimization is linked to a higher incidence of mental illness. Because of this, the current study introduced a new heading to the literature listing violence against women as a factor affecting women's mental health. These include gender-based violence, intimate partner violence, domestic violence, rape, cybercrimes, trafficking, female genital mutilation, sexual abuse, dowry related violence etc. Studies related to these factors are presented in the following section.

- **Gender-based violence**

Violence against women is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological, or economic harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life. Violence against women and girls is one of the most prevalent human rights violations in the world. It knows no social, economic, or national boundaries. Worldwide, an estimated one in three women will experience physical or sexual abuse in their lifetime. Gender-based violence undermines the health, dignity, security, and autonomy of its victims, yet it remains shrouded in a culture of silence. Victims of violence can suffer sexual and reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections including HIV, and even death (UNFPA, 2017). Up to 38% of killings of women are carried out by a partner. This problem not only has severe effects on victims of violence and their families, but it also has high societal and financial implications. According to estimates, the cost of violence against women in some nations can reach 3.7% of the GDP, which is more than double what most governments spend on education (The World Bank, 2019). However, numerous negative health consequences, including chronic mental health conditions including anxiety, sadness, and post-traumatic stress disorder (PTSD), are associated with gender-based violence against women and girls (Hossain et al., 2020). It is preferred to screen and treat psychological distress in

women with a history of violence, and it is advised that psychosocial care be included in court services (Sewalem & Molla, 2022).

- **Intimate partner violence**

Intimate partner violence is the most dangerous mental health issue in the entire world. The violence that happens in-between the partners has gotten more attention in the area of mental health. Women have recently been encouraged to come forward and report this type of violence in their marital lives. Russo et al. (1997) conducted a review of the literature on the health effects of intimate violence and discovered that childhood physical and sexual abuse and partner violence were interrelated and that both abuse history and partner violence were associated with an increased risk of depressive symptoms, lower life satisfaction, and lower perceived health care quality. Partner violence was also related to lower self-esteem and perceived health status. Sexually abused women had more difficulties in interpersonal relationships, including lower perceived health care quality even with self-esteem and depressive symptoms controlled. Marital rape is the act of sexual intercourse with one's spouse without the spouse's consent. The lack of consent is the essential element and need not involve violence. Marital rape is considered a form of domestic violence and sexual abuse (Campbell & Soeken, 1999). However, Cole et al. (2005) report that women with no sexual victimization had significantly fewer mental health problems than women who had experienced sexual insistence and women who had been threatened or forced to have sex. Findings from this study underscore the importance of health, mental health, and criminal justice professionals' assessing for a range of sexually abusive acts when working with victims of partner violence.

Here, Bonomi et al. (2006) indicate that women with recent physical or sexual IPV were 2.8 times as likely to report poor health and had SF-36 scores that ranged from 5.3 to 7.8 points lower, an increased risk of depressive symptoms, severe depressive symptoms, and more than one additional symptom. A longer duration of IPV was associated with incrementally worse health. The women's health was adversely affected by the proximity, type, and duration of IPV exposure. In the Indian context, there are several studies related to mental health and intimate partner violence

(Bergen, 2006; Mukhopadhyay, 2007; Chowdhary & Patel, 2008**;** Nayak et al., 2010). In this regard, Kamimura et al. (2014) find women in India to be at greater risk of intimate partner violence. Women who have experienced partner violence are more likely to report poor physical and mental health. Yet women experiencing intimate partner violence do not seek help or they rely on informal help sources. Evidence shows that both women who experience intimate partner violence and children who are affected, either directly or indirectly, are at a higher risk of developing mental health conditions. Men perpetrating intimate partner violence may also be at higher risk of mental health conditions (WHO, 2022).

- **Domestic violence**

Kumar et al. (2005) conducted a survey on 9938 Indian women and found 40% of them to have poor mental health. Logistic regression showed that women reporting "any violence" slapped, hit, kicked, or beaten or all of the four types of physically violent behavior were at an increased risk of poor mental health. The findings indicate a strong association between domestic spousal violence and poor mental health and underscore the need for appropriate interventions. Domestic spousal violence against women has far-reaching mental health implications. In accordance with Ankur (2010), domestic violence refers to any act of gender-based violence that results in or is likely to result in, physical, sexual, or psychological harm or suffering to women. Malhotra and Shah (2015) find girls from nuclear families and women who married at a very young age are at a higher risk for attempted suicide and self-harm. Social factors and gender-specific factors determine the prevalence and course of mental disorders in female sufferers. Low attendance in hospital settings is partly explained by the lack of availability of resources for women. Around two-thirds of married women in India are victims of domestic violence. According to Ferrari et al. (2016) domestic violence and abuse survivors who seek support are found to have experienced high levels of abuse, depression, anxiety, and especially PTSD (post-traumatic stress disorders).

A feminist analysis of battered women rejects theories that attribute the cause of violence to family dysfunction, inadequate communication skills, women's

provocative behavior, stress, lack of spiritual relationship with a deity, economic hardship, class practices, racial-ethnic tolerance, or other factors. These issues may be associated with the battering of women, but they do not cause it. Removing these factors will not end men's violence against women. It is now generally recognized that experiencing domestic violence and abuse is associated with mental health problems, including anxiety and depression, among women (National Domestic Violence Hotline, 2017). In a study by Sharma et al. (2019), a quarter of the women reported unhealthy mental status in the past 4 weeks. Women who had experienced domestic violence showed poor mental health status and more suicidal tendencies when compared with women who had not experienced violence.

Rape

According to the NCRB (2018) report, the Annual Crime Report of the Ministry of Home Affairs, one woman reports a rape every fifteen minutes on average. Sehgal's study (2020) highlights how rape survivors bear psychological scars and continuously deal with mental health issues that include depression, anxiety, PTSD, substance abuse disorders, alcoholism, drug addiction, chronic fatigue, social withdrawal, sleep disorders, anorexia, bulimia, and borderline personality disorders. The trauma caused by such sexual assaults is severe and often followed by feelings of helplessness, guilt, and self-blame. In many cases, victims are so terrified by the incident that they start avoiding mirrors. The most painful reality of our society is that the victim is frowned upon, disregarded, and often blamed. The structured system always fails to provide mental solace and peace to the survivors. Abused women reporting experiences of forced sex are at significantly greater risk of depression and post-traumatic stress disorder than non-abused women. Post-traumatic stress disorder after rape is more likely if there is an injury during the rape or a history of depression or alcohol abuse. In the absence of trauma counselling, negative psychological effects have been known to persist for at least a year following a rape, while physical health problems and symptoms tend to decrease over such a period. Even with counselling, up to 50% of women retain symptoms of stress. Nandini et al. (2022) report that the women who experienced rape were facing mental disorders like anxiety, sleeping

disorders, obsessions, acute stress disorders, etc. More surprisingly, the women who were facing mental disorders due to sexual violence have been and continue to be exposed to further sexual violence.

- **Cyber crimes**

Jeffereys (2014) suggests that the victims of cybercrimes are psychologically traumatized by the incident. Culturally, the victim of a morphed picture uploaded on the internet is seen as impure and damaged. They are forced to live in isolation, are verbally abused, killed for honor, are unable to live a normal life, are divorced if already married, separated from children, and are humiliated everywhere. However, Cripps and Stermac (2018) examine cyber-sexual violence, which refers to the form of harmful sexually aggressive behaviors committed with the facilitation of digital technologies. Such harmful behaviors can include non-consensual pornography and other image-based sexual exploitation, online sexual harassment, cyber-stalking, online gender-based hate speech, and the use of a carriage service to arrange or attempt to arrange a victim's sexual assault. Many women and girls have to endure physical and verbal attacks. Many are harassed and even driven to suicide by online violence. A large number also have to face hate speech and trolling online (Uysal et al., 2019).

Alsawalqa (2021) also highlights the cybercrime victim's mental health issues. Online harassment and bullying have a negative impact on self-esteem, they cause people to doubt their opinions as well as their self-worth both mentally and physically. For young adults, cyberbullying can and does lead to self-harm, isolation, and suicide. As harassment escalates, it impacts people's ability to work effectively, and to feel safe. When cyberbullying involves sharing addresses and phone numbers, it rightfully makes people fearful for their lives. This abuse is compounded by an ill-equipped and skeletal legal system where the police are reluctant to file reports and complaints. This reluctance stems from a lack of understanding of cybercrimes, cultural and societal biases, and a deep-rooted belief that not much can be done against the harassers. These biases include the perspective that it is somehow the victim's fault for being present online or that it isn't a crime since the harasser and the victim are not face-to-face.

They do not understand how real and significant a problem this is, and this discounting has a further adverse effect on victims' mental health. Another study provided evidence indicating that experiences of cyber-sexual violence are associated with symptoms of depression, anxiety, stress, and posttraumatic reactions, regardless of individuals' disclosure experiences. Most of the three million women and girls who are currently being trafficked for sex have a mental illness (Novoteney, 2023). Considering the size of the problem and the magnitude of the trauma, so little is known about the cumulative misery these young people endure and what to do about it.

- **Trafficking**

A significant proportion of people who are exposed to trafficking develop psychiatric disorders. In any given population of young people, the prevalence of psychiatric disorders is as high as 20 percent. In a much more vulnerable group of people who have gone through the multiple traumas of trafficking, there is likely to be a higher prevalence of psychiatric disorders. However, exact numbers for the prevalence of psychiatric disorders are not available. In their work with the survivors of trafficking, researchers have found psychiatric disorders in more than 40 percent of the population (UNODC, 2008). The effects of human trafficking have a profound impact on the victim's mental and physical health. It's not uncommon to hear that many human trafficking victims experience self-injury, depression, sexually transmitted infections, post-traumatic stress disorders, anxiety disorders, and suicidal thoughts. Human trafficking, or sometimes referred to as "modern day slavery" is an extensive national phenomenon in India (Bales, 2012). However, the most frequently reported problems include depression (88.7%), anxiety (76.4%), nightmares (73.6%), flashbacks (68.0%), low self-esteem (81.1%), and feelings of shame or guilt (82.1%) (Lederer & Wetzel, 2014). Every year, about 20-65 million victims are trafficked worldwide, with India being a prominent source, transit, and destination country. They experience forced labor, physical abuse, sexual slavery, commercial sexual exploitation, and other forms of maltreatment (Patel, 2015).

Evidence of severe mental illness, including schizophrenia and psychotic disorders, has also been detected among trafficked people in contact with secondary

mental health services in England. The study also found an increased risk of compulsory psychiatric admission and a longer duration of psychiatric admission among trafficked versus non-trafficked patients who were matched for gender, age (within 2 years), diagnosis, in-patient status at first contact, and year of most recent contact. Seven percent of trafficked patients had a history of psychiatric admission prior to trafficking (Oram et al.,2015). Similarly, a study of trafficked people in the Greater Mekong sub-region found that 61% of men and 67% of women, as well as 57% of children, reported probable depression (i.e., symptoms indicative of depression as measured by a standardized screening tool) and probable PTSD was reported by 46% of men, 44% of women, and 27% of children (Kiss et al., 2015). Research from various countries shows that depression, anxiety, post-traumatic stress disorder (PTSD), self-harm, and attempted suicide are common among survivors in contact with refuge services (Ottisova et al., 2016)**.** Shero (2017) in this context found that human trafficking survivors have an alarming higher-than-average rate of suicidal thoughts with a percentage of 23% of survivors having attempted suicide, compared with 3% of the population with no prior domestic violence exposure**.** In another study, Levine (2017) revealed that most survivors have depression, anxiety, posttraumatic stress disorder, or a more severe diagnosis of disorders of extreme stress (DESNOS). In addition to these diagnoses, many victims of sex trafficking also have secondary psychological issues such as alcohol and drug abuse, as well as concurrent medical illnesses, which add to the psychological burden that sex trafficked victims endure. The NCW has reported an increase in child abuse, sexual abuse, and trafficking during the COVID-19 lockdown period (NCW, 2021).

- **Female genital mutilation**

Female Genital Mutilation/Cutting (FGM/C) is the procedure of removing healthy external genitalia from girls or women for socio-cultural reasons. There is much scientific literature on the adverse physical health complications that can result from having FGM/C, but little is known about its psychological impact and treatment. In a study by Vloberghs (2013) found respondents suffering from post-traumatic stress disorder (PTSD), and symptoms related to depression or anxiety. A structured

narrative review finds eight of ten studies report psychological consequences, such as PTSD and affective disorders. Also identified were socio-cultural differences in the meaning of perceived consequences for different individuals. Studies reported inconclusive results regarding the psychological impact of FGM/C on women's lives. While these findings provide an indication of the adverse psychological effects of women/girls having FGM/C, in particular, studies that focus on the role of cutting extent, circumstances surrounding the cutting, and girls' level of knowledge of what was going to take place, and their relationships to psychological outcomes. Raising awareness of the risk of negative psychological consequences is important, with maternal health care professionals requiring training on how to treat and care for women and girls who are suffering problems that result from having FGM/C (Mulongo et al., 2014). Another finding presented by Ahmed (2017) is that after female genital mutilation, girls had significantly higher levels of psychological problems in terms of somatization, depression, anxiety, phobic anxiety, and hostility compared to non-FGM girls. Im et al. (2020) also reported similar findings that FGM/C was strongly associated with negative physical and mental health outcomes, including post-traumatic stress disorder and depression, anxiety, and somatic symptoms. Piroozi (2020) also finds women who suffer from FGM/C are more vulnerable to mental health disorders such as depression.

- **Sexual abuse**

Kendler et al. (2000), in an epidemiological and co-twin controlled analysis of 1,411 twin pairs, reported significant odds ratios for a range of psychiatric disorders in sexually abused women after controlling for the family environment. The effects were strongest for drug and alcohol dependence and bulimia nervosa. While Dinwiddie et al. (2000) in an Australian twin study with 5,995 twin pairs, also found significant odds ratios for child sexual abuse and major depression, panic disorder, and alcohol dependence. Sexual abuse, also referred to as molestation, is usually undesired sexual behavior by one person towards another. It is often perpetrated using force or by taking advantage of another. When force is immediate, of short duration, or infrequent, it is called sexual abuse. The offender is referred to as a sexual abuser

or molester. The term also covers any behavior by an adult or older adolescent towards a child to stimulate any of the involved sexuality. However, Nelson et al. (2002) in an Australian study involving 1,991 twin pairs found that in twins where one had been sexually abused and the other had not, the abused twin had significantly higher rates of major depression, attempted suicide, conduct disorder, alcohol dependence, nicotine dependence, social anxiety, rape as an adult, and divorce. The use of a child or other individual younger than the age of consent for sexual stimulation is referred to as child sexual abuse or statutory rape (Clark & Quadara, 2010). However, child sexual abuse involving penetration has been identified as a risk factor for developing psychotic and schizophrenic syndromes (Cutajar et al., 2010). Canton-Cortes and Canton (2010) found that negative mental health effects that have been consistently associated in research with child sexual abuse include post-traumatic symptoms, depression (Fergusson et al., 2008), anxiety (Banyard et al., 2001), and eating disorders **(**Swanson, et al., 2011).

- **Dowry related violence**

Dowry-related violence is a serious problem that affects the lives of women and girls. Dowry includes gifts, money, goods, or property given from the bride's family to the groom or in-laws before, during, or any time after the marriage. Dowry is a response to explicit or implicit demands or expectations of the groom or his family. Here Kumar and Jeyaseelan (2005) demonstrate how harassment by in-laws on issues related to dowry emerged as a risk factor for poor mental health. Dowry-related violence is most prevalent in South Asia, in the nations of India, Pakistan, Sri Lanka, and Bangladesh. The most common forms of dowry-related violence are battering, marital rape, acid throwing, wife burning, and other forms of violence. Perpetrators use methods of starvation, deprivation of clothing, eviction, and false imprisonment as a means of extortion. They often use violence disguised as suicides or accidents, such as stove or kerosene disasters, to burn or kill women for failing to meet dowry demands (UNDAW, 2009). Connor (2017) illustrates the serious mental health impacts of repeated emotional and physical trauma inflicted by a husband who was dissatisfied with his wife's dowry.

2.3.3. Personal Factors

Studies in this aspect are mostly focused on lack of self-esteem, unfulfilled aspirations and lifestyles and their impact on mental health.

- **Lack of proper self-esteem**

Kearney-Cooke (1999) shows that adolescent girls tend to have lower self-esteem and more negative assessments of their physical characteristics and intellectual abilities than boys. These findings explain why the incidence of suicide attempts, depression, and eating disorders is substantially higher in girls. Low self-esteem is characterised by a lack of confidence and feeling bad about oneself. People with low self-esteem often feel unlovable, awkward, or incompetent. People are often described as having either high self-esteem when they think very well of themselves and their abilities, or low self-esteem when they are filled with doubts and criticisms about themselves and their abilities. People with low self-esteem may experience many problems in their lives. Most of the women have low self-esteem whereby they think about themselves as weak and helpless **(**Rosenberg & Owen, 2001). Longmore et al. (2004) argue that self-esteem is a predisposing factor for other mental health issues, including depression. In line with previous research, Huang (2010) points out that there are significant gender and age differences in self-esteem. Across all nations, men had higher levels of self-esteem than women did, and both genders showed age-graded increases from late adolescence to middle adulthood.

Low self-esteem is not categorised as a mental health condition in itself, but there are clear links between the way we feel about ourselves and our overall mental and emotional well-being. However, Erol and Orth (2011) found low self-esteem is not only related to depression, but also to learning disorders, antisocial behaviour, eating disturbances, and suicidal ideation. Another study by Sowislo and Orth (2013) observed that a feeling of worthlessness, which indicates low self-esteem, is found only in a relatively small portion of people who are diagnosed with depression. Persons with high self-esteem recognize their qualities and will generally strive for a happy and successful life. Those with low self-esteem have negative feelings about

themselves, believing that they are not worthy of love, happiness, or success (Gold, 2016; Kling et al., 1999). According to Murti (2020), low self-esteem and body confidence are rampant among young Indian women, with 60% of Indian girls having low to medium self-esteem, causing 65% of girls to avoid engaging with friends, family, or outdoor activities.

- **Unfulfilled aspirations**

Drebing and Gooden (1991) reports that failure to achieve "dreams," was associated with poorer mental health in women. Lowering a patient's unrealistic aspirations can be part of the psychological strain reduction strategies in cognitive therapies by clinicians and mental health professionals (Zhang et al., 2013). It is a lack of happiness or satisfaction, from not having achieved one's desires or full potential. Women, like men, have many dreams, but most of them, such as education and employment, go unfulfilled in a patriarchal society. Unfulfilled dreams have a lonely tone, as though when our dreams are fulfilled, life has short-changed us **(**King, 2014). Another study by Johnstone and Lucke (2021) report no differences in mental health scores of stay-at-home mothers according to prior work aspirations. However, stay-at-home mothers had marginally lower life satisfaction and were more dissatisfied with the progress of their careers when they had previously aspired to paid work, compared with unpaid work. Although women describe their current situation as a choice their choices were deeply embedded within gendered, social, and economic contexts.

- **Lifestyle**

Lieverse et al. (2013) discovered that an irregular lifestyle and lack of social rhythm, which includes social contacts, are also associated with mood disorders in elderly patients. However, Kotter et al. (2016) in a study with first-year medical students, found that leisure-time activities such as playing music or being active in a religious community were not predictive of self-reported mental health at follow-up 1 year later. Another study from Velten et al. (2018) underlines the importance of healthy lifestyle choices for improved psychological well-being and fewer mental

health difficulties. They conclude that in German and Chinese students, some healthy lifestyle choices like more frequent physical activity, non-smoking, regular social rhythm etc are related to improvements in mental health over a 1-year period. In a study Labrum (2022) observes that making sure we do even basic tasks like getting dressed or showering can make differences in how we feel emotionally. Making sure your day is filled with some level of enjoyment, a sense of achievement and a closeness to others is key to improving mood in particular. By maintaining a routine, it keeps energy levels up and adds rhythm into daily life which can reduce spending time worrying, ruminating and focusing on negative thoughts. In addition, women's relationships with friends, family members, and romantic partners can also impact their mental health. For example, friendships or romantic relationships that are abusive or unsupportive can significantly negatively impact a woman's sense of self-esteem and confidence (McLean, 2022).

- **Lack of trustworthy relationships and loneliness**

It is a situation of helplessness. A lack of friendship can trap someone in solitude. Sharing the language of affection could help to ease the pain. Those who have friends frequently go through life unaware of others who are so isolated as to be socially visible. Temporary times of loneliness are common and can pass quickly. Loneliness can be a chronic condition with serious, harmful effects on both one's physical and mental health. The effects of long-term loneliness on psychological health include diminished sleep quality, weakened health, and even increased mortality. Many mental health problems can be caused by a lack of close personal relationships and having no one to rely on (Solomon & Davidson, 1997). Another research published by Cacioppo et al. (2009) indicates that loneliness is contagious and occurs in social clusters. Lonely people spread their feelings of loneliness through social networks, and the spread of loneliness is stronger than the spread of perceived social connection.

Another study by the Mental Health Foundation (2010) reports that 48% of people are getting lonelier in general. Loneliness affects many at one time or another. Only 22% never feel lonely, and one in ten of them feels lonely often (11%). More

than a third of them have felt depressed because they felt alone. The pain of loneliness is the sharp end of a milder feeling of social disconnection that research suggests is widespread. While the Mental Health Foundation survey, (2010) also pointed out the interesting gender differences among the findings, that women are more likely than men to feel lonely sometimes (38%, compared with 30%). A greater number of women than men have felt depressed because they felt alone and have sought help for feeling lonely. Women are also more likely to be aware of loneliness in others. More women than men have a close friend or family member whom they think is very lonely. A study from Ospina (2020) found that loneliness correlates with subsequent increases in symptoms related to dementia, depression, and many other issues related to mental health, and this holds after controlling for demographic variables, objective social isolation, stress, and baseline levels of cognitive function.

2.3.4. Economic Factors

Literature in this aspect include studies that highlight lack of economic independence and lack of property rights as factors affecting women's mental health. Studies related to these factors are presented in this section.

- **Lack of economic independence and property right**

Rural women are economically dependent on men, especially in developing countries. Women are more likely to be dependent during their adult lives. As a daughter, it is considered her obligation to obey her father's decision. They have hardly any choice in their marriage. After marriage, women are more likely to depend on their husbands for economic support. This economic dependency is the outcome of the sexual division of labour in which primary responsibility for childcare and family work falls on women and the charge of securing an income for the family falls on men. Women's labour force participation rates are lower than men's. If this rate of participation increases, it will help to increase the family income and decrease their degree of dependency on men. Economic dependency is a hurdle to their personal growth and achievements and affects their ability to pursue their self-interests (Sorensen & Lanahan, 1987). However, Koenig et al. (2003) found that where women

have a higher economic status than their husbands and are seen as having sufficient power to change traditional gender roles, the risk of violence and mental health issues is high. While Babu and Kar (2009) point out that women with no income of their own and urban domiciles have been cited as risk factors for domestic violence. Women engaged in small businesses and farming were more likely to be abused than women who were housewives or who had occupational status equal to that of their husbands. Thus, for the prevention of intimate partner violence against women, long-term strategies aiming at livelihood and economic empowerment as well as the independence of women would be suggested (Babcock & Deprince, 2013).

In this context, Williams et al. (2013) point out that socioeconomic factors like income and financial independence have repeatedly been shown to have an impact on the health of women in mid-age. Dhungel et al. (2017) identified various factors associated with IPV and showed that the economic dependence of wives on their husbands was among the most important ones. Villa (2017) suggests that security and ownership of land decrease the risk of domestic violence for some women because economic independence means they are empowered to leave an abusive relationship. However, economic dependency seems to be an important associated factor responsible for depression in the elderly along with other factors like socioeconomic status, pension status, etc. In India, women aged 15–49 have more than 10 years of education. But coupled with early marriage, motherhood, and domestic violence, Indian women do not have the education or economic independence to fall back on (Yadavar, 2018). Furthermore, studies have shown that women face greater health disadvantages than men, which are exacerbated by poorer socioeconomic conditions (Hosseipoor et al., 2019; O'Neil et al., 2020). John and Kuruvilla (2022) in their study on married women in Kerala attempt to understand and re-examine the link between intimate partner domestic violence and the ownership of property among women. The findings reveal how women get dispossessed of their assets and are further subjected to domestic violence for want of assets. Women who managed to hold on to their assets were found to overcome and recuperate from domestic violence, and autonomous ownership of these assets boosted their self-esteem and recovery.

2.3.5. Biological Factors

Studies related to biological factors highlight postpartum depression, and discuss the way menopause, infertility and ailments affect women's mental well being. All these factors though related to specific biological events in women's lives, their linkage with mental health outcomes result from closely related sociocultural conditions and expectations rather than hormonal or other physiological conditions of women's bodies.

- **Postpartum depression**

Postpartum depression (PPD), also called postnatal depression, is a type of mood disorder associated with childbirth. Symptoms may include extreme sadness, low energy, anxiety, crying episodes, irritability, and changes in sleeping or eating patterns. Onset is typically between one week and one month following childbirth. PPD can also negatively affect the newborn child. Risk factors include prior episodes of postpartum depression, bipolar disorder, a family history of depression, psychological stress, complications of childbirth, lack of support, or a drug use disorder. Braverman and Roux (1978) have reported an increased risk of postpartum depression in women who experience marital problems during pregnancy (Kumar, 1994). In a study by Jebali (1991)**,** it was explored that many women will experience postnatal depression after the birth of their child and will receive treatment, which is medically prescribed. She explores it from the alternative viewpoint of feminist theory. Postpartum depression is a condition exclusive to women. One in seven mothers is likely to experience postpartum depression. Yet health professionals may still ignore or trivialise this distressing and common disorder, either because they do not understand it or because they do not know how to help. A study by Boyce and Todd (1992) found a highly significant correlation between caesarean section and developing postpartum depression at 3 months. They reported that women in their study who had an emergency caesarean section had more than six times the risk of developing postpartum depression. Another study by Hannah et al. (1992) also found a strong association between caesarean section and postpartum depression at 6 weeks. According to Chandran et al. (2002), the incidence of post-partum depression was

11%. Low income, the birth of a daughter when a son was desired, relationship difficulties with mother-in-law and parents, adverse life events during pregnancy, and lack of physical help were risk factors for the onset of post-partum depression. Depression occurred as frequently during late pregnancy and after delivery as in developed countries, but there were cultural differences in risk factors.

Another study by Savarimuthu et al. (2010) revealed 26.3% of the total 137 study participants were diagnosed to have post-partum depression. After adjusting for age and education factors like age less than 20 or over 30 years, schooling less than five years, thoughts of aborting the current pregnancy, unhappy marriage, physical abuse during the current pregnancy, and after childbirth, husband's use of alcohol, girl child delivered in the absence of living boys and a preference for a boy, low birth weight, and a family history of depression were found to be associated with PPD. Another finding from O'Hara and McCabe (2013) highlights postpartum depression as a serious mental health problem. Arora & Bhan (2016) opine that many Indian families practice outdated post-delivery rituals and traditions and some of these rituals may do more harm than good to the mother. In many areas in the northern and western parts of India, for instance, the mother and baby stay isolated from the family and community for 40 days after delivery. While this may be done to protect them from infection, the effective isolation makes the mother lonesome and vulnerable. In such cases, the mother experience severe mood swings, excessive crying, difficulty bonding with the infant, loss of appetite or overeating, insomnia or sleeping too much, panic attacks, or in extreme cases, thoughts of harming herself or the newborn child. Freak cases where a depressed mother has killed her own child have been reported in the US and the UK. In India, such instances go unreported or misreported (Arora & Bhan, 2016).

While most women experience a brief period of worry or unhappiness after delivery, postpartum depression should be suspected when symptoms are severe and last over two weeks (NIMH, 2017). On World Mental Health Day, the National Institute of Mental Health and Neurosciences released India's National Mental Health Survey Report (2015-2016). It is reported that 1 in 20 people in India suffers from

depression. Particularly alarming are the statistics that show depression rates are much higher for women compared to men. And women are particularly prone to depression in their child-bearing years, commonly manifested as postpartum depression. Despite health professionals knowing this, India's reproductive health programmes do not include services for the prevention or treatment of postpartum depression (NMHS, 2017).

Upadhyay et al. (2017) point out that the broader public health discourses, both maternal health, and maternal mental health are usually overlooked. It is estimated that 10–35% of women around the world, including India, suffer from depression during pregnancy and postpartum. The Times of India (2020) reports that the uncertainty and anxiety that prevailed in society during the COVID-19 global pandemic is also increasing the level of stress and fear of social isolation in pregnant women and new mothers. Many women are wondering if their feelings are normal, or if they are just the baby blues, or if they may be experiencing true depression or anxiety. Gynaecologists and mental health experts believe that there is a rise in post-partum depression cases in their clinics during the pandemic period. Jijila et al. (2022) propose that even though PPD is found in association with pregnancy and delivery, the major risk factors leading to PPD are not merely biological but mostly sociocultural. Based on the findings of their study on 84 young mothers in the age group of 25-35 in Kerala, they have identified the risk factors leading to PPD as to include various outdated customs and rituals during and after the delivery, worries about newborn's health, sleep disturbances, lack of time for self-care and bodily changes, lack of support and care from husband and in-laws, hopelessness related to career ambitions and unplanned pregnancy.

- **Menopause and PMS**

A study by Kauffert et al. (1992) revealed that menopause is one of a series of factors that may increase the risk of depression for women in middle age who also face issues such as children leaving home, the death and illness of family members, the stresses of daily living, and the onset of chronic disease. Rather than hormonal changes, it seems to be her health coupled with the shifts and stresses of family life in

a woman's menopausal years that may trigger her depression. Another study by Avis et al. (1994) found that natural menopause was not associated with an increased risk of depression. Experiencing a long perimenopausal period (at least 27 months), however, was associated with an increased risk of depression. While Freeman et al. (2004) found that depressive symptoms increased during the menopause transition and decreased in postmenopausal women. Hormonal associations provided corroborating evidence that the changing hormonal milieu contributes to dysphoric mood during the transition to menopause. Cohen et al. (2006) analysed that premenopausal women with no lifetime history of major depression who entered perimenopause were twice as likely to develop significant depressive symptoms as women who remained premenopausal, after adjustment for age at study enrolment and history of negative life events. The increased risk for depression was greater in women with self-reported vasomotor symptoms. Another study by Bromberger et al. (2007) indicates that most midlife women do not experience severe depressive symptoms. Those that do are more likely to experience high depressive symptom levels when perimenopausal or postmenopausal than when premenopausal, independent of factors such as difficulty paying for basics, negative attitudes, poor perceived health and stressful events.

Woods et al. (2008) opine that the late menopausal transition stage was significantly related to depressed mood. Hot flash activity, life stress, family history of depression, history of "postpartum blues," sexual abuse history, higher body mass index, and use of antidepressants were also individually related to depressed mood; the hormonal assays and age of entry into and duration of the late menopausal transition stage were unrelated. Freeman (2010) indicates that the likelihood of depressed mood in the menopausal transition is 30% to three times greater compared with that during pre-menopause. Women with a history of depression are five times more likely to have a diagnosis of major depression in the menopausal transition, whereas women with no history of depression are two to four times more likely to report depressed moods compared with premenopausal women. Other risk factors for depressed mood in perimenopausal women include poor sleep, hot flashes, stressful or negative life events, employment status, age, and race**.** Bromberger et al. (2011)

also pointed out that women were two to four times more likely to experience a major depressive episode when they were peri-menopausal or early post-menopausal. The risk of major depression is greater for women during and immediately after the menopausal transition than when they are pre-menopausal. However, Peisley (2017) suggests that women who had severe PMS in their younger years or postpartum depression may have more severe mood swings during perimenopause. Women with a history of clinical depression also seem to be particularly vulnerable to recurrent clinical depression during menopause. Though menopause is a biological state of cessation of monthly periods, several sociocultural factors and events in women's lives and not the hormonal changes alone are responsible for PMS.

- **Infertility**

A study from Hart (2002) points out that infertility is not a disease, and its treatment can affect all aspects of people's lives, which can cause various psychological-emotional disorders or consequences, including turmoil, frustration, depression, anxiety, hopelessness, guilt, and feelings of worthlessness in life. Another study by Matsubayashi et al. (2004) report infertile women in Japan as well as in the Western world to have high levels of emotional distress, anxiety, and depression. The reasons for anxiety and depression in infertile women are easy to presume but remain unclear. Anxiety and depression in childless Japanese women were significantly associated with a lack of husband support and feeling stressed. Cwikel (2004) point out how fertility treatments, ranging from medical monitoring to hormonal remedies and in vitro fertilization (IVF), are both a physical and emotional burden on women and their partners. A couple that is trying to conceive will undoubtedly experience feelings of frustration and disappointment if a pregnancy is not easily achieved. However, if the difficulties progress and the man and or woman are labelled as having fertility problems, then this may result in a severe insult to self-esteem, body image, and self-assessed masculinity or femininity. Gulseren et al. (2006) found the severity of psychologic symptoms to be greater in those in the infertility group who had attempted nonmedical solutions, who were under pressure from their husbands' families because of their infertility, and who reported bad relations with their husbands. The group of patients who achieved pregnancy showed significantly lower levels of anxiety and depression scores than the group of patients who did not. Age

attempts at nonmedical solutions, pressure from the husband's family because of infertility, and anxiety level at the start of the study were variables that predicted pregnancy negatively. Another finding from Cousineau and Domar (2007) observes that the medicalization of infertility has unwittingly led to a disregard for the emotional responses that couples experience, which include distress, loss of control, stigmatization, and a disruption in the developmental trajectory of adulthood.

Here Damti et al. (2008) identify the psychological risk factors for infertility in women as depression, anxiety, and stress-dependent changes like altered heart rate and increased blood cortisol levels. Infertility in both men and women has become quite common these days and is on the rise in India. As per estimates, there has been a 20% to 30% rise in infertility in the country in the last five years. In India, male infertility is largely an ignored phenomenon, and women are subjected to a lot of social stigmas for being unable to bear children. The conflux of personal, interpersonal, social, and religious expectations may bring a sense of failure, loss, and exclusion to those who are infertile. Relationships between couples can become very strained when children are not forthcoming. One partner may seek to blame the other for being defective or unwilling. Childless couples are sometimes excluded from taking leading roles in important family functions and events such as birthdays, christenings, confirmations, and weddings. Moreover, many religions assign important ceremonial tasks to the couple's children. Many societies are organized in such a way that children are necessary for the care and maintenance of older parents. Childlessness is of particular concern because of the global extent of the problem and the social stigma attached to it (Lee & Hadeed, 2009). Another study by Akyuz et al. (2010) concluded that the history of infertility is not a major factor in postpartum depression while a history of depression may contribute to its development during pregnancy and in the postpartum period. Infertile women who experience severe anxiety and stress could be more prone to depression and should therefore be monitored closely. With regard to infertility, women have to bear a disproportionate burden due to the societal expectations on women's gender roles as mothers. Motherhood is glorified in women's lives whereas fatherhood is never treated on an equal footing in men's lives.

Ailments and Mental Health of Women

For women, the breast is not seen as a simple organ but a symbol of beauty, seduction, and motherhood. Hence, mastectomy is considered an extreme source of mental health diseases, especially depression and anxiety disorders (Keskin & Gumus, 2011; Khan et al., 2016). Gynecological cancer patients often suffer from psychological problems such as depression, anxiety, and nervousness caused by the cancer diagnosis and treatments. Patients diagnosed with cervical cancer commonly experience anxiety and feel that they are going to die in a devastating condition. (Mawardika et al., 2019). Cancer incidence and mortality are rapidly increasing worldwide and the most common types in women are breast cancer and gynecological cancer (Sung et al., 2021). The association of mental health disorders in patients with breast or gynecological cancer increases their distress (Aquil et al., 2021). In accordance with the findings of Ghamari et al. (2021) women with ovarian cancer seemed to be more vulnerable than women in the general population to anxiety, depression, and adjustment disorder over the first two years following diagnosis. Furthermore, survivors of ovarian cancer with a mental health diagnosis showed an 80% increased probability of dying compared to survivors without a mental health diagnosis. Another study by Hu et al. (2023) suggests that women who receive a diagnosis of gynecological cancer ought to undergo a psychosocial evaluation. Women should receive care and social assistance to help them deal with their illnesses. Women who received greater emotional support during the cancer phase had better quality of life and less mental discomfort, according to a study on women with gynecological cancer. Therefore, creating a loving and caring environment will enhance a woman's outlook on battling gynecological cancer.

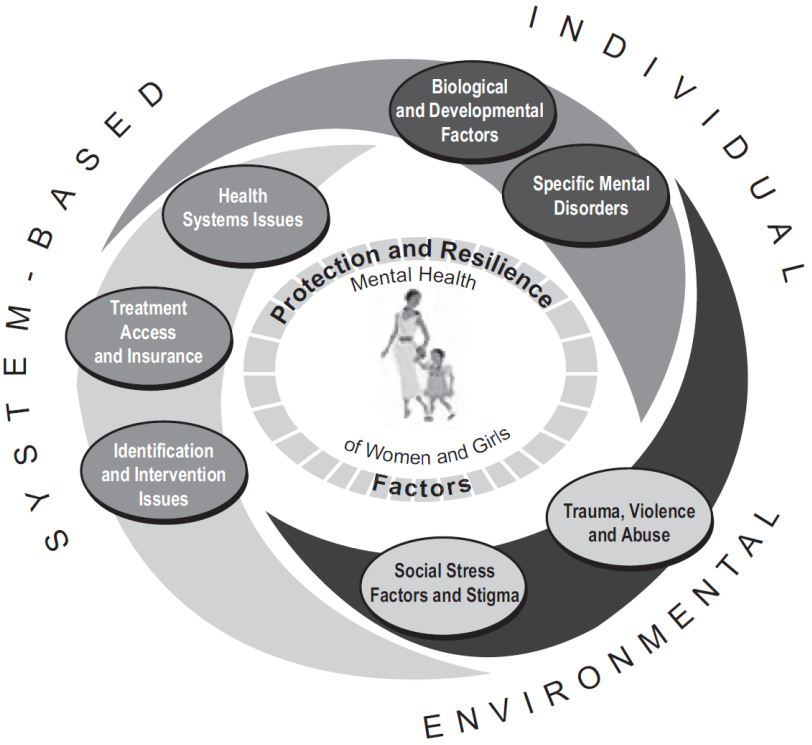
Thus, with regard to ailments also, sociocultural expectations of women as care givers and their lack of economic independence often aggravate women’s traumatic experiences. Poverty, malnourishment and overburdened workloads result from women’s secondary status in society and this in turn lead to higher levels of morbidity among women. The cumulative effect of all these result in poor mental health of women.

2.4. Conceptual Framework of the Study

A conceptual framework of elements impacting women's and children's mental health developed by the US Surgeon General's Workshop on Women's Mental Health in 2005 is presented in Figure 2.1.

Figure 2.1

Mental Health- Conceptual Framework **(**US Statistics on Women's Mental Health, 2005)



As per the above conceptual framework, there are various factors contributing to mental health of a person that are broadly categorised as system based, individual and environmental factors. Though sociocultural factors are listed under the broad head of environmental factors, while looking through a gender lens this conceptual framework is not comprehensive enough. Also, medical conditions are given an overemphasis in the framework which might be appropriate in a medico-legal context.

Hence based on the literature reviewed, and in tune with the feminist propositions on women's mental health, a new conceptual framework was formulated for the present study which is presented in Figure 2.2.

Figure 2.2

Mental Health of Women - Conceptual Framework Based on Review of Literature

2.5. Gaps in Research

The review of related literature helped the investigator in many ways. The review has given an idea about the mental health status of women worldwide, at the national and regional levels. Most studies reveal gender differences in various aspects of mental health, and several studies discuss the factors that affect women's mental health. Almost all studies indicate that women experience more depression than men. But the determinants of gender difference in depressive disorders are far from being established and their combination into integrated etiological models continues to be lacking.

In earlier studies, there is an overemphasis of biological factors as determinants of women's mental health. The sociocultural determinants are getting attention in recent studies but comprehensive studies with a feminist perspective are lacking in the area. Majority of the studies are quantitative which list out a few factors as responsible for gender difference in mental health. Studies using experiential analysis could not be located. The pathways through which gender implicate upon women's mental health are to be studied in detail in order to improve women's mental wellbeing and happiness. This necessitates undertaking the present study that would also add to the feminist scholarship in the area of mental health and its determinants.

Chapter III
METHODOLOGY

CHAPTER III
METHODOLOGY

The methodology followed in the study is detailed in the present chapter. The research setting, profile of the area of study, research aims, operational definition of key concepts, the study design, participants recruitment, tools used to collect data, data gathering and challenges, participants' demographics, data analysis structure, analysis techniques used and the ethical considerations are presented here.

3.1. The Research Setting

The empirical part of the research was conducted in the three districts of Kerala, namely Malappuram, Kollam, and Ernakulam. Kerala is a state in the southwest region of India with the lowest positive population growth rate (4.91%) and the highest human development index (0.633) in the country, according to the Human Development Report, 2023. It also has the highest literacy rate (93.91%), the highest life expectancy (74 years), and the highest sex ratio as defined by the number of women per 1000 men (1083 women per 1000 men) among all Indian states (Census, 2011). There are 14 districts in the state.

Kerala ranks top in gender-related indicators in India. Capability measures are world-class, but the best indicators of literacy, education standards, fertility rate, and maternal and infant mortality rates have not improved women's choices. Recent surveys indicate that women have a significant measure of morbidity, particularly in mental wellness (John & Gunasekaran, 2020). Community-level intervention policies suggest that low mental health is a strongly gendered phenomenon. The treatment of mental health in Kerala is muted and poorly researched. Yet the act of women seeking treatment has gone up steadily since the 1970s. It has been indicated that the gender discrepancy in mental health is due to sociocultural stressors (Kodoth & Eapen, 2005; Malhotra & Shah, 2015). In Kerala, gender roles are instigated at an early age and reinforced throughout life (Ekatha, 2013). Women's primary responsibilities are still considered related to the family, in the roles of homemaker, caregiver, and mother.

Women's social relationships are not given importance. Ideal women are expected to be docile and submissive. Females are considered as 'others'. Rates of gender-based violence are still high and the dowry system is prominent in society among all religious communities (Sharma, 2022; Upadhyay, 2017). Male authority is protected and respected. In short, patriarchy and its control over women's lives are high in Kerala (Nagarajan, 2019).

Educational reforms have encouraged women to pursue higher education and female literacy is high with low gender gaps. However, education is centered on the feminine roles of wife, caregiver, and mother. The goal of education most often is to find an educated husband. Educated unemployment has increased among women, especially in rural areas. Women have a high workload in the household, which is unpaid and undervalued and a majority of them lack economic independence (Singh et al., 2019). In a survey on mental health in Kerala, that comes out strongly from the data showed that the level of mental distress is high in Kerala for both men and women and also that it is consistently higher for women as compared to men (National Mental Health Survey, 2017). Women have to agree with patriarchal ideology to a greater extent than men and is considered a much more potent or statistically significant explanation for mental stress in women than men (Mukhopadhyay, 2007).

3.2. Profile of the Area of Study

The study participants were selected from three districts, namely, Malappuram, Kollam and Ernakulam, representing north, south, and central Kerala respectively.

Malappuram is a northern district of the state, with the Muslim community constituting the major population. Comparatively low work participation, lack of higher education facilities, dependence on traditional agricultural work, and low marriage age of both men and women are the specialties of the district. Earlier women's education was not encouraged enough among Muslims, though changes are coming up these days. Early marriage, adolescent pregnancy, the dowry system, and polygamy exist in this region even today. Restricted mobility of women is yet another feature commonly seen in this district. It is more prevalent among highly religious

people (Forero-Pena, 2004; Mambra et al., 2021; Kuruvilla & Nisha, 2015; Singh et al., 2019; Jijila & Kuruvilla, 2019; Kodoth, 2004; Sahma & Vahid, 2020; John & Varier, 2017). Religious rituals and practices are followed more rigorously in this region. The decision-making power of women is very poor in this district (Kuruvilla & Thasniya, 2015). In Kerala, the decision to wear a Purdah more often comes out of compulsion and not a free choice. In this case, it is associated with covering the face most of the time (Abdelhalim, 2013). Concerning gender role perception of women, religion appears to be an important factor in creating the social knowledge and discourse that construct the individual's view of gender and the role and place of gender in society. Every religion enforces some or other restrictions on women (Kuruvilla & Nisha, 2015).

Kollam is a southern district of Kerala, located 70 km north of the state's capital, Thiruvananthapuram. It is one of the more densely populated districts where the Hindu community constitutes the major population. The people of Kollam are very religious and traditional in nature. Dance and music are integral parts of the culture of the people. Generally, their lifestyle is quite simple, and they place great importance on education. Kollam is infamous as a high dowry demanding district in Kerala (Karindalam, 2021; John, 2022). Recently, an educated woman committed suicide because of the dowry-related violence in Kollam (On Manorama, 2022; The News Minute, 2022). A district-level official who handles domestic violence cases in Kollam said their office receives between 20 and 39 domestic abuse complaints every month. Dowry is the common factor in almost all domestic violence incidents in the district, though other reasons behind the violence vary, from alcohol addiction to suspected infidelity (Sabith, 2021).

Ernakulam is one of the most developed districts in Kerala, located in the heartland of the state. It is the commercial capital of the state, yielding the highest revenue among all districts. Ernakulam is one of the most advanced districts in terms of education, income, and urbanization. As per the official Census 2011 and population data 2022 of Ernakulam district, Hindus constitute 45.99% while Christians form a significant 38.03% of the total population. Atrocities against women

in Kerala's financial capital, Kochi, are on the rise. Shocking reports of assaults on women at their own homes by those dear and near to them are emerging from the city. The number of crimes against women in the town has been on the rise over the past four years. In 2021, 500 cases were reported in Ernakulam related to violence against women and it has increased to 775 in 2022 (Kerala Police Official Site, 2022). Domestic violence continues unabated, going by the 1560 cases that Snehitha has intervened in Ernakulam since the help desk's inception in 2013 (Praveen, 2021).

3.3. The Research Questions

The study was conceived to find answers to the following research questions:

- What will be the present mental health status of women in Kerala?
- Will there be a significant difference in the mental health status of women belonging to different sub-samples formed on the basis of the classificatory variables like religion, income levels, caste, and employment status?
- Will paid employment and economic independence improve the mental health of women?
- Is alcohol dependency of men a significant factor that adversely affects women's mental health?
- Whether domestic violence has a toll on women's mental health?
- What are the major factors that affect the mental health of women in Kerala?

3.4. The Research Objectives

To find answers to the research questions, the study was conducted with the following objectives:

- To assess the mental health status of women in Kerala for the total sample and the sub-samples formed based on the classificatory variables like religion, income level, caste and employment status.

- To compare the mental health of women in Kerala belonging to different groups formed based on the classificatory variables.

- To explore the factors affecting the mental health status of women in Kerala.
- To suggest measures that would enhance the mental health of women in Kerala.

3.5. Operational Definition of Key Concepts

a. Mental Health

Mental health is not only a condition of absence of mental illness, but it has several other dimensions. In accordance with the WHO definition, in the present study, the term 'Mental Health' refers to a state of well-being and happiness in which the individual realizes her abilities, copes with the normal stresses of life, well-adjusted with self and people around her, works productively and fruitfully, and makes contributions to personal and societal development.

b. Gender Perspective

Gender is an important factor in determining the mental health status of a person. There are a lot of privileges for men everywhere, but women are barred from such special rights. Besides, there are a lot of restrictions and biases worldwide exclusively targeted against women. Male-centered societies consciously ignore women's issues and mental health. In the present study, the term "gender perspective" refers to the assessment and analysis of the mental health of women with an understanding of the biases and discrimination existing in a patriarchal society against women; studying the factors contributing to the mental health status amidst the debilitating conditions that may arise from their socio-culturally determined secondary status in the society.

c. Women in Kerala

Women in Kerala in this study include only married women born and brought up in Kerala who live with their partners and families and fall within the reproductively active age group of 25-45.

3.6. Study Design

The study was designed as both descriptive and exploratory. A mixed method involving both quantitative and qualitative methods was employed in the present study to get valid and reliable data and results. Mixed Method is seen as a methodology integrating both qualitative and quantitative approaches within one research project. The movement has been around since the 1980s when sociologists tried to resolve the disagreement between the qualitative and quantitative paradigms by combining both in a third way (Hypotheses, 2019).

Mixed method designs, according to Green et al. (1989) are the ones that use at least one quantitative method and one qualitative method, neither of which is inherently related to any certain paradigm of inquiry. Johnson et al. (2007) description of a mixed method approach as "a type of research in which a researcher or a team of researchers combine elements of qualitative and quantitative research approaches for the broad purposes of breadth and depth of understanding and corroboration" is the most comprehensive definition available. To examine an issue of interest more deeply, methodological eclecticism entails choosing and integrating the best applicable techniques from qualitative, quantitative and mixed methods. It goes beyond just combining qualitative and quantitative methods (Tashakkori & Teddlie, 2011). By leveraging the advantages and addressing the biases of the different approaches, mixed methods aim to increase the interpretability, significance, and validity of constructs and inquiry outcomes. The present study focused on the mental health status of women and explored the factors contributing to the low and high mental health status of women in Kerala. For a thorough investigation of the problem, using only statistical methods is insufficient and a subjective approach is also necessary. As a result, the current study placed a strong emphasis on a qualitative dominant approach. Although both quantitative and qualitative methods were employed for data collection, the analysis was carried out with the aim of qualitising the whole data in order to identify the real issues and potential solutions for the mental health challenges of women in Kerala and that too in terms of subjective dimensions. Due to the need for both an objective and subjective approach, the present research has utilized both

quantitative and qualitative research approaches. That is why a mixed methods design was adopted with the aim of providing stronger evidence for the research findings.

3.6.1. Quantitative or qualitative?

Quantitative questionnaires and surveys are one way to examine the mental health status of women. This method does not allow them to get insights into the factors influencing or contributing to their mental health status. Qualitative research examines the impact of a person's experiences, beliefs, and actions on their life (Reeves et al., 2008). A qualitative approach better matches answering the research questions. Open-ended questions are questions that cannot be answered with a "yes," "no," or "I don't know" answer; they are designed to open dialogue about a topic to gain a person's opinions, experiences, feelings, thoughts, and explanations for actions (Handcock et al., 2007).

The study in the first phase was quantitative in nature. The first part was a randomized survey on the mental health status of women from various strata based on the selected classificatory variables such as religion, income level, caste, and employment status. The WHO (ten) well-being index was used to collect data. The mental health status was arranged in ascending order based on the first phase scores, and 25 women each were chosen from the highest and lowest mental health groups, respectively.

The second phase of the study was fully qualitative in nature and was an attempt to explore the factors contributing to the mental health status of women through unstructured interviews. However, women shared their experiences with the researcher clarifying and conducting follow-ups through repeated interviews on topics related to gender-based violence, alcoholism of husband, other controlling and restrictive nature of husband and families, and the patriarchal nature of familial settings. The qualitative aspect of the research also included what kind of strategies they used to survive challenging situations. Thematic analysis was performed on the data obtained from 50 transcribed and coded face-to-face unstructured interviews. So, the study is a combination of quantitative and qualitative methods.

3.7. Participants Recruitment

The population for the study consists of all married women in Kerala. The initial sample consisted of 300 married women belonging to the three districts of Kerala, namely Malappuram, Kollam, and Ernakulam, within the reproductively active age group of 25 to 45. Based on the literature reviewed, married women were found to be more likely to have more responsibilities at home and need more time for adjustment with their husbands and in-laws (Malhotra & Shah, 2015) than single women. Alcoholism of the husband is found to be a major factor influencing the mental health of women (Dostanic et al., 2022; Nayak et al., 2010). Premenstrual syndrome, infertility and pregnancy are factors that are applicable more to the mental health status of married women (Bina, 2008). Hence, the present study focuses on the mental health status of married women only. Single women and aged women were not included in the present study so as to focus more on the gendered family dynamics and pathways through which gender impacts the mental health of women.

Four major classificatory variables, namely, religion, income level, caste, and employment status were identified through the review of related literature in the area of mental health. 'Religion' is found to have significant yet contradictory impacts on women's mental health (Behere et al., 2013; Gupta & Coffee, 2020). The religious rituals and practices negatively influence the mental health of women, and in Kerala, women are highly restricted by religion (Jijila & Kuruvilla, 2019). Other studies report a positive impact of religious faith on women's mental health (Archer, 2017). Therefore, the present study has paid attention to the mental health status of women belonging to the three major religions in Kerala, namely, Hindu, Christian and Muslim. A comparison of their mental health status was also attempted.

Another classificatory variable 'Income level' also was found to have a significant influence on the mental health of women. Every social class has a unique social structure and lifestyle. Women's mental health is impacted by poverty, economic dependence, and class prejudice (Pandey et al., 2021) because of which more focus on the income aspects is essential.

'Caste' is an important factor related to women and their well-being. The SC/ST community is highly excluded and faces discrimination in society (Khubchandani et al., 2018; Mohindra et al., 2006). Caste discrimination exists in all areas and the lower castes continue to be marginalized (Jiwani et al., 2022). Hence caste is also included as a classificatory variable.

Finally, employment status is another variable that affects the mental health of women. Research reveals that women who are employed and those who are not will have different mental health conditions (Xue & McMunn, 2021). Economic dependence, role conflict, unemployment etc affect women's mental health (Strandh et al., 2013). Because of this, the study selected employment status as a classificatory variable while examining the mental health status of women.

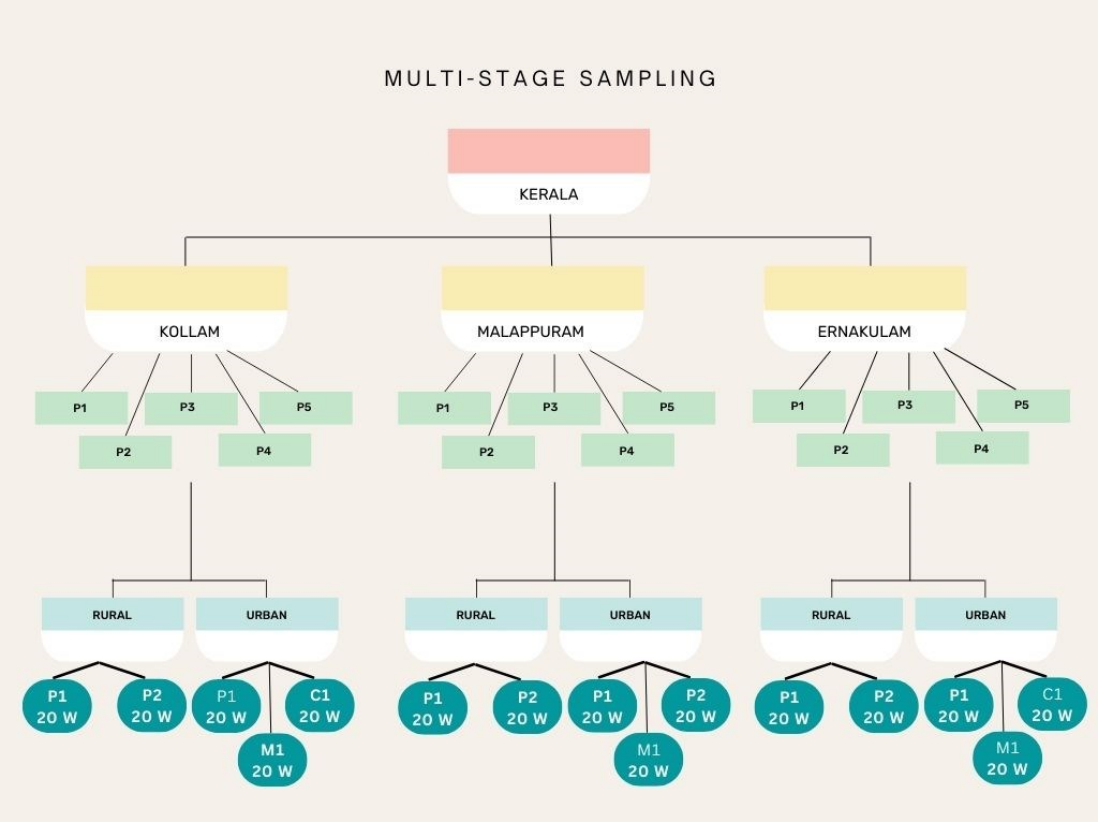
Ethical clearance was obtained and informed consent was taken from individual study participants before conducting data collection.

3.7.1. Multi-stage sampling

The study participants were located from the three districts of Kerala by using multi-stage sampling. Multistage sampling is a sampling method in which the population is separated into groups or clusters, for the purpose of research. Since the population is large and widely spread geographically, multistage sampling was found to be more practical to get a representative sample. Multistage sampling also allows each stage to use its own sampling method.

The multi-stage sampling procedure of the present study is presented in Figure 3.1.

Figure 3.1
Multistage Sampling



The three districts representing the three regions of north, south, and central Kerala were identified through random sampling. Three panchayaths and two municipalities/corporations each from the each of the three districts were further selected through random sampling. Due care was given to include at least two panchayaths each from the rural areas. Twenty women each from each panchayath/ municipality/ corporation belonging to different religions, income levels, castes, and employment status were located through stratified sampling with the help of Asha workers and Anganwadi teachers.

3.7.2. Inclusion criteria

The current study includes married women only between the ages of 25 and 45 to focus more about women and their issues in married familial settings where women may have to adjust a lot with their partner, in-laws, and children. As revealed from literature, most of the gender-based violence, like domestic violence, intimate partner violence etc., is related to the partner of a woman and his family members. Hence married women, without mental illness; either housewife or employed; belonging to different income levels; different castes and only in the age group of 25-45 were included as participants of the study. Those women whose husbands reside abroad or are widows or deserted were also not included.

3.7.3. Exclusion from research participation

Women below 25 and above 45 were not included as respondents in the present study. Women who were under medical treatment were also excluded as they may not be able to respond to the interview to be conducted in the second phase of the study that analyzes the factors that have resulted in their present mental health status. Unmarried women and those women who are 45+ were also excluded as the research intends to explore the impact of marital relations on women's mental health. Divorced women and deserted women are also excluded in this study to focus more on the condition of women who live with partners.

3.8. Tools Used to Collect Data

The data necessary for the study were collected from both primary and secondary sources. The researcher used the personal and family information schedule to collect information about the social and personal details of the study participants such as age, religion, income level, caste, educational level, present locale, employment status, etc. The WHO (ten) Well-being Index was used to assess mental health status and fifty in depth interviews were used to analyze the factors affecting mental health.

3.8.1. WHO (ten) Well-being Index

The WHO (Ten)Well-being Index (1996) was used for assessing the mental health status of women. It contains ten statements: four on depression, anxiety, and vitality, and the remaining six on various coping skills and life adjustments. The well-being questionnaire was developed for a European multicenter study by the WHO European regional office. The aim was to assess not only depression and anxiety (negative well-being) but also positive well-being. The questionnaire was designed based on Zung's self-rating scales for depression, anxiety, and psychological distress with additional new items for positive well-being. In order to further reduce the number of items in the final scale and to retain comparability with the WHO (Bradley) questionnaire, 10 items were identified. Firstly, one item was chosen to represent each of the first three WHO (Bradley) dimensions, i.e., depression, anxiety, and energy. A dimension common to many measures of patient outcome was retained, as were 6 items of positive well-being. Two items from the list of 16 were replaced by two others that were included in the Bradley scale. There was no significant difference between national subgroups on either parameter of Loevinger's coefficient of homogeneity and Cronbach's alpha for the resulting 10-item scale. This ten-item scale is termed the WHO (ten) Well-being Index. During the questionnaire completion, each item was answered on a numerical scale from 1 (all the time) to 4 (none of the time), but in the analysis, the scales were altered to 0-1- 2- 3 scales to simplify the scoring. WHO 10 is an adequate index for measuring overall well-being, including both positive and negative dimensions. It is a single general dimension of subjective well-being.

Scoring procedure

In the WHO (ten) well-being index, four alternative responses have been given to each statement. Items with "all of the time" responses are to be given a score of 0, with "none of the time" responses a score of 3.

3.8.2. Unstructured Interviews

When gathering in-depth information on people's opinions, thoughts, experiences, and feelings, unstructured interviews are an appropriate method. Interviews are useful when the topic of inquiry necessitates complex questioning and

extensive probing. Face-to-face interviews are appropriate when the target population can communicate more effectively in person than in writing or over the phone. The interviewer has no specific guidelines, restrictions, predetermined questions, or list of options in an unstructured interview. The interviewer asks a few broad questions to elicit an open, informal, and spontaneous discussion from the respondent. The interviewer also probes with additional questions and or investigates inconsistencies to gather more detailed information on the subject. Unstructured interviews are particularly useful for getting the stories behind respondents' experiences or when there is less information about a topic (George, 2022). The factors contributing to the mental health status of women were collected through unstructured interviews.

3.9. Data Gathering and Challenges

Since Kerala is a state with high literacy and educational standards for women, the WHO questionnaire was completed by the respondents themselves. The researcher first approached the Asha and Anganwadi workers of the selected areas of study and with their support located the study participants. Due consideration was given to include women belonging to the four classificatory variables of religion, income level, caste and employment status.

The requirements of the study and their willingness throughout the study were sought. While a few of them expressed their fear of privacy and confidentiality during the interview, they had to be replaced with new study participants. It was an exceedingly challenging task for the researcher to convince the study participants. Most of the respondents had a misunderstanding about the word 'mental'. They think that those who are mad or mentally challenged are referred to as mental. After learning more about mental health, many of them were eager to talk more about their experiences. In such circumstances, Asha workers and Anganwadi teachers were helpful. The respondents gained more trust through communication with the researcher and later extended full cooperation after being informed about the research and the subject.

The WHO ten Well-being Index both in Malayalam and English were shared among 400 study participants through Google Forms, anticipating the chances of

incomplete responses and inability to respond in certain cases. Finally, after deleting the incomplete responses out of 328 received, 300 responses were finalized for scoring. The data collection was done during the period from September 2021 to May 2022. After the scoring procedure, the scores were arranged in ascending order to identify the High Mental Health (High MH) and Low Mental Health (Low MH) groups based on the highest 25 and lowest 25 scorers.

Fifty face-to-face in-depth interviews were used to gather data from the study participants belonging to the High and Low MH groups. The researcher interacted with the study participants in accordance with the COVID-19 protocols. The respondents were encouraged to convey additional opinions and share their subjective feelings related to each question. The face-to-face in-depth interviews were also helpful in gathering information from their actions, words, and expressions. The researcher could identify the emotions-the grief and trauma of the respondents. The interactions extended from two to four hours. In some cases, two to four sessions were required to complete the interview with a single study participant. Being a sensitive topic, establishing a rapport with the participant was very significant. It also took time to convince them of confidentiality and make a few of them comfortable to open up. Women, especially in the upper class and urban women were found to be wary and uninterested in discussing their personal lives. A few of them seemed to be scared to talk about their bitter experiences even after their suffering for long years, perhaps due to the quite prevalent women blaming and victim shaming among the literate Kerala society.

For further communication, most of the women had given their husbands' phone numbers. Thus, getting in touch with them for clarification and additional information proved challenging. Every time the researcher calls, the husband will be either at work or away from home. In these instances, the researcher had to first persuade the husband to provide the wife's phone number. Throughout the investigation, this was the thing that bothered the researcher most. Yet the process of gathering data offered a wide range of experiences and knowledge about women's experiences and subjective feelings.

3.10. Participants' Demographics

The profile of the initial sample of 300 study participants based on the classificatory variables such as religion, income level, caste, and employment status are presented in the following sections.

3.10.1. Profile of the participants based on religion

Though the study was anticipated to have an equal number of participants from the three major religions, namely, Hindu, Christian and Muslim, the initial sample consisted of a slightly unequal number of each category.

Table 3.1
Profile of the Final Participants Based on Religion

Sl No	Religion	Participants	% of sample
1	Hindu	125	41.7%
2	Muslim	83	27.7%
3	Christian	92	30.7%
	Total	300	

According to Table 3.1, the sample consisted of 41.7% Hindus, 27.7% Muslims, and 30.7% Christians. The highest representation of study participants is from the Hindu religion and the lowest is from the Muslim religion. It was found that Muslim women are highly controlled by their husbands, and they are not willing to participate in the study without their husband's permission. In the case of the husband, they have a lot of misguided ideas about women's mental health and women's rights. So, data collection from the Muslim community was more difficult. Some of them expressed their helplessness, others were reluctant to be interviewed out of fear, lack of privacy and inability to open up.

3.10.2. Profile of the participants based on income level

The total participants were categorized into three based on their monthly family income:

Upper-income group: Income from 1 lack above, Middle-income group: 25000 to 50000- and Lower-income group: Below 10000 respectively. The profile of the final participants based on the classificatory variable of income levels is presented in Table 3.2.

Table 3.2

Profile of the Participants Based on Income Level

Sl No	Income levels	Participants	% of sample
1	Upper income	57	19%
2	Middle income	188	62.7%
3	Lower income	55	18.3%
	Total	300	

As per Table 3.2, the income-wise classification of the total participants shows 19% of women from the upper-income group, 62.7% from the middle-income group, and 18.3% from the lower-income group.

3.10.3. Profile of the participants based on caste

The caste-wise split up included General, OBC and SC/ST categories. The profile of the final participants based on the classificatory variable of caste is presented in Table 3.3.

Table 3.3

Profile of the Participants Based on Caste

Sl No	Caste	Participants	% of Sample
1	General	108	36 %
2	OBC	149	49.7%
3	SC/ST	43	14.3%
	Total	300	

As per Table 3.3, the caste-wise classification of the total participants includes 36% from the General category, 49.7 % from OBC, and 14.3% from SC/ST. Table 3.3 shows a high percentage of participation from the OBC category and a low

percentage of participation from the SC/ST community. Most of the SC/ST people were found to be fearful, and they expressed less interest in participating, most of them were unwilling to talk with the researcher or lacked a smartphone and the internet. In such cases, the smartphone of the husband or children was used to respond to the Google Form. A few of them were not willing to participate even when the researcher approached them through community workers.

3.10.4. Profile of the participants based on employment status

The employment status-wise split up included Government, Private, Housewife and others (daily wages) categories. The profile of the final participants based on the classificatory variable of employment status is presented in Table 3.4.

Table 3.4

Profile of the Participants Based on Employment Status

Sl No	Employment status	Participants	% of Total Sample
1	Government	24	8.0 %
2	Private	77	25.7%
3	Housewife	143	47.7%
4	Others (Daily wage)	56	18.7%
	Total	300	

Table 3.4 shows the employment status-wise classification of the total participants. As per Table 3.4, 8.0 % of the sample is from government service, 25.7 % from private sector, 47.7% from homemakers, and 18.7% from other categories. The majority of the women are doing household work like cooking, cleaning, childcare, and total home maintenance, while the women from government service are very few. Most of the study participants are working in different sectors, like private and various daily wage sectors. Those few in the government sector seemed to be busy in their work and less interested in participating in the study. They said that they needed to finish a large amount of work in the office by the evening, and then they had to do so much house chores at home. So, if they permit time for the interview,

they must struggle greatly at home. While they have just finished their work at the office and are running home to meet their responsibilities, it appears that they are already stressed and are having difficulty keeping up with their day-to-day work.

3.11. Profile of the Study Participants Involved in In-depth Interviews

The demographic profile of the final 50 study participants who belonged to the High and Low MH groups is presented in Table 3.5.

Table 3.5

Profile of the Final 50 Study Participants

Variables		**High MH**	**Low MH**	**Total**
Religion	Hindu	13	13	26
	Muslim	7	9	16
	Christian	5	3	8
Income levels	Upper income	6	6	12
	Middle income	15	10	25
	Lower income	4	9	13
Caste	General	3	8	11
	OBC	18	13	31
	SC/ST	4	4	8
Employment level	Government	3	1	4
	Private	3	1	4
	House wives	15	11	26
	Others daily wages	4	12	16

3.12. Data Analysis Structure

Both quantitative and qualitative analyses were attempted to attain the objectives of the present study.

3.12.1. Quantitative analysis- ANOVA

In the first part of the analysis where the assessment of the mental health status of women was attempted, quantitative methodology was adopted. The data from Google Forms were coded through SPSS and the analysis part was done by ANOVA to assess the mental health status of respondents and compare the mental health of women belonging to groups formed by various classificatory variables.

The statistical analysis tool known as analysis of variance (ANOVA) divides the observed aggregate variability present in a data set into two categories: systematic factors and random factors. In the provided data set, the systematic components have a statistical impact, but the random factors do not. In a regression study, researchers utilize the ANOVA test to ascertain the impact that independent variables have on the dependent variable (Kenton, 2022). ANOVA is used while evaluating three or more variables and is used to determine whether or not differences in means between samples are significant. Multiple two-sample t-tests are comparable to it. It is suitable for a variety of problems and produces fewer Type 1 errors. ANOVA reveals differences between groups by comparing the mean score of each group and includes spreading out the variance into diverse sources. The present study objectifies to compare the mental health status of study participants who represent women in Kerala and belong to the sub-samples formed on the basis of classificatory variables like religion, income level, caste, and employment status.

Each classificatory variable carries three or four categories. The classificatory variable religion carries three categories such as Hindu, Muslim, and Christian. Another classificatory variable income level is divided into three categories Upper, Middle, and Lower-income group. Caste as a classificatory variable is categorized into three groups General, OBC, and SC/ST. Finally, employment status carries four groups Government, Private. Housewife and Others (daily wages). To compare the mental health status of women, the researcher used one-way ANOVA and it provides results on whether there is any significant difference in mental health of compared groups and which variables are associated more.

3.12.2. Qualitative analysis- Thematic analysis

The data from 50 in-depth interviews to explore the factors affecting the mental health of women were subjected to Thematic Analysis. Thematic Analysis is a research analysis methodology that is best thought of as an umbrella term for a set of approaches for analyzing qualitative data that share a focus on identifying themes (patterns of the meaning) in qualitative data (School of Psychology, 2017). In the present study, thematic analysis examines individual feelings and experiences of women belonging to the High and Low MH groups as received from the in-depth interviews. The emerging themes from the participant's data were collated according to a particular topic of conversation. As a qualitative, emic-based research project, the researcher based the structure of the thematic analysis of participant interview data upon a process outlined by Nowell et al. (2017).

Coding is only the initial step toward an even more rigorous and evocative analysis and interpretation of a report. Coding is not just labelling; it is linking ideas (Saldana, 2015). Organizing the coded data into groupings of similar ideas reveals the key themes of the participant's responses to the research questions. Identifying patterns and key themes means that some initial codes could become sub-codes of a major key barrier theme. The most frequent topical responses by participants to the interview and clarifying research questions would identify the knowledge, beliefs, actions, and attitudes of the participants, and their responses would become the initial coding criteria for the thematic analysis process later.

The following stages were involved in the thematic analysis process:

1. Familiarizing with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

The process and outcomes of the thematic analysis are discussed in more detail in the Analysis chapter.

3.13. Ethical Considerations

The researcher collected informed consent from the participants and clarified their doubts about the study. The ASHA and Anganwadi workers who facilitated the recruitment of study participants were also given detailed information about the study, its objectives and requirements so as to be conveyed to the respondents. The 50 study participants involved in in-depth interviews were assured of their anonymity and confidentiality of information shared. Ethical clearance for the present study has also been granted by the Calicut University Human Ethical Committee.

3.14. Conclusion

This chapter has discussed how the researcher set out the research process systematically. This chapter began with the research setting, profile of the area of study, research questions and operational definition of key concepts used in the study. Then the chapter discusses the study design in detail- how the participants were recruited, the tools used to collect data, the data-gathering procedure and the challenges faced by the investigator. This was followed by participants' demographic details, data analysis structure and analysis techniques used. The ethical structures that underpinned the research methods chosen have also been included in this chapter. False names are given to the study participants to ensure anonymity. Detailed analysis and findings are presented in upcoming chapters.

Chapter IV
Analysis 1: MENTAL HEALTH STATUS OF WOMEN IN KERALA

CHAPTER IV

ANALYSIS 1: MENTAL HEALTH STATUS OF WOMEN IN KERALA

The survey using Google Forms was conducted to assess the mental health status of women in Kerala. Three hundred married women within the age group of 25 to 45, from the three districts of Kerala, namely Malappuram, Kollam, and Ernakulam selected through multi-stage sampling constituted the study participants. The Personal and Family Information Schedule was used to collect information about the social and personal backgrounds of the sample, such as age, religion, income level, caste, education level and employment status. The WHO (ten) well-being index was used to assess the mental health status of women in Kerala and was distributed through Google Forms after getting consent from the study participants. Quantitative methods have been used for the analysis of the data according to the research needs.

In this part of the analysis, to assess the extent of mental health of women in Kerala, descriptive statistics like mean and standard deviation of the mental health scores of the total sample and the sub-samples based on the classificatory variables namely, religion, income level, caste and employment status were found out first. Comparisons of the mental health of the sub-groups formed based on classificatory variables were attempted through ANOVA. Wherever significant differences were obtained in ANOVA, it was followed by the Post-hoc (LSD) test. The data and results of the analysis are presented in the upcoming sections:

4.1. Mental Health Status of Women in the Total Sample

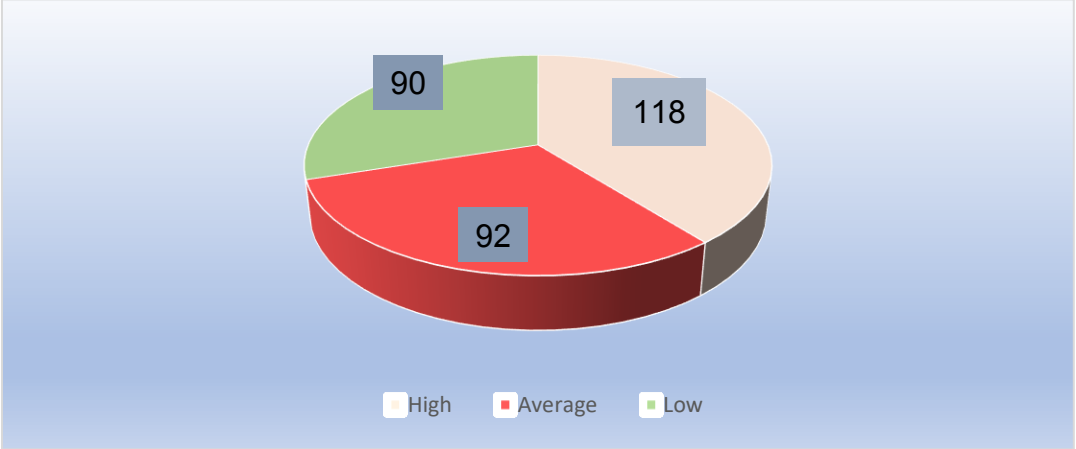
The scores of mental health were classified into three categories High-, Average- and Low- based on the traditional sigma +1/-1 distance method from the mean scores of mental health. The mean score was 17.11 and the standard deviation was 2.923. Accordingly, those women with a mental health score between 12 and 20 formed the Average- Mental Health Group (Average MH), those above 20 constituted

the High -Mental Health Group (High MH) and those below 12 formed the Low Mental Health Group (Low MH).

Figure 4.1 shows the level of mental health among women in Kerala for the total sample.

Figure 4.1

Extent of Mental Health Among the Total Sample



As Figure 4.1. reveals, 39.3% of study participants are in the High MH group, 31% in the Average- and 29.7% women in the Low MH groups respectively. The fact that 29.7% have low mental health indicates the presence of challenges to the emotional well-being and happiness of women irrespective of the high women development indicators in the state. Mukhopadhyay (2007) pointed out that women in Kerala appear to subscribe to patriarchal ideology to a greater extent than men and is considered a much more potent or statistically significant explanation for mental stress in women than it is in men. In Kerala, nearly one-fourth of the women screened positive for depression which is at a high magnitude keeping in view the prevalence rate of the country and the global 10 estimates (Lijin, 2012). Having any reproductive morbidity, recent experiences of domestic violence and substance abuse by the husband were found to be associated with depression among women by Lijin (2012). Kuruvilla (2020) referring to the Low MH status of women in Kerala proposes the lack of decision-making capacity, economic dependency and the lack of sharing of household responsibilities to create more mental stress among them.

4.2.Mental Health of Women Belonging to Different Religions

Studies comparing the happiness and well-being of people belonging to different religious communities could not be found. However, literature on the relationship between religiosity and mental health is available and reveals inconsistent results. Jijila and Kuruvilla in their study on 300 adolescent girls in Kerala have found a positive correlation between religiosity and mental health for the total sample and the sub-samples belonging to Hindu, Muslim and Christian religious communities (Jijila & Kuruvilla, 2019, p.61). Abdel-Khalek and Naceur (2007) also found that there is a considerable and positive correlation between women's optimism, happiness, life satisfaction, mental and physical health and religiosity. Similarly, Edwards et al. (2002) have revealed a positive correlation between forgiveness capacity and religious faith in their sample of college students. However, research has also indicated that those who follow extreme religiosity are more likely to experience mental health issues (Dein, 2010). According to Agarwal (1989), numerous outdated customs and belief systems may impede constructive development and contribute to mental illness. When religious rites are broken, whether knowingly or unknowingly, it can cause great distress for the religious communities. Cohen & Koening (2004) pointed out that there is occasionally a correlation between low mental health or neurotic behaviour and religious beliefs or practices.

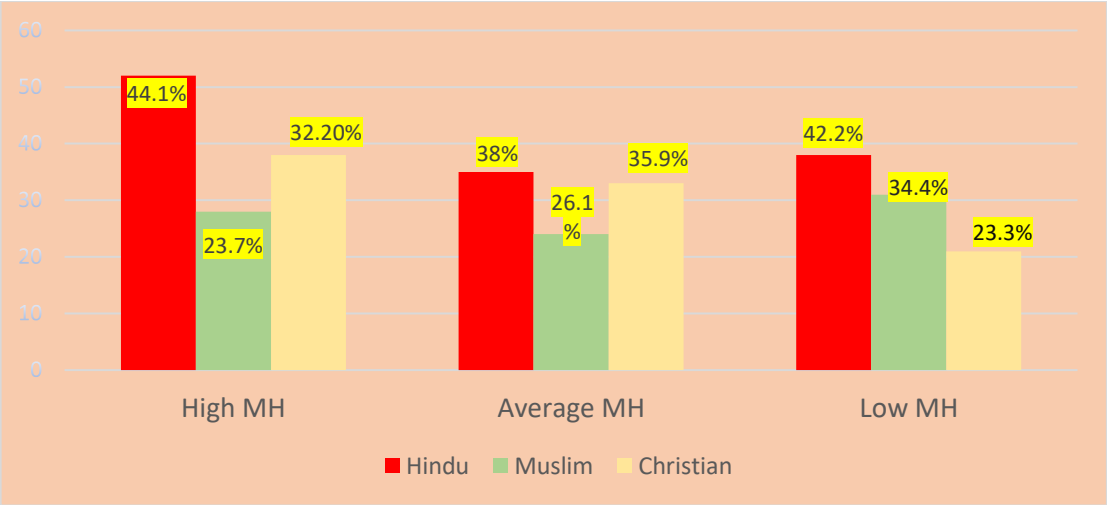
There are consequences for mental health and illness in every religion and belief system. In traditional Hindu families, there is a strict code of conduct for women that forbids dialogue and the expression of emotions, particularly negative ones. As a result, women are more likely than men to suffer from internalizing disorders like depression (Sharma et al., 2013). The conventional role of the female in the Hindu community is frequently constricting, monotonous, and confining, which can cause despair (Nambi, 2005). The studies made clear that Hindu women experience numerous traditional biases that have a negative impact on their mental health. Another study found that a number of cultural factors, primarily resulting from women's subservient status, have been demonstrated to have an impact on the prevalence, clinical picture, health-seeking behaviours, course, and management of

psychopathology in women in Arab Muslim communities. There is no doubt that women are more likely to experience suicidal thoughts and behaviours as well as mental illnesses including depression, somatoform disorders, anxiety, or eating disorders (Douki et al., 2007). Both these studies point out that religious practices and restrictions are prevalent in both Muslim and Hindu communities, which have an impact on women's mental health. According to Matheson and Kenett (2021), pressures that might cause depression and nervousness are prevalent in American culture, particularly in the church. In addition to attempting to be excellent friends, wives, and mothers, Christian women frequently shoulder the burden of their ministries' responsibilities. Because of this, women occasionally neglect their own needs, which results in mental illness.

There are three prominent religions in Kerala- Hindu, Muslim, and Christian. The sample of the present study consisted of 41.7% Hindus, 27.7% Muslims, and 30.7% Christians. When the total sample was categorized into High-, Average- and Low-MH groups based on the scores of their mental health, the High MH group consisted of 44.1% Hindu, 23.7% Muslim and 32.20% from Christian communities. Figure 4.2 shows the mental health status of women belonging to different religions.

Figure 4.2

Mental Health Status of Women Belonging to Different Religions



According to the findings from the study, Hindu women are more in numbers both in the High- and Low MH groups. In this context, a study conducted among women in Kerala has found postpartum depression to be higher among Hindu women than Christian and Muslim women, with religious rituals and customs after delivery as major contributors to their low mental health conditions (Jijila & Kuruvilla, 2022).

The present study has 125 Hindu women in the total sample of which 52 are in the High MH group and 38 in the Low MH group. Thus 41.6% of women have good mental health, while 30.4% have poor mental health. Concerning the 83 Muslim women in the total sample, there are 28 women (33.7%) with High MH- and 31(37.3%) with Low MH. The current study included 92 women from the Christian community out of which 38 (41%) were in the High MH and 21(22.8%) in the Low MH groups.

4.2.1. Comparison of mental health of women belonging to different religions

To compare the mental health of women belonging to different religious communities, the scores of mental health were subjected to an ANOVA test. The results revealed no significant difference between the mental health scores of Hindu, Christian and Muslim women. Table 4.1 shows the ANOVA test results.

Table 4.1

Comparison of Mental Health of Women Belonging to Different Religions

	Mental health				
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.257	2	.128	1.507	.223
Within Groups	25.289	297	.085		
Total	25.546	299			

Here the F value is only 1.507, which is not significant even at a 0.05 level. However, there are some studies that reveal religion and mental health have a significant positive correlation (Estrada, 2019; Jijila & Kuruvilla, 2019; Abdel-Khalek

& Naceur, 2007; Paul et al., 2006). As per the findings of Jijila and Kuruvilla (2019), the majority of adolescent girls have "no issues accepting the patriarchal restrictions implemented through the agency of religion as norms and are ready to follow all the do's and don'ts imposed upon them in the name of religious teachings" (p.59). In the case of adolescent girls, there is a positive influence of religion on mental health. But the present data confirmed no significant association between religion and mental health status of adult women.

4.3.Mental Health of Women Belonging to Different Income Levels

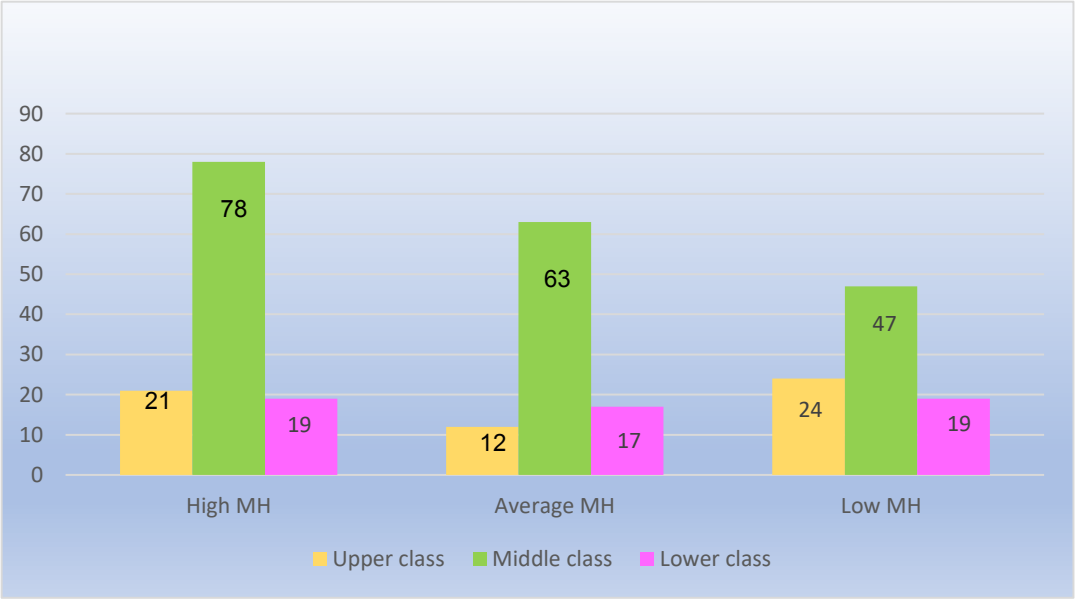
Every woman's daily life and family structure are impacted by economic changes. The quality of life of people is determined by the level of their well-being. Women often face income-level discrimination and financial insecurity (Botreau & Cohen, 2020; UN Women, 2019). The pressures associated with poverty are numerous and include both physical and mental ones. Additionally, a person's economic level is a constant and accurate predictor of a wide range of outcomes over the course of their lifetime, including their physical and mental health. As a result, income level has relevance in every area of behavioural and social science, including study, practice, education, and advocacy (APA, 2010). For poor women in emerging nations going through restructuring, rates of sadness and anxiety have dramatically increased (WHO, 2013). Insecure housing tenure increased chronic stressors, and decreased social support are more common for women who work in low-status and insecure occupations with little to no decision-making authority (WHO, 2013). Depression is also strongly predicted by low employment rank (Rizvi et al., 2015). Taking into consideration the linkage between mental health and economic status, the present study has investigated the mental health status of study participants belonging to different classes determined by their monthly income levels.

The study participants were categorized into three–upper, middle- and lower-income groups based on the monthly income of the family. Income status depends on employment, assets, salaries, and savings. A monthly income of a family above Rs.50,000 constituted the upper-income group, between 10000- 50000 constituted the middle-income group and below 10000 formed the lower-income group in the present

study. The income level-wise classification of the total participants includes 19% of women from the upper-income group, 62.7% from the middle-income group, and 18.3% from the lower-income group. When the total sample was categorized into High, Average and Low MH groups based on the scores of their Mental health, the High MH Group consisted of 17.8 % from the upper-income level, 66.1% from the middle-income group and 16.1% from the lower-income group. Figure 4.3 presents the mental health status of study participants belonging to different income levels.

Figure 4.3

Mental Health Status of Women Belonging to Different Income Levels



As revealed in Figure 4.3, in all three mental health groups, middle-income group women constitute the majority. Though lacked statistical significance in further analysis, it is a matter of concern that more women belonging to the upper-income group were found in the Low MH group. As reported by Arvind et al. (2019), upper-class women seem lonely and have nobody to talk with which might be a reason for their Low MH status. The findings could also be partially related to those of Xiong et al. (2020) who observed the high-income level to be the most likely to report an increase in feelings of depression during COVID-19. Lower- and middle-class women have a lot of opportunities to talk with others and mingle with all the women who are nearby (Sarwar & Imran, 2019). But in the case of upper-income group

women, they are highly restricted by their families (Kim & Cho, 2020). As observed by the WHO (2013), addressing the gender differences in mental health will require greater parity in gender roles and responsibilities, pay equity, the eradication of poverty, and a renewed focus on the preservation of social capital.

There were 57 women in the upper-income group category out of which 21 were in the High MH group and 24 in the Low MH group. There were 188 women in the middle-income category, with 78 women in the High MH group and 47 in the Low MH group. There was a total of 55 women in the lower-income category, with an equal number of 19 in the High MH, and 19 in the Low MH groups.

4.3.1. Comparison of mental health of women belonging to different income levels

A one-way ANOVA test was conducted to compare the mental health of women belonging to different income levels and the results revealed no significant difference between the mental health status of women belonging to upper, middle-, and lower-income groups. The ANOVA test results are shown in Table 4.2.

Table 4.2

Comparison of Mental Health Scores of Women Belonging to Different Income Levels

Mental Health					
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.439	2	.219	2.595	.076
Within Groups	25.107	297	.085		
Total	25.546	299			

The F value of 2.595 is not significant even at 0.05 level. Here, income level difference is not found to be a factor determining the mental health status of women. Other researchers have discovered conflicting findings regarding the relationship between mental health status and income levels. Carter et al. (2017) reported a direct and significant correlation between income-level discrimination and anxiety and

depressive symptoms. According to Abdi et al. (2021), structural determinants, gender, and social class, including socioeconomic position, education, employment, and money, were most frequently linked to mental health. Sidhaye and Patel (2010) also found that socioeconomic status is independently associated with common mental disorders in the population of women in India. The present study did not find any correlation between income level and mental health. Perhaps there might be other overwhelming factors that account for the differences in mental health scores of the study participants, an analysis of which is attempted in the second part of the study.

4.4.Mental Health of Women Belonging to Different Castes

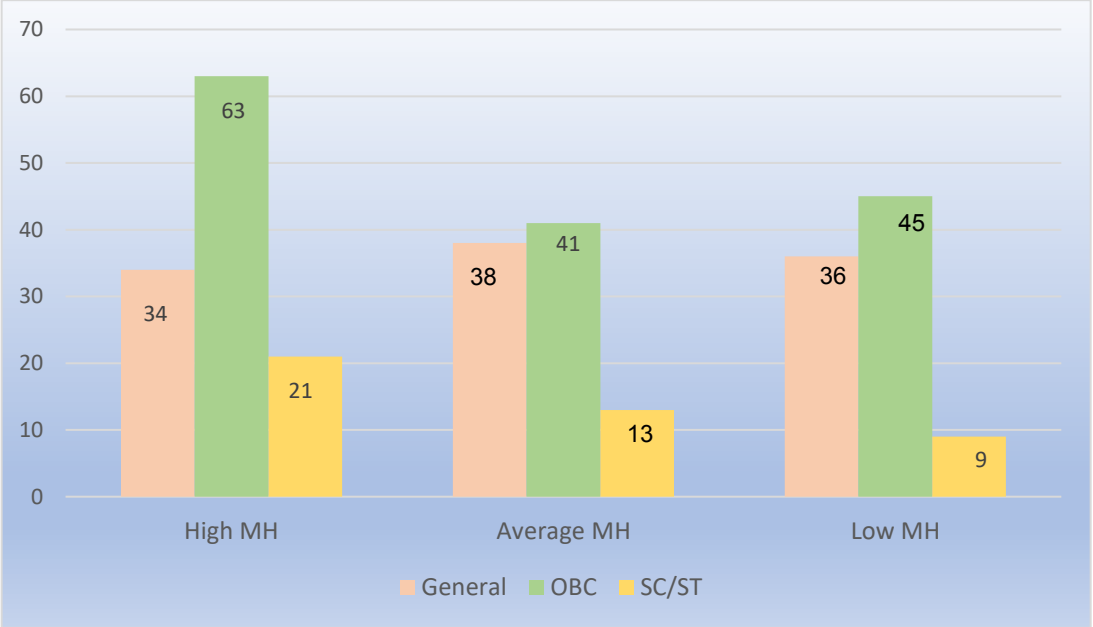
Caste still influences customs, attitudes, and social conventions, which affect women's independence and job opportunities (Deshpande, 2010). Due to ongoing prejudice as well as historical advantages and limitations, caste discrepancies still exist today. Economic and social disparities associated with caste predict that women from lower castes will bear a greater burden of ill health (Sen, 2002). According to Mohindra (2006), women in the lower castes (SC/ST) and other backward castes (OBC) were more likely to have poor mental health than women from higher castes. Similarly, previous research has found that lower-caste women face more social exclusion, more job loss and more barriers to healthcare (Deshpande, 2010; Haq, 2013; Pal, 2015), and thus may suffer from both poor mental health and loneliness. Another finding from Gupta and Coffey (2020) who used World Health Organization data from six states including Assam, Karnataka, Maharashtra, Rajasthan, Uttar Pradesh and West Bengal was that SC communities had worse mental health than higher caste individuals before the pandemic in a dataset of 10,125 people.

In the present study, the total sample was categorized into three different castes using the conventional three-way classification system adopted in Kerala (KPSC, 2006). Scheduled castes and scheduled tribes (SC/ST) make up the first category at the bottom of the caste structure. Next is a residual category of lower castes among Hindus, Christians and Muslims as a whole and is known as other backward castes (OBC). The highest-ranking general category group is that of the upper or forward castes among Hindus and Christians.

The caste-wise classification of the total sample includes 36% of participants from the general category, 49.7 % from OBC, and 14.3% from SC/ST. When the total sample was categorized into High-, Average- and Low-Mental Health groups based on the scores of their Mental Health, the High MH Group consisted of 28.8 % from the general category, 53.4 % from OBC and 17.8% from SC/ST community. Figure 4.4 presents the mental health status of women belonging to different castes.

Figure 4.4

Mental Health Status of Women Belonging to Different Castes



As per Figure 4.4, the upper /general category falls almost in equal numbers in all three MH levels. OBC women constitute almost 50 per cent of the High-MH and Low-MH groups. A higher proportion of the SC/ST women come under the High MH group. Unlike the findings in the literature, more OBC and SC/ST women in the present study have better mental health than the general-category women. Jiwani et al. (2022) in a recent study on fear of coronavirus among rural Indian women found that women in the SC/ST and OBC groups reported more symptoms of mental illness relative to the GC group. It was also reported that the OBC group, but not the SC/ST group, reported higher levels of perceived loneliness.

In the current study, there were 108 women in the general category of which 34 were in the High MH group and 36 women were in the Low MH group. Out of the 149 OBC women 63 (42.2%) fall in the High MH group and 45 (30.2%) in the Low MH group. There were 43 SC/ST women in the total study participants of which 21 (48%) were found to belong to the High MH category and 9 (20.9%) in the Low MH group.

4.4.1. Comparison of mental health of women belonging to different castes

A one-way ANOVA test was conducted to compare the mental health scores of women belonging to different castes such as general, OBC and SC/ST. The F value is 4.768, and the p value is 0.05 revealing a significant difference at 0.05 level between the mental health scores of women belonging to different castes. The data and results of ANOVA for comparing the mental health scores of women belonging to various castes are presented in Table 4.3.

Table 4.3

Comparison of Mental Health Scores of Women Belonging to Different Castes

Mental Health					
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.795	2	.397	4.768	.009*
Within Groups	24.751	297	.083		
Total	25.546	299			

*. The mean difference is significant at 0.05 level.

Table 4.3 shows a significant difference between the mean scores of mental health of women belonging to different castes. Several studies support the present finding that caste is a significant factor that determines the mental health status of women (Agoramoorthy & Hsu's, 2021; Deshpande, 2010; Gupta & Coffey, 2020; Haq, 2013; Mohindra 2006; Pal, 2015).

The significant F value warrants further analysis to understand which among the three castes has the highest mental health and which group has the lowest. For this, the Post-hoc (LSD) test was attempted.

4.4.2. Multiple comparisons of mental health scores of women belonging to different castes

Table 4.4 shows the results of Post-hoc (LSD) test for multiple comparisons of the mental health scores of women belonging to different castes.

Table 4.4

Multiple Comparisons of Mental Health Scores of Women in Different Castes

Dependent Variable: Mental Health

LSD

(I) CASTE	(J) CASTE	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
SC/ST	OBC	.0535	.0500	.285	-.045	.152
	GENERAL	.1421*	.0521	.007*	.040	.245
OBC	SC/ST	-.0535	.0500	.285	-.152	.045
	GENERAL	.0886*	.0365	.016*	.017	.160
GENERAL	SC/ST	-.1421*	.0521	.007*	-.245	-.040
	OBC	-.0886*	.0365	.016*	-.160	-.017

*. The mean difference is significant at 0.05 level.

Table 4.4 shows SC/ST and OBC women have better mental health than the general category. The results are contradictory to the findings of previous researchers (Agoramoorthy & Hsu's, 2021; Deshpande, 2020; Gupta & Coffey, 2020; Haq, 2013; Mohindra 2006; Pal, 2015) who have found SC/ST women to have worse mental health than OBC and general category. Generally, the SC/ST community is

categorized with a low standard of living and as a lower class in society. Women of the SC/ST group in the current study, have a higher proportion (55.81%) of working women. There are 24 working women and 19 housewives in the SC/ST category. Perhaps the income from work and the resulting increased mobility and sense of security might have contributed to their comparatively better mental health conditions. However, the finding of SC/ST women among the study participants to have better mental health when compared to their counterparts warrants further analysis to identify the actual reasons for the same.

4.5. Mental Health of Women with Different Employment Status

Understanding the effects of unemployment on mental health is especially crucial given the rise in unemployment, one of the most severe effects of the recent economic crisis. Evidence has repeatedly demonstrated a link between increased depression symptoms and unemployment (Buffel et al., 2015; Paul & Moser, 2009). The educated are more severely affected by this issue since they are unable to use their knowledge and talents to improve the economy and society. The unemployment rate among the young females is much higher than that of the young males. Women in the state of Kerala are well educated when compared to their counterparts in the rest of the country but the phenomenon of educated unemployment of women is high in the state.

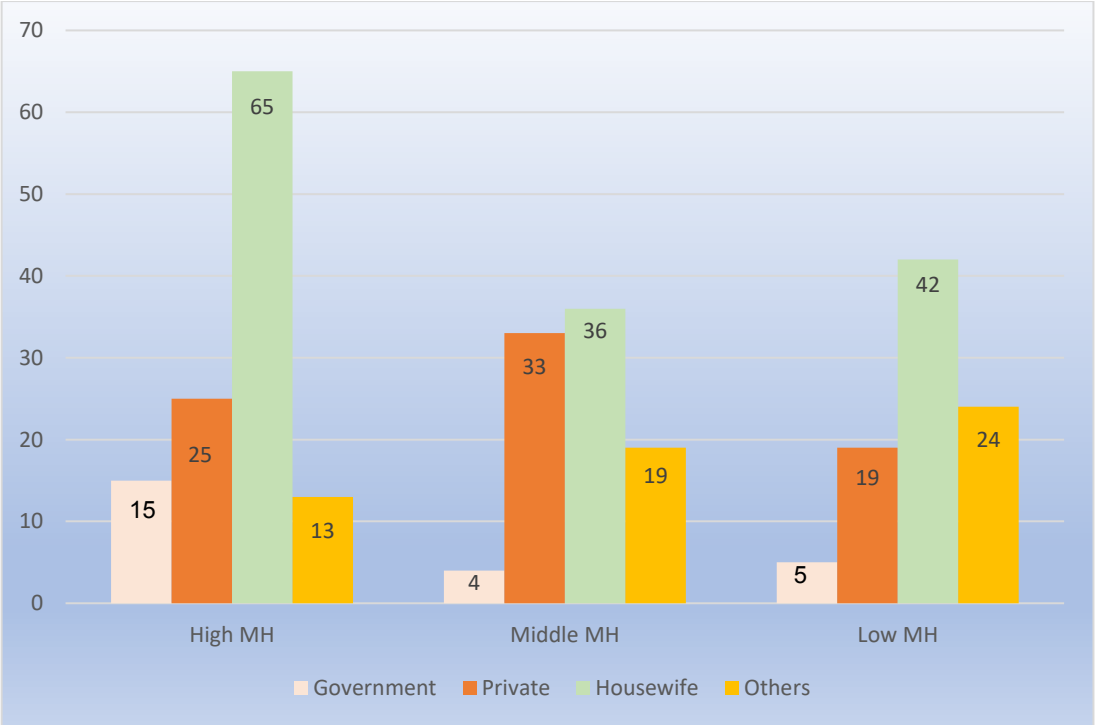
Data from the Periodic Labour Force Survey (PLFS) for 2018–19 show that women in Kerala participated in the labour force at a rate of 28.3% compared to 69.8% for men. The "household responsibility syndrome" is one of the main barriers that is keeping women out of the workforce (Jesna, 2021). It is argued that because of commitments at home, they are unable to pursue better employment opportunities. Women consequently seek employment in the unorganized sector, where payment is low, and benefits are insufficient. It also aids with the balance of their household responsibilities. According to ILO (2014), the percentage of women participating in the labour force in Kerala society is "stagnant." The work participation rate has been showing an increasing trend in recent years and it has reached 37% in 2023 (PLFS, 2023) which is still less than the national average. For women, especially educated

ones, not enough opportunities are being created. Kerala has made great progress in raising the educational levels of women, but their unemployment rate is still very high (Jesna, 2021). Unemployment among educated women is a serious and dangerous issue. Kerala has an extremely high rate of unemployment, and female unemployment in the labour force is substantially higher than male unemployment (State Planning Board, 2021).

There are four types of employment status identified for the present study, such as Government, private, housewives and other-employed. The employment status-wise classification of the total sample includes 8.0 % from government service, 25.7 % from private sectors, 47.7% from housewives and 18.7% from other-employed categories. Figure 4.5 presents the proportion of women belonging to different types of employment status in the High, Average and Low MH Groups.

Figure 4.5

Mental Health Status of Women with Different Employment Status



There are 24 government employees in the total sample, out of which 15 (62.5%) are in the High MH category and five (20.8%) in the Low MH group. Out of the 77 private employees in the total sample, 25 (32.4%) are in the High MH group and 19 (24.6%) in the Low MH group. The current study has 143 women from the housewife category in the total sample, out of which 65 women (45.4%) are in the High MH group and 42 (29.3%) in the Low MH category. From among the 56 other-employed women in the total sample, 13 women (23.2%) fall in the High MH category and 24 women (42.8%) in the Low MH group.

4.5.1. Comparison of mental health scores of women with different employment status

A one-way ANOVA test was conducted to compare the mental health scores of women with different employment statuses. The data and results of ANOVA are displayed in Table 4.5.

Table 4.5

Comparison of Mental Health Scores of Women Belonging to Different Employment Status

Mental Health					
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1.124	3	.375	4.541	.004*
Within Groups	24.422	296	.083		
Total	25.546	299			

*. The mean difference is significant at the 0.05 level.

Table 4.5 reveals a significant difference at 0.05 level between the mental health of women belonging to different employment categories like government, private, housewives and other employed (daily wages) categories.

4.5.2. Multiple comparisons of mental health scores of women with different employment status

Since the F value was significant, the Post-hoc (LSD) test was used to determine which employment status is associated with higher mental health and which category has the lowest mental health. Table 4.6 shows the results of multiple comparisons of the mental health status of women with different employment statuses like government, private, housewives and other employed (daily wages) categories.

Table 4.6

Multiple Comparisons of Mental Health of Women with Different Employment Status

Dependent Variable: MENTAL HEALTH						
LSD						
					95% Confidence Interval	
(I) JOB	(J) JOB	Mean Difference (I-J)	Std. Error	Sig.	Lower Bound	Upper Bound
PRIVATE	HOUSEWIFE	-.0583	.0406	.152	-.138	.022
	OTHERS	.0768	.0504	.129	-.022	.176
	GOVT	-.1435*	.0672	.033*	-.276	-.011
HOUSEWIFE	OTHERS	.1351*	.0453	.003*	.046	.224
	GOVT	-.0851	.0634	.180	-.210	.040
OTHERS	GOVT	-.2202*	.0701	.002*	-.358	-.082

*. The mean difference is significant at the 0.05 level.

Table 4.6 shows a significant difference at 0.05 level between the mental health of women with different employment statuses. Here, government employees have the highest mental health and other employed women have the lowest mental health status.

In the case of government employees, they are likely to be financially more secure and in a better position to make decisions in their daily lives. Financial independence is essential for all women. If they are financially secure, they can solve most challenges that may spring up. This might be one of the reasons why mental health issues among government employees are lesser even though they have work-related pressures, manageable by themselves to a great extent.

Those women who are employed as daily wages constitute the other employed category. Studies reveal a connection between the increased prevalence of depressive and anxiety disorders in women who earn daily wages and having a lower social status (Mental Health First Aid India, 2020; Stieg, 2020). They face lots of work-related stress and physical illness in their daily lives **(**Amstad et al., 2011; Frone, 1991; Parasuraman et al., 1996; Sharma et al., 2016) which affects their mental wellbeing. They also face economic issues like low salaries, loans, and poverty. Daily wage workers make their living by providing for their daily requirements, but during the lockdown, many lost their jobs and were unable to do so. They have several kinds of mental health problems including frustration, tension, stress, anxiety, depression, sleep disturbance and other mental health problems (Banjari & Sahu, 2022).

According to the WHO (2022), more than half of the world's workforce participates in the unregulated, informal economy, where there are no laws protecting workers' health and safety. These people frequently labour in hazardous conditions, put in long hours, lack access to social or financial safeguards, and experience discrimination, all of which can be detrimental to their mental health. Although working circumstances for unorganized sector labourers in India had never been ideal, they have gotten worse over the previous ten years, as seen by the over 166% increase in suicide among daily wage employees between 2014 and 2021(NCRB, 2022). In the COVID-19 scenario, regular/daily wage workers who were alone, incompetent, and uneducated had significantly worse mental health due to longer periods of relocation, lack of shelter, and unhygienic living conditions (Banjari & Sahu, 2022). Daily wage employees made up the greatest percentage of suicide victims in 2021, up from 37,666 in 2020 to 42,004 in 2021, according to the NCRB. These factors all corroborate the conclusion of the present study that women who work for a daily pay have the worst mental health conditions.

Previous research suggests that government employees struggle with their mental health (Santos, 2016; Sovold et al., 2021; State Health Resource Centre, 2019). Nonetheless, the current study emphasizes that government employees have better mental health conditions when compared to private and other employed individuals.

4.6.Conclusion

While the total score for the WHO (ten) Wellbeing questionnaire is 30, the highest score obtained in the study is 25 and the lowest score is 10. The mean score being 17.11 itself indicates the less rosy picture of the mental health status of women in Kerala. Analysis of the mental health scores of the study participants belonging to the various groups formed based on classificatory variables show no significant difference in the mental health of women belonging to the various categories identified based on religion or income level. At the same time, caste and employment status are found to have an important role in determining the mental health status of women. This section concludes that, overall, participants' mental health appears not to be at the higher level as revealed by the statistical analysis, and the analysis of variance reveals that out of the four classificatory variables studied, two factors are significantly correlated with participants' mental health while two others are not. In the second section of the analysis, case studies are employed to support these conclusions and are covered in the chapter that follows.

Chapter V
Analysis II: FACTORS AFFECTING MENTAL HEALTH OF WOMEN

CHAPTER V

ANALYSIS II: FACTORS AFFECTING THE MENTAL HEALTH OF WOMEN

Qualitative research relies upon the emic perspective of participant narratives to gather data about a research topic (Palinkas et al., 2015). In this study, this perspective is provided via unstructured interviews with 50 women in Kerala, 25 each from the High and Low MH groups identified from the analysis of initial data scores on mental health status. The researcher had personal interactions with the study participants about their mental health issues and happiness. The goal was to get familiarized with the women gathering data from responses to the research questions and identify patterns of meaning commonly held by the participants (School of Psychology, 2017), familiarization being the first step of the thematic analysis process (Nowell et al., 2017). This chapter will discuss the interview dataset analysis via word queries, phrase searches, and mapping of related concepts to explain the interrelated codes and underlying themes of Thematic Analysis (Guest et al., 2012; Nowell et al., 2017). The key themes that were identified across the data are visualized in tables to make them more precise.

5.1. Background

Three hundred participants were selected from three districts of Kerala and their mental health status was analyzed using statistical methods. The initial scores of mental health were arranged in ascending order and the High and Low MH groups of study participants were identified from those with the highest 25 and lowest 25 scores. In-depth interviews were conducted with the fifty study participants. It is important to note that not every participant responded to every question, as was her right. Some participants did not know how to answer some of the questions asked or were confused about whether to open up even though they were pre-informed about the topic. Several of them were found to be scared to discuss personal matters despite the assurance of confidentiality on the part of the researcher. At the same time, there were study

participants who seemed to be happy to share more and more of their feelings and experiences.

The study participants in the Low MH group were interviewed first as the focus of the study was to analyze the factors affecting the mental health of women. Their responses were used as points of reference while conducting the interviews with the participants in the High MH group. The in-depth unstructured interviews with each one of them exposed a quantum of data on their subjective well-being, the facilitating and debilitating factors that have led to the present situation, and the specific means by which they try to keep going/endure the situation.

5.2. Coding and Emerging Themes

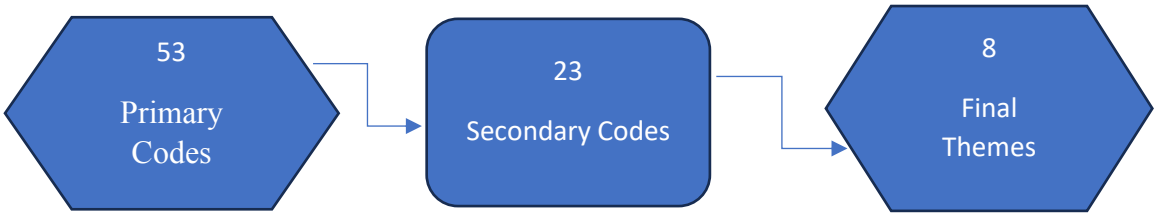
Nowell et al. (2017) described the purpose of thematic analysis: "thematic analysis, is a method for identifying, analysing, organizing, describing, and reporting themes found within a data set" (p. 2). The researcher analysed the dataset using word frequency queries, word tree searches, and mind-mapping of words and phrases relating to a commonly held idea within or across primary and secondary codes, and this process revealed the underlying key ideas that connected across the dataset. Themes are defined as the underlying interconnected ideas, beliefs, or values that are identified and summarized into larger topical ideas that a group of participants shares (Caulfield, 2019; Guest et al., 2012; Nowell et al., 2017).

The researcher initially compiled a table of primary codes based on the topical questions and participants' responses. Secondary themes were developed out of the participant narratives giving details of their shared experiences. According to the thematic analysis proposed by Nowell et al. (2017), the secondary coding process is undertaken for all primary codes, which is stage two of the thematic analysis process. The researcher compiled a list of 53 primary codes after closely examining the data to identify common themes, topics, ideas and patterns of meaning that come up repeatedly. 23 secondary codes were developed by meaningfully associating the 53 primary codes. Closely related secondary codes were subjected to further reviews and meaningful collation to reach the eight final themes as the factors affecting the mental

health of women. Interestingly all the eight major themes were socio-cultural factors. The process of coding and emerging themes is presented in Figure 5.1.

Figure 5.1

The Process of Coding and Emerging Themes



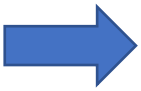
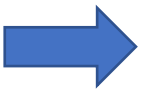
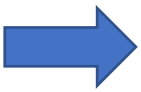
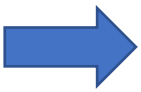
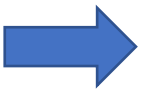
5.3. Final Themes Related to the Mental Health Status of Women

The 23 secondary codes/ categories and the eight final themes that have emerged from the thematic analysis process as factors influencing the mental health status of the study participants are presented in Table 5.1.

Table 5.1

Categories and Final Themes Emerged from the Interview Dataset

Sl No	Secondary codes	Final themes
1	• Domestic violence • Dowry-related violence • Sexual abuse • SRHR violations	**Gender-based violence**
2	• Unfulfilled job aspirations • Unfulfilled higher education aspirations	**Unfulfilled aspirations**
3	• Unhappy with economic dependency • Financial difficulties	**Economic dependency**

4	• Adjustment issues with in-laws • Adjustment issues with husband • Overburdened with family responsibilities • Suspicious nature of husband		**Adjustment issues with husband and in-laws**
5	• Drug/alcohol abuse of husband/son • Irresponsible attitude of son/husband		**Alcoholism of Partner**
6	• Lack of emotional support from parents and family. • Normalize abusive relationship		**Lack of support from natal home**
7	• Outdated customs and rituals • Conflicts with a progressive attitude • patriarchal nature of husband/ in-laws • Lack of decision-making capacity even with personal matters • Restrictions on mobility		**Conflicts with patriarchal norms**
8	• Lack of friends to open up • Lack of trustworthy relationships		**Lack of confiding relationships**

A striking finding in this context was that women in the High MH group also were facing similar issues as that of the women in the Low MH group which could be categorized as social and cultural factors. However, many variations were found in the number of study participants experiencing the same among the two groups. The frequency of incidents, the gravity of experience and the approach of participants to

the incidents varied much in the High and Low MH groups. The approach to any incident in turn is found to be influenced by several other interconnected factors like the nature of socialization received and the kind of exposures the individual woman has gone through at various stages of life, the kind of support received from friends and family members and the problem-solving ability of the individual concerned and so on. Table 5.2 presents the number of women in each group who have been subjected to the specific type of experiences which are categorized as the eight final themes.

Table 5.2

Final Themes and Agreeableness of Women in Low and High MH Groups

No	Themes	Agreeableness No. of women in Low MH	Agreeableness No. of women in High MH
1	Unfulfilled aspirations	20	5
2	Lack of Economic independence	22	15
3	Adjustment issues with husband and in-laws	23	4
4	Alcoholism of partner	20	3
5	Lack of support from natal home	16	2
6	Lack of confiding relationships	16	3
7	Gender-based violence	25	20
8	Conflicts with patriarchal norms	25	8

5.4. Socio-cultural Factors Influencing Mental Health Status of Women

The eight final themes are socio-cultural factors and include unfulfilled aspirations, economic dependency, adjustment issues with in-laws, alcoholism of husband, lack of support from natal home, lack of confiding relationships, gender-based violence and conflicts with patriarchal norms. The detailed narration of each factor centered on the lived experiences of study participants is presented in the upcoming sections:

5.4.1. Unfulfilled aspirations

Twenty out of the twenty-five women in the Low MH group were found to be well-educated but had to give up their career aspirations after marriage and delivery. Among the 14 employed women, 12 are in the informal sector with a low pay package. The unpaid work of women in the family is the key trigger that keeps the 11 unemployed women stuck in their homes. However, five women in the High MH category also shared to had unfulfilled aspirations, but with time, they have become contented with what they are at present. They also claimed that their husbands' income provides them with a high level of security.

Twenty women in the Low MH group agreed that they had many aspirations in life but were unable to fully realize them. Most women are well-educated, and they lost their career aspirations after marriage and delivery. They said they were stuck within the family and household chores. The husband and his family are always unsupportive, and they don't even allow them to finish their studies. The inability to complete studies was found to have a significant impact on women's mental health. Higher education and jobs were the top two goals in life for the twenty respondents with poor mental health.

Fathima, a 29-year-old, low-income Muslim woman, stated:

> *"I am a mother of two children now. As a wife, mother and daughter-in-law, I am doing my best. In my school and college times, I was studying in deplorable conditions at home due to financial constraints and lacked adequate attention and support for my education. Still, I was a top student in my college. However, after marriage, my education and career aspirations were shattered by my husband and his family. They sought a domestic helper for their home, and in our society, marriage essentially means relocating women to another household's kitchen."*

In this regard, one of the women from a high-class Christian family also shared,

> *"I am 34 years old, got married after I completed my MBA and it happened on the basis of a rare contract. When the alliance came up, my father demanded that, under no circumstances, I should be sent to work after the wedding. That contract ended my dream of going to work after marriage. My father is not interested in women going out to work. Therefore, I got married to a man who was paid much more dowry than what they expected, and he did not allow me even to talk about going for paid work. After marriage, when I applied for a job and received the offer letter, my mother-in-law tore the letter in front of me. It is something that still hurts me."*

As per the study participants, unfulfilled aspirations create high pressure and anger in their minds. There is no choice for women about their marriage and after marriage, their husbands and in-laws are always making decisions for the women. Eleven women in the Low MH group are stuck in families with household chores, and baby care. Though the others go out for paid work, the majority are engaged in daily wage work. Whether they are educated or not, after marriage, the fulfilment of women's aspirations depends to a large extent on the decision of their husbands and in-laws. Women were found to have no choice even to decide upon their likes and dislikes.

25-year-old upper-class Hindu woman, Jani said,

> "*When I expressed my desire to find employment, my husband said that it would be challenging to manage a job if I got pregnant and that my salary was unnecessary for his family. He questioned, why should you seek employment? I replied that I was at a young age, and I had to find a job and I wished to be economically independent. The husband's home is like a cage for me. After marriage, I was very frustrated because I could not join for higher studies. My husband never tries to understand how frustrated I am. When I see some of my friends pursuing their studies in colleges and universities, I cry and curse my parents for forcing me into marriage too early."*

Jisha, from a high-class Christian family, shared her feelings,

I have completed my MBA and have not been able to go for a job for six years now. My qualifications, it seems, hold no value in the eyes of my partner and family. They believe my place is at home, tending our baby, husband, and elderly in-laws of the family. It's disheartening to watch my classmates head off to their jobs while I am confined to the house. My husband and in-laws will never allow me to work outside, because if I go to work, they will lose their unpaid domestic helper.

27-year-old Muslim middle-class woman Ameena stated,

I was very eager to go for higher studies and get employed. Immediately after graduation, I got married. My goal was to get a government job. At the time of engagement, my husband's family agreed to let me go to work after marriage, but they later refused. After giving birth to my daughter, the load of responsibilities became heavy limiting me to taking care of the newborn and my job aspirations remain just a dream. There are frequent fights between me and my husband regarding my ambitions to find a job. Once during the fight, he said that he married an educated woman like me to educate his children rather than to send her out for employment and earn income. Such comments break my heart.

As shared by the study participants, in Kerala, women are not free to make their own decisions. A talented woman who aspires to get employed in a high profession becomes confined within her husband's house. Women often fail to find placement and are demotivated by family members. The study participants in the Low MH group were found to be irritated and turning against their husbands and families. According to these study participants, "women are captivated in the homes through marriage and motherhood. Almost all the 11 housewives in the Low MH category concurred that despite their education, they are unable to find employment. They are unhappy and angry because of their economic dependence and inability to meet their requirements on a personal level. Even among the other nine women who are employed on a daily wage basis with a low salary, frustration is found to be a common experience.

Ten women in the High MH group conveyed, that they are happy to have achieved their goals, while the remaining 15 members are comfortable with their current circumstances.

A lower-class Hindu woman claimed,

> *"My husband and his family provide me with good care and support. There is a shortage of money, but still, I get much love and care. We are working towards a better living. Understanding and support from family are the keys to my mental well-being."*

Several of the women in the High MH group believe that their husbands' income provides them with a high level of security and that they are free to pursue any career if they want it.

> Sandhya, a middle-class Hindu woman echoed this sentiment, saying that she is content with the life she has. Her partner is a strong support while she tries to complete her education. She added, *"In our home, there is no gender difference in doing household chores. For me, that's a great blessing. In my case, I started travelling and eating out after my marriage. My husband and his family never interfere in my personal space".*

Another Muslim middle-class woman Hiba claimed,

> *"After getting married and having a child, I started my education. I thought that it would be difficult to balance motherhood with adequate study time, but my husband and his family support me in managing both. When I go to college, my mother-in-law will take care of my baby. After college, there are no household chores left for me. Everything will be done by her. Many of my friends complain about their mothers-in-law. When compared with that, I feel I am lucky. Since I am studying for TTC, there is a lot of chartwork to be completed every day. While I am studying or doing my homework, she will be engaging my son in other things without disturbing me, my son loves my husband's parents more than me. "*

The women in such situations are happy because they can pick up where they left off with their studies and jobs, and they see this as an opportunity to realize their aspirations. Ambitious married women are compelled to progress only with the assistance of their husbands and families. However, this is not the case for all women.

The various forms of unfulfilled aspirations as reported by the study participants in the Low and High MH groups are summarized in Table 5.3.

Table 5.3

Various Forms of Unfulfilled Aspirations

Sl. No	Unfulfilled aspirations	Low MH	High MH
1	Unable to go for higher education	20	5
2	Inability to run a business or go for a job	18	7
3	Inability to make decisions even in personal matters	20	15
4	Unable to buy a smartphone	4	0
5	Inability to buy a new or modern dress	15	3
6	Inability to own a house	19	4

Thus, marriage has become a shackle for many women. Very few of them escape from these shackles and try to attain their goal. The unpaid work of women in the family is the key trigger that keeps them stuck. Women's unpaid labour provides relief to families, particularly the elderly mothers-in-law, and an attempt is made to keep them at home through marriage and childbirth. As a few of the study participants opined, to some extent, the husband's fear that a woman will become superior to him by working and earning is a stumbling block to women's aspirations. In this context, the opinion of Chaturvedi and Sahai (2019) that a woman’s ability to work and pursue a career depends mostly on her husband and in-laws is fully applicable.

Women's mental health in Kerala is significantly impacted by traditional norms that severely limit the goals and dreams of women. Several studies have pointed out that unfulfilled aspirations of women can affect their mental health status

(Johnstone & Lucke, 2022; King, 2014; Zhang et al., 2013). It is to be noted that in all such circumstances, only women will be harmed, whereas men can pursue their goals without being constrained by patriarchal norms. Women have dreams and aspirations, regardless of whether they can fulfil them, they are willing to work hard to achieve them, even if partially.

5.4.2. Lack of economic independence

As opined by several women in the Low MH group, acceptance by women themselves and the prevalent belief that women are incapable of managing money make women economically dependent; as a result, educated women who cherish financial independence must have to bargain and negotiate with their husbands and in-laws.

The major incidents related to economic dependency that emerged from the data as to have affected the mental health of the study participants are given in Table 5.4.

Table 5.4

Incidents of Economic Dependency

Economic dependency	Low MH	High MH
Lack of money to buy personal things	23	10
The shame of being unemployed	13	4
Lack of money even to go to hospital	18	1
Made fun of incapability of handling money matters	24	15
Mandatory reporting to husband about the usage of money	25	5
Lack of money to visit natal home	24	4

Another significant factor influencing women's mental health is their economic dependency. The vast majority of women in the Low MH group had unmet expectations, and virtually all expressed regret over their current circumstances. There are 11 housewives in the Low MH group, and seven of them have advanced degrees and aspirations for their future. Some of them had to quit their careers at the time of pregnancy. The rest of them are unemployed and not permitted to go out to work. A few women from the middle-class Hindu community shared that their families and spouses do not want them to work and questioned who will take care of the husband and children if they go to work outside. As a result, women stop working and are forced to stay at home which in turn makes them frustrated and unhappy. When unexpectedly put in a dependent position, it causes great distress in them. They also conveyed they were no longer able to request money for necessities from their husbands as freely as they did with their fathers.

Here, 35-year-old Seena from a middle-class Hindu family shares,

> *" Before marriage, my father used to give me cash for my personal needs. He had a sense that as a person one would have such needs. That's why my father never asked about why I needed money. But after marriage, I face that question every time and must beg my husband for every single penny required for my personal needs, even to buy sanitary pads. I have no job and no income of my own, so I have to bear everything. I know it is not a case only for me, many women like me have to plea for money from their husbands."*

22 women including those who are employed in the Low MH group agreed that they are economically dependent on their husbands. The working women must have to give their salaries to their husbands so that men will decide how to spend women's earnings. Women in such circumstances ought to ask their spouses for cash even for personal purposes. While wives' incomes are used for household needs, husbands spend a major share of their earnings for personal use. They contend that a woman's wage should only be used for her family; she shouldn't use it for herself. He will either drop her off or pay her the bus fare.

Jasna, a 29-year-old Muslim woman from a wealthy household in the Low MH group shared:

> *"My husband would take me to the public hospital if I ever had health issues because it provides less expensive medical care; if not, he would get some medicines from the pharmacy. I don't like visiting the government hospital because of the long wait periods and congested environment. However, he refuses to pay me cash to visit a private hospital. He is truly not interested in spending his money on my hospital needs, despite his claim that government hospitals offer better care, and I was uncomfortable with it. My delivery also occurred in a government hospital, and I got worse treatment there, and I had some postpartum complications. There was no good behavior from the doctors during the delivery and the delivery process was simple for them. But as a first experience, I had to face a lot of difficulties. They used to speak badly and use abusive language. But my husband insists on going to the government hospital where he gets cheap cost treatment. I often think that if I had the money, I would have gone to the hospital of my choice"*

Not just housewives, even working women do not have financial independence as they must hand over their salaries to their husbands. Lack of financial freedom is the main cause of worry for employed women in the Low MH group. Men make women prioritize their families and childcare, after which men take on the role of the family provider and assume to protect women and children. Women are heavily required to comply with this type of duty assignment for them to remain at home with their families. Employed women are also not free from restrictions. The majority conveyed that they are expected to be home by 6 p.m. when the work is done and their whole salary is to be used for family purposes.

The women in such situations are fighting hard to get to work while being resisted by their parents and in-laws. A few of the working women opined that marriage would provide the husband's family with a housekeeper or servant for their home. "*The in-laws will be happy if we divide the labour of running the home and the office equally, and there won't be any issues with the daughter-in-law."* opined

Nimisha, a government employee in the Low MH category. As a consequence, working women face role conflicts and fail to manage home care, childcare and office work. This will make a lot of noise in the family, and the so-called daughter-in-law does all the house chores, so she will be a good woman; otherwise, she will be considered bad for the family.

In the High MH group, most women receive support and care from their husbands' families; they believe that "*if we receive any financial gain, we should specially make the in-laws happy."* They claimed it was a management strategy. "*Without their support, we cannot do much in our society, so we should try not to mess with them."* Lakshmi 34-year-old Hindu woman conveyed that when she gets her salary, she will buy some items for the house and clothes for her in-laws and that they are overjoyed to receive such presents from her.

Women in the High MH group were generally found to be contented with the gifts that their spouses give them, whether it is given monthly or yearly. They think it is quite a generous act from the husband's side to buy them clothes. 32-year-old Shamina shared, "He rarely buys a dress for me, so I don't complain and accept it even if it's not to my liking." Another Muslim woman Khadeeja from a wealthy household said she would be contented with the gifts her husband got for her and added, *"If I need anything, he will fulfil it. I never experience dependence on him as a bad thing."*

Some of the employed women in the High MH group have taken a stand that they have the right to do what they want. There are occasional interpersonal conflicts with the in-laws, but they don't take it a serious issue. Anita, 33-year-old from a high-class Christian family said,

> *"I had a job even before marriage. After marriage, I continue my work. Now I have a two-year-old daughter. It is very difficult to manage baby care and work but am able to manage many things on my own as I get a decent salary. I never mind the things they say; one day my mother-in-law didn't care for the baby, and they were waiting for me to clean and bathe the child. They thought over time I would stop my work, but I arranged for a maid to take care of my*

child. I have a good salary; therefore, I can afford to pay the maid's wage. Every woman experience challenge in her life; I am aware that my husband cannot ignore his parents and I have no issue with that; so, I will attempt to manage my struggles by myself."

Sadhiya, a 26-year-old Muslim woman in the High MH group claimed:

"I am so lucky to have a family like this. Because my in-laws pushed me to finish my education and encouraged me to seek a government job. My mother-in-law always said that women should have a job and financial security. Even though my mother-in-law got a job at a young age, her husband did not allow her to go to work. So, she will always encourage us and say that no one else should have that experience. The fact that they never asked me to become pregnant and give birth is one of the biggest reliefs. Perhaps their older sons have already given them enough of grandchildren".

Aarathi, a 35-year-old Hindu middle-class woman in the High MH group asked, "If husbands are supposed to protect their women, then why should we assume that we are their slaves? After marriage, aren't husbands meant to take care of their wives?" Such women never consider the necessity for any degree of financial independence; they believe that their "husbands should look after wives, and they will do so admirably. In turn, women ought to look after their husbands and fulfil their wants in line with their preferences." Women who are happy to be their husbands' dependents do not require economic independence.

Getting money from their husbands is a technique, according to a few women in the High MH group. "*They will give you the money if we ask them according to their mood*." Additionally, they stated that the women's brilliance matters in it. As Bill and Melinda Gates Foundation (2019) reports, according to society, money is the domain of men. Society does not view it as a woman's role to earn money or her right to make financial decisions. Hindustan Times (2021) also report the same that many women depend on their husbands to take care of their essential financial needs.

However, in the present study, three educated working women in the High MH group were found to enjoy their financial independence and do not prefer to depend on their husbands. They shared their happiness in assisting husbands when they seek support.

In Kerala, many women struggle to support their families while balancing office jobs and other everyday obligations. Society never acknowledges the pressure that women undergo. They have obligations to their loved ones, co-workers, and the social status of "in-laws." A woman is expected to get up early in the morning to make meals, do other housework and laundry, take care of the kids, take care of her in-laws, and take care of her spouse. Then she has to go to work and do her job, and in the evening, she has to do the same things until she goes to bed. Traditional role expectations like this prevent many women from going out for employment which in turn makes them dependent. Very few housewives among the respondents have the opportunity to keep their husband's salaries. Still, there is no right for women to use it for any purpose without husbands' knowledge or permission in some cases.

As Foa's Resource Theory (1971) proposes economic dependency of women implies a lack of resources and options to cope with or change their spouse's behaviour. The theory posits that resources can be both rewards, providing pleasure, and costs, inducing pain, anxiety, embarrassment, or mental and physical effort. Certain groups of women, such as homemakers, those with disabilities, and the unemployed, who rely heavily on their spouses for financial stability, often serve as the primary caregivers for their children. In the context of this study, women are financially dependent on their husbands. This dependency extends to employed women who lack control over their earnings and rely on their husbands for financial sanctions. These women often do not have the freedom to spend their money as they wish and are typically responsible for taking care of the family.

Several studies point out such economic dependence on women (Kermode, 2007; Malhotra & Shah, 2015; Pandey, 2021; Pennington, 2018; The World Bank, 2022) and observe how all sorts of restrictions are placed on women, whereby they lack personal freedom and rarely have access to any money of their own. Hindustan

Times (2021) also report the same that many women depend on their husbands to take care of their essential financial needs. In the present study women whether employed or housewives have no economic independence. However, in the High MH group, women are satisfied with what their husbands give them. The present study reveals that economic dependency leads to Low MH among women and it may lead to more stress and depression which at times may cause suicide tendency among women. In this context, the National Crime Records Bureau (2021) report highlights that Indian women make up 36% of all global suicides in the 15 to 39 years age group and most of them are housewives (NCRB, 2021).

According to Maslow's Hierarchy of Needs, an individual's mental well-being is closely tied to their ability to fulfil five key needs. If these needs are not met, it can negatively impact their mental health. In the context of women who are financially dependent on their husbands, they often struggle to achieve the fourth and fifth levels of this hierarchy. The fourth level pertains to the need for esteem, encompassing self-respect and the respect of others. Women in economically dependent situations often find it challenging to gain respect from others and may struggle with self-esteem. They may even have to ask their husbands for money for personal expenses. The fifth level, self-actualization, is also difficult for these women to attain. Self-actualization involves realizing one's full potential, which can be hindered by economic dependency. Despite these challenges, Maslow's theory remains highly relevant in understanding the experiences of the women in this study.

5.4.3. Adjustment issues with in-laws

The study reveals that 23 out of 25 women in the Low MH group face adjustment issues with in-laws, especially with mothers-in-law. The comparison with neighbouring daughters-in-law, dowry-related violence, conflicts with progressive attitudes, forcing women to quit jobs, generation gap, disagreement to obey patriarchal customs and rituals and fear of losing control over their son are the major factors faced by women in Kerala. The husband will be considered a henpecked if he supports his wife, and patriarchal ideas are particularly brutal to women and hurt their mental health. Almost all the women in the High MH group reported having their husbands' and in-laws' support which keeps them happy.

The major incidents related to adjustment issues with in-laws as conveyed by the respondents are given in Table 5.5.

Table 5.5

Incidents Related to Adjustment Issues with In-laws

Adjustment issues with husband and in-laws	Low MH	High MH
Need to obtain permission to go to the natal home	24	5
Lack of sharing in household chores	18	10
Son preference of husband and in-laws	12	2
Comparison with co-sisters and daughters-in-law in the neighbourhood	24	3
Issues with the timing of sleep and wake-up	20	6
Forced to follow the traditions and practices	20	10
Dowry-related issues	24	4
Treated like a servant	18	0
Demand to leave the profession	10	0
Monitoring phone calls and messages	21	2

In the Low MH group, 23 women reported having trouble adjusting to their in-laws, particularly their mothers-in-law. The main causes of these adjustment problems include comparison with other daughters-in-law and neighbour's daughter-in-law, dowry-related violence, not allowing women to go to work, etc. In-laws frequently make comparisons between their lives and those of their daughter-in-law. The fundamental rule in-laws put forth as explained by the study participants is that since the mother-in-law suffered greatly after marriage, the daughter-in-law should also suffer similarly. Twenty women shared that to visit their natal homes, they must obtain permission, and for them asking their husbands for approval is acceptable while asking permission from in-laws is repulsive because, unlike the mother-in-law, it is easy to convince the husband. Shanthi, a 39-year-old from a wealthy family expressed her eagerness to return home. She said, *"I am granted two- or three-days permission to visit my home only once in six or seven months; otherwise, they let me go only for deaths and funerals happening in my family."*

Another woman named Sheela from a lower-class Hindu family explained,

> *"The in-laws forbid women from visiting their maternal homes because they must handle all the household chores by themselves. The in-laws treat their daughters-in-law like servants who need not be paid. In my case, I have to finish all the work at home and prepare food for the days while I am away."*

36-year-old Nancy from a Christian middle-class household shared that her husband is unable to gift her anything because his mother creates issues, citing the fact that "*her son has never given her anything so far*" and that "*he does such things now because of his wife's influence*." The in-laws will open our online orders and start some dramatic emotional scenes.

Another issue shared by several study participants is the imposing of customs and rituals. A woman after marriage should take a bath in the early morning (ezhara veluppinu eneekanam), sweep the yard, and make breakfast before awakening the male family members. Shaila 34 years old from a wealthy Hindu household shared that adhering to these kinds of unwanted practices and customs is simply intolerable. The majority of Hindu women conveyed that while they had all experienced this form of oppression, it is gradually changing and practiced occasionally in some homes in the name of safety and serenity. The in-law mothers are the primary enforcers of such customs in families.

Fifteen women asserted that their mothers-in-law misrepresented them to their sons. While she is on the phone, the in-laws watch her and oddly speak to their son which in turn may develop trust issues between the young couple. In-laws always demand their authority in the family whereby they discourage daughter-in-law having any say and advise sons "*not to become henpecked*." Accepting women's decisions is not considered good, and men are supposed to make all the decisions in the house. As shared by Saritha, "My mother-in-law keeps a close eye on her son, and if he rebels against his mother, I am blamed further." If the spouse becomes hostile toward the mother-in-law, the in-laws blame the daughter-in-law for being the cause of everything and curse her without cause.

According to women who live with husbands and family, the primary source of conflict in the family is the mother-in-law. They claimed that the in-laws cause unintended issues and hamper their lives. Jeena, a 32-year-old wealthy Christian woman shared,

> *"My family had given me a car, 100 sovereigns of gold, and one crore rupees as part of the dowry when I got married. Unfortunately, my husband and his family utilized the dowry to settle their debts. My husband had brutally raped me, and when I talked about this to my mother-in-law, she gave the straightforward warning that if I don't give in to him, he will find other women for that. My internal organs were damaged by urinary infections, but I never received any help from my in-laws or my parents in this situation."*

Eighteen women in the High MH group reported having their husbands' and in-laws' support. Raji, a 28-year-old Hindu woman in the High MH group said,

> *"Not even my own family provided me with the same level of care. My mother-in-law supports me with all kinds of assistance, encouraging me to study, making lunch for me, looking after my kid, and so on. Nothing was ever required of me, and I am free to do anything I want. While I do my best to assist her, my mother-in-law is unaffected if I do not do anything. She has never had the opportunity to study in her life, and she had no one to help her; even her husband did not support her studies".*

Similarly, Sujatha another member of the High MH group said that her in-laws were very supportive of her efforts to pursue a degree and secure a job. After getting married, she carried on with her education and secured a job in the government. She receives excellent career support from her in-laws. The majority of women in this group shared similar stories of help and support from their families. However, the spouses and in-laws of seven of the women in the High MH category do not provide them with complete support, though. But if they finish all the house chores before heading to college or work, the in-laws allow them to go out and continue their studies or careers. Although they still raise complaints about the daughters-in-law, they will assist them.

According to Thamanna, a 25-year-old Muslim woman *"At least they support me sometimes and allow me to finish my studies, and I would not mind if they notified me anything was wrong."*

The same was said by Anju, 31-year-old Hindu woman. These women struggle to balance their academics and careers while simultaneously managing family responsibilities. However, they believe they have the chance to continue their education and employment and are optimistic that they might be in a better situation in the future. Their better mental health might be because they have the chance to venture outside and interact with colleagues and friends. They also get opportunities to open up their feelings and get support from reliable friends, unlike the majority of women in Kerala who still lack the freedom to visit their natal homes or have any confiding relationships to share their feelings.

Issues with fathers-in-law are less common. The attitude of the in-laws toward their daughters-in-law is the main contributor to domestic violence and violence stemming from dowries. In this context, Rodrigues (2015) reports that due to a sudden change in their mothers-in-law's behaviour after marriage, more and more women are choosing to live apart from their husbands. Other studies also point out that adjustment issues with in-laws and other family members are one of the leading causes of divorce and other mental health issues (Nambi, 2005; Nadam & Shylaja, 2015; The Times, 2019; Vasudevan et al., 2015,). Most of the time, husbands are powerless and unable to support both the wife and mother on equal terms. The mothers-in-law born and brought up in the patriarchal society knowingly or unknowingly have a major influence on the mental well-being of young women in Kerala.

5.4.4 Alcoholism of Partner

Twenty women with alcoholic husbands shared how their husbands sexually exploited them and how the issues created due to alcoholism affect the whole family, especially the children. 36-year-old Rajitha asserts how women face social exclusion, and the children also face some peer teasing when their father is a drunkard. Nobody is ready to talk about sexual exploitation because it is still taboo.

The major incidents related to the alcoholism of partners are given in Table 5.6.

Table 5.6

Incidents Related to Alcoholism of Partner

Alcoholism of Partner	Low MH	High MH
Excessive drinking	20	0
Children's studies are affected	20	0
Physical abuse	18	1
Verbal abuse	25	22
Economic debts	19	2
Sexual abuse and perverted sex	19	4
Alienation from kin and society	16	0

Twenty women from the Low MH group claimed that the alcoholism of their spouses was a significant factor that destroyed their peace and happiness. Children experience problems such as social marginalisation and academic difficulties as a result of their father's alcoholism, which has far-reaching impacts on the kids at home. Due to their alcoholic nature, women are found to develop several physical and psychological disorders. 32-year-old Shyni from a low-class Hindu family claimed that her drunken husband regularly violates her sexually. When she refuses to let him, he beats her and performs some pornographic sex. Elsa, a 33-year-old respondent from a high-class Christian family said that her husband uses some instruments in her vagina, and due to this, she has some physical issues, and her uterus was removed. She is currently being abused by her husband and family, who claim she is incapable of bearing children. She said he was the reason for her present condition, and he still curses her. His family supports him, and they force him to divorce her.

36-year-old Bindu who is from a middle-class Hindu family said,

> *"My husband creates problems with our children, and they are fearful every day. My husband had doubts about my son because he was not of his*

complexion. Once the child was beaten by him whereby, he fell which caused him to lose a lot of blood from his head and my child became unconscious. Following this incident, the police, other social workers, and neighbours all stepped in to help resolve the problems. He is both my spouse and the father of my children, so I did not file a complaint against him. He upsets the family only when he is intoxicated."

The spouses of Keralite women, especially alcoholic husbands, are motivated by such thoughts that wives wouldn't file any complaint against their children's father. The study participants with alcoholic husbands confessed that having a husband for their namesake protects them from harassment and sexual assault by the public. A 36-year-old Muslim woman, Sumaya from a middle-class family shared an incident of how her husband was dropped off at the house by friends late at night, that he was undressed, and that she found him in the yard.

"I accompanied him to the bathroom where I poured water on his head. But as soon as he awakens, he asks me, "Who the hell are you to look after me?" Members of the Mahal committee have frequently told him not to drink in their community. He started drinking daily after disobeying them. I felt helpless as I looked at the faces of my children because sometimes there wasn't anything in the house to cook. What should I do? I am unemployed and have only primary education. We currently live in a house near the mosque arranged by the Mahal committee."

Women's conditions are terrible, and they are powerless to leave these unhealthy and irresponsible marriages. With motherhood, the women struggle to raise the children and later, the mother and children together battle to survive. Though social drinking is becoming far more acceptable in society, the problem of drinking is often viewed as stigmatic. Thus, the family members of alcoholic participants often feel estranged and are looked down upon by others. In this study, women with alcoholic husbands reported feeling ashamed in society. This leads to a marked reduction in social engagements. As Parsakarathy (2015) revealed, the wives of alcoholic husbands also reported general social dysfunction. Rajitha, a 36-year-old

Hindu middle-class woman is worried that her son frequently raises the issue of being called the son of an alcoholic by his friends. The kids suffer the loss of self-esteem and confidence and become marginalized by society. Because all children have the right to a safe and happy childhood up until the age of 18, and because their parents have a responsibility to support and care for them, this situation is extremely dangerous. However, an alcoholic environment is hardly a peaceful environment, and the kids do not receive any support or attention from their parents. Every day, the children witness their mothers' tears. It will have an impact on their thoughts, making them uncontrollable and disinterested in studies. In the present study, 13 women in the Low MH group shared similar stories. However, the effects of a husband's alcoholism extend beyond the wife to the kids and the family structure as a whole.

According to Sindhu from a lower-class Hindu family, she once ran out of her house due to her husband's abuse and went to the police station at midnight. She opened up,

> *"He kicked me in the abdomen, pulled my hair, and threw me against the wall. When he drinks, he always behaves in this manner. His cruel attitude and actions killed our son. Once he hit him and my child fell on his head and passed away because the injury was so severe. I felt incredibly sad and depressed after that, but he maintained the same attitude. He still abuses me while drunk."*

It is difficult for many women to survive with their alcoholic husbands. Women experience much social discrimination, and women and kids are stigmatized as the wives and children of drunkards. Even after filing a complaint against the husband, women are compelled to compromise and go with the alcoholic husbands by the police. Their propensity for settling issues pushes women back into violent relationships. Nothing has changed about the concept that women should endure all forms of abuse in relationships. All the human rights that apply to women get violated while the husbands are alcoholics.

Dhanya from a wealthy Hindu family explained how her husband regularly consumes alcohol and frequently takes advantage of her sexually,

> *"After drinking, he craves my company in bed and tries out novel sexual actions on me. Initially, I was unaffected by this, but later on, he started forcing me into doing everything he desired. I experience daily discomfort from vaginal infections and was scared to discuss this with a doctor. I hate his pornographic and unnatural sexual acts, but he always does the same. If I talk about this to anyone, what would they think?"*

Not just one woman reported this; 15 women in the group with Low MH shared how they all keep quiet and put up with their alcoholic husbands' sexual exploitation. Due to fear of what other people may think, the women are not ready to discuss issues relating to their sexuality with anyone. Patriarchy has a big part to play in why sex and sexuality are still taboo subjects in women's lives. Women who discuss foreplay and contraceptives risk being accused of being prostitutes or of not being virgins. Virginity plays a significant role in Indian and Keralite women's lives. Women are unaware of sex and sexuality; they are expected to know about sex after being married, which is the traditional concept in Kerala society.

In relationships with alcoholic partners, verbal abuse such as using insulting comments towards women and their families is frequent. Twenty women concurred that their drunken husbands verbally abused them. They all conveyed that if they dared to question the husband about his regular drinking, he would lose his temper and insult their dignity.

There are alcoholic husbands in the High MH group also, but there is less violence when they are intoxicated. The husbands always act maturely and make sure not to disturb anyone, especially their wives. Clara, 34-year-old from a wealthy Christian household says,

> *"I enjoy having sex with him when he is drunk. he is more lovable and conversing with him at that time is enjoyable."*

Another Hindu woman from a middle-class family stated she liked her husband's drunken behaviour. They claimed that because there is no longer any physical, mental, or sexual abuse, they love the husband's behaviour when he drinks.

Furthermore, drinking is under control and not excessive. They are more conscious of their neighbours and society, which is why they control themselves to not be known outside. They attempt to drink covertly to avoid upsetting their neighbours or the greater society. Therefore, there is very little harm done to women or with women's support even if they drink.

Alcoholism is a significant factor influencing the mental health status of women in Kerala. Several studies substantiate the present finding that the wives of alcoholics undergo intense trauma and stress in their domestic environment, which brings about major psychological problems (Vaddiparti & Benegal, 2010) The high levels of anxiety, depression, neuroticism, and poor self-esteem are a few of the symptoms on the slope. Domestic violence, emotional violence, and economic violence are the most frequently occurring and well-recognized problems faced by the wives of alcoholics (Dostanic, 2022; Sharma, 2022; UN Women, 2020). Children may struggle academically and face ridicule from their peers, while women may experience feelings of sadness, stress, alienation and helplessness. The family is an integral part of the larger community system, and substance abuse by a family member can disrupt the balance of the family structure.

The state of Kerala has the discredit of largest consumption of liquor in the Indian subcontinent. Despite the violence and associated trauma, the study participants continue to stay back in abusive relationships with their husbands as most of them are economically dependent on their husbands and have no place to go. In the patrilocal culture of the state, married women are least welcome in their natal homes. Without any fallback options, they live a life for their children. The learned helplessness proposed by Walker (1977) is fully applicable in the case of study participants with husbands who are regular consumers of liquor.

Women's mental health is significantly compromised for government profit because there is no effective government regulation on the sale of alcohol in the state. Violence against women can be reduced to a great extent if alcohol sales are properly regulated. This study clearly demonstrates how drinking by husbands has an impact on women, kids, and families.

5.4.5. Lack of support from natal home

20 out of the 25 study participants in the Low MH group reported about the unsupportive attitude of their parents and relatives. They said that they are least welcome to their homes. There is no one to support them. They have not enough education, no regular job, and got married before completing their studies. They are forced to stay with the husband because there is no other option in this situation. W*omen in the Low MH group lack the emotional support of their parents, whereas women in the High MH group receive the care and support of their fathers, mothers, and other family members.*

The major incidents related to lack of support from the natal home as conveyed by the study participants are given in Table 5.7.

Table 5.7

Incidents Related to Lack of Support from Natal Home

Lack of support from natal home	Low MH	High MH
Forced to stay in a violent relationship	20	0
Normalizing violence	22	12
Regular advice that women should adjust	23	12
Glorifying men's superiority as to be respected	20	12
Parents do not understand the feelings of their daughters.	23	0
No support from own family, husband's family & other relatives	20	4

20 women in the Low MH group were worried about the unsupportive attitude of their parents and relatives. Arathi, a 24-year-old, from a middle-class Hindu family, said that when she talked about her husband's abuses to her mother, her mother convinced her that it is normal in married life. And she also added, "Don't think about

divorce because you have two younger sisters at home." Thus, women are forced to stay in abusive relationships. Sindhu from a middle-class Hindu family also expressed the same experiences. 28-year-old Anlin from a wealthy Christian family, on the other hand, conveyed that her mother-in-law tortures her every day in the name of dowry. Her in-laws always compare her with their neighbour's daughter-in-law.

Ancy from a Christian high-class family says,

> *"Am 35 years old, educated but unemployed just because my husband's family never allowed me to go to work outside. He and his family have broken all the promises they made before marriage. But my parents never ask them about it. My husband's family treats me as a servant. My parents married me to this hell, I do all the housework, I wash all the clothes in this house, I have to clean all the bathrooms, and can you believe that I am only a sex toy of my husband? My parents will be happy if I die here, and even then, they will say that this is normal in married life."*

Arathi, a 30-year-old from a lower-class Hindu family said that she faces abuse from her husband in connection with dowry. She said,

> *"Once my husband threw me out of his home because he didn't get the rest of the dowry amount that my parents agreed to pay. I know my parents are unable to pay the one lakh to him. Because of this reason, his entertainment is experimenting with some perverted sexual acts on my body. I am so helpless, and my own family is too. I am still mad at my parents for pushing me into this relationship. They destroyed my studies and my career too."*

Arifa, a 30-year-old, from a lower-class Muslim family also shared a similar story of dowry harassment and how her parents remained helpless and indifferent in the situation.

Annie, a 34-year-old Christian woman shared how her parents discouraged her studies and employment and how they got her married to a similar family and remain calm. She said,

"I often feel as though I have moved from one difficult situation to another. Even though I do not have any privileges, my husband's family nevertheless has the same vibe as that of my natal home. It is still a wonder to me how I managed to finish my degree at home. I implore God to spare anyone else from having such parents. They never provided any emotional backing for my studies, always pushing me towards marriage instead. My mother, despite being the executor of my father's orders, is the worst mother I have ever known. She lacks the courage to stand up to my father, and as a result, she complies with everything he says. If my father decides against my studies, she won't allow me to read or study. All the household chores were left to me. Now they seem to be relieved of their responsibilities and do not even listen to my plight in married life."

Six other women from the Low MH group shared similar stories about how their mothers never supported them; instead, remained indifferent and advised them to go back to their husbands' homes. The mothers teach their daughters how to cook, respect men and behave properly in another home. After marriage what is happening to their daughters is never enquired about. Mothers always push them back into abusive relationships. One woman added that her father's and mother's love and care lasted until her marriage. "After that, I am a stranger to them. They are the infrequent visitors who come and go. When my parents hear that I have a problem, they start advising me. They claim that a true wife must support her husband through adversities". Such advice makes the women suffer even more.

In the case of women in the High MH group, the situations seemed to be different. Fidha, a 26-year-old Muslim woman from a middle-class family in High MH group, claimed,

"My parents were always there for me when I needed assistance. Prior to my marriage, a marriage broker misled my parents, and it was only after the wedding that I discovered my husband was involved in illegal business. All the details came to light post-marriage. Six months into our marriage, my husband was arrested by the authorities. He exploited me financially. He threatened me

not to tell my parents and used my gold and cash given at the wedding time for his own business needs. However, when I explained the events to my parents, they intervened and warned him. As a result, he quit his unnecessary business and started to care for the family."

Eighteen women in the High MH group also mentioned receiving support from their natal families in different ways, and how they feel secure and happy as there is someone to support them. When a woman says, "I cannot live with him," the problem is considered hers, not his. Society never tells a man to change his attitude; rather, it tells women to bear with it. Women commit suicide when they cannot bear the torture. They never go back to their homes because of the lack of support. According to the study participants, even today, there is an attitude in our society that it is better to die than to come home as a divorcee. Here, a second marriage is still considered bad for women, but it is possible for men. However, when the researcher asked why they sustained with their abusive husbands after enduring so much violence, most of the women said that they could not go back to their natal homes as there was no support from their parents.

While a majority of women in the Low MH group lack the expected emotional support from their mothers, almost all study participants in the High MH group were happy with the support and care they receive from their fathers, mothers, and other family members. There are not many studies in this regard as this is an area which has not received sufficient attention from researchers. Examining how the family context influences outcomes for children or how family members provide assistance for mentally ill women has been the main focus of research on the relationship between family and mental health. Though there are studies which reveal how women are likely to experience postpartum depression when husbands and other family members fail to offer support to young mothers (Agostini et al., 2015; Jijila & Kuruvilla, 2022; Srinivasan et al., 2015), researchers rarely discuss how important family support is, to ensure women's mental health.

5.4.6. Lack of confiding relationships

Experiences and subjective feelings of study participants from the Low MH group point out that trust issues and lack of friends or family members to rely upon during challenging times are major factors affecting women's mental health. 16 out of the 25 women in the Low MH group confessed that they lack good friends or other trustworthy relations in their lives. Having to share a lot and nobody to hear is a pathetic situation. At the same time, an interesting observation in the study is that three of the women in the High MH group were found to be using advanced psychological help without the fear of any taboo.

The major incidents that connect the lack of a confiding relationship with the mental health of women are presented in Table 5.8.

Table 5.8

Incidents Related to Lack of Confiding Relationships

Lack of confiding relationships	Low MH	High MH
No trustworthy relationship to open up	20	3
Stigma related to mental health issues	25	10
Fear of women blaming	21	4
No freedom to talk to friends, neighbours or relatives	24	14
Lack of access to the mental health support system	20	14

One of the biggest problems for women is that there is no one they can rely on. Women reported that they were unable to disclose all their activities to their husbands. Sometimes for a better conversation and more suggestions they may require the help of another person. Study participants confessed to having so many issues with their in-laws and other family members, yet they are unable to fully disclose them to their husbands. Because women who confide in others are considered ungrateful, especially to their spouses. Sometimes spouses inquire about it with their in-laws and other family members, which causes serious misunderstandings and arguments in the

household. Therefore, women tend to hide their feelings, which increases tension and depressive symptoms. For the sake of the family's harmony, ten of them confessed that they conceal their emotions and cry in silence.

Lack of trustworthy friendships and relationships was reported by 16 out of 25 women in the Low MH group. Whenever they open up their feelings and worries to someone more problems will arise in the family and the situation gets aggravated. Women face a lot of trust issues in their lives.

34-year-old Liya from a prosperous Christian family shared,

> *"I trusted a family friend and talked about my abusive spouse. She also tried to support me and alert my mother-in-law about the abuse. My husband stopped speaking to me when the situation got worse. Now his entire family sees him as a rapist. Although the family and other members helped to resolve the issues, he still kept a distance from me. My friend advised me to speak with him first, but I chose not to. He doesn't talk to me like he used to, and it makes me lonely and miserable."*

Hadhiya, a 29-year-old Muslim woman reported that she is being mistreated by a member of her joint family, where she lives. Because this is likely to do further harm to the family, she cannot inform her husband. When she was unable to tell anyone else, she finally told her mother, who then told her son-in-law. Finally, things ended up as if she was the problem; she committed the offence and everyone including her husband blamed her.

36-year-old Ananya from a middle-class Hindu family is depressed that she is neither in her husband's family nor in the neighborhood she has any friends. She stated that:

> *"Am trapped within the confines of my husband's home, I find myself yearning for companionship. The neighbourhood is devoid of friends, and my ageing in-laws show little interest in the conversation. I am a social butterfly, thriving on interaction and dialogue, but my wings are clipped in this environment. My husband, unfortunately, is not one for conversation either. If I use my phone,*

they claim am constantly on the phone and might give my spouse some unpleasant advice. In this traditional household, I am expected to master domestic chores under the watchful eyes of my mother-in-law. The pressure is immense, and the stress is palpable. It feels as though I am losing my voice, my ability to express myself dwindling with each passing day. Communication, the simple act of talking and being heard, brings me joy. But in this house, it feels like a luxury that is just out of reach. I feel am in a cage and trapped in a world where my voice echoes back at me, unheard and unacknowledged."

Another area of concern is the lack of space and voice to discuss matters of sexuality. They never talk to their husband about sexual misconduct from others or even tell their husband about their sexual preferences. One woman from a middle-class Hindu family shared that "I *occasionally do sob quietly after which I feel better. I never talk to my husband about sexual misconduct or sexual preferences."* Men as reported by most study participants misunderstand women's demands and sex-related experiences.

29-year-old Christian middle-class woman Katherine said,

"Once I decided to discuss some intimate matters with my husband hoping to bring some spark back into our relationship. I talked about different sexual poses that I had read about in a book. However, he reacted unexpectedly. He questioned me about where I had learned about such things and who had taught me. This reaction from him left me feeling hurt and confused. I merely wanted to enhance our intimacy and bring us closer as a couple. But his distrustful response made me feel as if I had done something wrong. I started to feel a growing sense of unease in my relationship. I felt as if I was walking on eggshells around him, scared of his reactions. The trust that once formed the foundation of our relationship seems to be crumbling."

Such stories were shared by four other study participants. Here women are not expected to talk about sexual matters with their husbands. It is a reminder that open communication is essential in any relationship, and that trust once broken can be

challenging to be rebuilt. Respondents opined that the patriarchal ideology around women and sex is still present in society.

In the High MH group, women receive comparatively better support or assistance from their natal home and have established reliable relationships in their neighbourhood.

Akhila, a 39-year-old middle-class Hindu woman, claimed,

> *I have a circle of friends in my natal area, and I eagerly anticipate my monthly home visits to share the tales and challenges in my husband's home. They also look forward to my visit to discuss their own experiences and problems. These meetings are like a story-sharing moment for us. I think sometimes spending time with my neighbourhood friends and sharing our collective highs and lows reduces a lot of stress.*

Another woman, Kadheeja, who is 41 years old and from a lower-class Muslim community, also shared a similar experience. In their own homes, they are free from restrictions and exempted from household chores. As a result, they relish their time spent with friends and relatives in their natal neighbourhood.

Nancy, 30-year-old, from a high-class Christian community says,

> *"Am working in a private sector and I have a wide circle of friends. I still keep in touch with them. I have a supportive husband, and I can share anything with him. But sometimes I have something I don't want to tell him. During such instances, I prefer my mother to discuss the issues, and she is the secret keeper in my life more than my husband."*

As per the respondents from this study, to relieve tension and anxiety, everyone needs a trustworthy companion with whom they can share their issues. Women who are employed tend to have like-minded colleagues and friends with whom they can discuss their anxieties and apprehensions related to their spouse, their families or in-laws. Women seemed to be perplexed and unsure of what to disclose and what to keep private. They express their annoyances to others, who then share

them with someone else, and so on. Then their lives become increasingly difficult, and they end up in a vicious cycle of blaming from all sides.

McLean (2022), emphasizes how poor friendships and familial relations might affect the mental health of women. To reach their greatest potential, people must have healthy social connections. Strong, reliable networks help people cope with negative circumstances by offering emotional support. Insufficient social connections can result in loneliness, which can have detrimental effects on one's mental and physical health (Mushtaq et al., 2014; Tiwari, 2013). However, several of the study participants confessed that they lacked good friends and other reliable relations in their lives. Having to talk a lot and nobody to hear is a cruel situation. Three women in the High MH group agreed that they are using advanced psychological help with no more taboo. This deserves a big appreciation.

The lack of strong friendships is causing mental health problems among women in the present study. According to Maslow's Hierarchy of Needs, an individual must fulfil five stages of needs for their psychological health. The third stage emphasizes the necessity for love, belonging, lasting intimacy, companionship, and acceptance. In the present study, women are experiencing a deficiency of reliable friendships in their lives, leading to trust issues and stress. After marriage, several of them get confused with the belongingness feeling. They are no more part of the natal homes and they fail to get acceptance at the husbands' homes. Consequently, women become unable to meet all other higher needs essential for their well-being.

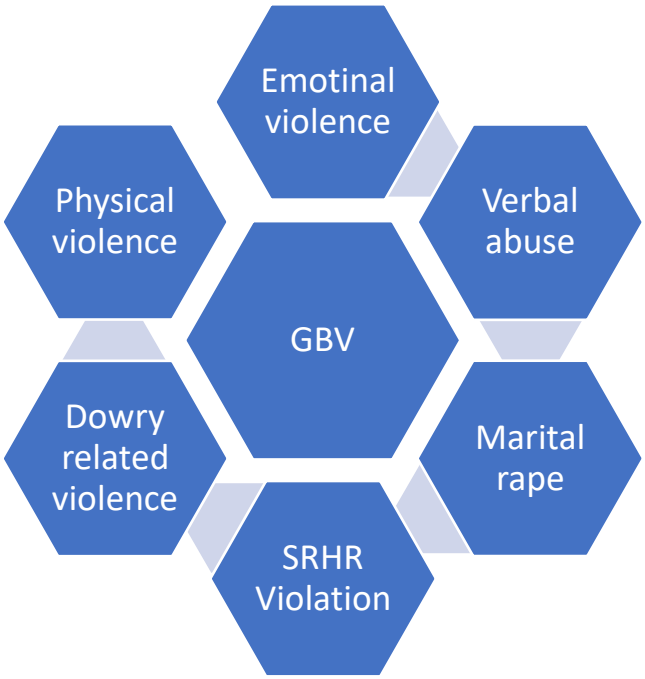
5.4.7. Gender-based violence

The findings reveal that all 25 women in the Low MH group experience various forms of gender-based violence in their lives. It includes various forms of domestic violence, especially dowry-related violence, sexual abuse, lack of SRH rights and son preference. Similarly, 20 women out of the 25 in the High MH group also face various forms of violence, but the frequency and intensity of violence are lesser in their case. Women in the High MH group also were found to normalize the violence by saying- "these things happen in every home.

Gender-based violence was found to be the most prominent factor affecting the mental health of the study participants. The various forms of gender-based violence as reported by the study participants are presented in Figure 5.2.

Figure 5.2

Major Forms of Gender-Based Violence Faced by the Study Participants



Women belonging to both the High and Low MH groups are victims of one or other and in some cases, all forms of gender-based violence. The number of women subjected to the various forms of violence is shown in Table 5.9.

Table 5.9

Incidents of Gender-Based Violence

Gender-Based Violence	Low MH	High MH
Physical violence	18	1
Verbal abuse or psychological abuse	25	22
Economic abuse	19	2
Dowry related violence	12	3
Sexual abuse/marital rape	19	4
Lack of SRH rights	22	9
Son preference	9	3

The main forms of gender-based violence faced by the study participants are dowry-related violence, various forms of domestic violence, intimate partner violence (such as marital rape, perverted sexual acts, verbal and other physical violence), and lack of SRHR rights. Incidents of domestic violence as shared by the study participants are of the following forms:

- Hitting
- Pulling hair
- Slaps on the face
- Threatening
- Throwing out of home at night
- Constant blaming
- Belittling
- Verbal abuse
- Bad words about family and parents
- Sexual abuse
- Marital rape
- Extramarital relations of husband
- Keeping gold under in-laws' custody

Dowry-related issues and quarrels are a major form of violence in families, especially in the Low MH group. Though it is a form of domestic violence, its frequency necessitates it to be given under a separate title. Dowry-related issues as shared by women in the Low MH group are of the following forms:

- More demands for cash
- Frequent quarrels
- Threat of desertion
- Comparison with other daughters-in-law in the family and neighbourhood
- Gold under in-laws' custody

- Having a job is not considered as an exception to dowry.
- Not permitted to go for a job as it is considered an escapism from household work

All the 25 women in the Low MH group shared that they are victims of various forms of domestic violence at home. Janaki, who is 42 years old, still endures threats and humiliation in the name of dowry. She said,

> *"I am a mother of three children, and they are at their age for marriage. but still, I am hearing some bullshits from my husband and in-laws about the pending dowry my parents should have given at the time of my marriage. My husband and in-laws accused my parents of cheating them and placed the blame on the entire family."*

Sexual abuse: Vast majority of women are unaware of the concept of marital rape. But they conveyed how their husbands engage in some lewd behaviour and never seek their consent before having sex.

Savitha, a middle-class Hindu woman in her 30s said that her husband forcefully opens her mouth and does all dirty things which she cannot even resist. She said,

> *"I found myself in constant pain, plagued by recurring health issues such as urinary tract infections", she began, her voice barely a whisper. "The physical discomfort was unbearable, but what was even more distressing was the emotional turmoil. Whenever he drank, his cruelty knew no bounds. I was unaware of marital rape. I had always believed that marriage was a sacred bond, a partnership based on mutual respect and consent. But I was wrong. After marriage, life is a game of chance, we are at the mercy of our fate."*

Another woman Ayisha, a 35-year-old high-class Muslim woman said,

> *"I was advised by my doctor not to conceive again, as it could endanger my life, However, my husband, who refuses to use contraception, dismissed my concerns. He even threatened to seek other women for his sexual desires if I didn't comply. He doesn't respect my boundaries, even during my menstrual*

> *cycle. I feel so helpless and have no one to confide in about this. If I talk about this to my parents, they will respond that it is quite natural, not to make him an enemy and obey him and satisfy his needs." She sighed and said, "A woman must satisfy her husband and do anything for his happiness."*

This is the story of a woman trapped in a cycle of abuse and societal expectations, struggling to find her voice amidst the noise.

Anlita, a 28-year-old high-class Christian woman, shared that,

> *"In the privacy of our bedroom, my husband's behaviour is monstrous. He forces me into degrading sexual acts, often resorting to physical violence. I feel trapped, with no means of escape. He constantly threatens me, boasting that he could easily find a lot of girls for his enjoyment. His words are like daggers, piercing my heart. I have no job, no financial support from my family. I feel like a bird with clipped wings, unable to fly away from this cage of abuse. If only I had some financial assistance, I would take my child and leave this house without a second thought." she concluded, her voice filled with determination and a glimmer of hope.*

Almost all the women in the Low MH group shared similar stories of enslavement and helplessness where they have to become objects of sexual pleasure to their husbands. They are powerless to escape the high levels of gender-based violence which in turn have a high toll on women's mental health.

Gender-based violence is less frequent in the High MH group as compared to the Low MH group. They are not, however, free from violence. As per Table 5.9, 22 out of the 25 women in the High MH group are subjects of verbal/psychological violence.

Athira, a 39-year-old Hindu woman while admitting that her spouse occasionally punishes her and uses derogatory language towards her, justified his acts on the grounds that all of it was the result of her faults and added that he is a decent man who takes the best care of her and her kids. She continued by saying,

"My husband sometimes reprimands me and uses harsh words towards me and my family. I understand that it's all a result of my mistakes. He is a good man who takes excellent care of me and our children. He is not a man with ill intentions, but rather an innocent soul who is overly concerned about me. Men are always like this. They are cautious about their wives; it does not imply that there is no love because they try to correct their women."

There are instances of SRHR violations in the case of nine women. They also occasionally come across their husbands' committing acts of aberrant sexual behaviour and marital rape. Just like women in the Low MH group, most of these women are also not aware that marital rape is illegal. Some of them have not even heard about marital rape. The majority of women in the High MH group view violence as normal male conduct.

As opined by 35-year-old Muslim woman Laila belonging to the High MH group, after marriage, women become their husbands' property and are responsible for attending to their sex requirements. Communities still hold on to these kinds of ingrained beliefs, and several women still believe that they are mere bodies without any dignity and integrity.

Naseeba from the high-class Muslim family said that she cannot say no to him because he loves her a lot. That is why he uses me sexually. According to her, he expresses love through sex, and she enjoys it too. Saritha, a 36-year-old middle-class Hindu woman also added the same and asked,

"Why should we oppose our husband? They have the right to use us sexually."

As per the opinions of the respondents, most of the married women in Kerala believe that, after marriage, they become their husbands' property, and that husbands have the right to exploit wives. The study participants were found to be unaware of the concepts of consent and pleasurable sex. For them, sex is all up to their husbands' wishes. If they have any reservations about engaging in perverted activities, they never tell their husbands about it and the reasons they expressed include fear of the husband going for extramarital affairs, belief that denying sexual pleasure to the husband is a

sin and that the husband owns the wife's body. The women in all categories live with this fear and do whatever their husbands want.

Another woman, Karthika opined that they would look for other women if we do not enable them to seduce us. Only women will suffer the loss. According to the study participants, women cannot and should not go after other men even when their husbands have extramarital relations. It may affect children's development and destroy family integrity, they opined.

All the 50 women involved in in-depth interviews undeniably agree that they are the victims of some or other form of gender-based violence at least once in their married life. Women still have a mindset that is firmly rooted in the conventional patriarchy, and they continue to do so. Consequently, they consider gender-based violence as a normal thing in the lives of women. This, in part, encourages women to stay back in a relationship and keep putting up with its challenges. Several studies support this finding (UN Women, 2022; World Bank, 2019; WHO, 2021) while the atrocities that are committed may vary. In 2022, the UN reported that gender-based violence remains largely unreported due to the impunity, silence, stigma, and shame surrounding it. The same pattern is present among Keralite women as well. In some abusive relationships, women remain muted in the hopes that things will eventually improve. It can be concluded that views regarding violence among women have not changed much over the years. It is a sad fact that despite their education, most of the study participants accept the idea that they are instruments to be used at the whim of males and to be thrashed when they become enraged. At the same time, there are a few women in both the High and Low MH groups who raise their opposition to any form of violence from their husbands.

Shooshtari et al. (2018) in their study highlight how economic empowerment improves women's mental health. Parasuraman and Somaiya, (2016) give another dimension that increasing women's income and their control over family spending can lead to improvements in child nutrition, health, and education. However, the willingness of a man to apologize can help women forgive and forget men's minor forms of violence. In the High MH group, there is affection and love between women

and their husbands. However, women with Low MH seemed to lack any intimacy with their husbands and they endured terrible physical and psychological abuse. As a result, women with Low MH worry about how men are encroaching on their space and the cruelty they exhibit toward them. The study results endorse the consequences that gender-based violence can have on the mental health of women.

In the context of this study, women are denied their right to sexual expression and pain relief, which are fundamental needs according to Maslow's Hierarchy of Needs (1943). As a result, these women are unable to meet their first basic needs. Furthermore, women who experience gender-based violence are also deprived of the second need, which encompasses safety and security, including protection from harm or impending deprivation. The study reveals that women are subjected to various forms of gender-based violence such as domestic violence, sexual violence, and SRHR violations, thereby depriving them of safety and security. Consequently, women who endure gender-based violence are unable to progress through the five stages of Maslow's Hierarchy of Needs Theory. This lack of fulfilment leads to mental stress and dissatisfaction in their lives.

The cycle of violence and the battered woman syndrome as proposed by Lenore Walker (1979) were found to be common among most of the study participants sustained in abusive relationships. Walker suggested that ongoing abuse could wear down a woman's resolve to leave, leading her to remain in the relationship. Though there may be women in abusive relationships who repeatedly try to leave and often take proactive measures to lessen the abuse they face and protect their children, in the current study majority of women living with alcoholic husbands endure the brunt of their husbands' violence because they have no other place/home to go, not even their natal home.

5.4.8. Conflicts with patriarchal norms

The present study found that 20 out of 25 women in the Low MH group are dissatisfied with the unfavourable patriarchal behaviour in their husbands' homes. All the 25 women confessed that they are not permitted to make any decisions in their lives. Women who are aware of who they are and what rights they have will argue for their space and voice which ends up in friction with their husbands and their families. However, as suggested by the respondents, women in this country have undervalued themselves. The most revolting thing is that 15 women in the High MH group believe that "men will be men and women do not need to acquire male privilege. In society, women never receive the same rights as males.

Twenty of the twenty-five women in the Low MH group shared that their husbands' homes exhibit several forms of unfavourable patriarchal behaviour. Women who are educated and aware of who they are and what are their rights will stand up against their husbands and their families to defend their freedom and rights. After marriage, women in states like Kerala become the property of their husbands. She should follow his orders, and he is free to make whatever decisions. The majority of Indians think that women should be submissive to their husbands' authority after marriage. In comparison to her parent's house, the woman will become more under the supervision of her husband at home. A woman may have enjoyed freedom in her own home, but after marriage, she must seek her husband's approval for all of her decisions and adhere to his wishes. The common saying that "every woman has to move to another house after marriage" has been part of our socialization in this country. As a result, they must abide by particular etiquette guidelines after reaching their husband's homes. Women are expected and at times forced to get up early in the morning, take a bath and do the prayers, prepare food for the family, wash all the clothes, do all cleaning and mopping, take care of the aged members, entertain guests and the list goes on.

According to Maya, a 32-year-old Hindu woman from the Low MH group, many men continue to believe that hitting their wives is acceptable. It is indeed patriarchal to believe that men have the right to beat their wives. Most men believe they have the right to beat their wives for any reason like forgetting to put vermilion, the salt in curries being a little high, the number of curries being lesser for lunch or dinner, failure to arrange the brush and paste when the husband wakes up, and so on. Abiya a 41-year-old middle-class Christian woman stated,

> *"I was irritated in such circumstances. He will throw out the food if it is the same as yesterday's menu. He buys only two or three vegetables per week, even though he needs a variety of curries every day. I am always worried about how to cook a variety of dishes with only three vegetables because I don't have a job and my husband's parents would not let me go shopping. My husband once poured the curry on my face as it tasted ginger which he did not like. My eyes and nose burned for two days. I was feeling like leaving the house right then."*

Farhana, a 28-year-old Muslim woman from a rich household shared,

> *"Once when my father-in-law arrived home, I was watching TV on the sofa in the hallway. He said I did not respect him. Women in their households are expected to stand up when the older men enter; otherwise, women are being disrespectful. So, he made a big deal out of the occurrence by immediately telling all their family members and neighbours about it. I became a topic of conversation in the family since this incident, and everyone treats me like a criminal."*

The study participants in the Low MH group, who are educated and in the workforce were found to be irritated by the growing control and restrictions and they try to question the patriarchal nature of society.

"Women should obey their husbands." is a statement made by Annamma from a wealthy Christian community, "and that is supported by the Holy Bible." Faiza, a 39-year-old Muslim woman stated that she would gladly serve her husband and accept

his arrogant behaviour. When the researcher enquired about her employment, Faiza stated that since he takes such good care of her, why should she go to work? Her husband does not like her to go for a job, and his family is also against it. The family's peace is important, so, her responsibility and duty are to care for her husband and his children. The majority of women in the High MH group said that women should stand up when a man enters the home, as part of respecting men; otherwise, they think women disrespect them.

But Priya, a 31-year-old Hindu woman from the High MH group strictly opposes this kind of attitude of women. She said it is all out of date and she never believes in this kind of suppression. And she added that "women should have a stand of their own just like men." Habeeba, a 28-year-old Muslim woman also shared such an outlook,

> *"My husband didn't like me riding a two-wheeler. I know he has some egoistic beliefs that women should not ride bikes, and he considers it as a man's domain. I realized that his undue care was keeping me from my passions, so I started riding a bike and eventually a four-wheeler."*

The major incidents of conflicts with patriarchal norms as expressed by the study participants are given in Table 5.10.

Table 5.10

Incidents Related to Conflict with Patriarchal Norms

Conflict with patriarchal norms	Low MH	High MH
Enforcement of dress code (vermilion, purdah (etc.)	18	6
Lack of decision-making opportunity	20	14
Enforcement of traditional customs and practices	18	4
Restricted mobility	11	14
Referring to women as feminists	12	3

Enforcement of dress code: In the High MH group, several study participants are willing to embrace patriarchal attitudes and accept them as part of traditions. Women are made to believe that their husbands insist they wear vermilion as a means of protection. Here, Sabitha, a 30-year-old Hindu woman claimed, "By letting other men know that she is married and someone else's property, wearing vermilion makes us safer in public. As a result, women are protected from social violence such as eve teasing and sexual abuse."

> Anjali, a 35-year-old from a low-income Hindu family asserted that her husband may meet with some accident and die if she doesn't use vermilion and that women put vermilion to protect their husbands. Here, women blindly believe that applying a vermilion is a must-do activity for married women.

Sajna, a 40-year-old Muslim woman says that the purpose of wearing the purdah is to protect oneself from other men. According to her, women who wear shaped dresses are more likely to be taken advantage of by men, hence husbands shield their wives from other males in the community by insisting on wearing purdah.

Regarding the question of putting vermilion, Kavitha, a high-class Hindu woman in the High MH group claimed,

> *"Numerous women question me about why I do not wear vermilion and that married women need to do so in favour of their husbands. I decline it and retort that I don't like it and my husband never insists on it."*

Similar attitudes were shared by five other women also. Thus, very few women in the High MH group exhibited their discontent with the insistence of the dress code.

Lack of decision-making power: In connection with their decision-making capacity, all the 25 women in the Low MH group confessed that they did not have any decision-making power at home; they felt irritated, and they wished their husbands or other family members at least asked their opinion. And women have no right to decide their personal matters either. In this context, women must seek permission for everything, whereas men make all decisions about their wives on their own. As per the findings of the present study, one of the main causes of Keralite women's poor mental health

is the lack of opportunities to make decisions. Women are still controlled and confined within their families, and society treats them in a secondary position. *"Pennbudhi pinbudhi"* which translates as "if women decide anything, it will be a flop," seems to be something Keralite men frequently tell their wives. Regardless of her education, a woman's decisions are treated as worthless in her family and society just because she is a woman.

Riya, a 35-year-old, well-educated teacher from a Christian community reveals,

> *"As a teacher, I have authority over the students. I take part in extracurricular activities like sports, arts, and other programs at my school actively, and other teachers frequently ask me for my advice and opinion on many issues. I feel delighted when my colleagues seek my advice because I had never received such values from my family, not even from my husband."*

Thus, education is not a parameter of women's decision-making capacity within the family. Anitha, a 30-year-old Hindu high-class woman shared,

> *"My husband told me that you can't understand the situation, so please don't try to be a dump. After this incident, I stopped interfering in such situations, escaped myself, and now I always ask my husband's opinion. I realize it's not my area, and I'm curious why men's decisions haven't failed."*

Ancy, a 30-year-old high-class Christian woman said,

> *I have no freedom even to choose the menu for our family meals. We all should eat what my husband prefers because everything is under his control. When I go to my home, I will eat like people who have not eaten for a long time. Everyone in my home laughs at me. But only I know what I feel inside me."*
> And quite unexpectedly she started crying.

Another participant named Akila in the Low MH group shared that her husband will force her to submit loan applications if he needs a loan from Kudumbasree. He never asks me for my opinions. He has no experience with loans

and has never collected money to cover a monthly payment. She will then have a hard time paying back the loan.

A few women from the High MH group are somewhat involved in making decisions. Their husbands consult them before making furniture and other home maintenance purchases, including kitchen appliances, fridge, TV, etc. Many of them are free to cook whatever they want, and their spouses seldom interfere negatively. Every time, they seek their husbands' approval before moving on. Bindu, a 40-year-old Hindu woman from a middle-class family argues,

> *"It is normal to accept my husband's patriarchal behaviour at home, and this will promote family peace. Women who rebel against the chauvinistic actions of men are castigated as "disrespectful women" or "feminists." "I've suffered for a very long time in my life; now that I'm in my 40s, I feel I am being valued, and at least he asks my opinion on family matters, but the final decision is his," she said.*

18 women in the High MH group like their husbands making decisions for them. Haritha from a middle-class Hindu family stated,

> *"I don't bother about decision-making because I am unable to make my own decisions and I am happy with my husband's choices. I believe that if my husband says no to me, and if I dare to go ahead with my own plans, negative things are going to happen. So, I would not be upset if he refused any of my requests. He wants to keep me safe."*

Asiya, a 33-year-old from a middle-class Muslim family said that she asks her husband's advice because he is her banker, so she said, *"I should ask him before I do or buy anything. Otherwise, he will not like it."* Thus, women are always conscious of their husbands' reactions. If a woman makes a wrong decision, the men lash out at her. Harsha, a 29-year-old middle-class Hindu woman from the High MH group claimed,

> *"Although there is some sort of conversation before making any purchase, taking out a loan or funding children's education, he will ultimately decide*

what to do, and he never does so without my knowledge. I am happy with his choices because I've always received some consideration in his life, and that's enough for me."

Most women in the High MH group genuinely believe that they cannot make decisions. Mariya, a 35-year-old Christian woman from a lower socioeconomic class confessed that she could not make decisions and expressed satisfaction with her husband's options. She claimed that he made better decisions than she did and that he was aware of the positive and bad outcomes of his decisions.

Thus, when it comes to making decisions, arrogant and patriarchal types of limitations are placed on women as felt by the study participants in the Low MH group. Their experiences indicate the continued oppression of women in the patriarchal culture. Women are expected to place their husbands in a powerful position, and women must be under their control and supervision. If any woman talks about her rights and choices, she will be labelled as a bad woman or a feminist.

The majority of women in the High MH group seemed to be content with the decisions their husbands make, while those in the Low MH group are battling for the chance to take part in decision-making. The present findings are in agreement with that of Nirola (2017) that the primary drivers of violence are unequal power dynamics, gender discrimination, patriarchy, women's economic dependency, and a lack of participation in decision-making.

If a woman makes a decision, the men will always complain and belittle it, demotivating them and pushing them to follow men's decisions. Shohel et al. (2021) conclude that men largely control women's loans in accordance with underlying, persistent patriarchal gender norms. The severe gendered division of labour that maintains restrictions on women's behaviour, mobility, and decision-making areas as well as men's supremacy in home and economic decision-making was perpetuated by the inter-generational reproduction of patriarchal gender relations. While every woman still aspires to live with her spouse and family and be able to make her own decisions, she never has her male partners' backing.

However, the respondents in the High MH group argued that men put a lot of effort into taking care of their families, so they cannot manage home tasks. It is a great thing to work outside and earn money to support the family. Women ought to ensure happiness and peace for their husbands and their families. More issues will arise when a wife starts criticizing her husband in any way. Therefore, women should avoid talking back and wait for their husbands to calm down. The success of the family depends on women's adjustment. The most revolting thing is that these 18 women in the High MH group believe that “men will be men" and that women do not need to acquire male privilege. Women are to be married into another house, so girls should learn how to cook, clean, and do other household chores, as well as how to respect their husbands and their family members. They also opined that mothers should train their daughters from childhood onwards.

Enforcement of traditional customs and practices: As per the findings of the study, the majority of Hindu families still practice untouchability related to menstruation in their homes. In the Low MH group out of thirteen Hindu women, eight women said that during menstruation, they are separated from others, when a family member goes to Sabarimala or when someone dies, or even after childbirth. In the High MH group, out of 13 Hindu women, 10 shared how they happily accept the untouchability practices for their family's safety.

Ahalya, a 35-year-old Hindu woman from the middle class stated that she had lived freely in her natal home and was not controlled by anyone. However, after getting married, she is subjected to a variety of limitations and compelled to follow objectionable practices and dreadful customs. She said,

> *"In my husband’s home, I am untouchable during my menstruation, they do not let me sleep in our rooms. I must spend four nights sharing a small kitchen storage area with rats and other insects. Once I screamed while sleeping because a rat was moving over my body, and the rest of the family mocked me for being scared of a rat by itself."*

Eight more women in the Low MH group shared the untouchability practiced in their homes during periods and the associated customs. It is a myth and a long-held

belief in the Hindu community that women are impure while menstruating, and it is still practiced in several families. Aswathi, a 39-year-old from a wealthy Hindu family said,

> *"During the first year of my marriage, my in-laws used to encourage me to take a bath in a river or pond once the periods were over. Before daylight, I ought to wash and clean everything in that house that I touched, even the clothes I touched. The practice has now changed as we live in such a crowded region. My mother-in-law pours some water on my head after cleaning and taking a bath, after which only I can enter my room."*

Menstruating women should not stay in a place where someone has recently passed away. For seven days, the women are kept in a nearby house without access to their families. According to Hema, 26 years old from a wealthy Hindu family, she finds it uncomfortable to remain at the homes of other neighbours or relatives. She said,

> *"When the grandmother of my husband passed away, I was compelled to remain at the neighbour's house. Why should I move to another home just because I am on my period? We have a house here with plenty of space to stay. it was disgusting, and everyone looked at me like a bad omen."*

In the case of working women, after doing all the housework in the morning, the four days of menstruation are particularly challenging. They may get late for work and occasionally have to take leave, which affects their pay in the daily wage system.

When a woman is menstruating, she suffers hormonal imbalances and has to get enough relaxation and sleep. All such behaviours significantly harm women's mental health. Eight women in the Low MH group belonging to the Hindu community find menstrual-related traditions and practices irritating. They confessed that being untouchable violated their sense of honour and damaged their ability to maintain mental stability.

The same untouchability continues in the Hindu community after delivering a baby. One of the study participants shared that she had postpartum problems and could

not care for the infant on her own after delivery. Nobody would touch the mother or baby for the first two weeks, in their belief, that the mother and child are untouchable for 15 days. If they are touched, the person who takes the child should take a bath. Another woman namely Jaya from a middle-class Hindu family also agreed that her family also practices untouchability during menstruation and after delivery. She claimed that,

"I experienced some difficulties giving birth, and I was discharged from the hospital after nine days. However, the baby and I were isolated in a room. At that time I longed for help from my mother and husband as I was already depressed and in a terrible mood. They gave me food, I had to wash the plate myself and keep it in my room. It was a terrible experience for me because the plate I used was not used by others. Following delivery, when the mother requires proper care and rest, I was denied it on the grounds of untouchability."

Here, the women do not get any assistance at night when the babies wake up and cry. If anybody touches the baby or the mother, they should take a shower and clean their bodies. Even though the term "Ayitham," which means "Untouchable," was banned by the Indian Constitution in 1955, the families still use it. But in Kerala homes, untouchability still keeps women isolated when they need greater care and support at a critical moment in their lives.

Rubeena, a 30-year-old Muslim woman from a middle-class family explained that certain customs surround childbirth, such as the woman's family should give some gold to the newborn. She contends that such practices only make matters worse for parents who are already struggling financially because of dowry and wedding expenses. Additionally, women must endure criticism from the families of their husbands on the baby's lack of wealth and jewellery. Ann Mariya, 34 years 34-year-old woman from a Christian joint family also said, “It is a prestigious issue in my family, so if it's a loan or not, my father arranged the gold for the baby at the time of returning to my husband's home after delivery. The relatives and neighbours came to see the baby only to check the ornaments and their weight.”

All such traditions and practices have a big impact on how women feel about themselves. However, such harmful and unlawful practices were found more in the Hindu community.

On the other hand, Binisha, 38 years 38-year-old middle-class Hindu woman in the High MH group believes menstruation and childbirth rituals as to be beneficial to women and families. She asserted,

"Women are impure during menstruation, thus anything she touches will be considered impure, and the deity will punish the entire family. These practices are perfectly acceptable; the other members provide for our needs and take excellent care of us. We may ask them for everything we need, and they will provide it to us."

Thus, women are ready to withdraw from the room for four days to follow their beliefs. This viewpoint is opposed by 31-year-old Vasanthi from the High MH group. She argues,

> *"I never perform such menstruation rituals at home. The practices are incredibly exploitative of women and a woman should not be under any emotional strain while she is bleeding."*

Thressya, 33 years old, from a Christian community, claimed that her home is free of any customs of menstruation, childbirth, or other rituals. She added that "although there is anxiety due to the economic situation following delivery, both families have made arrangements for jewellery for the child. Both my family and I are not under any pressure."

However, in the case of the group with High MH, most of the women are content to stay idle for four days because they believe in God's curse. As a result, they happily adhere to the practice of untouchability. At the same time, they automatically curse the woman who is having her period if anything unpleasant occurs to them because of this strongly ingrained mindset.

In India, in the name of religion and sociocultural norms, women have been purposefully denied opportunities for advancement for generations. At the social-

political level, women experience unjust treatment, untouchability, repression and unnatural indoctrination, an inferior status, and a rigid caste hierarchy. The social structures of society and religious traditions have a significant impact on how women are viewed and treated. It is backed by tradition, education, and religion and preserved by strong cultural norms. It reproduces itself endlessly through these norms and structures, which are themselves patriarchal in nature (Nirola, 2017). When we discuss untouchability, we are more pointed about caste-related untouchability and violence (Barbara, 2010; BBC, 2019; Sur, 2022; Thorat &Joshi, 2020). but there is very little discussion among the community about the marginalization of women on the grounds of menstruation.

In conclusion, despite the diversity of customs and traditions in India, some of them continue to harm women. These customs related to menstruation, childbirth, and other rituals can have severe consequences for women's mental health. While some women accept these practices as a part of their life, others are actively challenging them, highlighting the need for greater awareness and change in societal attitudes and norms.

Restricted mobility: Another element that was found to adversely impact the study participants' mental health is their restricted mobility. As reported by the majority of them, men appear to have considerable influence over and restrictions on women. Ninety percent of the participants in the final sample acknowledged the limitations and control imposed by their husbands. Twenty women from the Low MH group shared that the men in their lives forbid them from visiting their natal homes. Nearly all of the women participants with High and Low MH status have to deal with this unfair attitude from men in their married lives. Fathima, a 37-year-old middle-class Muslim woman with Low MH status argues that *"he gives no reason in not letting me go to my own house. I don't know why all men are like this".* Another woman Nisha, a 29-year-old high-class Hindu woman said.

> *"Men should live in women's houses after marriage so that they can understand how much stress and sadness we feel in their homes. However, males always have the advantage of living a life of luxury in both their own*

homes and the houses of their wives. Only women have this secondary status in society."

A Muslim middle-class woman Siya said that her husband punished her by forcing her to stay out of the house because she had gone to her natal home without asking him. With a cold, she had to sit on a chair outside until morning. She said this with trepidation, adding,

"I was forced to sit outside in the chilling cold until morning. That day, I made a firm resolution never to visit my parents' home without seeking his permission. The memory of that day is etched in my mind, a poignant reminder of the trials I've faced, and one that I will never forget for the rest of my life."

Regina, a 30-year-old Muslim woman said,

"I should ask permission from the husband and his family to go out for hospital cases, purchases, or any other personal needs. If they realize it is a necessity, they let me go; otherwise, they deny my request. Talking about all of my difficulties with others is so revolting and irritating. Sometimes my needs are unwanted for them, and they say no to me, and the quarrel begins there".

These are not rare occurrences; it is the situation of most women who live in patriarchal family settings.

Paradoxically, the majority of women in the High MH group expressed satisfaction with the way their husbands have authority over them and control their mobility. Ayisha, a Muslim woman who is 41-year-old, expressed her sentiments by stating,

"I don't feel safe venturing out without my husband. If I'm unwell, or suffering from fever or headache, he takes the initiative to procure the necessary medicines for me, and these ailments eventually pass. As wives, we should respect and adhere to our husbands' wishes and preferences."

Another woman from a middle-class Hindu family claimed that her husband couldn't live without her because of this he wouldn't let her go to her natal home. She

believes that he loves her more and that if she is gone, he will be sad and have no one to turn to for support. "Who will cook for him?" Families are filled with these kinds of emotional dramas, and women are frequently the targets of emotional blackmail. But sadly, they are found to be happy with such an arrangement.

Housewives with lesser education are typically the targets of men's emotional dramas. Another Hindu woman from a middle-class family claimed that her husband follows a morning breakfast routine. Her absence will cause her husband's eating schedule to fall out of order. As a result, she rarely visits her parents unless something is very important. Compared to less educated housewives, educated, and employed women are more aware of such emotional strategies to restrict their mobility and try to resist it. Arathy, a 30-year-old middle-class woman from the High MH group said, *"I am indifferent to the opinions or comments of others; I have the freedom to travel wherever I desire. While I do inform my husband about my plans, I believe he is the only one to whom I owe any explanation."* Despite her lack of education, she is courageous enough to challenge her in-laws. Another high-class Christian woman named Rima, 27-year-old from the High MH group also expressed her freedom and independence saying, *"I am fully capable of driving myself and I make it a point to visit my parents whenever I wish. So far, no one has imposed any restrictions on me."*

Almost all women feel restricted by their husbands and their families to visit natal homes. For the less educated housewives, their husbands are their primary concerns and they do not even visit their parents. If they go to their natal home, their husbands may not get proper food, and it may end up in a fight between the couples. On the contrary, there are eight women who go to visit their father and mother, thinking that, for one day their husbands should adjust, and they are all ready to listen to the blamings that followed by their acts.

The key conclusion is that visiting natal homes is difficult for both High- and Low-MH groups of women. Women are emotionally bonded to the men in their houses in one way, and men behave aggressively in the other way to keep women confined in their homes. However, some previous studies also corroborate the present findings. Parker and Brotchie (2010) found that mental health symptoms increased with mobility limitations, particularly in women. Studies also reveal that lack of freedom of movement is associated with poorer mental and physical health in women

(Adeel, 2016; Gailits et al., 2019; Pennington et al., 2018; Rajkhowa & Qaim, 2022). While restrictions on women's freedom of movement are prevalent throughout India, current study emphasize that despite its higher women development indicators, women of Kerala have to endure lot of restrictions because of the patriarchal nature of husbands and families. This in turn has its implications on women's sense of freedom and happiness. Yet women who have internalized submissiveness as the norm of life are less affected. Women who are aware of their talents, opportunities, and rights will have constant discomfort with any kind of restriction on their mobility.

Kohlberg's Theory of Moral Development (1958) explores the process by which individuals navigate ethical dilemmas and make decisions. While there are parallels between cognitive and moral development, they are primarily separate entities. This theory suggests that decision-making evolves from a self-centered, problem-solving approach to a more altruistic, principle-based one. This theory is subject to various interpretations, regardless of whether it focus on men, women, or different cultural groups. Numerous factors influence one's moral development, with gender socialization playing a significant role in shaping moral beliefs. The current study underscores that women's moral values are largely shaped by the socialization practices they undergo. Women often fall victims to gender-insensitive socialization practices in our society. The enforcement of traditional norms and practices can lead to poor mental health among women who are aware of the fallacies involved in several traditional beliefs and customs. Traditional moral values often limit women's decision-making abilities and exclude them from male-dominated areas.

5.5. Other Factors Affecting Mental Health of Women

There are a few other factors that affect mental health of women which are not common to all the study participants. The extent of their impact warrants a separate title as other major factors. They include role conflict, infertility and ruminating tendency.

5.5.1. Role conflict

The study reveals that 14 women in the Low MH group who work outside homes agreed that they regularly face role conflicts due to the inability to manage work-life balance. According to them the patriarchal attitude towards women's paid labour, the expectation of women's responsibilities as homemakers and care givers and the traditional belief that men are the bread winners are the major sources of role conflict. Women often have trouble sleeping, along with linked mental health problems like anxiety, fluctuating blood pressure, depression, etc. But the 11 employed women in the High MH group have better support from husband and in laws which enable them to manage their professional and household responsibilities.

The various aspects related to role conflict are given in Table 5.11.

Table 5.11

Various Aspects of Role Conflict

Role conflict	Low MH	High MH
Work pressure	13	6
Difficult to manage the household, childcare, and office work equally	12	4
Pressure of husband and in laws to resign from job	10	0
Lack of sleep	14	3
No hired hands	10	2
Physical and mental stress	9	3
Lack of sharing of household chores	10	2

Fourteen women including government, private, and other daily-wage employees from the Low MH group confessed that they regularly face role conflicts. Women are forced to fulfill their professional workload at par with their household responsibilities. Here, Gayathri, 32-year-old woman from a middle-class Hindu

family expressed her extreme frustration with her inability to manage office and household duties. Before her child wakes up, she must finish all the kitchen duties. She then sends the child to school while taking care of her patriarchal husband. She says,

> *"Although I could convince my child about my hectic schedule, I was unable to persuade my husband. He has a very arrogant character, and I find it tough to put up with him on occasions. He likes variety in his breakfast, so if I make some simple snacks, he won't eat them, and he would respond in a sexist, disrespectful manner. The office work will be waiting for me once I finish the housework. My husband and his family are least supportive and do not even try to understand my circumstances."*

Another woman Ancy from a wealthy Christian family revealed that she works as an assistant manager in a private company, that she is under intense work pressure there, and that it takes her more and more time to get home at night. Her husband and in-laws force her to resign the job. Unfortunately, she also suffers overnight sexual abuse from her husband, which leaves her tired and depressed. She said,

> *"I enjoy going to work, but I feel like giving up my profession because of family duties. I am indeed unable to care for my child's needs in terms of his studies, and my husband has never supported his education. I can succeed in my work more if he helps me."*

Habeeba, a 36-year-old Muslim woman from a lower class claimed that she lacks the time to think about her happiness. She starts working early and does not stop until she goes to bed. Her spouse has such a patriarchal mentality that he never helps her out with childcare or housework. He believes that she should complete the work at home if she wants to go to work. He argues that one should become self-sufficient at home before moving outside. She said she is very irritated about his behaviour and sometimes she thinks about killing him. She has this mindset because of her husband's alcoholism and irresponsible attitudes. She says he goes to work and returns home drunk. “I don’t need him at all, if he was a good person, he would have at least handled

the kids and their homework. His father and mother are also under my care as I am the only one in the family who is struggling and earning money."

Geetha from a low-class Hindu family said that her in-laws do not like her going out for paid work. She said they have some financial issues and want to pay back the loans. Her husband is unable to handle the entire financial burden. "He has never been as supportive of me as I am. He will complete his work properly, but I am responsible for taking care of all the household and professional duties, including the children's studies". Her in-laws purposefully do not help her since if she goes to work, no one will be there to care for them. She added,

> *"Until I arrive at night, they leave all the plates and dishes in the sink. Seeing the waste and dishes in the sink is quite disgusting. I have a tough time balancing both my house chores and my outside work. I would be happy to perform any task for cash but work at home is worthless in the absence of reward or appreciation."*

Almost all the working women in the Low MH group face challenges in balancing their home chores and professional workload. And no one offers any help to them. As a result, they are continuing to work hard under severe pressure. Most women do not get enough rest or sleep regularly. It is a sad fact that majority of these women are working in the unorganized sector where the workload is higher, and the pay is lesser. However, the advantages of economic gains outweigh their difficulties.

With the support of their families and husbands, seven out of eleven employed women in the High MH group are attempting to manage personal and professional responsibilities on an equal basis. Only four women acknowledged that they occasionally struggle with office work, housework, and other responsibilities. However, they said that they had some downtime in the office or other workplaces. But their in-laws are helping in addition to making dinner, they take care of the kids. Women can then relax and spend some time talking with them. Anna, 33-year-old Christian middle class woman claims,

> *"My mother-in-law looks after and feeds the kids after school. I am so pleased that they do some kind of favor. I don't need to worry about anything because my kids are secure. Sometimes my husband may place a food order to reduce my dinner time workload."*

Another middle-class Hindu woman Arathi claimed that there is no pressure to fulfill targets and that she is satisfied and comfortable with her work life. In addition to helping her out around the house and taking care of his kids and their schoolwork, her husband will arrive early in the evening. She then stated that "I need only finish half of my responsibilities a day." She also highlighted how with the assistance of her family she could manage workplace conflict.

This part concludes that those with Low MH experience stress at work and lack of assistance from their husbands and families in household duties. The patriarchal notion of men as breadwinners, biased attitude towards women's labour, and the expectation of women's responsibilities as homemakers are the main sources of conflict between women's roles. Women often have trouble sleeping, along with linked health problems like anxiety, fluctuating blood pressure, depression, etc. The family and husbands treat women as homemakers first, then if they want, they are allowed to go to work. As a woman, she should finish the household chores before going to work outside. Here some studies also conclude that women's perceptions of both work-to-family conflict and family-to-work conflict were significantly negatively related to their mental health (Ervin, 2022; Zhang et al., 2017; Zhou et al., 2018). However, in the case of High MH group, they are very free with their work, and their families understand their goals. Almost all the women in the Low MH group are going to work for their economic necessities. As a result, they are struggling to balance things at home and work.

5.5.2. Infertility

The study highlights that women dealing with infertility often endure significant mental trauma. Among the participants, three women grappling with infertility issues reported experiencing high levels of physical, sexual, and emotional violence from their husbands and other family members. The study also revealed a reluctance among men to disclose their own fertility issues. This reluctance is rooted in societal norms that equate fertility with masculinity, leading to the stigmatization of men who are unable to become a father. Consequently, men often remain silent about their fertility struggles and instead shift the blame onto women. The findings underscore the complex interplay of societal norms, gender roles, and the stigma associated with infertility.

Three of the respondents in the Low MH group acknowledged that they experience extreme physical and emotional abuse from their husbands because of their infertility. Leela from a wealthy Hindu family share that she had repeatedly attempted suicide. Because her spouse verbally and sexually abuses her every day, torturing her with harsh words and sex toys. Her husband says that "You have no use of this uterus". He selected a range of sex toy purchases and challenged her to let the device go as far as possible inside her vagina, he said that her uterus will undoubtedly get it. She explained that the doctor informed that the sperms do not reach the uterus, which is why fertilization does not occur, and that is why her spouse is acting in such a brutal manner. The actual reason why sperms fail to reach the uterus needed further medical examinations for which the husband is unwilling to cooperate. He is scared whether he has some problem but is interested in putting the blame on her. After that, he makes it his habit to pester her with large sex objects because he is self-conscious about his small penis. She also added,

> *"Everything is manageable, except his mistrusting behaviour. I felt that he had gone insane. His parents and friends have also discussed treatment options with him, but he escapes from everyone and continues tormenting me.*"

Haritha, 35-year-old from a middle-class Hindu family shared that due to uterus problems, she was unable to become pregnant. When her husband realized it, he started drinking and began hitting her. Call her "machi" (infertile woman) and insult her in front of the family and relatives. After much prayer for the child, she ultimately recommended adoption. When she mentions adoption, he verbally attacks her and exclaims, "How can you tell me like this? I don't want such 'bastards' in my life. Go and die if you are unable to deliver a child." It has been so long, she has taken a lot of pills, and spent a lot of money for a baby and finally she has given up hope and remains frustrated.

34-year-old Abida from a wealthy Muslim household belongs to the High MH group. She said she was frequently harassed by her in-laws and relatives on the grounds of infertility. But her husband truly cared about her and was very supportive. He drove her to the doctor and started the medications. When that happened, his family swore at him and demanded to divorce her. However, he never gives in to their warnings and continues to care and support her. Both are teachers, and they continue treatment. She added,

> *"It's my problem because I can't have children, but he never uses such slurs or foul language against me. My in-laws and other relatives constantly criticize me and spread false information regarding IVF therapy. The IVF treatment plan was resisted by the family members. My in-laws said that an IVF child would not be in my husband's blood. Therefore, a child born into someone's blood will not be allowed to grow up in this family. Both men and women are under pressure since not enough people are aware of infertility treatments."*

The cultural, patriarchal, and societal attitudes towards infertility are highly harmful to women who experience infertility. The societal and self-stigma that infertile women experience jeopardizes their psychological wellbeing and self-esteem. According to Mumtaz et al. (2013), women perceive more stigma than men and that being stigmatized was more painful than being infertile. However, men's attitudes about infertile women and male chauvinism all have a detrimental effect on

the mental health of women. Women lack support and care from their husbands and his family members, and they behave very rude towards women who are unable to deliver a child. All the three infertile women among the 50 study participants are undergoing the threat of getting divorced from their husbands, either because of pressures from the in laws or because of the husband's own craving to beget a child. The husband's family as a source of conflict and stigma for infertile women is supported by numerous studies, with the major concern being the pressure from the spouse's family to remarry their son or get divorced (Carter, 2011; Flederjohann, 2012; Kearney, 2016; Luk & Loke, 2015).

A married woman who is childless is portrayed as a curse to the family. They just refer to women as a waste and never ask whose fault it is. Motherhood is one of the important roles of women in traditional societies, and those who are unable of fulfilling this task are weaker in the eyes of public and would suffer humiliation (Hasanpoor, 2019; Younesi et al., 2006). Taebi et al. (2021) rightly said that husbands, families, and peer groups are the most important source of emotional support for infertile women. The experiences shared by study participants clearly show that the husband's unwavering love and support help women navigate through the process of infertility treatment and ensure their happiness and mental well-being.

As Erikson's Psychosocial Theory of Development (1950) posits, each stage of life involves a crucial task that is vital for an individual's mental health and overall wellbeing. The seventh stage, Generativity vs. Stagnation emphasizes creativity, productivity, and the establishment of the next generation. However, women who are infertile may not be able to create the next generation following which they have to face shame and guilt. They often experience significant discrimination and violence in their lives. As a result, they may struggle to progress through the psychosocial stages of development.

5.5.3. Ruminating tendency

The Response Styles Theory (RST), proposed by Nolen-Hoeksema in 1991, suggests that women are more prone to ruminate on symptoms of depression and stress compared to men, leading to increased stress levels in women. Rumination is

considered a significant risk factor for the onset of depression and anxiety and is a contributing factor to various negative emotional states (Michl et al., 2013).

In the present study, twenty of the participants in the Low MH group confessed that they tend to ruminate. It was observed that women often dwell on issues that arise in their daily lives, leading to heightened stress levels. This habit of overthinking can disrupt their tranquility and negatively impact their day-to-day existence. For instance, 37-year-old Muslim woman confessed to having lied to her husband about a financial matter. This incident has been a source of constant worry for her, demonstrating how such tendencies can lead to persistent distress. She explained,

> *"My husband is a stern and tough individual. His domineering demeanor has left me feeling apprehensive about engaging in conversations with him. There was an instance when my brother needed financial assistance for his business. I knew my husband would disapprove, as he has always been reluctant to lend money to my family. So, I decided to secure a loan from Kudumbashree without informing him. I am aware that I should have discussed this with him, but I didn't have the courage to do so. I understand that my actions were not entirely right, and I fear the repercussions once he discovers this. The anticipation of the potential consequences fills me with dread. This incident remains my most closely guarded secret and my greatest fear."*

Leena a middle-class Hindu woman in Low MH group endures a great deal of hardship due to her husband's abusive behavior. She shares,

> *"My husband consumes alcohol excessively and showers me with frequent bouts of verbal and physical abuse. It is only the thought of my children that prevents me from contemplating suicide. I am always worried about his misbehaviours and can't stop thinking about the uncertainties surrounding my children's future. I can't forget any of his cruel acts, each of which surfaces in my mind when he commits a new one and that happens every other day. The daily conflicts leave me in tears, and the memories of these altercations persist in my mind, further fueling my frustrations."*

Women with ruminating tendencies often suffer from sleep deprivation and may even blame themselves for their circumstances. This self-blame further exacerbates their mental distress.

A woman from a high-class Hindu family confesses,

> *"During a heated argument with my husband, I raised my voice, and unfortunately, the rest of the household overheard our dispute. In the heat of the moment, I uttered harsh words that I now regret. Following our disagreement, his attitude towards me softened and he began treating me with affection. However, this incident frequently resurfaces in my mind filling me with guilt and self-contempt. That was the first and only time we had such a confrontation. Yet, despite its singularity, the memory of that incident continues to linger in my mind."*

Merin from a Christian middle class family shared,

> *"Once, when I was pregnant with my second daughter, my mother was hospitalized. She expressed a desire to see me, but due to the household responsibilities imposed on me, I promised to visit her the next day. I planned to complete all the chores early in the morning so that I could spend time with her. However, to my utter shock and despair, she passed away that very day before I could see her one last time. I had not anticipated the severity of her condition, and this incident continues to shatter my heart. Whenever I recall this event, I am overwhelmed with grief and often find myself in tears. Each night before sleep, my mother's last words echo in my mind. Sometimes, I even perceive myself as a heartless daughter who prioritized household duties over her mother's last wish. Even though it has been thirteen years since my mother's demise, the pain is still as fresh as ever. This incident serves as a harsh reminder of my perceived folly and continues to haunt me."*

The narratives underscore that women often engage in overthinking about past incidents. This heightened concern can lead them into a cycle of rumination. Such constant dwelling on past events can result in sleeplessness and heightened anxiety.

Women in abusive relationships tend to ruminate over the various distressing events they have experienced. The lingering pain from these past incidents continues to disturb them significantly. They may believe that their persistent recollection of certain incidents, such as a mother's desire to see her daughter even after thirteen years, is a sign of their loved one's unfulfilled wishes. Research has indicated that the tendency to ruminate can result in sleep deprivation, stress, and depression in women. This cycle of negative thinking not only affects their mental well-being but also has a profound impact on their overall quality of life (Hilt et al., 2010; Kamijo & Yukawa, 2018; Singh et al., 2023).

Interestingly, the ruminating tendency was found to be a more common phenomenon among women in the Low MH group. As women in the High MH group accept all the restrictions, violence and insults as normal and are fully submissive to men in their life, ruminating tendency was rarely reported by them.

5.5.4. Postpartum Depression

Postpartum depression (PPD) is a serious mental illness that involves the brain and affects one's behaviour and physical health. If a woman perceives empty, emotionless, or sad all or most of the time for longer than two weeks after pregnancy, or if she feels like doesn't love or care for the baby, it might be due to PPD.

In the present study, while discussing their lived experiences, three young mothers below 35 years and another in her 40's from the Low MH group narrated their post-delivery experiences of how they felt helpless, worried and without energy to do anything or even care for the baby. 43-year-old Jasmine confessed how at one point of time she thought of committing suicide after killing the infant baby. Giving birth to a baby girl was unacceptable to her husband's family. She shared how she was not given nutritious food and coupled with lack of sleep at night she used to feel giddiness throughout the time.

While conducting the pilot study on ten married women to understand the type of issues that need to be addressed in the unstructured interviews to be conducted on factors affecting mental health, three of them mentioned about postpartum depression

they have experienced as young mothers. The issue of three out of ten women attracted the attention of the researcher and accordingly a parallel study on a sample of 84 young mothers in the age group of 25-35 was conducted on the topic of PPD and associated factors among women in Kerala. Data was collected through a Postnatal Depression Rating Scale (EPDS) followed by unstructured interviews.

The study highlights that even though PPD is found in association with pregnancy and delivery, the major risk factors leading to PPD are not merely biological but mostly sociocultural. The risk factors leading to PPD include customs and rituals during and after the delivery, worries about newborn's health, sleep disturbances, lack of time for self-care and bodily changes, lack of support and care from husband and in-laws, hopelessness related to career ambitions and unplanned pregnancy.

The findings were published in an international (UGC Carelist) journal titled Eastern Journal of Dialogue and Culture. The publication is attached as Appendix-IV.

5.6. Barriers to Accessing Mental Health Care Services

This section continues the sixth stage of Thematic Analysis (Nowell et al., 2017) by reviewing and further analysing the themes that emerged from the data (Caulfield, 2019). The participants were asked what barriers there are in engaging with mental health professionals and whether they could identify any factors that discourage them from getting professional advice. The most frequent discouraging factor shared was that they are not interested in talking about their personal life to others. Other barriers such as stigma related to mental health, cultural and patriarchal issues, shame & embarrassment, anticipated women blaming, gender of the professional, trust issues, lack of awareness and restricted mobility were also shared by the study participants as reasons for their inability to seek mental health services.

The data revealed a common theme across all the women's narratives. They did not engage in discussion about the violence they faced from their husband. They are not ready to talk about sex, sexual violence, family issues, marital rape, consent,

and sexual health issues to professionals or even to their husbands. Women do not talk among themselves, even intergenerationally about anything they considered to be taboo or embarrassing. The only exception was among younger women under 40 who discussed sexual or family issues with colleagues and close friends. There were a few study participants, especially in the High MH group, who try to justify their husband's violence and patriarchal behaviour as normal, and they accept them with pleasure.

In the light of respondent's stories, the patriarchal family structure has an important role in the silence of women in our society. The women are trained to cover up family problems within the family itself. These kinds of suppression make them more stressed and unhappy. As per the respondents, the lack of decision-making capacity, economic dependency, sexual violence, domestic violence, and intimate partner violence, restricted mobility, conflicts with patriarchal norms, imposed traditional rituals and practices all affect their mental wellbeing. Unlike their elders, women below 40s were found to be bold enough to break the silence and stand against the patriarchal attitudes of men and their rules for women. But unfortunately, they are facing a lot of mental health issues and struggles in their life. Out of 50 women from High and Low MH group, only three of them consult a mental health professional. The study participants and the key informants all mentioned about the issues and helplessness of women in accessing mental health services. The women would never discuss such issues in public, at work, or even with their husbands. The social taboo and negative cultural conditioning about mental health act as strong deterrents, increasing the anxiety about help-seeking for mental health problems.

5.7 Conclusion

The Radical feminist argument of family as a site of women's oppression is fully endorsed by the findings of the study. The family has become a crucial agency of patriarchy. The power structure within the family is highlighted in the narratives of the 50 study participants. Nirola, (2017) explains how the structure of the family and the home are crucially tied to and determined by the economic dominance of men in production. It is to be noted that more women in the High MH group were found to wholeheartedly succumb to patriarchal ideologies. They are also happy to elevate and

treat males like superior humans. They are quite satisfied with the arrangements their husband makes for them. Eighteen of them represent the ideal of the traditional wife, who obeys whatever is told by the husbands. Furthermore, they seemed to be unaware of their rights and freedom. The idea that women must be submissive to men and that they are the ones who pay for their food and clothing is still widespread in their minds. The group of housewives who believe in this way were found to have better mental health. More women in the Low MH group seemed to be conscious of their rights but remain helpless to overcome their patriarchal controls. Also, more of the younger women were found to be not prepared to put up with their spouses and families who act in patriarchal, egotistic ways. This in turn has a negative toll on their mental wellbeing. Perhaps this might be one of the reasons for the rising rate of divorces in the state of Kerala.

However, the study points that not all males fervently support patriarchy or gain equally from it, and that some women may, on the other hand, contribute significantly to its upkeep. Within the family, community, and state, men continue to hold all positions of power and control. Women are thus denied of their legal rights and prospects. As opined by Sultana (2012), patriarchal beliefs limit women's mobility and disapprove of their right to self-determination and property rights. As women's thoughts and thinking abilities increase thanks to the women empowerment programs undertaken by various agencies at the state level, by the academia and the NGOs in the state of Kerala, patriarchal mindsets become more concerned and do not allow them to grow. This in turn leads to further oppression of women with a negative toll on their mental health.

Chapter VI
SUMMARY, FINDINGS AND SUGGESTIONS

CHAPTER VI

SUMMARY, FINDINGS AND SUGGESTIONS

In this chapter a summary of the study on mental health status of women in Kerala is presented. The present investigation has helped to understand the mental health status of women and the major factors affecting it. An overview of the study along with key findings, linking outcomes to research questions, other interesting findings of the study, implications of the study and recommendations for further research are included in this chapter.

6.1. Overview of the Study

As per the Indian Psychological Association, women in Kerala exhibit significantly poorer mental health compared to their counterparts, despite their commendable performance and higher standing in various developmental indicators such as infant and maternal mortality rates, literacy rates, and other relevant benchmarks. This stark contrast in their mental well-being prompted them to undertake research focused on the mental health of Keralite women. The primary objective of this study was to assess the mental health status of women in Kerala and to identify the key factors influencing their mental health. Additionally, the research strongly emphasizes analysing subjective feelings and experiences from a gender perspective. It is noteworthy that most studies in the field of mental health tend to adopt a general or psychological perspective. Furthermore, an effort has been made to compare the mental health status of women across different groups based on classificatory variables such as religion, income level, caste, and employment status. Regardless of the high societal positions women may hold, this research underscores the persistence of expectations for them to adhere to traditional gender roles within their households, specifically in being obedient to their husbands. The findings of this study shed light on a compelling revelation: in Kerala, women who assert their rights tend to experience more pronounced mental health challenges. Conversely, women who perceive themselves as enjoying independence within the framework of their

husbands' preferences are, to some extent, found to be mentally healthier. It is essential to acknowledge that these women may not be fully cognizant of the potential entrapment within their circumstances and do not necessarily feel confined to their homes. In summation, the primary objective of this study, which was to provide informative insights into the factors influencing the mental health status of women in Kerala, has been effectively achieved.

6.1.1. Objectives of the study

- To assess the mental health status of women in Kerala for the total sample and the sub-samples formed on the basis of classificatory variables like religion, income level, caste and employment status.
- To compare the mental health of women in Kerala belonging to different groups formed based on the classificatory variables.
- To explore the factors affecting the mental health status of women in Kerala.
- To suggest measures that would enhance the mental health of women in Kerala.

6.1.2. Methodology

This study adopts a mixed-method research design, combining both descriptive and exploratory approaches. The integration of qualitative and quantitative methods within a single research project enhances the validity and reliability of the data and results. The study consists of two distinct phases:

1. The first phase involves the assessment of mental health status through a survey administered to a sample of 300 women using Google Forms.
2. The second phase centres on the analysis of factors affecting mental health status. This phase encompasses unstructured interviews with fifty women, specifically selected from the initial sample of 300 women who were having the highest 25 and lowest 25 scores of mental health.

6.2. Key Findings of the Study

The major findings of this study are summarised as follows:

- The overall mental health status of women in Kerala appears to be relatively low, as revealed by the classification into High, Average, and Low MH categories through statistical analysis. Specifically, 118 women out of the total 300 study participants were categorized as having High MH, 92 fall in the Average and 90 were classified as having Low MH. The mean score of mental health was found to be just above 50% of the total score which suggests that the mental health status of women in Kerala is notably low.

- Neither class nor religion appears to make any significant difference in the mental health of women.

- Caste and employment status emerge as factors that can affect a difference in the mental health status of women.

- Women who assert their rights tend to experience more pronounced mental health challenges, highlighting the complexities of implicating traditional gender norms.

- Conversely, women who conform to traditional gender norms and embrace patriarchal ideologies were found to report higher levels of happiness.

- The study emphasizes that factors such as unfulfilled aspirations, economic dependency, adjustment issues with in-laws, alcoholism of husband, lack of support from natal home, lack of confiding relationships, gender-based violence (particularly dowry-related violence), and conflicts with patriarchal norms affect women's mental health.

- The study highlights the stigma surrounding mental health and the misinterpretation of mental health-related awareness, which often discourages women from seeking help from mental health professionals.

- Several of the study participants were navigating between cultural expectations of being obedient wives and the desire to challenge patriarchal norms. Those who aspired to uphold traditional gender roles posed challenges to women who sought to break free from these stereotypes, leading to complex social and cultural dynamics.

- Although education and employment offer some support to women, the persistence of patriarchy can relegate them to secondary status.

- Mutual understanding and support from husbands and families, acceptance of gender roles and patriarchal culture, a nonchalant attitude toward patriarchal behaviours of husband and in-laws, economic security from husbands, and economic freedom contribute significantly to better mental health among women.

6.3. Linking Outcomes to Research Questions

In this section, the answers to the research questions are presented:

1. What will be the present mental health status of women in Kerala?

The first research aim sought to assess the current mental health status of women in Kerala. The study reveals that the mental health status of women is generally low. The participants were categorized into High, Average, and Low MH groups through statistical analysis, with a significant number falling into the Low MH group. The mean score remaining fifty percent of the total score is a matter of concern, as even those in the average group are at risk of declining mental health. With the best physical health indicators in the country, a significant number of women falling in the Low MH group is pointing to an unfavourable situation in the state as far as women's happiness and well-being are considered.

2. Will there be a significant difference in the mental health status of women belonging to different sub-samples formed based on classificatory variables such as religion, income level, caste, and employment status?

- The study found no significant difference in the mental health status of women belonging to different religions.
- Similarly, variations in income levels did not appear to make any difference in the mental health status of women.
- However, caste does play a significant role, with SC/ST and OBC women showing better mental health than those in the general category.
- Employment status is also significant, with government employees generally reporting better mental health compared to private sector workers, housewives, and daily wage labourers. Daily wage workers were found to have the lowest mental health.

3. Will paid employment and economic independence improve the mental health of women?

Based on thematic analysis, being employed and economically independent does not necessarily result in significantly better mental health for women. In many cases, women's economic independence is limited, as they do not have control over their earnings. The study highlights that caste plays a significant role in this regard, as SC/ST women often enjoy more economic freedom.

4. Is alcohol dependency of men a significant factor that adversely affects women's mental health?

Alcoholism of husbands emerges as a major factor adversely affecting women's mental health in Kerala. Women and children in these households often face violence and emotional distress due to the drunken behaviour and mannerisms of the so-called head of the household. This issue has severe consequences for the well-being and prospects of both women and children.

5. Whether domestic violence has a toll on women's mental health?

Domestic violence, often stemming from alcoholism and dowry-related issues, was found to be the most significant factor impacting women's mental health. Women

are compelled to stay with their alcoholic husbands and suffer various forms of physical, sexual, and emotional violence. Some women maintain the sentiment that despite his alcoholism, he is still the father of her children. This kind of emotional attachment along with economic dependency on the husband and having no other place to go sustains women in abusive relationships. However, it leads to significant mental stress among them. The learned helplessness exacerbates the mental trauma of women with alcohol-dependent husbands. Many of them suffer in silence due to the lack of support from their natal homes. This silence in turn contributes to serious mental health issues among women.

6. What are the major factors that affect mental health of women in Kerala?

Thematic analysis of the large quantum of interview data revealed several factors, both positive and negative as influencing women's mental health in Kerala.

Factors having positive impacts:

- Support and care from husband and in-laws
- Economic security from the husband or financial independence of the woman concerned through her gainful employment
- Acceptance of traditional gender roles and other patriarchal norms
- A nonchalant attitude toward patriarchal behaviours from husband and in-laws.

Factors having negative impacts:

- Gender-based violence, including domestic violence, intimate partner violence, and marital rape
- Sexual and reproductive health rights violations
- Dowry-related violence
- Adjustment issues with in-laws

- Alcoholism of husband
- Unfulfilled aspirations
- Role conflict due to the inability to maintain work-life balance
- Traditional customs and practices
- Economic dependency
- Restricted mobility
- Lack of support from natal homes
- Conflicts with patriarchal norms
- Lack of confiding relationships
- Infertility

In summary, the research outcomes effectively address the six research aims. The findings underscore the need for comprehensive approaches to address the mental health challenges faced by women in Kerala.

6.4. Other Major Findings

- Lack of proper post-postpartum care and infertility are also found to be affecting the mental health of women at specific periods of time.
- Ruminating tendency was a common phenomenon found among women with low mental health.
- Role conflict due to inability to manage personal and professional lives was found to be a significant factor affecting the mental health of women, especially in the Low MH group, who specifically lack sharing of household chores by husband and in-laws.

6.5. Interesting Observations Related to the Final Themes

The research yielded several unexpected/ interesting findings that shed light on the complex interplay of factors affecting the mental health of women in Kerala:

1. Limited influence of religion and income level: Contrary to initial expectations, the study found that religion and income level do not make significant differences in the mental health of women in Kerala. Despite the strong influence of religious values and rituals in participants' lives, women belonging to all three major religions were included in both the high and low mental health groups. Similarly, the income level of the family was not found to have a substantial impact on the mental health outcomes of women as there were several upper-class women in the low mental health group and several lower-class women in the high mental health category.

2. Mental health challenges among women who assert their rights: Women who are conscious of their individuality and aware of their rights actively fight against discrimination and subordination within their families and marriages. They were found to experience more mental health conflicts. Women who take on more active roles in society, including advocating for gender equality, often face verbal abuse and mental trauma. This underscores the deeply ingrained patriarchal norms and the resistance faced by women who challenge these norms.

3. Satisfaction with Limited Freedom: Conversely, women who expressed satisfaction with the limited freedom granted by their husbands and families appeared to experience fewer mental health issues. This suggests that, in some cases, women who conform to traditional gender roles and accept a degree of dependence on their husbands may experience a sense of security and reduced mental stress. This on the other hand will negatively implicate upon women’s individual development and their contributions to societal development.

4. All the sociocultural factors affecting mental health were found to be applicable in the case of women both in the high and low mental health

categories. The frequency and gravity of incidents varied in both groups with the Low MH group at a more disadvantaged condition. However, women in the High MH group exhibited a different approach to unhappy incidents in their lives - accepting it as natural/ social norm or ignoring with indifferent attitude.

These unexpected findings emphasize the nuanced nature of women's mental health in Kerala, where the interplay of cultural, social, and gender factors play a crucial role. The findings also highlight the importance of considering the broader societal context and the influence of traditional beliefs and practices when addressing women's mental health issues in the region.

6.6. Implications of the Study for Policy Making

This research has shed light on the mental health status of women in Kerala. The final exploration with qualitative in-depth interviews with 50 study participants has brought out the eight major factors that influence women's mental health. Though the generalizability may be limited, as warranted by feminist research the eight final themes postulate significant hypotheses for major studies in the future. Each and every factor provides scope for major research in the area of women's mental health.

Yet the present study holds significant implications for policy-making in the area of mental health practice. Policy makers and mental health professionals can use these findings to develop strategies that consider the unique challenges and experiences of women in Kerala. This framework should aim to address not only individual mental health but also the broader social and familial contexts that impact women's well-being.

As proposed by Dennerstein et al. (1993), health policies that incorporate mental health into public health and address women's needs and concerns from childhood to old age can be developed in numerous ways to further mainstream gender perspectives. Ethical considerations and the competence of practitioners are central to the formulation of integrated health programs capable of redressing the trauma of rape, the stigma of sexual or domestic violence, the depression of isolation or gender

oppression, and the anxiety of scarcity. Bio-psycho-social or cultural aspects of mental health treatments need to be augmented with attention to safety, advocacy, and access of women to support networks.

Kerala has experienced a rapid rise in mental health morbidity between 2002 and 2018. It was exacerbated during the COVID-19 pandemic. The most recently reported health human resource and infrastructure availability in the state appears to be inadequate to cater to the requirements of mental health care, even as improvements and upgradations are underway. As suggested by Joseph et al. (2021), service and system design changes will have to be mapped and evaluated over time. A recent study found that during the COVID-19 pandemic in Kerala, depression was a major problem faced by people under home quarantine (75.2%) followed by stigma (69.5%) and anxiety (69.4%) (Ravindran et al., 2021). In response, the state adopted inter and intra-departmental coordination to ensure continuity of services and access to additional support like medications and rations – in part to mitigate these challenges (John & Gunasekaran, 2020).

Based on the research findings, the following policy recommendations are proposed to address the mental health challenges faced by women in Kerala:

1. Awareness Campaigns: Support and promote awareness campaigns like the "Reach Out" social media campaign and the "Act Now" special campaign film. These initiatives can help destigmatize mental health issues, encourage open discussions, and educate the public about the importance of seeking help when needed.

2. Women-Friendly Policies and Programs: Introduce women-friendly policies and programs that encompass extended maternity benefits, equal pay for equal work, flexible work arrangements, gender-sensitive family counselling units, parenting classes, awareness campaigns on gender-based violence, collective relaxation programs for women, safe spaces for expressing problems and emotions, and comprehensive sex education programs. These initiatives should be designed to uplift and protect women's mental well-being across all socioeconomic levels.

3. Media Engagement: Encourage media outlets to take up campaigns and programs that emphasize equal sharing of household responsibilities and its positive impact on women's mental health. Media should portray women's empowerment and equality as the norm and raise awareness about gender equality. Additionally, media can play a role in highlighting the adverse effects of alcoholism-related violence against women and advocate for stronger law enforcement in this regard.

4. Government Action on Alcoholism: Governments should take decisive action to regulate alcohol distribution and address alcoholism-related violence against women. This may include stricter alcohol control measures and effective law enforcement to protect women from harm.

5. Awareness on Tele-Counselling Services: Majority of the study participants were not aware of the available tele-counselling services whereby women fail to access them. Such awareness could be spread through Kudumbasree mission, ASHA workers and other community health providers.

6. Training Non-Specialists: State governments should invest in initiatives that train non-specialists, such as general practitioners, psychiatric nurses, social workers, and community health workers, to provide basic mental health care services, particularly in rural and remote areas. Community health organizations may take a role in intimate partner violence prevention and intervention because it would be easier for abused women to visit a community health center for general health issues and to receive additional services related to intimate partner violence, if necessary, rather than visit a center specifically for intimate partner violence.

As suggested by Jagadish et al. (2019), continuous monitoring on an outpatient basis, more house visits, constant communication, and mobilizing mental health professionals for door-to-door visits to increase contact between patients and mental health professionals and bridge the gap between patients and mental health services is the way forward to attain the goals of the National Mental Health Act, 2017.

In summary, this research serves as a critical step in shedding light on the mental health status of Keralite women and the factors influencing it. By incorporating a gender-sensitive approach into mental health policies and practices, stakeholders can work towards improving the mental well-being of women in Kerala and addressing the complex societal and familial issues that impact their mental health.

6.7. Recommendations for Further Research

The study emphasizes the importance of a gender perspective in mental health research. Regardless of the discipline, whether it be clinical psychology, sociology, medicine, or social work, researches should approach mental health issues with an understanding of the secondary status of women in society. This perspective recognizes that women face unique challenges and opportunities that differ from those of their counterparts. Building on the findings of this study, several areas for further research are suggested to gain a deeper understanding of women's mental health in Kerala and beyond:

1. Each of the eight factors that were found to affect women's mental health in the present study postulates hypothesis for elaborate future studies.

2. Research specifically focused on the mental health status of unmarried, divorced, or single mothers and queers in Kerala could be undertaken as these categories were not included in the present study in its pursuit to understand the family dynamics of married women living with their husbands and how it affect their mental health. The unique challenges and stressors faced by other categories may differ from those of the present study participants.

3. Recognizing that socio-cultural factors related to women's mental health can vary significantly based on geographical locations, studies in different cultural contexts within Kerala and in other states of the country could be conducted.

4. The research could be expanded to include larger groups of Keralite women from all districts of the state. A broader sample size will provide more comprehensive insights into the mental health status of women in Kerala and enhance the validity and generalizability of research findings.

5. Conduct longitudinal studies to track changes in women's mental health over time. Long-term research can help identify trends and factors influencing mental health status, as well as the effectiveness of interventions and policy changes.

6. The intersectionality of various factors such as gender, caste, class, and religion, in influencing women's mental health and accessing mental health services could be explored.

By pursuing these avenues for further research, scholars, policymakers, and mental health professionals can gain a deeper understanding of the complex dynamics influencing women's mental health and work towards more targeted and effective interventions and policies.

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APPENDICES

APPENDIX- I

PERSONAL INFORMATION SHEET

- Name : .....
- Age : .....
- Phone Number / Mail ID: .....
- District : .....
- Work : Government ☐ Private ☐ Housewife ☐
  Others ☐
- Religion : Hindu ☐ Muslim ☐ Christian ☐
  Others ☐
- Area of residence: Urban area ☐ Semi-urban area ☐
  Rural area ☐
- Monthly Income of Family: Below 1000 ☐ 25000-50000 ☐
  Above 100000 ☐
- Class: Upper class ☐ Middle section ☐
  Lower class ☐
- Cast: General ☐ OBC ☐ SC/ST ☐
  Others ☐

APPENDIX- II

WHO (ten) Wellbeing Index (1996)

Sl. No		Rating from All of the time		\None of the time	
1	I feel down hearted and blue	0	1	2	3
2	I feel calm and peaceful	3	2	1	0
3	I feel energetic, active or vigorous	3	2	1	0
4	I have been waking up feeling fresh and rested	3	2	1	0
5	I have been happy, satisfied or pleased with my personal life	3	2	1	0
6	I have felt well-adjusted to my life situation	3	2	1	0
7	I have lived the kind of life I wanted	3	2	1	0
8	I have felt eager to tackle my daily tasks or make new decisions.	3	2	1	0
9	I have felt I could easily handle or cope with any serious problem or major change in my life.	3	2	1	0
10	My daily life has been full of things that were interesting to me	3	2	1	0
Please circle a number on each of the following statements to indicate how often you feel each of them has applied to you in the last week Notice that higher numbers mean better wellbeing					

APPENDIX- III

ക്ഷേമ സൂചിക

		എപ്പോഴും		ഒരിക്കലുമില്ല	
1	എനിക്ക് സങ്കടവും നിരുത്സാഹവും തോന്നുന്നു	0	1	2	3
2	എനിക്ക് ശാന്തതയും സമാധാനവും തോന്നുന്നു	3	2	1	0
3	ഞാൻ ഉർജസ്വലയും സജീവവും ആയി തോന്നുന്നു	3	2	1	0
4	ഞാൻ ഉന്മേഷത്തോടെയും സമാധാനത്തോടെയും ആണ് ഉണരുന്നത്	3	2	1	0
5	എന്റെ വ്യക്തിപരമായ ജീവിതത്തിൽ ഞാൻ സന്തുഷ്ടയും സംതൃപ്തയും ആണ്	3	2	1	0
6	എന്റെ ജീവിത സാഹചര്യങ്ങളുമായി ഞാൻ നന്നായി പൊരുത്തപെടുന്നതായി തോന്നുന്നു	3	2	1	0
7	ഞാൻ ആഗ്രഹിച്ച തരത്തിലുള്ള ജീവിതം ഞാൻ ജീവിക്കുന്നു	3	2	1	0
8	എന്റെ ദൈനംദിന ജോലികൾ കൈകാര്യം ചെയ്യാനും പുതിയ തീരുമാനങ്ങൾ എടുക്കാനും എനിക്ക് ഉത്സാഹമുണ്ട്.	3	2	1	0
9	എന്റെ ജീവിതത്തിലെ ഗുരുതരമായ എന്തെങ്കിലും പ്രശ്നങ്ങളും വലിയ മാറ്റങ്ങളും എളുപ്പത്തിൽ കൈകാര്യം ചെയ്യാനും നേരിടാനും കഴിയുമെന്ന് എനിക്ക് തോന്നുന്നു.	3	2	1	0
10	എന്റെ ദൈനംദിന ജീവിതം രസകരമായ കാര്യങ്ങളാൽ നിറഞ്ഞിരിക്കുന്നു	3	2	1	0

താഴെ കൊടുത്തിരിക്കുന്ന പ്രസ്താവനകൾ നിങ്ങളുടെ ജീവിതത്തിൽ എത്രത്തോളം ബാധകമാണെന്ന് സൂചിപ്പിക്കുന്നതിന് ഓരോ ചോദ്യത്തിന്റെയും താഴെ കൊടുത്തിരിക്കുന്ന ഓപ്ഷനിൽ നിന്നും ഏതെങ്കിലും ഒരു നമ്പർ സർക്കിൾ ചെയ്യുക

APPENDIX IV

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Postpartum Depression and Associated Risk Factors among Women in Kerala

Jijila M K
Department of Women's Studies, University of Calicut, Kerala, India.
Moly Kuruvilla
Department of Women's Studies, University of Calicut, Kerala, India.
Jaya AR Dantas
Curtin School of Population Health,
Curtin University, Western Australia.

Abstract. -- Postpartum Depression (PPD) is an important facet related to the mental health of women which is not given due attention in India. It implies a gap in the attainment of the Sustainable Development Goals (SDGs) especially SDGs 3.2, 3.4 and 3.7 related to maternal and child health and 5.6 related to Reproductive Health Rights. The effects of postnatal depression on the mother, her marital relationship, and her children make it an essential condition to diagnose, treat and prevent. Data was collected using a Postnatal Depression Rating Scale (EPDS) followed by unstructured interviews with 84 young mothers in the age group of 25-35. The study documented the major risk factors related to the PPD of women in Kerala. The findings imply the need to introduce an active screening programme for PPD as part of the postpartum care.

Keywords: Postpartum Depression, Perinatal Care, Reproductive Mental Health, Rituals and Traditions related to Delivery, Unplanned Pregnancy.

Introduction

In the context of Sustainable Development Goals (SDGs) 2030, SDG 5.6 aims to ensure universal access to sexual and reproductive health and reproductive rights as agreed in the Program of Action of the ICPD (International Conference on Population and Development), the Beijing Platform for Action and the outcome documents of their review conferences. Postpartum depression (PPD) is a significant aspect of reproductive

mental health and hence related to the attainment of SDGs 3.2, 3.4 and 3.7 aimed at maternal and child health. The term 'postpartum' means the time after childbirth. The postnatal period is widely accepted as a time of increased risk for developing severe mood disorders. There are three common forms of postpartum affective illness: the blues (baby blues, maternity blues), postpartum (or postnatal) depression, and puerperal (postpartum or postnatal) psychosis, each of which differs in its prevalence, clinical presentation and management[1].

The situation usually begins between one and twelve months after delivery. In some women, postpartum blues continue and become more severe. In others, a period of wellbeing after delivery is pursued by a gradual onset of depression. The symptoms of PPD include tearfulness, despondency, feelings of guilt, loss of appetite, sleep disturbances, inadequate feelings, inability to cope with the infant, poor concentration and memory, fatigue, and irritability [2]. Some women may worry excessively about the baby's health or feeding habits and see themselves as bad, inadequate, or unloving mothers[3]. Reports of suicidal ideation are also common. While very severe postnatal depressions are easily detected, less powerful presentations are dismissed as normal or natural consequences of childbirth.

Factors contributing to postpartum depression

If PPD is to be forbidden by clinical or public health intervention, its risk factors need to be identified scientifically. World Health Organisation[4] in 2008 classified the factors generally contributing to PPD under five heads such as biological, obstetric, clinical, psychological and social factors. Looking through a gender lens, the authors highlight the significance of social factors in determining the extent of PPD. These may include the following:

- Life Events: Experiences such as the death of a loved one, relationship breakdowns or divorce, losing a job or moving home are known to cause stress. They can trigger depression in pregnant and postpartum women.
- Social Support: Receiving social support through friends and relatives during stressful times is thought to be a protective factor against developing depression[5].
- Marital Relationship: Braverman and Roux[6] and Kumar *et al.*[7] have reported an increased risk of postpartum depression in women who experience marital problems during pregnancy.
- Socio-economic Status: Socioeconomic deprivation indicators such as unemployment [8][9][10], low income and low education have been cited as risk factors in mental health disorders [11].

Bara[12] reveals financial difficulties, domestic violence, past history of psychiatric illness in the mother, marital conflict, lack of support from the husband and birth of a female baby as leading to PPD. Other reported risk factors include recent stressful life events, family history of psychiatric illness, sick baby or death of the baby and substance abuse by the husband.

Globally, PPD is the most common complication associated with childbirth. Psychiatric illness (often associated with suicidality) is one of the leading causes of maternal death in the UK [13], as well as a leading killer of women of childbearing age in both India and China[14]. With disrupted reproductive healthcare services during Covid-19, the PPD rates in countries worldwide are reported to be escalated. In Spain, 15% more women have developed symptoms of PPD than the pre-pandemic rates. In the U.K., where pre-pandemic rates of postpartum anxiety (PPA) and depression (PPD) used to hover around 15%, roughly 43% of women with babies between birth and 12 weeks during the country's first lockdown met the criteria for PPD; 61% checked the boxes for PPA[15].

If an Indian mother is asked about how happy she thinks mothers are, she may not give a straight answer. Even as the societal pressure demands that a mother be happy and rejoice in every aspect of motherhood, the social and material realities for women in India are so harsh that the idea of happiness can be an alien concept. The emotional wellbeing of a mother is an important but often neglected aspect of society and cannot be taken for granted[16].

India is experiencing a steady decline in maternal mortality, which means that the focus of care in the future will shift towards reducing maternal morbidity, including mental health disorders. In India, women who deliver at a health facility often stay there for less than 48 hours after delivery[17]. This leaves little opportunity for health personnel to counsel the mother and family members on the signs and symptoms of PPD and when to seek care. In low- and middle-income countries, the proportion of women who visit the health facility for postpartum visits is generally low. Consequently, mental disorders often remain undetected and unmanaged, especially for those who have home births[18].

The context of the study

During Covid-19 pandemic, 0-35% of women around the world including India are estimated to suffer from PPD[[19]][[20]]. Goecker[21] reports one in five women in India to have experienced PPD before 2020 and predicts a sharp increase during Covid-19. The uncertainties of Covid-19, difficulties like lack of transportation facilities to access healthcare services, fear of infection, unwanted pregnancies along with prolonged

lockdowns and social isolation may have escalated postpartum depression during Covid-19 pandemic. The present paper is based on the findings from the research on the extent of PPD and the risk factors associated with it among young mothers in Kerala, India.

The study participants were 84 young mothers in the age group of 25 -35 years, selected from five districts across the state of Kerala through purposive and snowball sampling. The study participants were mainly located with the help of ICDS (Integrated Child Development Services which is a flagship programme of India for early childhood care and development) and ASHA (Accredited Social Health Activists in India who are community workers and serve the vulnerable sections of society) workers. As per the inclusion criteria, only those mothers in the specified age group and who had their delivery within the past one year were eligible to be study participants. Due attention was paid to include equal number of women belonging to the three major religions of Kerala, Hindu, Christian and Muslim. 64% of the participants were housewives and the others were engaged in paid work. 46% were postgraduates, 29% having a degree and the rest of the mothers had higher secondary education. The primary data on the extent of PPD and the risk factors associated with it were collected using a PPD Rating Scale standardised with the well-established Edinburgh Postnatal Depression Rating Scale (EPDS). After getting their informed consent, the PPD scale was sent via Google Forms to the participants. The results were further substantiated and triangulated through in-depth interviews with twenty mothers, ten each from the High- and Low-PPD groups to understand their personal encounters and get further insights into what heightened and intensified their conditions. Due to Covid-19 public health protocols, interviews were conducted through personal interaction with women in the neighbouring districts and through video calls with those residing in distant districts. The data collection was completed during the months of April to June 2021.

A. Extent of PPD and the associated risk factors among women in Kerala

The results of the analysis show that the mean score of the PPD for the total sample is 43.4, and the standard deviation is 10.53. The conventional Mean +/- one sigma method was used to identify the High -, Average- and Low- PPD groups. Accordingly, there were 12 mothers in the High-PPD, 19 mothers in the Low- PPD and the rest belonged to the Average- PPD groups.

B. Risk factors leading to postpartum depression

The risk factors associated with PPD among women in the present study are presented in Table 1.

Table 1: Major risk factors causing PPD among young mothers

Sl.No.	Factors Affecting PPD	Percentage of Agreeableness
1	Customs and rituals during and after the delivery	71
2	Worries about newborn's health	69.9
3	Sleep disturbances	68.7
4	Lack of time for self-care and bodily changes	60.2
5	Lack of support and care from husband and in-laws	43.4
6	Hopelessness about career and ambitions	33.8
7	Unplanned pregnancy	19.3

Source: Primary data

1. Customs and rituals during and after the delivery

The major cause for PPD among the study participants during and after the delivery is the customs and rituals which often have a religious support. In general, pregnant women in Kerala return to their natal family at the seventh month, especially during the first and second pregnancies, stay there for the delivery and a minimum of 90 days postnatal care. The customs make the girl's family meet all the expenses related to childbirth and for making gold ornaments for the newborn. Rituals like untouchability (assigned due to the cultural notion of impurity associated with childbirth) and isolation also make the young mothers more depressed and stressed. One mother explained her traumatic feelings during the mandatory isolation period. She could not sleep well, was forced to do all the baby care alone, and nobody offered any help, especially during night time. Many Indian families practice outdated post-partum rituals and traditions, whereby the mother and baby stay isolated from the family and community for a minimum 40 days after childbirth. While this may protect them from infection, effective isolation makes the mother lonely and vulnerable. Women from poorer households may not have easy access to healthcare or may not recognize signs of PPD and this forced

isolation creates more stress in postpartum women[22]. Some previous studies also support this argument [23][24][25][26][27].

2. Worries about newborn's health

Young mothers were found to have lots of worries regarding the newborn's health and it was found to be a reason for PPD among almost 70% of the sample. In spite of their wide reading on infant health especially among pregnant mothers, lack of practical experiences in handling babies made them tensed and confused. There were two mothers in the High- PPD group who did not have enough breast milk and could not breastfeed and were blamed by the husband, in laws and even relatives for the same. Guilt, worry and helplessness provoked one of them to even attempt suicide. Swaddling and feeding the infant, burping the baby, problems related to bowel movements are factors that cause worries in the young mothers. Opportunity to see and experience such things is rare in the nuclear families of present society, especially in urban areas and large cities in India. At the same time, the knowledge from books and online does not seem to help in several cases. Sessions on proper baby care with community midwives are a gap in India's reproductive health care system, especially that of Kerala, irrespective of its exemplary low infant and maternal mortality rates.

3. Sleep disturbances

Sleep disturbances are high in women after delivery and is found to be a cause for depression among 69 % of the study participants. Studies from other countries also support this finding[28][29]. When babies wake up at night and cry, sometimes even five to six times a night, it is considered as the sole responsibility of mothers to take care of them. When the baby has health issues like fever or cough, mothers are unable to sleep and provide care to their babies. These sleep disturbances in turn make the mothers prone to irritability, agitation and anger and sometimes depression and sadness.

4. Lack of time for self-care and bodily changes

Almost 60 percent of the study participants reported lack of time for self-care as a reason for their PPD. Without proper sleep and anxieties concerning the care of the newborn, women often do not get any time for themselves. The ritualistic healthcare and 'post-delivery bath' are elaborately performed but the young mothers are not found to be happy with such rituals. Instead, they prefer more rest and free time to be on their own.

The weight gain and sudden changes to their bodies during pregnancy and after delivery are found to develop PPD among the young mothers. Women of present generation are more conscious about their fitness and body but are often withheld from exercising as part of the rest and care during the postpartum period. A young mother

shared that she was pressurised to take ghee and high calorie food in the name of nutrition. Her mother was adamant about presenting the daughter, as to be well taken care of and healthy, to the son in law and his family members. It is a usual custom in Kerala that the girl after delivery should put on weight as an indication of staying healthy.

5. Lack of support and care from husband and in-laws

Mothers from the High -PPD group face a lot of issues from the family side. A majority of the young mothers said that they do not have any support and care from the husband or in-laws. Adjustment problems with in-laws are serious issues that aggravate PPD in a young mother who struggles with baby care. One of the study participants said that she does not like to go to her husband's house after the birth of second child because she cannot properly manage both the babies and the domestic chores at husband's house. Sometimes both babies cry at the same time at night, and it is difficult to put them to sleep, and there is no support from the husband's side. She also shared how she is pushed out of the bedroom to put the babies to sleep.

Verbal abuse related to dowry and the family status of the young mother are causes of distress. In most cases, husbands support the in-laws and blame their wives. One young mother confessed how she hit her husband once in a while because of his neutral attitude towards his mother's sharp and cruel words and how she was compelled to leave her husband's home for several months during the pregnancy.

6. Hopelessness related to career ambitions

Occupational hazards like work stress, being forced to join the workplace during pregnancy, lack of maternity leave also affect young working mothers. They are forced to balance their domestic chores within the household along with caring for their babies. Moreover, many young mothers complain of being abused for their inexperience in child care by the husband and his extended family members. Lack of family support is reported to be the main reason for the high PPD among employed mothers by several authors [30][31][32]. In other instances, women are pressured to quit their jobs and /or./ education, the moment they are pregnant, and they will have to bear the brunt if anything goes wrong. Any spotting or bleeding during their pregnancy means the end of a career to pregnant women. Torn between child caring responsibility and career aspirations, young mothers may fall into PPD.

Though employed women have economic independence, their anxieties regarding job security and challenges related to managing the new responsibilities of baby care along with office work create challenges for women in the informal sector. This becomes a serious issue for those without support from husband and other family members who insist on women quitting their jobs in order to care for the baby.

7. Unplanned pregnancy

The overemphasis on mothering is a burden for young women in Indian society, where they often are left with no choice. The lack of Sexual and Reproductive Health (SRH) rights plays a major role in developing high PPD among young mothers in Kerala. Women, in general, lack the decision-making power related to mothering- whether to become/when to become pregnant, how many children, spacing between pregnancies or how long she is to breastfeed. The sad part is that majority of women are even ignorant about their SRH Rights. 19.3% of the total sample stated that their unplanned pregnancy caused stress and depression. Despite the varieties of contraceptives available in India, unplanned pregnancy was found to be the major reason for PPD in all the ten women in the High- PPD group. Most women shared that their plan to abort the unwanted pregnancy was discouraged by the elders on the grounds that aborting the first pregnancy may lead to infertility in the future. This is a prominent misconception without any scientific base, prevalent even among the educated women of Kerala. Religious beliefs also were found to be a major reason that withhold women from accessing contraceptives or abortion to avoid unwanted pregnancy. Lack of access to contraceptives, husbands' indifference and irresponsible behaviours were mentioned as reasons for unwanted pregnancy by three among the ten women.

C. Factors that protect mothers from postpartum depression

In the case of Low- PPD mothers, they had great support and care from husbands and their own maternal family and marital family during pregnancy and postpartum. Their only fear and tension were about the baby's health like birth weight and other issues like bowel movements, feeding habits and sleep cycles. They had mothers and other family members to help when the baby wakes up at night and cries. Almost all young mothers narrated how they felt a kind of competition between the two families- natal family and husband's family- on who cares more for the baby. Both the families needed a baby, whether a girl or boy and they are happy with it. One young mother said that pregnancy, delivery and postpartum are all a heavenly feeling for her. Mothers' support and care and husband's love are highly reflected in the Low- PPD women in Kerala. All of them had either the mother or mother-in-law or a maid or nanny to take care of the baby during the first few months. Another important finding is that all the 19 mothers from the Low-PPD group had planned pregnancies. They were physically, mentally and emotionally ready to conceive and welcome the baby. The few employed women in the Low- PPD group were government employees with maternity leave benefits. Majority of them conveyed that they had no major financial issues and were managing the monetary needs through proper planning. The protective factors are summarised in Table 2.

Table 2:Factors protecting young mothers from PPD

Sl.No.	Factors Affecting PPD	% of respondents Agreeableness
1	Care and support from husband	100
2	Care and support from other family members, especially presence of a mother figure	100
3	Planned pregnancy	100
4	Maternity leave in the case of govt employees	100
5	Financial stability	80
6	Hired hand to take care of baby	60

Source: Primary data

D. Religious beliefs, practices and postpartum depression

Religion is believed to be a protective factor that assists in reducing depression, anxiety and other mental health issues. Studies by Rahman[33] and Rahman et al.[34] highlight beneficial effects of religious beliefs and traditional wisdom in reducing PPD. Religious teachings, traditional practices and a network of informal social support were also observed as a way of maintaining wellbeing and providing relief from distress [35][36].In their study on adolescent girls in Kerala, Jijila and Kuruvilla also found a positive correlation between religiosity and mental health but it also highlighted the possibilities of negative impact that extreme religiosity can have on mental health of adolescent girls[37]. As Agarwal also points out, many outmoded religious rituals and belief systems might inhibit positive growth and may lead to mental ill-health[38]. Violation of religious rituals, whether willingly or unwillingly can generate considerable anxiety among the religious groups. There are several rituals and customs related to pregnancy and delivery that still exist among highly religious people.

The statistical analysis in the present study showed that there is no significant difference in the extent of PPD based on the classificatory variable of religion. But among the twelve High-PPD women, seven were Hindus who had to follow more isolation and untouchability than their counterparts. Similarly, among the 19 Low- PPD women, only four were Hindus, six were Christians and nine were Muslims. However,

more focussed studies are required to affirm how religious beliefs influence the reproductive mental health of women in India.

Conclusion

Women's health in India is often equated with sexual and reproductive health. During pregnancy, health services for women focus on ensuring safe delivery. After childbirth, the spotlight shifts to the child and the mother's wellbeing receives less attention. Furthermore, mothers may be reluctant to admit their suffering either because of social taboos associated with depression or concerns about being labelled as a mother who fails to deliver the responsibilities of child care[39]. In the public health system in most low- and middle-income countries, including India, primary-care workers are supposed to be in regular contact with recently delivered mothers. However, at postnatal visits, community health workers tend to focus on promoting essential infant care practices, with lower priority given to the mother's health[40.] Analysis of demographic and health survey data from 75 countdown countries showed that postnatal care visits for mothers have low coverage among interventions on the continuity of maternal and child care[41].

Researches from India and other Asian countries have consistently shown that gender-related attitudes through life can be critical triggers for PPD. Misconceptions regarding contraception and abortion need to be eliminated through appropriate interventions. Women should be empowered enough to avail their SRH rights like bodily integrity, autonomy and decision making on all aspects related to pregnancy and delivery. This calls for comprehensive changes in their socio economic and political status within families and the society.

Societal attitudes also present a formidable challenge to the prevention of PPD. A baby is always considered a mother's responsibility. In a tradition bound society like India, the role of father in the upbringing of children and child care still needs to be accepted. Despite this, interventions are predominantly medical, while support from husband and other family members in its prevention or remedial action is rarely discussed. A number of professionals such as gynecologists, midwives, community health workers, pediatricians and allied health professionals may have to step up and provide screening, treatment, preventive counseling and rehabilitation services for cases of PPD. Shidhaye Rahul et al.[42]report the option of integrating mental health services in primary care by training health workers to identify signs of depression among women and sensitising health providers in Madhya Pradesh. While this approach may target the treatment gap, the real game-changer for postpartum depression as proposed by Arora Teertha and Nandita Bhanwill be advocacy and interventions for shifting gender-based attitudes and reducing violence within homes[43]. The findings of this study imply the need to introduce an active screening

program for PPD in health facilities as part of postpartum care. The gaps in reproductive mental health need to be given more attention, analysed with a gender perspective and fixed to attain the goals of SDG 3 and SDG 5.

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INFORMED CONSENT FORM

I hereby confirm that I have been informed about my involvement in this research.

I have also received, read (or had it read to me) and understood the participant information sheet regarding the nature and purpose of the study, safety, and its potential risks / benefits and expected duration of the study and other relevant details of the study including my role as a study participant have been explained to me in the language that I understand.

I understand that what I say will be documented and that the information collected during the research study will be kept confidential. The representatives of sponsoring agencies, government regulatory authorities, ethics committee may wish to examine my records/study related information at the study site to verify the information collected. By signing this document, I give permission to these individuals to access my records.

I also agree that the data collected during this study can be processed in a protected computerized system. I am aware that I shall receive no compensation for my involvement in the study.

I may at any stage, without prejudice, withdraw my consent and participation. I am not required to give a reason for withdrawal.

I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate.

I have agreed that if certain elements of my responses need further clarification, the researcher is allowed get in touch with me for the same.

[Note: that there are some instances where signed consent may be substituted with verbal consent; the researcher will sign the form on behalf of the participant after having received verbal consent]

I have read this consent form (or had it read and explained to me), and all of my questions have been answered to my satisfaction.

My signature below confirms that:

□ I agree to participate in the study

Signature of participant: _____ Date: _____

Researcher Signature: _____

Permission to Audio Record

□ I DO NOT give the researcher/research staff permission to audio-record my interview

□ I give the researcher/research staff permission to audio-record my interview

Signature of participant: _____ Date: _____