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Mental Health and Family Structure Among Primary-School Girls in India

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Abstract

The organization, stability and emotional climate of the family are some of the factors that influence the mental health of girls in the primary-school years, in addition to biological and developmental factors. The evidence base is much more robust in relation to adolescents than primary-school girls, and in India, child mental health is discussed more rapidly than in other countries. This review thus summarizes Indian and some international literature to explore the impact of family structure on mental health among primary-school girls in India with the consideration of nuclear, joint, single-parent, skipped-generation, migrant, and conflict-affected families. The article suggests that the family structure is not to be viewed as a mere label on the level of the demographics; its impact is moderated by the quality of caregiving, gender norms, economic security, mental health of parents, school connectedness, and access to support services. Girls are particularly vulnerable in the literature where family transitions are accompanied by poverty, parental absence, domestic conflict, bereavement or heavy household responsibility. In parallel, risk may be mitigated by extended kin support, emotionally-available caretakers, positive parenting and school based mental health systems. According to the review of related literature, policy interest and a promising platform of school mental health is increasing in India, yet implementation is still disjointed and urban-based. Primary education requires a family-sensitive and gender-responsive approach thus incorporating early screening, teacher sensitization, parent involvement, counselling pathways and referral networks. This review finds that to enhance the mental health outcomes of primary-school girls in India, the move should be out of the deficit perspective of non-traditional families and on to the aspect of relational safety, continuity of caregiving and integrated support to home, school and community.

Keywords: Primary-School Girls, Mental Health, Family Structure, School Mental Health, Child Well-Being

Introduction

The mental health is part of the healthy child development, learning, social participation and well-being of the person later in life. According to the World Health Organization, one out of seven teenagers in the world have a mental disorder, with depression, anxiety and behavioural disorders being among the most common causes of illness and disability among the youth ^[1]. Whereas a lot of the discussion in the popular press is focused on the teenage years, the roots of mental health go deeper, back to the primary-school years, when children learn to regulate their emotions, have a sense of self, social competence, and safety and care expectations. The topicality of the problem in India is increased by the demographic size. The recent

mapping of child and adolescent mental health services by UNICEF has shown that India has approximately 436 million children and adolescents, but the mental health services to this group of people are still inadequate, disjointed, and often not provided until the distress is dysfunctional ^[2].

The concept of mental health cannot be interpreted outside of family context with regard to primary-school girls in India. The family structure determines the day-to-day supervision, emotional, economic resources, discipline, conflict exposure, and division of household duties. Nevertheless, the family structure cannot be viewed in a limited sense. A joint family can be supportive in the sense that it provides a number of adults who are caring, yet it can

also create stress when conflict, hierarchy, or gendered restrictions are the order of the day. A nuclear family could be emotionally stable and stable, but weaken in case the workload of parents, migration, or marital distress decreases the time of caregiving. Single-parent, widow-headed, or transnational families are not necessarily pathological; their impacts are dependent on stigma, income, continuity of caregiving and support of the community. To the point, the label is not as important as the mechanisms. This is particularly critical in India where social significance of widowhood, separation, labour migration and gender expectations may influence the emotional worlds of girls in unique ways^[3, 4].

This paper is a narrative review and not empirical research. This is simply because there is yet a paucity of directly focused literature on primary-school girls in India as a unit of analysis, and much of the existing evidence is lumped together between boys and girls or between middle childhood and adolescence. However, there is enough literature to synthesize in a cautious journal-like manner. The paper will accomplish the following objectives, first, to conduct a review of the literature with respect to the topic of child and school mental health in India; second, to analyze how various forms of family structure can influence the mental health of primary-school girls; third, to identify gendered routes to vulnerability and resilience; and fourth, to provide implications on research, schools, and policy. The thesis statement is that mental health of primary-school girls in India is influenced not so much by the formal constitution of the domestic environment as those of domestic care quality, stability, and equity and whether schools are prepared to identify and act on early distress^[3-7].

Review of Related Literature

Indian literature on child and adolescent mental health has grown significantly over the last few years. Balamurugan *et al.* carried out a systematic review of school children and adolescents in India and found depression, social, behavioural and emotional problems, anxiety, psychological distress, stress, social phobia, violence exposure, and attention-related problems to be predominant issues in the studies^[7]. Another highlight of the review was the fact that school mental health services in India are inadequate and unevenly distributed. Similarly, a scoping review of interventions in adolescents in India reported that most of the interventions were school-based, tended to utilize life-skills curricula, and that such programmes led to better depressive symptoms, coping, problem-solving, school climate, and overall well-being^[4]. These investigations are significant since they define two consistent themes: child mental health issues exist at material levels, and schools can serve as feasible points of entry to early detection and low-intensity support. These reviews also concentrate much on adolescents, but the same reasoning can be used when it comes to younger children whose distress may initially manifest as somatic complaints, irritability, inattention, fearfulness, withdrawal, peer problems, or loss of interest in the classroom.

The same concern is reflected in policy and service reviews. Girase *et al.* explain that the policy and programmatic response to youth mental health in India is described as being fragmented across sectors although there is the Mental

Healthcare Act, the National Mental Health Policy, and various youth-focused programmes^[3]. The authors state that one of the significant gaps is intersectoral integration, early detection, and enhanced referral pathways. Kumar and subsequently Raman and Thomas both note that school mental health in India has traditionally been built up in a piecemeal way, frequently relying on individual projects as opposed to a systemic approach^[5, 6]. Their analyses apply to primary girls since early distress hardly finds its way to psychiatric services. Class teachers, mothers, grandparents or peers are more likely to notice it. In schools where the teacher is overworked, counsellors are missing, or stigma is great, emotional issues are kept in the shadows until they start to impact on attendance, behaviour or school performance^[5, 6].

Family structure and children mental health literature can be used to explain the mechanism through which home environment is connected with psychological outcomes. Researchers Gruning Parache *et al.* examined children aged between 3 to 17 years and discovered that mental health varied according to family structure and socioeconomic background with disadvantage being more highly concentrated in certain non-traditional family structures^[8]. Although this work is not India-specific, it is conceptually effective as it shows that the correlation between family structure and child mental health is mediated by social and economic conditions and not by structure itself. Evidence in India is of the same kind. In a study on unmarried Indian young people who lived in single-parent families, Sinha and Ram indicated that the mental health outcomes were worse in such families and the impact was even greater in female populations^[9]. Though this work is about older youth, it implies that girls might internalize family loss, insecurity, and social stigma in especially consequential ways. In primary-school girls, the processes can manifest themselves not as verbalized depression, but in the form of worry, clinginess, silence, bodily complaints or loss of confidence. Surveys of younger Indian children also highlight the importance of family issues. In a study of school-going children aged 6-12 years in Punjab, Kaur and Gill established that behavioural problems were related to parental attitude, parental education, maternal occupation, and chosen demographic variables; notably, girls were higher in the mean scores in certain areas including peer problems and total difficulty scores^[10]. This is particularly applicable to the current subject since it encompasses the age group of the primary-school directly. According to the study, younger children have a behavioural and emotional problem, which is rooted in family processes, such as the style of caregiving and educational background. To add to this, a meta-analysis of school going adolescents in India by Kamath *et al.* indicated a high pooled prevalence of depression with prevalence seeming to be higher in girls than boys^[11]. Although this meta-analysis is about older students, it supports the general finding that female children and adolescents in India might be at increased risk of internalizing when the stressors add up. Lastly, the case of Uttar Pradesh and Bihar demonstrates that child marriage is linked to worse mental health in adolescent girls, which is how gendered social norms and family choices can contribute to psychological vulnerability in the long run^[12]. Collectively, the literature indicates that there could be a

continuum of development: early family stress during girlhood can be a factor in emotional load that will be more apparent during adolescence.

Family structure and mental health of primary-school girls in India

The years of primary school may be seen as a fairly silent developmental phase, but in the case of most girls this is the time in which gendered selfhood is formed. Girls start getting to know what is expected of them at their homes, what kind of emotion they can have, how much voice they are allowed to make, or forcibly take, whether their labour is appreciated or assumed. These lessons will be able to foster emotional security and confidence in homes characterized by warmth and predictability. Similar duration may create fear, guilt, hypervigilance, and over-compliance in houses where there is instability or neglect of children. The family structure has an issue as it influences the sharing of care, power, and strain. It is possible that a girl in a stable single-parent family with an understanding grandmother and an empathetic school will perform better than a girl in a two-parent family with conflict and violence as the order of the day. Therefore, a family-structure analysis has to shift the stable household types to lived arrangements of caregiving [8-10].

Young girls in joint families should have some advantages in the form of grandparents, aunts, elder siblings, and cousins. It has the ability to add up to supervision, emotional care and continuity of care in the case of an ill parent, long working hours, temporary absence. Joint families can even save girls being isolated. They might reproduce, however, rigid gender hierarchies, unequal treatment among sons and daughters, and decision-making politics that suppress children. The joint family membership may not be converted into psychological protection when there are several adults in the environment but none of them is emotionally sensitive to the child. In other instances, girls can take care giving or household responsibilities at a young age and these reduce the time she can spend on play, rest or study, leading to stress. Nuclear families on the other hand tend to have greater parent-child contact and less extended family intrusion, although it may be susceptible when the father and mother are employed long hours or because of the family-shattering effects of migration, separation, illness, or alcohol abuse. When younger girls rely so much on habits, these disturbances can result in perceived insecurity that is easily confused with stubbornness, inattention or so-called shyness.

Those of single parent and widow headed families require special consideration in Indian context. Stigma, financial pressure and emotional grief tend to go hand in hand. The parent that is not present may have passed away, emigrated, or divorced due to a war thus leaving behind the child whose life may comprise loss, social humiliation, role transition, and anxiety about the left caregiver. The results of Sinha and Ram regarding the worse mental health of poor females in single-parent families indicate that girls are possibly particularly vulnerable to such effects [9]. In the case of primary-school girls, the pressure may manifest in insidious forms: nonattendance to school, fear of being left alone, non-association with others, loss of concentration or pretense to maturity which covers up distress. The same risk

can be applied to households of skipped-generation where grandparents are the main caregivers due to migration or death of parents. The grandparents can offer incredible stability; they can also be frail due to age or health, or simply have less understanding of the modern school requirements. It is not structure per se but the question is whether the child is subject to continuity, affection, and consistent containment of the stress.

These pathways are enhanced by gender norms. In Indian families, girls grow up in order to be obedient, emotionally calm and in full of assisting others. These characteristics are rewarded in the society but may hide anxiety and depression. A primary-school girl in distress might fail to externalize distress by being aggressive; instead, she might remain quiet, excessively obedient, perfectionistic or show physical symptoms. Since these signs are easily normalized, her issues can be much more undetected with a longer period compared to boys whose behavioural issues are faster noticed by adults. As the literature on school-going children shows, girls might exhibit significant inability to establish peer relationship, prosocial burden, and internalized distress despite not being perceived as a problem child [7, 10, 11]. This has significant consequences to families and schools. By only screening visible misbehaviour, many girls will be invisible because they are drowning in the uncertainty of family instability, academic demands, and gendered responsibility.

Implications for Schools, Research, and Policy

The literature indicates strongly schools as a viable location of prevention and early care. Several Indian reviews find that school-based interventions are possible and can enhance coping and emotional competence and help-seeking [4-6]. In the case of girls in primary-school, this implies that mental health promotion must commence earlier than adolescence. Social-emotional learning, organized play, safe reporting, anti-bullying, and teacher training can be used as classroom strategies to recognize child distress without stigmatizing it. Interventions that face parents are also significant. Families require assistance not only with serious psychiatric disease, but also with the daily emotional communication, predictable routine, non-violent punishment, and equal share of attention between sons and daughters. Schools must be prepared to react sensitively and not morally where the family structure has been altered due to death, migration, remarriage or conflict.

Policy should also acknowledge the fact that child mental health cannot be provided by specialist psychiatry only. As observed by UNICEF and by review of the policy, there is a gap in care provision that requires layered care services that needs to be provided by teachers, community workers, counsellors, pediatric services and referral linkages in India [2, 3]. A family sensitive school-based model would be the best policy response to primary-school girls. Such a model would involve psychosocial routine observation in primaries, referral algorithms of unrelenting distress, school's sensitization of teachers to gendered symptoms, and community counselling access by bereaved, separated or highly stressed caregivers. The data systems must also disaggregate by age and sex such that girls in the middle childhood are not lost under general child and adolescent groups. Research ought to focus more on longitudinal

research on girls at a younger age, comparative research among the forms of families, and qualitative research that could encompass how girls themselves perceive the concept

of safety, belonging, and emotional burden in their households.

Table 1: Synthesis of Key Themes from the Literature

Theme	Main message from literature	Implication for primary-school girls
Burden of mental health problems	According to Indian reviews, depression, anxiety, behavioural and emotional difficulties are experienced by school-going children and adolescents [4, 7, 11].	Girls in primary school need to be identified earlier before distress becomes chronic in the form of internalizing problems.
Family structure as context	The socioeconomic strain, continuity of caregiving and emotional climate of the family, but not structure alone, affect child mental health [8, 9].	The assessment should enquire about who takes care of the child, the stability of care, and whether or not she feels safe and heard.
Gendered expression of distress	Girls can exhibit less overt symptoms of internalization and hence less noticeable to adults [7, 10, 11].	Screening of teachers should go beyond disruptive behaviour and encompass withdrawal, somatic complaints and perfectionistic distress.
School response	India School-based programmes are also possible and can enhance coping, climate and help-seeking [4-6].	The initial point of intervention can be teacher sensitization, parent involvement and referral channels in primary schools.

Conclusion

In India, the primary-school girls and their mental health are at the intersection of the development, gender and family life. There is no evidence available to substantiate the simplistic statements that any of the forms of family is uniformly detrimental or protective. Rather, it demonstrates that quality, stability, and equity of care giving are the determining factors by which family structure influences mental health. Vulnerability to risk can be increased by poverty, bereavement, parental absence, conflict, stigma, and unequal gender expectations and can be shielded by affectionate care giving, kin support, responsive school and available services [2-10].

The reviewed literature indicates that India has been passing into an era of increasing awareness of child and adolescent mental health, although primary-school girls are under-specified in research and programming. A journal and policy agenda on this topic should not then remain on general appeals to awareness. It must insist upon early and family responsive mental health promotion; systems in schools capable of identifying internalizing distress and support systems in recognition of girls not as future adolescents, as wives, or mothers but as children with current emotional rights. Enhancing mental health among this group is not a clinical or educational endeavor. It is a social justice requirement that starts at home and has to be maintained by the schools, communities, and even the public system.

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