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Structural Violations of Mental Health Equity among Divorced Women: Challenges and Policy Implications

Fathima Sherin Ottakkam Thodukayil, *Central University of Tamil Nadu*

Rahana Salahudeen Raseena, *Central University of Tamil Nadu*

Udhayakumar Palaniswamy, *Central University of Tamil Nadu*

Sigamani Panneer, *Jawaharlal Nehru University*

Sainaba Parammal, *SRM Institute of Science and Technology*

Abstract: The mental health equity of divorced women is a critical concern, as divorce can have significant emotional and psychological implications. Mental health equity refers to ensuring all individuals have equal access to mental health resources, support, and care regardless of their circumstances. Even though there are disparities in mental health care affecting mental health equity especially among divorced women, there is a noticeable gap in studies that delve into this issue. In this context, employing a mixed-method approach, this study explored the prevalence of mental health issues in divorced women and identified structural violations contributing to disparities in mental health care. The sample encompassed of divorced women in Kerala, representing diverse socio economic backgrounds, who were selected through purposive sampling. The data for the quantitative analysis was collected from 60 respondents in Kerala using the Depression, Anxiety, and Stress Scale (DASS21) to assess the mental health status of the women and a demographic questionnaire. In-depth face-to-face interviews with seven women were conducted for qualitative analysis. The findings of the study showed that the women experience significant mental health impairments in their post-divorce phase, and highlighted the impact of pre-existing structural violations and intersections of gender, class, and marital status of women in hindering their access to mental health care. Urgent policy interventions are needed to address these issues and cater to the specific needs of marginalized groups, especially, divorced women.

Keywords: Mental health equity; Divorced women; Structural violations; Intersectionality; Policy Implications

1 Introduction

Within the societal tapestry, divorce emerges as a profound and intricate transition resonating through the lives of partners and families, thereby underscoring its significance in shaping individual lives and the broader community. Divorce, once considered a private affair, has emerged as a critical lens through which we can examine the dynamics of mental health equity, particularly among women. Defined as "the formal termination of a socially and legally acknowledged marital union", divorce resonate within the intricate fabric of societal

structures and shape the lived experiences of those who undergo this profound transition. Causing in a modification of the responsibilities and rights of the individuals involved, it represents a significant life change with wide-ranging societal, emotional, legal, personal, economic, and individual implications (Price & McKenry, 1988). The reverberations of divorce echo far beyond the dissolution of individual marriages. The lived experiences of divorced women navigate a complex terrain marked by experiences, emotional turbulence, social scrutiny, and systemic challenges. These challenges, ranging from the complexities of family dynamics to the rupture of the marital bond and the subsequent plight of divorced women, traverse an array of emotional, social, and legal intricacies (Equit et al., 2022).

The incidence of divorce has risen significantly in both developed and developing nations over recent years (Sharma, 2011). According to the Census of India (2011), 1.36 million persons in India, constituting 0.11% of the total population, have experienced divorce. This significant rise in divorce rates emphasizes the need for a comprehensive examination of its impact, particularly on the mental health of women. Whether initiated by women or from the other side, divorce can profoundly impact the mental health of women in various ways and the repercussions echo through the intricate fabric of societal structures, further emphasizing the need for a comprehensive understanding of the mental health dynamics associated with divorce. Despite the strides made in reshaping societal norms, divorced women grapple with a unique set of structural injustices within the mental health domain. These inequalities create barriers that impede access to mental health resources and perpetuate the enduring stigma surrounding divorce, thereby amplifying the challenges they face in maintaining mental well-being.

2 Review of Literature

The mental health impact of divorced women is mostly pronounced due to specific social and cultural factors, particularly gender norms, exacerbating emotions of guilt, remorse, and isolation (Leopold, 2018; Leopold & Kalmijn, 2016). Divorced women reported heightened levels of depression, anxiety, stress, loneliness, social interaction anxiety, as well as elevated states of anger, including anger expression and overall anger intensity (Kausar & Nida, 2018). Unravelling these systemic discrepancies stands as a critical endeavour, pivotal in comprehending and remedying the intricate web of obstacles hindering mental health equity among divorced women.

Societal norms contribute to the reluctance in acknowledging and addressing symptoms, perpetuating a belief that such feelings are socially unacceptable (Trivedi et al., 2009). Recent findings highlight the existing challenges and potential barriers in the availability or accessibility of mental health services, especially for women who recognize the need for support but face obstacles in obtaining it. A poll revealed a higher proportion of women expressing a perceived need for mental health services within the past two years. However, only half of these women attempted to schedule an appointment for mental health care, and alarmingly, 40% opted not to seek mental health care at all (Melillo, 2022). This underscores the urgency of addressing the intricate intersection of structural violence and mental health inequity among divorced women.

Despite societal progress, there remains a pervasive undercurrent of systemic challenges within the domain of mental health equity. The inequality, framed as "structural violence," was introduced in Galtung's influential essay, "Violence, Peace, and Peace Research" (1969). He characterized structural violence as those processes, actions, or conditions that hinder

individuals from realizing their full potential, leading to their actual life achievements falling short of what they could realistically attain (Galtung, 1969). This perspective underscores the notion of structural violation, emphasizing how systemic factors can impede individuals from reaching their optimal life outcomes (Sinha et al., 2017). Among the myriad manifestations of such inequality, health disparities stand out as vivid indicators of the tangible impact of this structural violence. These disparities illuminate stark differences in access to health resources and care, vividly illustrating the consequences of unequal social structures and systems on individual well-being (McCartney et al., 2019). Structured inequality creates significant barriers that confine individual health behaviour, constraining their ability to make choices effectively. These limitations directly influence health outcomes by limiting the scope of available options (Petrovic et al., 2018). Individual agency is thus confined within the realistic choices accessible. Frequently, health-promoting decisions might not be feasible or may not be the most advantageous strategy for an individual, considering other limiting factors, regardless of whether healthier alternatives exist or not (Maar et al., 2011).

Structural violation is notably evident in the realm of mental health showcasing disparities and injustices within societal systems (Burns, 2015). These inequities often manifest as limited access to mental health services, discriminatory care practices, unequal resource distribution, and socio-economic barriers impede individuals from fulfilling their mental health needs (Bruwer, 2011; Burns, 2015; Simandan, 2018). The issue extends to women, constituting a pervasive problem aligning with broader patterns of historical structural violations leading to disparities in mental health equity (Sinha et al., 2017). Women face a significantly higher likelihood of anxiety diagnoses, with one in five women experiencing mental disorders compared to one in eight men (Auerbach et al., 2018). In the younger demographic, approximately 26% of women aged 16 - 24 report common mental health issues surpassing the 17% reported among adults (Auerbach et al, 2018). The prevalence of depression also affects women more than men (Albert, 2015; Auerbach et al, 2018). Despite the higher vulnerability, women underutilize mental health services due to the heightened stigma surrounding mental health issues (Kiely, 2019). Additionally, the prevailing tendency to undervalue women's health, contributes to the overall neglect of their mental well-being (Malhotra & Shah, 2015). These concerning trends emphasize the pressing need for targeted support and interventions (WHO, n.d.).

As an essential foundational step towards establishing equity in mental health, India has implemented various national and state level legislations integral to mental health policies. The interface of policy and legislation is crucial in making quality mental health care accessible in an effective manner. Shortage of mental health personnel poses a huge challenge in delivering mental health care perpetuating human rights violations in a social context marked by low awareness, illiteracy, superstitions, denial, and societal stigma (Gupta, 2021). The World Health Organization (WHO) outlines ten fundamental principles for mental health-care law encompassing various aspects like promoting mental health, ensuring access to basic mental health care, and the least restrictive form of mental health care. They underscore the importance of a qualified decision-maker and the utmost respect for the rule of law in mental health care practices. India's 2014 Mental Health Policy aligns with these principles, focusing on a rights-based framework for promoting mental health, preventing illness, facilitating recovery, de-stigmatizing mental health issues, integrating affected individuals into society, and ensuring socio economic inclusion (BN et al., 2013).

Legislation, crucial tool in guaranteeing that health-care services are provided in a suitable, sufficient, prompt, and compassionate manner should centre on safeguarding, enhancing, and advancing the mental well-being of the population. This extends beyond preserving the rights of individuals with mental illness, and ensuring fair treatment without discrimination (Freeman et al., 2005). The Mental Health Act of 1987 was a significant step forward during its time, aligning with global advancements and priorities in mental health. However, recognizing the evolving landscape and international standards, the Government of India introduced the Mental Health Care Act of 2017, marking a pivotal shift from emphasizing "collective rights" to prioritizing "individual rights" in mental health care. This new legislation aimed to stay abreast of global standards and address the changing needs of mental health support and treatment (Gupta, 2021).

Despite these advances in the legal framework, systemic barriers and inequalities within mental health care is a complex challenge that spans across global and national landscapes (Dako-Gyeke & Asumang, 2013). The World Health Organization (WHO) underscores the persistent presence of structural violations that impede access to and diminish the quality of mental health services. These violations manifest as entrenched obstacles, hindering individuals from obtaining the support and care they need. This global concern reflects inadequacies in resource allocation, service delivery, and societal attitudes towards mental health (Meghrajani et al., 2023). In India, these challenges materialize as a shortage of mental health professionals, inadequate infrastructure, and the existing societal prejudices represent significant structural violations in the mental health landscape (Dhyani et al., 2022). Despite Kerala's leading position in healthcare initiatives in India, evidenced by a dedicated mental health policy, the state grapples with the absence of a comprehensive mental health action plan. Notably, disparities persist in mental health care accessibility, particularly in rural regions, magnifying structural issues. Cultural perceptions about mental health continue to be barriers, impeding awareness and robust support systems, despite efforts to integrate mental health services into primary care. Although the implementation of district mental health programs across all districts is commendable, the state faces a significant challenge due to insufficient budgetary provisions. A mere 1.16% of the total health budget is allocated to mental health, with only a fraction effectively utilized (Gururaj et al., n.d., 2016).

Despite legal frameworks, structural violations within the realm of mental health are mostly faced by specific demographics like divorced women. The challenges faced by divorced women become a poignant illustration of systemic neglect, underscoring the intricate dynamics of broader societal issues affecting their mental well-being (McCartney et al., 2019; Waseem et al., 2020). The issue of structural violation in mental health equity experienced by divorced women in Kerala gains particular pertinence, given the distinct socio-cultural context of the region. Notably, the current landscape of mental health research lacks comprehensive exploration of the nuanced challenges faced by divorced women within the context of mental health equity. Despite advancements in understanding structural violations and mental health provisions, there remains a conspicuous gap in acknowledging and addressing the specific mental health needs of divorced women. Existing studies often provide limited insights into the intersectional complexities of gender, marital status, societal perceptions, and their impact on mental health equity for this demographic. The scarcity of research focusing explicitly on the mental health inequities experienced by divorced women represents a significant gap in understanding and catering to their unique needs. This research aims to bridge this gap by delving into the underexplored territory of mental health equity for divorced women, contributing to a more comprehensive understanding of their challenges and

advocating for tailored interventions and support mechanisms. The study, in this specific context, has two major objectives: (i) To assess the mental health status of divorced women in Kerala (ii) To study the structural violation in mental health experienced by divorced women.

These objectives were explored by posing the following research questions:

1. What are the prevalent mental health issues experienced by divorced women in Kerala?

2. How do socio-demographic variables such as age, educational attainment, employment status, and income levels correlate with specific mental health outcomes among divorced women in Kerala?

3. What structural barriers hinder divorced women in accessing equitable mental health support following divorce in Kerala?

4. How do systemic inequities within the mental health infrastructure impact the accessibility and adequacy of mental health support for divorced women in Kerala?

2.1 Theoretical framework

This study seeks to examine the mental health status of divorced women and explore the structural violations of mental health equity they face, employing feminist perspectives. A feminist analysis of divorce and mental health equity involves the deconstruction of deeply ingrained gender norms which not only dictate societal expectations but also impose structural limitations, further affecting the mental well-being. These norms, perpetuating a culture of blame and shame, not only shape individual attitudes but also become embedded within societal structures, contributing to systemic violations in mental health equity. The perpetuation of these norms within legal, economic, and healthcare systems further restricts access to mental health resources, exacerbating disparities and constituting a structural violation in providing equitable mental health support.

The lens of intersectionality within feminist theory- a theory that this study adopts as the major framework to look into the issue- developed by Crenshaw (1989), is instrumental in understanding how different social identities intersect and interact to shape experiences of oppression and privilege. One cannot truly comprehend the experiences of individuals without considering the many interactions and relationships of several social categories, as this intersectional experience is bigger than the sum of individual social categories (Crenshaw, 1989). The present study relies on intersectionality theory to analyze the intricate interplay between intersectional oppressions—specifically, the overlapping influences of gender, class, and marital status—and their role in perpetuating structural violations that impact mental health equity among divorced women. In other words, this research seeks to elucidate how interconnected oppressions contribute to mental health disparities, shedding light on the nuanced ways in which these intersecting identities manifest in structural violations, ultimately affecting mental health equity among divorced women.

3 Methods

This research adopted a sequential mixed-methods approach, commencing with quantitative measures using the Depression, Anxiety, and Stress Scale (DASS21) to assess mental health markers among divorced women in Kerala. Subsequently, the study transitioned to the qualitative phase which involved conducting interviews with participants identified as facing

significant mental health challenges, after through administering the DASS scale in the first phase. Through in-depth interviews, the second phase aimed to unveil the lived experiences of these women, shedding light on the intricate structural barriers impacting mental health equity post-divorce. Integrating quantitative findings with qualitative narratives provided a comprehensive understanding of both the prevalence of psychological distress and the intricate, often overlooked structural violation faced by divorced women in mental health equity.

The study sample consisted of divorced women from Thiruvananthapuram and Kollam districts in Kerala, chosen for their higher prevalence of divorce (Premsingh et al., 2014; Michael, 2013). Sixty women participated in the quantitative phase, and seven in the qualitative phase, all meeting criteria such as being divorced for at least one year, not remarried, having no prior mental illness, and being over 18. Participants were selected through purposive sampling, with the qualitative phase focusing on those identified with significant mental health challenges from the DASS21 results. Data collection spanned October to November 2023, utilizing community organizations, social media, and NGOs for initial contact. The DASS21, administered via Google Forms, provided quantitative data, while in-depth, face-to-face interviews, guided by a prepared schedule, offered qualitative insights. Confidentiality was maintained using pseudonyms. Quantitative data was analyzed using SPSS software (version 21), and qualitative data involved transcribing recorded interviews with participant consent, followed by thematic analysis. The study adhered to stringent ethical considerations, ensuring informed consent and participants' autonomy. Despite valuable insights, limitations included a small sample size, potential purposive sampling bias, and lack of comparison groups. These limitations suggest the need for further research to enhance understanding and support the mental health of divorced women

4 Findings

The results of this study as revealed in both quantitative and qualitative analysis, shed light on the mental health difficulties experienced by the women in the post-divorce phase and the significant structural violation they face in achieving mental health equity. While divorce often marks a critical transition in one's life, for many women, as the present study shows, there arise mental health struggles in the post-divorce phase. Table 1 shows the severity of depression, anxiety, and stress experienced by the respondents in this study. A deeper investigation using both quantitative and qualitative analysis reveals a disconcerting reality: divorced women encounter multifaceted structural violations when seeking essential mental health support. Major factors determining the treatment seeking behaviour of the women for the mental health issues they experience, as revealed from the quantitative analysis, are presented in Table 3. Following this, the major findings from the qualitative analysis are organized within distinct thematic categories and their corresponding subthemes.

The participants, totalling 60 in the quantitative phase, exhibit distinctive demographics. Marginally a greater number of participants belong to the age range 40-49 years (43.3%) and 29-39 years (41.7%). A significant majority (96.7%) married between 18-28 years, and 70% divorced between 29-39 years. Religious affiliations included 40% Hindu, 53.3% Muslim, and 6.7% Christian. Education levels showed 61.5% with only school-level education and 38.5% with college-level education. Employment status revealed 36.7% unemployed, with 3.3% in government jobs, 33.3% in the private sector, and 26.7% self-employed. Most participants (75%) were from rural areas. Income levels indicated that 74.6% earned below ₹10,000 monthly, with only 3.3% earning above ₹30,000. This data highlights age-specific

divorce patterns, religious composition, educational background, employment status, and income levels, providing a comprehensive overview of the participants' demographics.

The qualitative study involved 7 respondents from diverse socio-economic backgrounds, detailed in Table 2. These women, aged from their mid-twenties to forties, have varied durations of married life, ranging from one to six years. Their education levels span from higher secondary to post-graduate qualifications, impacting their employment opportunities and income. Employment status includes unemployed, self-employed, and government sector workers. Monthly incomes range from below ₹10,000 to ₹30,000, highlighting financial disparities and differing levels of economic stability among the participants. This diverse socio-demographic profile provides insights into the varied experiences of divorced women.

4.1 Psychological Spectrum: Mapping Depression, Anxiety, and Stress Levels

Table 1. Percentage of respondents with varying levels of depression, anxiety and stress

Level of Depression, Anxiety, and Stress	Percentage
Depression	
Normal	5.0
Mild	6.7
Moderate	15.0
Severe	43.3
Extremely severe	30.0
Anxiety	
Normal	6.7
Mild	1.7
Moderate	5.0
Severe	13.3
Extremely severe	73.3
Stress	
Normal	3.3
Mild	15.0
Moderate	56.7
Severe	18.3
Extremely severe	6.7

Table 1 illustrates the distribution of participants' reported levels of depression, anxiety, and stress. The distribution of depression levels among divorced women in the study paints a distressing picture of their mental health post-divorce. The noteworthy majority exhibiting varying degrees of depression, particularly the significant proportions classified as experiencing severe (43.3%) and extremely severe depression (30.0%), suggests a profound impact of divorce on their psychological well-being. This high prevalence of severe depression levels among a substantial portion of respondents underscores the depth of emotional turmoil and challenges faced by divorced women, highlighting the potential mental health repercussions associated with marital dissolution. The following personal narratives vividly echo the emotional turmoil experienced:

> "The initial shock gave way to a hollow emptiness that settled in my chest. It wasn't sadness alone; it was a darkness that seemed to swallow every glimpse of light. There were days when getting out of bed felt like an impossible task. The heaviness that weighed down my spirit made the simplest of activities feel like climbing a mountain. It was a battle within myself, where every step forward felt like a monumental effort" (Jessica).

> "Loneliness became an unwelcome companion. Even in a room full of people, I felt isolated, as if I existed in a world separate from everyone else. The once familiar surroundings felt foreign, and the future appeared like a daunting abyss. The loss wasn't just of a partner; it was the loss of a shared dream, a vision of what I thought my life would be" (Aysha)

Most of the respondents face the profound and pervasive impact of divorce on their mental health. The staggering prevalence of extremely high anxiety levels, evident in nearly three-quarters of the respondents, signals an overwhelming burden of intense emotional distress within this group. This prevalence of severe anxiety, coupled with a notable number of individuals exhibiting no symptoms of anxiety, paints a poignant picture of the mental health challenges faced by divorced women. Such heightened anxiety levels can significantly impact daily functioning, relationships, and overall well-being, underscoring the urgent need for specialized mental health support services tailored to address the complex and intense anxiety experienced by this demographic following divorce. Besides these statistics, respondents poignantly articulate the emotional upheaval experienced:

> "After the divorce, it felt like everything changed. I never felt steady, always unsure. I worried a lot about what would happen next, even in the good times. It wasn't just not knowing what would happen; it felt like being on an emotional ride that never stopped" (Anusha).

> Feeling anxious was like having a buddy that never left my side. It wasn't just about being by myself; it was more about worrying that I might mess up in this new phase of my life. It felt really tough trying to figure things out when I didn't know what to expect. Nights were the worst. Everything was so quiet, and all I could hear were my own thoughts freaking out about all the things that could go wrong" (Maya).

The distribution regarding stress highlights the prevalence of heightened stress levels among divorced women, indicating a substantial impact of divorce on their emotional health. The significant proportions experiencing moderate (56.7%) to extremely severe stress (18.3%) and only 3.3% having no symptoms underscore the profound challenges and emotional strains encountered within this demographic following divorce. It emphasizes the depth of emotional turmoil and the complexities faced by these women. In the midst of these statistics lies the raw, unfiltered narratives of divorced women, offering distressing glimpses into their struggles:

> "It's like being stuck in a never-ending storm of stress. I'm afraid of making wrong choices, especially about taking care of my kids. It's not just money; I worry about how this mess affects their feelings. I wish I could turn off this stress, but it's always there, hanging around" (Bhanumati).

> "The divorce made everything stressful, especially money. I had to handle everything—bills, the house, and all the everyday expenses. It was like juggling a bunch of plates,

> each one a bill I had to pay, and I was scared they'd all crash down. Making enough money was always on my mind, reminding me of all the new stuff I had to deal with" (Sarah).

The above verbatim reflects the different layers of emotional turmoil experienced by these women. It is evident from the narrative that the psychological and emotional strains they were experiencing were compounded by their identity as divorced women, the lack of social support they have, and the related financial difficulties post-divorce.

4.2 Seeking Professional Help: Mental Health Care among Divorced Women

Table 2. Table showing the respondents' treatment seeking behaviour

Treatment seeking behaviour	Percentage
Received treatment	5.0
Received, but dropped	6.7
Didn't receive any treatment	88.3

Table 2 presents the treatment-seeking behaviour of the respondents. Out of the 60 respondents, only a small fraction, 5.0%, actively sought treatment for their mental health concerns and another small fraction (6.7%) though initially pursued treatment discontinued it, indicating potential barriers to ongoing care. Most notably, a significant majority, constituting 88.3% of respondents, did not seek any form of treatment for their mental health issues. This distribution underscores a substantial gap in seeking professional help among divorced women experiencing mental health challenges post-divorce. Respondents' narratives, articulating the reasons behind their seeking behaviour, whether seeking, refraining, or discontinuing mental health support, vividly portraying the emotional upheaval experienced post-divorce.

> "I didn't want to carry the weight of my emotions alone. Yes, there was this worry about what people might think, but I realized my mental health mattered more. It was about prioritizing myself and my well-being, regardless of any judgments others might have made" (Aysha).

> "I was always worried about how others perceived me, especially after the divorce. Seeking help for my mental health felt like admitting to some chronic issue that others might misinterpret. I feared people would label me or treat me differently if they knew I was seeking therapy. It's this constant battle of wanting support but also fearing the judgments and misunderstandings that might come with it. And on top of that, there's the financial burden—I simply couldn't afford the service fees. So, I tried to manage on my own, struggling silently" (Sarah).

These narratives clearly point out how systemic barriers prevented the women from seeking the needed professional help for their mental health issues. In addition to the fear of judgment that generally experienced by everyone seeking treatment for mental health issues, these women face multiple vulnerabilities as divorced women. As it is clear from Sarah's narrative, even though she was sure that she needed professional support, it was impossible because of two reasons; the fear of judgement and also the financial difficulties post -divorce. It is evidently a form of systemic barrier that affect the divorced women more.

Table 3. Table showing the association of respondents' treatment seeking behaviour and age at divorce and monthly income

Socio-demographic Characteristics	Treatment Seeking Behaviour: Seeking *n*=3		Dropped *n*=4		Not seeking *n*=53		Fisher's exact test value	Fisher's exact test p-value
	No.	%	No.	%	No.	%		
Age at Divorce (in years)								
18-28	3	100	3	75	10	18.86	13.297	0.005***
29-39	0	0	1	25	41	77.35		
40-50	0	0	0	0	2	3.77		
Monthly Income (in Rupees)								
Below 10000	0	0	2	50	42	79.24	18.441	0.003***
10001-20000	1	33.33	1	25	6	11.3		
20001-30000	2	66.66	0	0	4	7.54		
30001-40000	0	0	1	25	0	0		

The Fisher's exact test was conducted to determine the association of respondents' treatment seeking behaviour with respect to their age at divorce and monthly income. The results of the test (Table 3) indicate a significant association (p=0.005) between age of the participants at the time of divorce and their treatment seeking behaviour. The descriptive statistics implies that older respondents tends not to seek treatment. Similarly, there is a significant association (p=0.003) between monthly income of the participants and their treatment seeking behaviour. Descriptive statistics shows that the respondents are more likely to seek treatment with increase in their monthly income.

4.3 Structural Barriers in Mental Health Equity: Insights from Narratives

Following the identification of a notable prevalence of psychological challenges among divorced women using the DASS, the narratives, from the in depth interviews conducted in the second phase of the study and the thematic analysis of the interview transcripts provided a deeper understanding and showed in detail how the structural violations play their role in preventing divorced women's access to mental health service. One of the primary discoveries of the qualitative analysis revolves around the obstacles divorced women face in accessing mental health services due to structural barriersThe findings are discussed in detail below.

4.4 Accessibility Barriers

The results showed that divorced women faced geographical, financial, and informational barriers to seek mental health support

> "The nearest mental health centre is hours away. I can't manage frequent travel due to lack of transport and resources. After my divorce, I realized how distant we were from any mental health support. Traveling there regularly isn't an option; I have my kids to look after. It feels like we're forgotten out here" (Anusha).

This transcript clearly shows how the woman's divorced status becomes a barrier to her seeking treatment. Being a single mother with limited social and financial support, she is

unable to access the available treatment facility, which happens to be quite distant from her home. This underscores how the inadequate mental health treatment facilities pose additional challenges for divorced women.

> "You'd think help would be easy to find, right? But no one tells you where to go after a divorce. I felt lost, not knowing where to turn. It's as if they expect us to figure it all out alone" (Sarah).

As pointed out by the respondent, divorced women may find themselves isolated in various aspects, facing a shortage of social capital and limited social connections due to their divorced status. Obtaining social support to address mental health issues is typically challenging, and being a divorcee exacerbates these difficulties, which acted here as a challenge to the treatment accessibility.

> "I felt completely lost after my divorce. There's no roadmap, especially for someone like me with limited education. If I were more educated, maybe it would have been easier to find help. It's like navigating through darkness without any guidance or direction towards mental health support" (Banumadhi).

The persistent challenges of geographical barriers and lack of accessible information continue to hinder mental health equity, especially for divorced women. Despite advancements, they still face the overwhelming burden of geographic isolation, with mental health services often situated far from their reach. Simultaneously, the absence of clear and accessible information, especially for the ones with lowered educational status, perpetuates the struggle. These barriers represent structural violations that remain deeply embedded in the system.

4.5 Affordability and Quality of Services

Another challenge experienced by divorced women in mental health equity is the affordability of mental health services.

> "I know I required help, but the financial burden post-divorce is overwhelming. Mental health support feels like something only the rich can afford. It's not just the sessions, it's all the extra costs – medicines, follow-ups – it all adds up. For someone like me, every rupee matters, and getting mental health care feels impossible" (Jessica).

> "I tried seeking help from government-run counselling services. It seemed more like a routine they had to follow rather than genuine support. It felt like they were just ticking off sessions from their duty list, not really providing the kind of help I needed" (Maya).

The above transcripts indicate that the financial challenges faced by respondents, particularly in the post-divorce phase, impact both the affordability and quality of treatment. Not only does the availability of services depend on cost, but so does the quality. This is a critical concern, given that divorced women are already struggling with significant financial difficulties. The interview transcripts further highlight the subpar quality of services within the public health system, representing a significant aspect of structural violation in mental health.

> "I approached counselling centre because I felt overwhelmed and couldn't handle everything on my own. Maybe my education and job helped me seek support. Having a job and being financially independent made me realize it's okay to seek mental health support" (Aysha).

It's clear that how the education and employment emerge as pivotal factors enabling some to recognize the importance of seeking mental health help, while its absence make the others more vulnerable. For the women being financially independent due to their job or having a certain level of education serves as a lens through which they perceive seeking support as acceptable.

4.6 Social Stigmatization

The findings show that divorced women often face societal stigma, causing barriers to access and support to mental health treatment. The decision to seek mental health assistance post-divorce is frequently accompanied by layers of societal judgment and unwarranted perceptions. These women encounter a societal expectation to swiftly overcome emotional challenges, with any admission of mental health struggles viewed as a testament to failure or fragility. The following narrative embodies the stigmatization divorced women face regarding their mental health post-divorce.

> "When I signed the divorce papers, it felt like the world saw me through a different lens. Suddenly, I was labelled—a divorced woman. This judgement extended to my mental health too. There's this unspoken expectation to move on swiftly, and admitting to mental struggles feels like failure. The pressure to quickly 'bounce back' professionally after divorce added another layer of stress, even if I have enough financial resources" (Jaza).

This woman, even though she is a well-educated, earning women, encountered societal expectation to swiftly overcome emotional challenges, with any admission of mental health struggles viewed as a testament to failure or fragility. This judgements and labelling seemed to be making it harder for women to seek professional mental health support.

> "Being a divorced woman already carries a stigma, but as a divorced woman from low socio economic status the stigma surrounding mental health was magnified. It's like much harder to seek help without being judged" (Banumadhi).

Thus, it is clear that financial difficulties intensify the stigma of both being a divorcee and seeking treatment for mental health difficulties, where the women clearly feel judged by the surrounding society. The intersecting identities prevent them from seeking treatment needed.

4.7 Self-stigmatization

The study found that the internalized self-stigmatization that arises post-divorce also plays a role in preventing the women from seeking treatment. The structural violations in the system further exacerbate this self-stigmatization.

> "I felt ashamed to admit that I needed help. It was this nagging voice in my head, telling me I should handle it all on my own. I know that feeling all too well. I kept thinking seeking help meant admitting I couldn't cope, like it was a personal failure. I was being harsh to myself for not being strong enough to handle it independently. It felt like I was failing, both myself and others' expectations of me" (Jessica).

> "I constantly questioned if seeking help was a sign of weakness. It took a while to understand that seeking support was actually a sign of strength" (Sarah).

These dialogues showcases how structural limitations and societal norms contribute to the self-stigmatization divorced women experience when contemplating seeking mental health support. It highlights the intertwining of systemic barriers with internalized beliefs, creating doubts about the legitimacy of their emotional struggles and the worthiness of seeking help.

4.8 Empowerment through Disclosure

> "Yet, in the silence, I found courage. Slowly, tentatively, I began to share fragments of my struggles. It wasn't easy—I faced raised eyebrows, hushed whispersbut with each disclosure, I felt a weight lift. The stigma that once bound me started to lose its grip. Sharing my experiences became a source of strength, connecting me with others who understood the journey of post-divorce mental health" (Banumadhi).

Even though the structural violations surrounding the mental health treatment affect the divorced women seriously in many respects, the results of this study also showed that once the women start to receive quality treatment and services, it empowers them in the post-divorce phase. The narrative above showcases the experience of the woman who felt bolder and stronger after divorce and became independent once after breaking the silence around mental health post-divorce.

5 Discussion

This study investigated the structural violations in mental health equity faced by divorced women in Kerala, using a mixed-method approach. The results of the study, obtained through both quantitative and qualitative analyses, reveal structural violations that play a role in creating disparities in well-being. The intersecting identities of the respondents and the structural violations appeared to collaborate in worsening the challenges they encounter in mental health care.

Among the key findings of this study is the striking prevalence of depression, anxiety, and stress experienced by divorced women. The data shows a concerning trend wherein a substantial proportion of women encounter increased levels of mental health challenges after divorce. The prevalence rates underscore the profound impact of marital dissolution on psychological well-being. Studies previously confirmed that women are much more traumatized and stressed out by divorce (Albrecht, 1980), and the resulting sadness causes depression and anxiety (Amato, 2010; Hughes & Waite, 2009; Sbarra et al., 2012). Depression is more prevalent among those who did not initially report having major marital issues (Brown & Lin, 2012). The aftermath of divorce can leave her feeling isolated and doubting her worth, with worries that she lacks support or comfort from others (Rathi et al., 2018). Furthermore, compared to their married counterparts, divorced women were more prone to experiencing feelings of melancholy, anxiety, stress, loneliness, and social interaction anxiety. They also seemed to exhibited higher levels of anger (Zafar & Kausar, 2014). It was also shown that the degree of distress varies from person to person and is influenced by a number of factors such as education level, number of children, and financial hardship. Some women are more susceptible than others to the stress brought on by divorce, the strongest predictor being financial difficulty (Sabour Esmaeili et al., 2015).

The second major finding of the study indicates that women with higher educational qualifications, a more favourable financial background, and younger age are more inclined to seek treatment for their mental health issues compared to their counterparts. The qualitative analysis of in-depth interviews further revealed that there are factors indicative of structural

violations in mental health equity, such as geographical, financial, and informational barriers to treatment accessibility. In this context, better services are often accessible to a select few who can afford expensive private clinics, as the public sector frequently falls short in delivering quality services in mental health care. In fact, these barriers are observed not only in specific regions but in various low-income countries as well (Cooper et al., 2010). It has been observed previously in many studies, financial challenge exacerbates existing disparities, particularly impacting those in marginalized communities who may already face various socioeconomic hurdles (Hailemariam et al., 2016). As the present study findings indicate, women's socioeconomic class contributes to these preexisting structural violations in mental well-being, where women of lower class face more challenges in accessing treatment. The qualitative analysis of in-depth interviews revealed that many women faced a lack of social and financial capital after divorce, placing them in a lower social class. In fact, social class is observed to have a crucial role in mental health equity (Simandan, 2018).

The findings also demonstrated that the women's identity as divorcees intersected with their class and gender, intensifying mental health inequality and pre-existing structural violations in mental health treatment. Gender exacerbates the gap between the prevalence of mental health issues and their treatment utilization (Kiely, 2019), where there is an underrepresentation of women in seeking mental health support due to the insufficient resources available to them (Barbieri et al, 2021; Hadjimina & Furnham, 2017). Women's marital status as a divorcee is also found to be acting as a major factor shaping the structural violations of mental health equity (Mahmoudpour, 2022; Waseem et al, 2020). As the present study results show, the structural violations can be aggravated by the intersections of all these factors, including the gender, class, and marital status of women.

This study also highlights the presence of social stigma and the resulting self-stigma as significant structural violations in mental health equity. These forms of stigma create formidable barriers to accessing and receiving adequate mental health care. Self-stigma, where individuals internalize negative stereotypes about mental health conditions, often leads to shame and reluctance to seek help (Crowe et al., 2018). This can significantly impact the well-being of divorced women, creating obstacles in maintaining and enhancing their mental health. When internalized, this stigma generates feelings of failure, shame, and guilt among these women (Konstam et al., 2016). Meanwhile, social stigma perpetuates discrimination and marginalization of those with mental health issues, hindering their integration into society and access to support systems (Brouwers, 2020). Addressing these stigmas is crucial in promoting a more inclusive and equitable mental health landscape where individuals, especially the divorced women, feel empowered to seek assistance without fear of judgment or discrimination.

In India, barriers to accessing mental health care services result in part from the noticeable gap in the mental health care programmes of the country with a stark shortage of mental health care professionals including psychiatric social workers. In 2011, a WHO report highlighted a stark shortage of mental health professionals in India, with just three psychiatrists per million people, and even fewer psychologists, which is 18 times below the Commonwealth norm of 5.6 psychiatrists per 100,000 people (WHO, 2021). Kerala, while having a higher number of psychiatrists per thousand population compared to the Indian average, still faced shortages in clinical psychologists, psychiatric social workers, and lacked psychiatric nurses. Particularly in the public sector, the deficit of mental health professionals was acute (Shaharban, 2018). A 2013 assessment revealed district-level shortages, with 75%

of psychiatrist positions vacant in Malappuram and Palakkad districts (Nandraj, 2016). Psychiatric social workers, who generally work as part of a mental health care team, reports professional challenges besides the shortage, which is reflected in their service (Paul, 2018). In India, the poorly defined role of social workers, particularly in mental health care, hinders their effectiveness and leaves many unaware of how to utilize psychiatric social workers for mental health support (George& Krishnakumar, 2014; Agnimitra & Sharma, 2023).

This shortage, in turn makes the mental health care services a costly affair, since people have to rely on private hospitals and clinics (Balagopal et al, 2019). This can be one of the major factors that refrain divorced women from seeking treatment, since most of them are in a disadvantaged socioeconomic status, especially in the post-divorce phase. Divorced women face compounded stigma, as they endure both the social stigma of being divorced and the stigma associated with seeking mental health support. Despite Kerala's reputation as a progressive state in many ways, it continues to report high levels of stigma and discrimination against divorced women and those seeking mental health care (James & Kutty, 2015; Raghavan et al., 2023). This significant social barrier is another factor discourages women from seeking mental health support.

Addressing these shortages requires comprehensive measures, including training healthcare professionals at the primary level and equipping non-specialist healthcare providers with appropriate skills (Kandeger et al., 2018).

5.1 Addressing Mental Health Equity: Way Forward and Insights for Implications

Policy and Practice Implications

Addressing mental health disparities among divorced women requires policy changes and targeted interventions. Social workers, alongside governmental and non-governmental organizations, can play a pivotal role in advocating for and implementing these changes. This involves advocating for policies that diminish societal stigmas around mental health help-seeking behaviour and promoting acceptance and understanding. Additionally, collaborative efforts with supporting systems can be instrumental. Social workers can work alongside healthcare institutions, legal entities, and community organizations to lobby for policy reforms aimed at increasing accessibility to affordable and specialized mental health services tailored to the unique challenges faced by divorced women. Comprehensive legislative changes that address financial insecurities, custody battles, and social stigmatization related to divorce are vital, aiming for a holistic support system for mental health.

Social Work Education Implications

Preparing social workers to effectively address the mental health needs of divorced women involves tailored education and training programs. Collaborative partnerships with educational institutions, mental health facilities, and community-based organizations are crucial. Incorporating cultural competency and trauma-informed approaches into social work curriculums ensures future practitioners understand diverse experiences and needs. Collaborative efforts can foster advocacy skills, equipping social workers with the tools needed to champion policy reforms and challenge systemic barriers in mental health care.

Social Work Practice Implications

Implementing a range of vital social work methods that prioritize the needs of divorced women is crucial. This includes employing empowerment-based strategies that foster resilience and self-advocacy among divorced women, allowing them to regain control over their mental health journey. Additionally, utilizing a strengths-based approach to identify and leverage the capabilities of these individuals aids in navigating mental health challenges. Collaborating with supporting systems such as legal entities, healthcare providers, and community organizations is essential. This collaborative approach fosters a holistic and comprehensive support network. Furthermore, active engagement in systemic advocacy to dismantle structural barriers and improve mental health resources is fundamental in promoting mental health equity. By employing these critical social work methods within their practice, social workers can effectively address the mental health needs of divorced women, advocate for systemic changes, and strive towards a more equitable mental health landscape.

6 Conclusion

Through the lens of feminist perspective and intersectionality, this study delved into the mental health status of divorced women in Kerala, and the structural inequalities shaping their treatment seeking behaviour. Unveiling the prevalence of depression, anxiety, and stress among this demographic, the findings spotlight the systemic challenges they face in seeking essential mental health support. The feminist perspective sheds light on the intricate web of societal norms and systemic barriers that impede divorced women's agency in accessing mental health resources. It uncovers the intersecting layers of oppression, gender biases, and social constraints that compound their mental health struggles. Moreover, the study reveals the limitations and structural violations within the existing support systems, perpetuating the marginalization of divorced women. It underscores the urgency of feminist-oriented interventions aimed at challenging societal norms, rectifying systemic biases, and empowering these individuals to navigate their mental health journey autonomously. Moving forward, a feminist approach demands systemic reforms, amplification of voices, and tailored interventions that centre on dismantling the structural barriers hindering access to mental health support for divorced women. Advocating for inclusivity, gender sensitivity, and intersectional awareness within mental health services becomes pivotal in ensuring equitable care. In conclusion, this study advocates for a paradigm shift embedded in feminist principles, calling for systemic changes that prioritize the empowerment and well-being of divorced women. It champions a future where mental health support is inclusive, gender-responsive, and reflective of the diverse needs of all individuals within society.

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Conflict of interest

There are no conflicts of interest.

Ethical consideration

This study was conducted in accordance with relevant ethical standards, ensuring participant confidentiality, obtaining informed consent, and disclosing any conflicts of interest.

References:

Agnimitra, N., & Sharma, S. (2023). Social work in difficult times: Emerging value frame in India. *Social Work Education*, 42(5), 710-727. https://doi.org/10.1080/02615479.2022.2088726

Albert, P. R. (2015). Why is depression more prevalent in women? *Journal of Psychiatry and Neuroscience*, 40(4), 219-221. https://doi.org/10.1503%2Fjpn.150205

Albrecht, S. L. (1980). Reactions and Adjustments to Divorce: Differences in the Experiences of Males and Females. *Family Relations*, 29(1), 59. https://doi.org/10.2307/583717

Balagopal, G., & Kapanee, A. R. M. (2019). *Mental Health Care Services in Community Settings*. Springer Singapore.

Brown, S. L., & Lin, I. F. (2012). The gray divorce revolution: rising divorce among middle-aged and older adults, 1990-2010. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, 67(6), 731–741. https://doi.org/10.1093/GERONB/GBS089

Cooper, S., Ssebunnya, J., Kigozi, F., Lund, C., & Flisher, A. (2010). Viewing Uganda's mental health system through a human rights lens. *International Review of Psychiatry*, 22(6), 578–588. https://doi.org/10.3109/09540261.2010.536151

Dako-Gyeke, M., & Asumang, E. S. (2013). Stigmatization and discrimination experiences of persons with mental illness: Insights from a qualitative study in southern Ghana. *Social Work and Society*, 11(1), 1–14.

Equit, C., Euteneuer, M., & Uhlendorff, U. (2022). Single mothers figuring out their future family life – understanding family development after separation and divorce drawing upon the concept of configuration. *Social Work and Society*, 20(1), 1–16.

Freeman, M., Pathare, S., & WHO. (2005). WHO resource book on mental health, human rights and legislation: stop exclusion, dare to care /: [principal writers, Melvyn Freeman and Soumitra Pathare]. *World Health Organization 2005*, 1–199. https://digitallibrary.un.org/record/565952

Galtung, J. (1969). Violence, Peace, and Peace Research. *Journal of Peace Research*, 6(3), 167–191. https://doi.org/10.1177/002234336900600301

George, M., & Krishnakumar, J. (2014). Revisiting the Landscape of Professional Social Work in India. *Social Development Issues (Follmer Group)*, 36(2).

Gupta, S. (2021). The role of policy and legislation in mental health care. *Indian Journal of Social Psychiatry*, 37(2), 230–234. https://doi.org/10.4103/ijsp.ijsp_160_21

Gururaj, G., Varghese, M., Benegal, V., Rao, G. N., Pathak, K., Singh, L. K., ... & Misra, R. (2016). National mental health survey of India, 2015-16: Mental health systems. Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS Publication, (130).

Hailemariam, M., Fekadu, A., Selamu, M., Medhin, G., Prince, M., & Hanlon, C. (2016). Equitable access to integrated primary mental healthcare for people with severe mental disorders in Ethiopia: A formative study. *International Journal for Equity in Health*, 15(1), 1–10. https://doi.org/10.1186/s12939-016-0410-0

Hughes, M. E., & Waite, L. J. (2009). Marital Biography and Health at Mid-Life. *Journal of Health and Social Behavior*, 50(3), 344. https://doi.org/10.1177/002214650905000307

James, T. T., & Kutty, V. R. (2015). Assessment of internalized stigma among patients with mental disorders in Thiruvananthapuram district, Kerala, India. *Asia Pacific Journal of Public Health*, 27(4), 439-449. doi: 10.1177/1010539514545645

Kandeger, A., Guler, H. A., Egilmez, U., & Guler, O. (2018). Major depressive disorder comorbid severe hydrocephalus caused by Arnold – Chiari malformation Does exposure to a seclusion and restraint event during

clerkship influence medical student' s attitudes toward psychiatry? *Indian Journal of Psychiatry*, 59(4), 2017–2018. https://doi.org/10.4103/psychiatry.IndianJPsychiatry

Kausar, R., & Nida, Z. (2018). Emotional and Social Problems in Divorced and Married Women. *FWU Journal of Social Sciences*, 8(1), 31–35.

Konstam, V., Karwin, S., Curran, T., Lyons, M., & Celen-Demirtas, S. (2016). Stigma and Divorce: A Relevant Lens for Emerging and Young Adult Women? *Journal of Divorce and Remarriage*, 57(3), 173–194. https://doi.org/10.1080/10502556.2016.1150149

Maar, M. A., Manitowabi, D., Gzik, D., McGregor, L., & Corbiere, C. (2011). Serious complications for patients, care providers and policy makers: Tackling the structural violence of first nations people living with diabetes in Canada. *International Indigenous Policy Journal*, 2(1). https://doi.org/10.18584/iipj.2011.2.1.6

Malhotra, S., & Shah, R. (2015). Women and mental health in India: An overview. *Indian Journal of Psychiatry*, 57(Suppl 2), S205. https://doi.org/10.4103/0019-5545.161479

Michael, Elizabeth Lovely Mary. (2013). *A study on the psychological wellbeing and quality of life of divorced Muslim women* (Doctoral dissertation, Mahatma Gandhi University, Kerala, India).

Paul, S. (2018). Are we doing enough? Stigma, discrimination and human rights violations of people living with schizophrenia in India: Implications for social work practice. *Social Work in Mental Health*, 16(2), 145-171. https://doi.org/10.1080/15332985.2017.1361887

Premsingh, J. G., & Philip, S. R. (2014). A Study on Increasing the Divorce Rate in Kerala. *IOSR Journal of Humanities and Social Science*, 19(6), 58–60. https://doi.org/10.9790/0837-19615860

Price, S. J., & McKenry, P. C. (n.d.). D*ivorce*. Retrieved November 10, 2023, from https://psycnet.apa.org/record/1988-97728-000

Rathi, P., Pachauri, J., & Pooja Rathi, C. (2018). Problems faced by divorced women in their pre and post-divorce period: A sociological study with reference to District Meerut. ~ 207 ~ *Journal of Pharmacognosy and Phytochemistry*, 7(1), 207–212.

Sabour Esmaeili, N., Yaacob, S. N., Juhari, R., & Schoebi, D. (2015). Predictors of Psychological Distress Among Divorced Women in Iran. *Journal of Divorce & Remarriage*, 56(3), 248–259. https://doi.org/10.1080/10502556.2015.1012700

Sbarra, D. A., Hasselmo, K., & Nojopranoto, W. (2012). Divorce and Death: A Case Study for Health Psychology. *Social and Personality Psychology Compass*, 6(12), 905–919. https://doi.org/10.1111/SPC3.12002

Sinha P, Gupta U, Singh J, S. A. (2017). Structural violence on women: An impediment to women empowerment. *Indian Journal of Community Medicine*, 42(1), 147–150. https://doi.org/10.4103/ijcm.IJCM

Trivedi, J., Sareen, H., & Dhyani, M. (2009). *Psychological Aspects of Widowhood and Divorce. Mens Sana Monographs*, 7(1), 37. https://doi.org/10.4103/0973-1229.40648

V, Shaharbana. (2018). Right to Health and Role of Mental Health Institutions in Kerala. *SSRN Electronic Journal*, November. https://doi.org/10.2139/ssrn.3153420

WHO Team. (2021). Mental Health Atlas 2020. In *WHO Publication*. https://www.who.int/publications/i/item/9789240036703

Zafar, N., & Kausar, R. (2014). *Emotional and Social Problems in Divorced and Married Women*.

Author´s Address:
Fathima Sherin Ottakkam Thodukayil
Department of Social Work, Central University of Tamil Nadu

Thiruvarur, Tamil Nadu, India, 610104
fsherinot@gmail.com

Author´s Address:
Rahana Salahudeen Raseena
Department of Social Work, Central University of Tamil Nadu
Thiruvarur, Tamil Nadu, India, 610104
rahanasr20@gmail.com

Author´s Address:
Udhayakumar Palaniswamy
Department of Social Work, Central University of Tamil Nadu
Thiruvarur, Tamil Nadu, India, 610104
pudhayakumar@cutn.ac.in

Author´s Address:
Sigamani Panneer
Centre for the Study of Law and Governance, Jawaharlal Nehru University
New Delhi, 110067
sigamani@mail.jnu.ac.in

Author´s Address:
Sainaba Parammal
Department of Psychology, SRM Institute of Science and Technology
Vadapalani, Chennai, 600026
zeinabazeinba@gmail.com