

Marital Distress as a Social Determinant of Women's Mental Health in Kashmir

Razia Malik¹, Dr Lalhmingmawii Gangte²

¹PhD Research Scholar, Department of Social Work, Jamia Millia Islamia, New Delhi

²Assistant Professor, Department of Social Work Jamia Millia Islamia, New Delhi

Abstract

Background: Marital distress among women in Kashmir constitutes a significant yet underexplored public health concern. While existing literature documents the broader association between marital quality and women's mental health across South Asia, the specific conflict dynamics and social determinants operating within distressed Kashmiri marriages and their direct consequences for women's psychological wellbeing have received limited systematic attention. This paper addresses that gap by examining what couples actually fight about, how those conflict points are narrated differently by each partner, and how they translate into measurable mental health harm for women.

Objectives: The study has two primary objectives: (1) to identify and document the key points of conflict between distressed couples in Kashmir, examining how these conflicts are experienced and narrated by women and men separately; and (2) to analyse the social determinants embedded within these conflict patterns and trace the pathways through which they produce adverse mental health outcomes for women.

Methods :A qualitative-led mixed-methods design was employed. Data were collected from 30 distressed couples (60 respondents: 30 women and 30 men) recruited from the Women Police Station, Anantnag, Kashmir, where they had registered marital dispute cases. Both partners were interviewed separately using a semi-structured thematic questionnaire and in-depth narrative interviews. Data was analysed using Braun and Clarke's (2006) six-phase thematic analysis, with separate analytical streams for women's and men's accounts before integration. Descriptive frequency mapping supplemented qualitative analysis.

Findings:Five key conflict domains were identified: unequal domestic labour and its denial; in-law interference and hierarchical enforcement; spousal non-recognition and symptom misattribution; male unemployment and displaced control; and infidelity with projected suspicion. Women's and men's accounts of the same conflicts diverged systematically what men narrated as causes of marital problems were, when read against women's accounts and situated within the Social Determinants of Health framework, the mental health consequences of structural conditions producing their distress. Women's mental health outcomes chronic anxiety, depression, cognitive overload, somatic complaints, and loss of identity were directly traceable to these conflict-embedded social determinants.

Conclusion: Marital conflict in Kashmir is not primarily an interpersonal phenomenon but a structurally produced condition whose specific dynamics function as social determinants of women's mental health. Social work practice, institutional mediation systems, and public health policy must address these structural roots rather than managing individual symptoms or counselling women to endure the conditions harming them.

1. INTRODUCTION

Marriage is a major social institution affecting women's health worldwide. A significant amount of international evidence suggests that the quality of the marital relationship is one of the most accurate indicators of women's mental health, often surpassing the predictive ability of income, education, or employment status (Proulx, Helms,&Bueher,2007).

The relationship is especially significant in societies where a woman's social status,economic security and moral values are connected to her marital status. Women who lack independent resources and whose social survival is contingent on the maintenance of marriage are structurally vulnerable to the mental health consequences of marital distress in ways that men, who possess greater social and economic alternatives, are not. The Social Determinants of Health (SDH) framework provides a conceptual basis for understanding marital distress as not only an interpersonal problem between two individuals but as a structurally produced condition (Marmot & Wilkinson, 2006; World Health Organisation, 2008). The social determinants of women's psychological wellbeing are related to the conditions under which marriage is formed, sustained and experienced, such as gender norms, economic arrangements, household power structures and family authority systems. When these conditions systematically disadvantage women, marital distress is not a private misfortune. It is a socially produced and therefore addressable public health concern.

In Kashmir, marriage has a strange social significance, far beyond the union of two persons. Marriage is among the most significant social institutions that influence women's lives in the region, since her identity, her position in her community, her financial security, and her moral worth are all essentially defined by whether she is married (Hamid, 2017). Women are expected to accept marital problems silently and to prioritize the continuation of the marriage over their own wellbeing, in line with what Kandiyoti (1988) describes as the 'patriarchal bargain', in which women accommodate oppressive structures as a rational survival approach in systems where there is no viable alternative. Social pressure to maintain marital compliance is applied at every level, from the household and extended family to formal institutions (Niaz, 2004). The specific features of Kashmiri social life including the prevalence of patrilocal joint family arrangements in which the bride settles in the husband's household (Chauhan, 2015), women's near-total economic dependency on husbands or in-laws (Patel, Rodrigues, & DeSouza, 2002), the authority of the mother-in-law within domestic hierarchies (Allendorf,2017), and the stigma surrounding marital disclosure that prevents women from seeking help create a distinct configuration of social determinants that shapes how marital conflict is generated, experienced, and responded to (Niaz,2004).

2. LITERATURE REVIEW

Marital distress is increasingly recognized as a social determinant of health shaped by gender inequalities, economic conditions, family structures, and power imbalances. The review draws on global, South Asian and Kashmiri literature to examine six inter-related dimensions of marital distress and its impact on women's mental health. Women's mental health and marital quality, conflict Low marital quality is consistently associated with psychological distress and reduced wellbeing. A meta-analysis by Proulx, Helms and Buehler (2007) of 93 studies found a significant relation between marital quality and personal wellbeing, with stronger effects for women. In a 16-year longitudinal study, Shrout et al. (2019) also found that the cumulative effects of marital disagreements were particularly harmful to wives' health. Poor marital relationships and economic deprivation were found to be important predictors of postnatal depression in India (Patel et al, 2002). Taken together, these findings suggest that marital distress is a

strong predictor of women's mental and physical health. Marital Conflicts in South Asian Context In South Asia, financial dependence, gendered expectations, low autonomy and family pressures shape marital distress. Niaz (2004) reported that conflicts with husband and in-laws were one of the major reasons of women's psychological morbidity in Pakistan. But the social and relational pathways through which marital distress impacts the health of Kashmiri women are not well understood. The main reason for women's mental strain is the unequal division of domestic labor. Hochschild and Machung (1989) used the term second shift to describe the extra load of housework. Recently, Carneiro et al. (2023) linked The work-family conflict and inequalities in domestic labor have been linked to common mental disorders among women(Carneiro et al.2023). In addition to physical labour, the cognitive load of planning and managing household tasks can also be a source of stress and emotional exhaustion, especially when women's labor is unrecognized. In-law Interference and the Joint Family System Studies in South Asia have shown the impact of joint families and hierarchical relationships on women's well-being and autonomy. Allendorf (2017) shows how patrilocal family arrangements shape the mother-in-law/daughter-in-law relationship through unequal authority and domestic expectations. Similarly, Khanna and Khatri (2021) associated women's psychological distress with pressures of a joint family, lack of spousal support, and domestic pressures. The findings provide a useful framework to understand the role of in-law interference in marital distress in the sociocultural context of Kashmir. Economic hardship, domestic violence and male unemployment "Economic insecurity breeds marital discord and gendered power imbalances. Male unemployment was associated with more physical violence against women. The findings indicate that unemployment may affect marital distress not only in terms of financial hardship but also in terms of gendered provider expectations and attempts to maintain domestic control. Spouses' non-recognition, epistemic injustice and help-seeking Husbands who trivialize or minimize women's emotional needs and health concerns can compound women's psychological distress. Fricker (2007) conceptualizes such dismissal as a type of testimonial injustice, whereby people are viewed as less credible because of their social status. Jack (1991) further showed how women's depression can be mediated through the suppression of emotional needs in an effort to preserve relationships. Stigma and social expectation were identified as barriers to help seeking for distressed women in South Asia (Niaz, 2004). Such mechanisms may impede detection, support, and intervention and thus prolong the health consequences of marital distress.

Research specifically examining the social determinants of marital conflict and their mental health consequences for women in Kashmir remains sparse. The present paper addresses this gap directly, drawing on data from both partners in 30 distressed couples to document what couples fight about, how those conflicts are narrated differently from each side, and how the structural conditions embedded within those conflicts translate into adverse mental health outcomes for women.

3. Research Objective

This paper has two primary objectives: 1. To identify the main domains of conflict between distressed couples in Kashmir, and how are these experienced and narrated differently by women and men? 2. To analyse the social determinants embedded within these conflict patterns, and how do they produce adverse mental health outcomes for women in distressed marriages?

4. Theoretical framework

4.1 Social Determinant of Health Framework

The Social Determinants of Health framework holds that the social conditions in which people are born, grow, live, work, and age fundamentally shape health outcomes (Marmot & Wilkinson, 2006). The WHO Commission on Social Determinants of Health (2008) argues that these structural conditions, not individual behaviour or biology, drive health inequities. This paper applies the SDH framework to propose that marital conflict domains are themselves social determinants: identifiable, structural conditions unevenly distributed across the population that produce measurable mental health harm. This reframing has significant implications for social work practice and policy, since it directs intervention toward structural change rather than individual adaptation.

4.2 Kandiyoti's Patriarchal Bargain

Kandiyoti's (1988) theory of the patriarchal bargain describes the strategies women develop within patriarchal systems to maximise security and minimise harm given the structural constraints they face. In classic patriarchy characteristic of South and East Asian societies, women's best survival strategy is to accommodate and reproduce patriarchal norms, since resistance carries severe social costs. Applied to the Kashmiri context, this framework explains why women endure conflict conditions that harm their mental health without disclosure or resistance: not because they lack agency or awareness, but because the social structure around them makes accommodation the least costly available option. The cultural expectation that women will save marriages through tolerance and patience is not merely a personal belief held by individual women; it is the behavioural prescription produced by a system in which women's social survival depends on marital continuity (Kandiyoti, 1988).

4.3 Epistemic Injustice

Fricker's (2007) concept of testimonial injustice the deflation of a person's credibility as a knower of their own experience, based on their social identity provides a critical theoretical frame for one of this paper's most important findings. When women's mental health symptoms are systematically reframed by husbands and in-laws as character flaws, personality failures, or moral deficiencies, they are not simply being misunderstood. They are being subjected to epistemic injustice: a social practice that removes their authority over their own experience and actively prevents symptom recognition, help-seeking, and recovery.

5. RESEARCH METHODOLOGY

5.1 Research Design and Paradigm

This study employs a qualitative-led mixed-methods design, situating the research within an interpretivist-constructivist paradigm with an explicit feminist epistemological commitment. The primacy of qualitative data reflects the nature of the research questions: understanding how conflict is experienced, narrated, and made meaningful by both partners in a distressed marriage demands depth, context, and attention to language and meaning that quantitative methods cannot provide. Descriptive frequency mapping of key conflict indicators and mental health symptom domains supplements qualitative findings with empirical breadth, making patterns legible to public health and policy audiences.

5.2 Research Setting

Participants were selected from the Women Police Station (WPS), Anantnag, Kashmir which is a formal state institution established to provide women with access to a dedicated space for registering cases of marital and domestic dispute. The WPS resolves cases primarily through mediation and reconciliation.

During the course of data collection, the institutional approach to mediation was observed to be predominantly patriarchal in character: women were typically counselled to save the marriage through endurance, tolerance, and patience, while the structural conditions generating their distress were not addressed. This institutional observation, while not the primary focus of this paper, contextualises the social environment within which participants were navigating their marital difficulties.

5.3 Sampling

The sample comprises 30 distressed couples 60 respondents in total, 30 women and 30 men, all of whom had registered marital dispute cases at the WPS, Anantnag. Both partners in each couple were interviewed separately. Purposive criterion based sampling was used; inclusion required both partners' willingness to participate, current marital distress (evidenced by WPS registration), age above 18, and informed consent.

Characteristic	Women (n=30)	Men (n=30)
Age range	22 – 46 years	24 – 52 years
Educational attainment	Primary to postgraduate	Primary to postgraduate
Employment status	91% economically dependent	43% unemployed or underemployed
Household type	70% joint family	70% joint family
Duration of marriage	2 – 20 years	2 – 20 years

5.4 Data Collection

Data was collected through two complementary instruments administered separately to each partner. A semi-structured thematic questionnaire explored key conflict domains: household labour division, in-law interference, economic conditions, spousal recognition, mental health, and help-seeking. Afterwards, in-depth narrative interviews were conducted where participants were asked to expand on their experiences in their own words. All the interviews were conducted in Kashmiri or Urdu, audio recorded after obtaining consent, transcribed and translated into English. Ethical safeguards included voluntary participation, the right to withdraw, full confidentiality, and availability of support referral for any participant experiencing acute distress.

5.5 Data Analysis

The data from all 60 respondents was subjected to thematic analysis using Braun and Clarke's (2006) six-phase framework. Crucially, analysis proceeded in two parallel streams, one for women's accounts, one for men's accounts, before integration, enabling systematic comparison of how the same marriage is narrated differently by each partner. Over 180 initial codes were generated. Codes were grouped into candidate themes, reviewed against the full dataset, and refined iteratively. Descriptive frequency mapping quantified the prevalence of key conflict indicators and mental health symptom domains across the 30 cases.

6. FINDINGS

PART : KEY POINTS OF CONFLICT

Table 1 provides a summary of prevalence across the sample before the thematic analysis is presented.

Table 1: Prevalence of Key Conflict Indicators Across 30 Couple Cases

Conflict Domain	Women's Account (n=30)	Men's Account (n=30)	Overall (n=30 couples)
Unequal domestic labour and its denial	92% reported sole responsibility for all household work	87% described housework as entirely the wife's role	93%
In-law interference	80% reported significant in-law interference in marital life	63% acknowledged in-law involvement; 37% aware it harms wife	80%
Spousal non-recognition of needs	90% reported husband does not acknowledge her needs or mental health	80% described wife's distress responses as personality problems	90%
Male unemployment and displaced control	43% of cases involved husband's unemployment or underemployment	57% of unemployed husbands raised wife's mobility as a conflict point	43%
Infidelity with projected suspicion	23% reported suspected or confirmed extramarital relationship		23%

6.1 Unequal Domestic Labour and its Active Denial

Women's Accounts: The Weight of Invisible

The most pervasive conflict domain across all the cases was the total and unacknowledged responsibility borne by women for all domestic labour: cooking, cleaning, childcare, managing the household's daily logistics, and the continuous invisible cognitive work of anticipating and organising every aspect of family life. Present in 92% of cases, this conflict was described not simply as exhaustion from physical labour but as a profound sense of injustice, the experience of performing visible, necessary, demanding work that is simultaneously denied to be work at all. Women described body aches, tiredness, and fatigue as constant companions and described those very symptoms being weaponised against them rather than generating sympathy or recognition. The specific phrase that appeared across multiple interviews with near identical formulation was spoken by in-laws in response to women's physical complaints: Most commonly reported by participants: "*Ye kyah cxe asan karan*".(What does she even do?)

A mother-in-law, in response to wife's body ache after a day of household work would say this. This sentence is doing something theoretically precise. It is not an expression of ignorance. It is a social negation, the deliberate erasure of visible labour from the category of work that serves the structural function of maintaining the existing domestic division by denying that any alternative is warranted. The woman's aching body is not evidence that she is working; it becomes evidence that she is making excuses.

A related conflict arose when women asked their husbands for help with even a single household task, an act that in many cases triggered immediate escalation from the mother-in-law: “*Waen karei meon nechuv garich kaem*” (Now my son will do the household work).

This sentence encapsulates the structural logic of joint family patriarchy in a single phrase. Three mechanisms operate simultaneously. First, the husband’s primary identity is reasserted as son belonging to his mother and not as husband and partner. Second, household work is coded as categorically beneath a man to perform; it would be a humiliation of his masculine identity and by extension of the family’s honour. Third, the ‘scene’ is a public performance, designed to shame both wife and potentially compliant husband back into their prescribed positions. Women described the immediate mental health consequence of such moments with a formulation that appeared across multiple cases: “*Mai bahu hu ya naukrani*” (Am I a daughter-in-law or a maid).

This question is not merely an expression of hurt. It is a moment of critical consciousness, a woman recognising with complete clarity the structural position she occupies. She entered this family as a wife. She is functioning as unpaid domestic labour with no recognition, no rights, and no recourse. The regularity with which this specific formulation appeared across cases suggests it reflects not individual experience but a shared structural reality.

Men’s Accounts: The Naturalisation of Domestic Labour

Men’s accounts of household labour consistently framed it as the natural and self-evident domain of the wife, requiring no acknowledgement because it is simply what a wife does. The formulation that appeared most frequently was: “*Ye chi zanann hinz kaem. Amis chaeni wen yeti maklan. Zanh chunei kanh cheez panie jai asan*” (It is (women’s)her work. She never completes it properly. She doesn’t get the house in order).

The analytical significance of this account is not simply that the husband does not help, it is that he frames the wife’s incomplete performance of an impossible workload as a personal failure rather than as evidence that the workload itself is unreasonably distributed. She never completes it, does not raise the question of whether one person completing all of it is a reasonable expectation. It assigns the problem entirely to her. A smaller but analytically important subgroup of husbands, approximately 30% of the sample, showed awareness of the unfairness while remaining unable to act on it. One such husband stated: “*Mei chi pata garei chi amis sarei kaem pewan. Yemen chene ye insaan te basan. Magar tohei waniv be kyah kare wen,be chus tang aamut. Wen ma wath be maelis maje waps. Amis chus be samjavan cxe kar bardasht thoda yotaam aes alag rozaw*” (I know she has a lot of work. Her in-laws taunt her. They don’t treat her as a human being. But I am helpless, I cannot stand against my parents. She should tolerate for some time, and then we will live separately).

This account reveals a form of harm that is distinct from ignorance or cruelty: the harm of being seen and still left in suffering. This husband perceives his wife’s situation accurately too much work, taunted, not treated as human. Yet the solution he offers temporal deferral is indefinite at its core, and the wife bears the entire psychological cost of that indefiniteness.

Domestic labour conflict in these cases is not simply about who does the dishes. It is about whether women’s labour counts as labour, whether their exhaustion counts as exhaustion, and whether their request for help counts as a legitimate need. The systematic negation of women’s labour by both husbands and in-laws is the conflict’s defining feature, and its health consequences are direct: chronic overload, invalidation of physical symptoms, and the progressive erasure of the woman’s sense of her own reality.

6.2 In-Law Interference and Hierarchical Enforcement

Women's Accounts : The Joint Family as a Site of Structural Harm

In-law interference was reported as a significant source of marital conflict in 80% of cases and operated across multiple registers simultaneously: as a direct source of distress for women, as a structural amplifier of other conflict domains, and as a social mechanism enforcing the conditions producing those other conflicts. The mother-in-law occupied a particularly powerful position not as an incidental antagonist but as a structural enforcer of the domestic gender order, whose authority within the household depends on maintaining that order. Women described a lived experience of permanent evaluation within the joint household. Their habits, movements, social interactions, ways of speaking, food preparation, and management of children were all subject to constant commentary and assessment. Symptoms of psychological distress forgetting things, being anxious, being preoccupied or lost were a particular target of mockery: *"yeman kate chei samaj yiman maeni pareshaeni, yem chi asaan yel mei kanh cheez chu galat gasaan ya mashrap chum gasan. Yem chi mazak banavan sarne thei bei chi wanan amis chu ye adat yel boam chus aasan"* (My in-laws taunt me. When I forget something because my mind is full of worry, they make fun of me in front of everyone. They call it a bad habit and accuse that this happens because she is never happy. They don't think of it as anything to do with what I am going through.

The taunting of psychiatric symptoms as character defects poor memory reframed as bad habits, anxiety reframed as temperamental failure is what Fricker (2007) describes as testimonial injustice: the systematic denial of a person's credibility as a reporter of their own experience. The woman who is anxious because her life circumstances are objectively distressing is told she is simply careless. The epistemic authority of those who hold household power is asserted against her own knowledge of her experience.

Men's Accounts: The Son's Structural Bind

Men's accounts of in-law interference revealed a structural position of genuine complexity, particularly for the aware but paralysed husband. These men consistently described being caught between two obligations that the social structure around them had not equipped them to negotiate the loyalty to parents and care for wife. In a cultural framework that defines a son's relationship to his parents as primary and unconditional, asserting the primacy of the marital bond against parental authority is experienced not merely as inconvenient but as morally transgressive, a betrayal of one's most fundamental social duty. This structural bind does not excuse the harm it produces for women. But understanding it structurally as a product of a cultural framework that positions marriage as a contractual addition to natal family membership rather than a new primary bond is important for social work intervention. The husband who cannot stand against his parents is not simply weak or passive; he is navigating a social system that constructed his most fundamental loyalties before he married. In-law interference in these cases operates not merely as interpersonal conflict but as structural enforcement: the maintenance of the domestic gender order through the mother-in-law's authority, the social sanctions she deploys (taunting, shaming, scene-creation), and the husband's structural inability to prioritise the marital bond over natal family loyalty. Understanding this as a social determinant, not a personality clash, is essential for designing responses that address cause rather than symptom.

6.3 Spousal Non-Recognition and Symptom Misattribution**Women's Accounts: The Need That Goes Unheard**

Spousal non-recognition of women's needs was documented in 90% of cases describing the highest prevalence of any conflict domain and was described by women as one of the most damaging dimensions of their marital experience. Non-recognition operated at two levels: the failure to acknowledge legitimate needs and the active reframing of mental health symptoms as personality failures. Women described

repeatedly attempting to communicate distress, exhaustion, or need for support, and having those attempts met with dismissal, redirection, or silence. A particularly significant pattern was the experience of asking for the smallest acknowledgement of mental or physical difficulty a moment of recognition, a brief practical help, a word of understanding and being denied it. The psychological consequence of this sustained non-recognition is what Jack (1991) describes as the progressive erosion of self that precedes depression: the woman who internalises the social consensus that her needs are unreasonable gradually loses confidence in her own perception of her experience.

Men's Accounts — Symptoms Reframed as Character

Men's accounts of the same marital reality were strikingly consistent in their reframing of their wives' mental health symptom presentations as personality defects. Table 2 presents the systematic mapping between what husbands said and what those accounts describe when read clinically.

Table 2: Systematic Reframing of Mental Health Symptoms as Character Flaws by Husbands

What Husbands Said	Symptom Being Described	Clinical Framework
"She shouts and is always angry"	Anxiety response to chronic invalidation and cognitive overload	Anxiety disorder: irritability and emotional dysregulation
"She is never happy with me"	Depressive anhedonia and relational despair	Depression: persistent low mood and loss of pleasure
"She always complains"	Repeated, unheard attempts to communicate legitimate suffering	Communication of unmet need being denied social legitimacy
"She is always grumpy"	Persistent low mood across multiple days	Depression: sustained negative affect
"She doesn't get ready"	Loss of motivation and self-care	Depression: psychomotor slowing, loss of self-investment
"She is always lost"	Cognitive impairment from chronic anxiety and overload	Anxiety/depression: concentration difficulties, dissociation
"She forgets things"	Working memory disruption from sustained psychological distress	Cognitive impairment: a recognised feature of clinical depression

The pattern across these accounts is consistent and theoretically decisive. Every item in the left column represents a recognisable clinical indicator of depression or anxiety being described by the husband not as a health concern warranting care but as a character flaw warranting criticism. This is epistemic injustice (Fricker, 2007) in operation: the woman's authority over her own experience is systematically overwritten by the husband's social authority, which reframes her symptoms as evidence of who she is rather than what she is going through.

The mental health consequences of sustained symptom misattribution are compounded: not only does the underlying distress continue unaddressed, but the woman progressively loses confidence in her own account of her experience, unable to trust her perception of reality against the social consensus denying it. This is a pathway from structural harm to internalised self-doubt that is at once psychologically devastating and socially produced. The systematic reframing of women's mental health symptoms as character flaws constitutes a second-order harm layered on top of the primary structural conditions producing those symptoms. It prevents recognition, blocks help-seeking, and deepens distress all while appearing to the husband and in-laws as an entirely reasonable assessment. Naming this as epistemic injustice is not merely an academic exercise; it has direct implications for how social workers should respond when husbands and families describe distressed women.

6.4 Male Unemployment and Displaced Control

Women's Accounts :Managing a Husband's Crisis

Male unemployment or underemployment was present in 43% of cases and generated a distinct and specific conflict pattern that went beyond simple economic stress. Women in these cases described the additional burden of managing not only their own distress and household labour but their husband's psychological response to economic failure, absorbing his frustration, managing his moods, and navigating the heightened control that accompanied his diminished economic role outside the home. Women described husbands who, unable to fulfil the culturally prescribed provider role, intensified their assertion of authority within the domestic sphere as a compensatory mechanism. Restrictions on the wife's movement where she could go, when, and with whom became significantly more pronounced in cases involving unemployment. The woman's mobility was the domain over which the husband could still exercise control, and it was exercised accordingly.

Men's Accounts : Mobility, Compliance, and Masculine Authority

In cases involving unemployment, men's accounts of marital conflict showed a striking pattern: conflict was narrated not around financial stress or employment difficulties but around the wife's behaviour specifically her going out without permission, arguing with his parents, and failing to maintain expected standards of domestic compliance. The economic failure was not named; its compensatory expression in heightened domestic control was. One of respondents said that: "*Amis chi yehai problem, ye chi shoor karan zyade, deyi krake hangtemang, ases kuen gasun te naere wanei bagarei, ye chi buth khewan meanis maelis majie, agar be khabar kyah te kare amis chune lagan*" (My wife's problem is she shouts. She goes out without telling me. She argues with my parents. She is never satisfied with what I do).

Reading this account against the wife's narrative of the same marriage in which she describes absorbing his moods, managing a household alone, and being restricted in her movement, the displacement mechanism becomes visible. The conflict he narrates is her failure to accommodate his displaced need for control. The conflict she narrates is living under that control while her own needs go entirely unacknowledged. Male unemployment generates marital conflict through a specific mechanism: the destabilisation of masculine identity in a culture that ties male worth to the provider role, and the compensatory reassertion of authority over the wife's behaviour and mobility. Women in these cases carry a double burden. The existing conditions of domestic overload and non-recognition, plus the additional psychological labour of managing a husband's identity crisis without recognition of either.

6.5 Conflict Domain 5: Infidelity and the Reversal of Suspicion

Women's Accounts : The Impossible Double Burden

In 23% of cases, women described their husbands as engaged in or suspected of extramarital relationships,

combined with those same husbands directing unfounded suspicion toward them. This reversal the husband who suspects his wife of the behaviour he himself is engaged in is a documented psychological and social manoeuvre that serves multiple protective functions for the perpetrator: it deflects attention from his own conduct, destabilises the wife's social credibility, and places her in the position of defending herself in the arena where she would otherwise be the aggrieved party. The mental health consequences for women in these cases were among the most severe in the dataset. Women described living in a state of chronic hypervigilance constantly defending against accusations they know to be unfounded, managing the simultaneous pain of confirmed or suspected infidelity, and being unable to trust their own perceptions against the social reality being constructed around them. *"Mei chi sarei paii ye kyah chu asaan karan. Yel be kenh wanan chas, sorui chu mei khacxhan zemei. Mei chu basan be gase waen pagal"* (I know what he is doing. But when I try to speak about it, he turns everything around. Suddenly I am the one who is suspicious, I am the one with the problem. I started to think maybe I was going mad). The phrase 'I started to think maybe I was going mad' is clinically significant. It describes the internalisation of epistemic injustice at its most extreme: a woman whose accurate perception of her own reality is so persistently denied that she begins to doubt her own cognition. This is a recognised psychological consequence of sustained gaslighting, the systematic denial of a person's reality and its mental health consequences are severe and specific. Infidelity combined with projected suspicion is a conflict pattern that produces its own specific mental health profile: hypervigilance, self-doubt, erosion of reality-testing, and the compounded pain of being both the victim of infidelity and the accused party. It represents one of the most psychologically damaging configurations in the dataset.

PART B: WOMEN'S MENTAL HEALTH

The social determinants embedded within these conflict patterns have proven to translate into adverse mental health outcomes for women. This section describes this in Table 3, mapping each conflict domain to its social determinant mechanism and mental health outcome and then discusses narrative analysis of how the pathways operate in practice.

Table 3: Master Mapping — Conflict Domains to Social Determinants to Mental Health Outcomes

Conflict Domain	Social Determinant Mechanism	Psychological Pathway	Mental Health Outcome
Unequal domestic labour and its denial	Structural invisibilisation of women's labour; in-law enforcement of domestic order	Chronic cognitive overload; invalidation of physical symptoms; denial of legitimate suffering	Cognitive impairment ('always lost', forgetfulness); somatic complaints; emotional exhaustion; identity loss ('am I a daughter-in-law or a maid?')
In-law interference	Hierarchical joint family authority; epistemic delegitimation of	Permanent performance anxiety; no safe space for authentic expression; psychiatric symptoms	Anxiety; depression; shame; social isolation; eroded self-worth

	symptoms; surveillance	social mocked as character flaws	
Spousal non- recognition	Systematic failure to acknowledge needs; reframing of symptoms as personality defects	Progressive self-doubt; internalised self-blame; silencing the self (Jack, 1991)	Depression ('always grumpy', 'never happy'); loss of motivation ('doesn't get ready'); divided self; hopelessness
Male unemployment and displaced control	Economic precarity destabilising masculine identity; compensatory assertion of domestic control	Restricted autonomy; hypervigilance around husband's moods; double burden of domestic and emotional labour	Anxiety; somatic symptoms from sustained stress; loss of agency; cognitive overload
Infidelity and projected suspicion	Systematic denial of woman's reality; reversal of victim and perpetrator	Erosion of reality-testing; internalised doubt; hypervigilance	Severe anxiety; possible dissociation; cognitive dissonance; expressed as 'I thought I was going mad'

6.6 The Reversal at the Core: Causes Narrated as Effects

The table above makes visible a systematic reversal that runs through all five conflict domains and constitutes this paper's most important analytical contribution. What husbands and in-laws narrate as causes of marital problems the wife's anger, grumpiness, complaints, forgetfulness, emotional unavailability, and failure to perform her domestic role adequately are, when read against women's accounts and situated within the theoretical frameworks applied in this paper, the mental health outcomes of the structural conditions producing those problems. The woman shouts because her reality is chronically invalidated and her legitimate needs go systematically unacknowledged. She is 'always lost' because she is carrying an entire household's cognitive labour alone while managing the psychological weight of a distressed, unsupported marriage. She does not 'get ready' because she is experiencing the loss of motivation that is a recognised feature of clinical depression. She 'always complains' because her attempts to communicate legitimate suffering have been repeatedly denied any legitimacy. This reversal is not merely an interpretive disagreement between spouses. It is a social mechanism through which the structural conditions producing women's distress protect themselves from recognition. If her distress responses are her personality problem, then the conditions generating those responses require no attention. Naming this reversal explicitly, in social work assessments, in mediation settings, and in institutional practice is a prerequisite for any intervention that aspires to address causes rather than manage symptoms.

6.7 Mental Health Outcomes: Frequency Findings

Descriptive frequency mapping of mental health symptom domains across the 30 cases, coded systematically from both questionnaire and interview data, yielded the following prevalence figures. These are narrative-coded descriptive statistics, presented as indicators of probable symptom presence rather than clinical diagnoses.

Table 4: Mental Health Symptom Prevalence Among Women (n=30, Narrative-Coded)

Mental Health Symptom Domain	Cases Present	Percentage
Depression-related symptoms (persistent low mood, hopelessness, anhedonia, loss of motivation)	25	83%
Anxiety symptoms (persistent worry, restlessness, fear, hypervigilance)	24	80%
Cognitive impairment (forgetfulness, concentration difficulties, being 'always lost')	22	73%
Somatic complaints (body aches, headaches, sleep disruption, appetite changes, fatigue)	22	73%
Emotional numbing or detachment ('performing wellness' while suffering privately)	20	67%
Identity erosion ('am I a daughter-in-law or a maid?'; 'I have lost myself')	18	60%
Suicidal ideation (where spontaneously disclosed)	7	23%
Sought any form of help prior to WPS registration	8	27%
Aware of any available mental health or counselling service	4	13%

6.8 The Pathway from Conflict to Health in Women's Own Words

The connections between structural conflict conditions and mental health outcomes are not merely analytical constructions imposed from outside. They are lived, described, and articulated by women themselves who, in many cases, have developed a clear analytical understanding of how their circumstances are affecting them, without having any social space in which that understanding can be received, validated, or acted upon.

"Maein mouj chi wanan ye chu sarnai pewan wuchun, maeti chi sakhti amich waerve. Khandar chu ye asan. Bardasht pewan karun. Guzaar pewan karun. Be chas sonchan guzar kath set kare be yel ne mei kanh muzraie chi yuoet karith. Mei makleow sehat bei chem wanan ye kyah chi karan, aeth peth kara be guzaar?" (My mother told me that every woman suffers. She suffered. Her mother suffered. This is what marriage is. You adjust. But I ask myself, adjust to what? To feeling like nothing? To being told I do nothing? To my body hurting and being told I am making excuses? I don't know who I am anymore.) This account traces the full pathway from structural condition to mental health consequence in a single narrative arc. The cultural valorisation of women's endurance transmitted across generations from mother to daughter is named. The specific conflict content the denial of labour, the invalidation of symptoms is named. And the outcome loss of identity, loss of self-knowledge, loss of the sense of being a person with coherent worth and existence is named with extraordinary precision. I don't know who I am anymore' is not a poetic expression of sadness. It is a clinical description of the self-fragmentation that Jack (1991) identifies as the endpoint of sustained self-silencing within a distressed marriage.

7. DISCUSSION

7.1 Marital Conflict as Social Determinant: What This Study Establishes

This study establishes, through systematic couple-level data from a Kashmiri context, that the specific domains of marital conflict documented here are not merely interpersonal disagreements. They are social determinants of women's mental health: structural conditions identifiable at the level of household organisation, cultural norm, and economic arrangement that produce predictable and measurable patterns of psychological harm for women. The WHO Commission on Social Determinants of Health (2008) calls for action on the structural conditions that drive health inequities. This study demonstrates that the marital household and specifically the patriarchal organisation of labour, authority, recognition, and economic power within it is one such structural condition. The study's most important contribution is its documentation of the systematic reversal between cause and effect in how marital conflict is understood by different actors within the same marriage. This reversal through which the mental health outcomes of structural conditions are reframed as the causes of those conditions is not incidental. It is a social mechanism through which structural harm reproduces itself by hiding within the victim's supposed personality. Social work practice, to be structurally effective, must be equipped to name and interrupt this reversal.

7.2 Limitations

Several limitations must be acknowledged. The sample of 30 couples, recruited from a single institutional setting, is not statistically representative of the broader population of distressed couples in Kashmir. Recruitment through the Women Police Station means the sample captures couples whose distress has reached the threshold of formal institutional intervention, potentially missing couples in earlier stages of distress or those who could not or did not access this institution. The narrative-coded symptom prevalence figures are descriptive and should not be treated as clinical diagnostic data. The researcher's social location within the Kashmiri context, while providing cultural and linguistic access, requires sustained reflexive vigilance.

8. IMPLICATIONS FOR SOCIAL WORK PRACTICE AND POLICY

8.1 For Social Work Practice

Structural assessment before individual intervention : Social workers must routinely assess the structural conditions within which marital distress is occurring domestic labour division, spousal recognition, in-law interference, economic dependency before or alongside any individual therapeutic work. A woman whose distress is structurally produced will not be served by approaches that address her responses to that structure while leaving the structure intact.

Training in symptom recognition and epistemic justice: Frontline social workers and healthcare professionals must be equipped to recognise mental health symptoms presenting in women's accounts of marital conflict, and to name symptom misattribution when it occurs. When a husband describes his wife as 'always grumpy' or 'never completing her work,' a trained practitioner should be asking about her mental health not adjudicating her performance.

Differentiating between husband positions: Social work practice with couples must distinguish between the deflecting husband (requiring consciousness-raising and accountability), the aware-but-paralysed husband (requiring structural and relational support to act on what he already knows), and the deflecting-through-suspicion husband (requiring both accountability work and safety planning for the wife). These are not the same situation and should not receive the same response.

Engaging in-laws structurally, not individually: Interventions addressing marital distress that exclude in-laws are structurally incomplete in joint family contexts. Social workers must develop skills for engaging the mother-in-law as a structural agent whose own position within the patriarchal household system may be a site for productive engagement, not merely a source of interpersonal conflict.

8.2 For Institutional Practice

The Women Police Station mediation model, as observed in this study, requires critical examination. Counselling women to endure, tolerate, and save their marriages without simultaneously addressing the structural conditions producing their distress or ensuring husbands and families are held accountable reproduces the patriarchal logic that makes the marriages dangerous to women's mental health. This is not a failure of individual counsellors; it is a failure of the institutional framework, which prioritises reconciliation as an outcome over women's safety and mental health as the primary measure of success. Recommendations for the WPS include: systematic mental health screening for women at the point of case registration; referral pathways to social work and mental health support independent of the mediation outcome; mandatory gender-responsive and trauma-informed training for all mediation staff; and a fundamental reorientation of the institutional success metric from 'couple reconciled' to 'woman safe, supported, and informed of her options.'

8.3 For Policy

At the policy level, three recommendations follow directly from this study's findings. First, marital and relational wellbeing indicators should be incorporated into mental health surveillance and public health assessment frameworks in Jammu and Kashmir, formally recognising the marital environment as a structural determinant of population mental health. Second, women's economic empowerment through employment support, skills training, financial literacy, and social protection must be recognised as a mental health intervention, given the role of economic dependency as a primary mechanism of structural entrapment across these cases. Third, family and marital counselling services with a genuine gender-responsive and structural orientation distinct from the reconciliation-focused mediation currently available must be developed as a formal component of the social work and health service infrastructure in Kashmir.

9. CONCLUSION

This paper has argued and demonstrated, through systematic couple-level data from 30 distressed marriages in Kashmir, that marital conflict is not primarily an interpersonal phenomenon but a structurally produced condition whose specific domains function as social determinants of women's mental health. The five conflict domains documented unequal domestic labour, in-law interference, spousal non-recognition, male unemployment and displaced control, and infidelity with projected suspicion are not simply things couples argue about. They are identifiable social conditions, rooted in patriarchal household structures and cultural gender norms, that produce measurable and predictable patterns of psychological harm for women. The study's central analytical contribution is the documentation of a systematic reversal through which these conditions sustain themselves: what husbands and in-laws narrate as causes of marital problems are the mental health consequences of the structural conditions they help maintain. The woman who shouts is the woman whose reality is chronically denied. The woman who is 'always lost' is the woman who is cognitively overloaded and psychologically exhausted. The woman who 'doesn't get ready' is the woman whose depression has not been recognised as depression. Naming this reversal in research, in practice, and in institutional settings is the precondition for any response that aspires to reduce women's suffering rather than manage or contain it. Two phrases from women's accounts in this study deserve to

serve as the paper's final anchor. "What does she even do?" Spoken to a woman whose body aches from a day of unacknowledged labour. "Now my son will do household work?" Spoken to a woman who asked her husband for help with a single task. These are not extraordinary statements from unusual households. They are the ordinary language of a social order that has organised itself, at the level of everyday domestic life, to deny women's labour, dismiss women's suffering, and enforce women's silence. For social work practice and public health policy in Kashmir, they are not background context for the real problem. They are the real problem.

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