



Globalisation and Mental Health Disorders Among Young People: Highlights from India and China

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Abstract: The contemporary debates and discussions that are contiguous to the ongoing process of globalisation, point at variety of perspectives, which have led to rather contrary analysis and interpretations vis-à-vis the globalisation and its bearing on individuals and groups across regional, national and local domains. Nevertheless, it is argued that globalisation induced cultural multiplicity and uncertainty have fundamentally altered the individual lived experiences specifically of young people, influencing their mental health and thereby leading to higher rates of neuro-psychiatric disorders and suicides? Though such impacts of globalisation on the mental health of young people are contested, and for the most part are undervalued and uncounted, but it is equally true that mental disorders can no longer be separated from the global milieu that shapes our lives and therefore, “growing up” today is not what existed before. With this background, this article at empirical level aspires to participate in a dialogue on globalisation, health inequality and global burden of disease with special reference to mental health of young people in India and china.

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Introduction

Globalisation is an unprecedented overarching and core ongoing process behind the social, cultural and economic transformations that are reshaping nations, societies and world order at large (Castells, 1996; Giddens, 1990). Of particular significance in this process of reshaping and transformation is the changing way we perceive time and space, what David Harvey (1989: 292) refers to “time-space compression”- the way the world has in effect been de-territorialised by the acceleration and wider

dissemination of capitalistic practices – where “people, information, money, and technology all flow around the globe in a rather chaotic set of disjunctive circuits that somehow bring us all together” (Friedman, 2008: 111): mobility, flexibility, differentiation, diversity, decentralisation and communication are in the ascendant, all of which presume to have transform tradition (Giddens, 1991). And in this process specifically, identities, subjectivities and sense of self are seen to have radically changed (Hall, 1988:159).

The labour markets concomitant to this process of transformation are seen to be flexible with less secure jobs, casualisation, training and retraining, and early retirement as markets demand. The education and employment are of key importance in the transition to adulthood and in the formation of social identity, with many commentators arguing that the “growing up” today is not what existed before (Bhat, 2013; Sironi, 2018). Nevertheless, the debates and discussions that are contiguous to this ‘grave new world’ (King, 2017) of globalisation point at variety of perspectives which have led to rather contrary analysis and interpretations vis-à-vis the globalisation and its bearing on individuals and groups across regional, national and local domains. The three different commentaries clustered around this process of global-local continuum are:

Hyper-globalist: View globalisation truly an entirely new historical process, which ultimately leads to an international order, where the role of nation-state is comprehensively diminished, and open markets and transnational institutions are the main operators of economic activity. This position therefore, sees a purely ‘borderless world’ and present the contemporary social, political, cultural, technological and economic changes as a new unparalleled phase in the civilizational progress (Held and McGraw, 2007: 5). At individual level, the new information and communication technologies’ have the effect of lifting social relations out of their local contexts, with an expanded access and freedom to individuals to engage and collaborate with anyone across great distances. In essence, this is actually an optimistic explanation of the process of globalisation – conceiving it as a route to global prosperity.

Sceptics: While having the similar viewpoint as hyper-globalisers that modernity has altered and now characterised by new circumstances, uncertainty and turbulence, and that new communication technologies have lifted social relations out of their local contexts, with a strong access to engage across wider distances, but not that these changes do signify an epochal shift, rather it is an ongoing form of internationalisation. Furthermore, while it is true that contemporary changes have influenced the lives of people across the globe, and therefore, are significant enough to merit a re-conceptualization of the experiences of people at different levels in

their everyday life – class, societal, regional or national. However, it strongly appears that these changes have been over-stated. Because, to ignore *local* (e.g. community bonds, gender, social class etc.), is to ignore the possibility of inequalities and differences in access to resources that are structural and systemic. Majority of the evidence we have discussed in what follows, lends support to this perspective that majority of the world's poor continue to suffer, since benefits derived from new means of communication technologies, modern medicine etc. are adhering to class patterns, with poor “attracting an unfortunate abundance of risks”, while the rich “can purchase safety or freedom from risks” (Beck, 1992: 35).

Transformationalists: Take up moderate position in defining the changes brought about by the process of globalization, as well as assessing its progressive sides. Whereas for transformationalists also globalisation doesn't do represent an epochal shift, but they don't accept the views of sceptics' either. Rather for them globalisation is an open-ended process as defined by Giddens (1990:64) “the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa”. Therefore, globalisation doesn't mark a new historical era, it is understood as representing an extension of pre-existing political, economic and cultural processes, that offer a magnitude of possibilities and a hope for a more equitable world, however at the same time, its effects at local, regional and national level are considered uncertain (De Maio, 2014: 10). Specifically, for young people such an uncertainty is viewed as an end result of the fragmentation of social inequalities due to the institutional isolation of most spheres of social life (Beck, 1999). And the inability by young men and women to identify priority hierarchies among the goals they intend to achieve during their lifetimes because of the high degree of uncertainty about their future (Chisholm *et al.*, 2001: 110-1). Precisely, transformationalists held that young people living in globalised world can't depend on continuity and stability, and have to accommodate change and uncertainty by creating and recreating their lives on lifetime basis- an activity they call *reflexivity* – the routine monitoring of yourself and your behaviour, in order to decide who to be, and how to live, since globalisation indeed offers something new, but not without challenges and turbulences.

Globalisation and Mental Health

Whether, under the remit of globalists, sceptics or transformationalists, it is largely agreed along this discourse that globalisation has become a controversial and contested topic. Its power and influence on the world order bring opportunities for some people and pose threats to others (McMichael & Beaglehole, 2000).

The utmost disparities reinforced by globalisation are a lot to be found within the margins of nation-states, rather than between underdeveloped and developed countries (Bhugra, *et al.*, 2004: 10-20). It is likely to escalate social inequality by aggravating differences in access to and distribution of resources (Stiglitz, 2002). George (1998) and Castles (2004) postulate that globalisation leads inevitably to the decline of the welfare state through the vetoing of investment towards greater social expenditure and full employment by international financial markets. Because, poverty, economic disparity, underdevelopment and mental health are co-related (Desjarlais, Eisenberg and Good, *et al.*, 1995; Bibeau, 1997), it is hardly surprising then that globalisation and its related social and economic changes affect the mental health of individuals and societies. Albeit, it is challenging to envisage the impact of globalisation on the incidence and course of psychiatric disorders, what is conversely true is that mental disorders can no longer be separated from the global milieu that shapes our lives. The social processes allied with globalisation, such as employment pressures, migration, poverty, culture, and social change can be risk or protective factors for disorders such as suicide, substance abuse, antisocial behaviour, anxiety and depression. Globalisation also has effects on the specification of health and social care to those with mental health problems, whether or not these have been fabricated by globalisation (Manning and Patel, 2008: 299-300). According to Kirmayer and Minas (2000) globalisation encroaches on psychiatry in three main ways: through its effect on the forms of individual and collective identity, through the impact of economic inequalities on mental health, and through the shaping and propagation of psychiatric knowledge itself.

These multifaceted associations between globalisation, health and social and mental health are only now started to be investigated, and scholars highlight the need for a clearly defined research and policy arrangements to respond to the challenges posed (Lee, 2000). Specifically, for the age cohort 15-35 years, there is paucity of literature on the association between globalisation and mental health. Since youth stand at the centre of this panorama of change, those youth who do not hold the aptitude and capability to espouse the gauntlet of competition are left out. To a certain degree, this has increased the alienation, affecting the mental and social health of a substantial portion of the youth population particularly in developing countries. However, for the most part mental health consequences of globalisation for youth remain undervalued and uncounted. At the empirical level, this article aspires to be a step toward rectifying that deficiency by participating in a dialogue about global health inequality and global burden of disease. A brief discussion of global burden of disease in young people with special reference to Asia

below is followed by some major evidence vis-à-vis consequences of globalisation for the mental health of young people in India and China.

Global Burden of Disease in Young People

There are today unprecedented 1.8 billion people between the ages of 10–24 years, making over one quarter of world population. The highest proportion (89 percent) of these young people live in low- and middle-income countries of global south, where this age group makes over 32 percent of the total population. India has the highest proportion of 10–24-year-olds, with 356 million, followed by China (269 million), Indonesia (67 million), Pakistan (59 million), Nigeria (57 million), Brazil (51 million) and Bangladesh with 48 million (UNFPA, 2014:1-12).

These big numbers pose big challenges as well as big possibilities, since these young people will live into the future than their elders, and that the global prosperity depends on whether they have opportunities and options in life, whether they are educated, healthy, have access to critical health care and are fully engaged citizens. Therefore, on the whole the cases for investing in young people today are clear and loud with more and more countries agreeing that young people can be a positive force for economic development and overall progress when provided with adequate and appropriate skills and opportunities. However, unfortunately of the numbers discussed above, nearly 286 million youth are living in poverty (ILO, 2015:47), 500 million youth aged 15-24 live on less than \$ 2 a day. Over 152 million young workers live in households that are below the poverty line (\$1.25 per day) (ILO, 2010) and around 126 million are illiterate (UNESCO, 2013), 70.9 million are unemployed (ILO, 2017), and 3.9 million live with HIV/AIDS (UNAIDS, 2018). Unsurprisingly, the largest proportion of youth living in poverty and unhygienic conditions can be found in Asia, which is home to 718 million young people aged 15-24 and will remain most young region until around 2080 (UN, 2015).

There are massive burdens of such a state of young people as literature suggests that if this segment of the population aged 15-24 exceeds a “critical level” of 20 percent of the overall population and is left with no alternative but unemployment and poverty, they are likely to join radical and illegal movements (Huntington, 2007; Bhat 2014: 472). Consequently, a greater incidence of civil conflict and socio-political ambivalence are likely to occur in such societies. Equally there are many other burdens of the fragile status of youth, and hence the well-being of young people in every sphere of the life is critical. One such issues, which has recently emerged in global development agenda is the global burden of disease in young people (Lassi,

Salam, Wazny, *et al.* 2015; Gore, Bloem, Patton, *et al.* 2011). As aforesaid, young peoples' health potentially affects future population health and concomitantly global economic development if timely initiatives aren't worked-out. Global Burden of Disease study 2010 and 2013 clearly show that significant burden of disease due to sexually transmitted diseases, mental disorders, non-communicable disease risks and injuries that arise during 10–24 years of age have aggravating effects on health later in the life (Mokdad, Forouzanfar, Daoud, *et al.*, 2016).

To ensure healthy life at all ages, an overarching health objective in the Sustainable Development Goals¹ has been framed, with youth activists, who have traditionally been ignored in global health agenda, involved in Gore the process of achieving these goals.² Nevertheless, more emphasis is needed in this respect as there is dearth of knowledge related to many risk factors in this age group, specifically there is little information on stress, mental health, and other related factors for this age group of 10–24 years (Patton, Coffey, Cappa, *et al.* 2012). This is especially true of low-income and middle-income countries, where because of the globalisation of economy and changing demands of labour markets, young people have highest intensity of stress in terms of worrying about school performance, admissions to tertiary education, and securing a job or an income etc. Indeed, effects of globalisation on mental health of young people are imperative to be concerned about in the light of the substantial and increasing burden of disease attributable to mental illness (Lopez, Mathers, Ezzati, Jamison and Murray, 2006; Prince, Patel, Saxena and Rahman, *et al.*, 2007). According to World Health Organisation (WHO) estimates for the year 1999, neuropsychiatric disorders and suicide amount to 12.7 percent of the global burden of disease (GBD) and related conditions. Specifically, suicide is among the top three causes of death of young people aged 15–35 (WHO, 2000) and is one of the leading causes of death of young women in India and China (Wortley, 2000). Nearly 8,00,000 deaths by suicide occurred in 2016 with majority between 15–34 age group (WHO, 2018: 7). The WHO (2004) report indicates that by the year 2020, adolescent psychiatric disorders will increase by more than 50 percent to become one of the five leading causes of disability among adolescents. The most common mental disorders affecting adolescents and young people worldwide is depression, predicted to be the leading single cause of disease burden globally by 2030. Yet currently 31 percent of countries do not have a specific public budget for mental health (Saxena, Thornicroft, Knapp, Whiteford, *et al.*, 2007), 40 percent of countries have no mental health policies and more than two-thirds of the world's population (68 percent), the majority of whom are in Africa and South Asia, have access to only 0.04 psychiatrists per 100,000 of the population (WHO, 2005).

Access to Health Care Services

Inequality in access to health care has gone unnoticed in the middle-income countries, specifically Asian, where some people have experienced significant improvements in the quality of their life, but there are many others, who still struggle to have access to even basic facilities. Owing to global economic pressures, the private sectors in majority of the Asian economies have capitalised on their comparative advantage to export human resources for health to more advanced and richer countries globally. While the financial returns from this strategy seem substantial, equity issues have surfaced locally, particularly in terms of the widening disparities in the public–private or rural–urban mix (Chongsuvivatwong, Phua, Yap, Pocock *et al.*, 2011). One example in this respect is China, where from last couple of decades the government prioritized economic growth over and above other considerations, which has ultimately resulted into serious issues related to access to public health care services, especially in rural areas (Meesen and Bloom, 2007).

There are many definitions of access to health care, with many scholars holding that access is by and large related to the timely use of services needed (Campbell *et al.* 2000), while others differentiate between the opportunity for use of services, the supply and the actual use of services. Still others take access to health services as realized need (Mooney, *et al.* 1991; Culyer and Meads, 1992). Hence, there is no universally accepted definition of access to health care services, however, the conceptual framework developed by Peters, Garg, Bloom, *et al.* (2008: 162) is an encompassing one, with four main dimensions of access and includes actual use of health services:

- **Geographic accessibility** – distance or time it takes from service delivery centre to the user.
- **Availability** – whether the right type of service is available according to the need, which includes having the appropriate type of service providers, materials required as well as waiting times it takes.
- **Financial accessibility** – ability of users to pay for the health care services, and the protection from the undue economic costs of health care services use.
- **Acceptability** – how responsive are health care service providers to the socio-cultural expectations of communities and individual users.

Having that said, nearly half of the world's population don't have such an access to essential health care services and many, who access required health services, suffer

undue financial hardships (WHO, 2018: 8). For example, in 2010 over 808 million people representing 11.7 percent of the world's population, spent 10 percent of their household income paying for health services. Of these people, over 179 million spent quarter of their household income for health-related services and an estimated 97 million, representing 1.4 percent of the world's population were impoverished by spending all their income on health care services.³ Seventy-six (76) countries have less than one physician per 1000 population, 87 countries have fewer than three nursing personnel per 1000 population. Indeed, in many countries, midwives and nurses comprise over half of the national health workforce (WHO, 2017). This is specifically true of South Asia, where access to essential health care services among the general and most disadvantaged populations is comparatively below the world average. For example, according to the World Health Statistics 2018: *monitoring health for the sustainable development goals*, the number of physicians per 1000 population in India is (0.8), Afghanistan (0.3), China (1.8), Pakistan (1.0), Nepal (0.6), Shri Lanka (0.9), Bangladesh (0.5). Altogether, the universal health coverage⁴ (UHC) in India is 56 percent, Pakistan (40), China (76), Bangladesh (46), Shri Lanka (62), Nepal (46).

Such a state of public health system doubles the burden of disease for these countries, as it directly translates into higher morbidity, lower life expectancy and driving many households below the poverty level. Because 'when health care is needed, but is delayed or not obtained, people's health worsens, which in turn leads to lost income and higher health care costs, both of which contribute to poverty' (Peters, Garg, Bloom *et al.*, 2008: 161). As World Bank *Development Report* (2007) highlights that dispossession leading to ill health are common in developing countries, where poor are particularly at risk. Hence, the inequity and inequality of poor health experienced by poorer people across the different regions of the world is significantly worse than a simple analysis of health inequality reveals (Reidpath and Allotey, 2007), with the lost income and higher health care payments further result in shocks that may adversely impact the mental wellbeing of people as well. Though, the impact of poverty on the mental health is contested and we are unable to control for the impact of other social factors, however, as aforesaid, the process of globalisation has resulted in an increase in social inequality, and the costs of such a measure of inequality has related impacts, which are more obvious not at the individual and household level only rather at country level as well. For example, in low-and-middle-income countries such as India, South Africa, Brazil and China etc., about 41.7 million people are estimated to need treatment for schizophrenia and related disorders, and majority (70 percent) of these people live in Asia (Mari, Razzouk, Thara, Eaton, Thornicroft, 2009).

Social Inequality, Educational Stress and Mental Health

Social inequality and poverty are more than low-income and low consumption. It includes non-monetary aspects such as social vulnerability, exclusion and denial of opportunities and choice etc. (Saxena, 2007: 883). The WHO (2009) report on *Mental Health, Poverty and Development*, clearly shows that people with the lowest socio-economic status have eight times greater relative risk for schizophrenia than those of the highest socio-economic status, and four times more likely to be unemployed or partly employed (Bhat and Rather, 2012). Indeed, scholars have described the interaction of poverty and mental ill health as a vicious cycle in which the conditions of poverty lead to high levels of stress, social exclusion, reduced access to health services, malnutrition and increased risk of violence, and thereby increased prevalence of and worse outcomes for mental disorders (Patel, 2001). Consider the largest concentrations of young people living on less than US\$ 1 a day are found in India 67.7 million and China 33.3 million (UN, 2015). Simultaneously the highest rates of suicide among young people are found in India and China (WHO, 2004). In India more than 65 percent of all suicides occur in persons below 35 years of age with 35 percent in the age group of 15- 24 years (NCRB, 2007), and nearly 90 percent of those who completed suicide belonged to the lower and lower middle socio- economic strata's (Gururaj and Isaac, 2001). Speaking generally, the number of suicides in India between 1995 and 2005, a decade in post reform period, has recorded an increase of 27.7 percent and 35.3 percent of suicide victims were youths of 15- 29 years of age (NCRB, 2005). Similarly, in China among young adults 15- 34 years of age, suicide has been the leading cause of death, accounting for 19 percent of all deaths. However, in rural China suicide rates were three times higher than urban areas – a difference that remained true for both sexes, for all age-groups, and over time.

For young people in Asia specifically in India and China, one of the major factors for adverse mental health besides social inequality and social exclusion is educational stress. There is a good volume of empirical evidences, which held that educational stress is a risk factor for psychopathology and hence adversely influences the academic performance of students as well as their quality of life. And this has been recorded in post-reform periods in both India and China, since the combination of economic restructuring in the world economy and the powerful ideological conception regarding how educational delivery needs to be changed, spread by international institutions as consequences of the process of globalisation, is having a significant impact on educational systems worldwide (Carnoy and Rhoten,

2002). Concomitantly, the most visible changes in the provision of education are the rise in private formal schooling and the increasing share of school costs (including the costs of the growing practice of supplementary tutoring) paid by parents. Classrooms moved away from a focus on egalitarianism and class struggle, instead emphasizing quality, competition, individual talents, and the mastery of concepts and skills important in the labour market (Brooded, 1983; Kwong, 1985; Lin, 1993).

Asian students in particular often have high academic burden, low satisfaction regarding their academic performance and strong external pressure to study. At times anticipated academic failure contribute to substance abuse among students or even suicide. According to the National Crime Records Bureau, in India, there is one student every hour that commits suicide (Saha, 2017). Likewise, Chinese National Survey conducted by the All-China Women's Federation (2008) reported that nearly 66.7 percent of the students in secondary schools considered education related pressure as the worst stressor in their lives, which at times leads to physical violence and substance abuse. Media reports on the subject of suicide in China reveal that educational institutions – exam-oriented and severe competitive – bear a large part of the responsibility for increasing suicide rate among students (China Daily, 2017). A survey conducted in 2010 found that a third of Chinese school children suffer from psychological stress. Nearly 80 percent of 6–12 years old were worried about exams and physical punishment by teachers and parents if they fail to perform (Teon, 2017). Equally, over 18 and 50 percent of Indian youth have high and very high levels of anxiety respectively. However, the zones of anxiety that the Indian youth fell into were found influenced largely by socio-economic status (SES) and education (DeSouza, Kumar and Shastri, 2009). As per the reports from Child and Adolescent Psychiatry Clinic, AIIMS diagnosis of adolescent depression in India has gone up from 0.4 percent in 1980 to 6.5 per cent in 2005 (Datta, 2008). According to a Lancet (2012) report, India has one of the world's highest suicide rates for young people aged 15 to 29. Among the specified causes of suicide, failure in examinations is the predominant. In 2016 alone, failure in examinations led to 2,413 suicides by students in India i.e. one student commits suicide every hour.

Concluding Remarks

As afore-discussed globalization – whether under the remit of globalists, sceptics or transformationalists – is largely agreed that it has become a controversial and contested topic. Its power and influence on the world order bring opportunities for some people and pose threats to others (McMichael & Beaglehole, 2000). The

utmost disparities and adversities reinforced by globalisation are a lot to be found within the margins of nation-states, where it escalates social inequality by aggravating differences in access to and distribution of resources (Stiglitz, 2002). Because, social inequality and poverty are more than low-income and low consumption. It includes non-monetary aspects such as social vulnerability, exclusion and denial of opportunities and choice, it is hardly surprising then that its related consequences affect the mental health of individuals and societies at large. What is equally true is that mental disorder can no longer be separated from the global milieu that shapes our lives. Specifically, the social processes allied with globalisation, such as employment pressures, migration, poverty, culture, and social change can be risk or protective factors for disorders such as suicide, substance abuse, antisocial behaviour, anxiety and depression. Even though, it is challenging to predict the impact of globalisation on the incidence and course of psychiatric disorders and empirical evidence that directly links globalisation and mental health of young people in India and China are lacking. Yet the potential disadvantages of globalisation for young people in terms of mental health are clear. Since young people stand at the centre of this panorama of change characterised by cultural multiplicity and uncertainty, they may be more susceptible to stress. Socio-cultural and in particular economic transformations, which display in the transformation of labour markets, the rise of the informal sector and increasing inequalities, have a stressing influence particularly for youth.

Today serious mental illness stands as a challenge equal to what HIV/AIDS was few decades back. Therefore, the case for creating a similar global fund for treatment of mental illness is loud and clear taking into account the size of the problem, need to combat related stigma and the associated human rights violations. In low- and middle-income countries, the provision of free basic treatment for mental illness has been shown feasible and economically viable (Chisholm, 2005:37-44). Specifically, in Asia – where around 41.7 million people (Mari, Razzouk, Thara, Eaton, *et al.*, 2009:6) are projected to need treatment for schizophrenia and related disorders – countries such as India and China can take lead role in providing the seed money to create such a global fund, which is indeed an ethical imperative from a demographic perspective as well. Since, India and China is home to 356 million and 269 million young people respectively largest ever in history, improving psychological and emotional well-being of this demographic gift should be made a primary aim of public policy not just within the health sector, but also in the education, housing, employment, trade and justice sectors with special reference to young people.

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Notes

1. United Nations Sustainable Development Knowledge Platform. *Transforming our world: the 2030 agenda for sustainable development*. Sustainable Development Knowledge Platform 2015. (accessed August 9, 2018).
2. United Nations Department of Economic and Social Affairs. *Children and Youth: Sustainable Development Knowledge Platform*. <https://sustainabledevelopment.un.org/majorgroups/childrenandyouth> (accessed August 9, 2018).
3. Tracking universal health coverage: 2017 global monitoring report. Geneva and Washington (DC): World Health Organization and the International Bank for Reconstruction and Development/The World Bank; 2017 (<http://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng.pdf?sequence=1>, accessed 14 August 2018).
4. UHC (Universal Health Coverage) embodies three related objectives, (a) equity in health care services, (b) quality health care services, (c) protection against undue financial risk for using health care services.

References

- Beck, U (1992). *Risk Society: Towards a New Modernity*, London: Sage.
- Beck, U (1999). *World Risk Society*, Cambridge: Polity Press.
- Bhat, M Aand Rather T. A (2013). “Youth Transitions in Kashmir: Exploring the Relationships between Habitus, Ambitions and Impediments”, *South Asia Research*, Vol. 33, No. 3, pp. 185-204.
- Bhat, M. A (2014). “(R)experiencing the Now-gone: Youth and Cultural Politics in Soviet and Post-Soviet Central Asia”, *Asian Affairs*, Vol. 45, No. 2, pp. 467-83.
- Bhugra D, Mastrogianni A and FRCPsych D (2004). “Globalisation and Mental Disorders: Overview with Relation to Depression”, *The British Journal of Psychiatry*, Vol.184, pp. 10-20.
- Bibeau, G (1997). “Cultural Psychiatry in a Creolizing World: Questions for a New Research Agenda”, *Transcultural Psychiatry*, Vo. 34, pp. 9-41.
- Broaded, M. C (1983). “Higher Education Policy Changes and Stratification in China”, *China Quarterly*, Vol. 93, pp.125- 41.
- Campbell M, Fitzpatrick R, Haines A, Kinmonth AL, *et al.* (2000). “Framework for Design and Evaluation of Complex Interventions to Improve Health”, *Lancet*, Vol. 321, No. 7262, pp. 694-6.

- Carnoy, M and Rhoten, D(2002). "What does Globalisation Mean for Educational Change? A Comparative Approach", *Comparative Education Review*, Vol. 46, No. 1, pp. 1-9.
- Castells, M (1996). *The Rise of the Network Society*, Blackwell: Oxford.
- Castles, F (2004). *The Future of the Welfare State*, Oxford: Oxford University Press.
- China Daily (24 April, 2017). *Suicide Top Cause of Death Among Young Chinese*, https://www.chinadaily.com.cn/china/2017-04/24/content_29054979.htm(accessed on 27 March 2019).
- ChisholmL, de Lillo A, Leccardi C and Richter R (2001). *Family Forms and the Young Generation in Europe: A Report by the European Observatory on the Social Situation, Demography and Family*, Milan: Italy, 20-22 September, ISBN 3-901668-31-4, pp. 110-11.
- Chisholm, D (2005). "Choosing Cost-effective Interventions in Psychiatry: Results from the Choice Programme of the World Health Organization", *World Psychiatry*, Vol.4, pp. 37-44.
- Chongsvivatwong V, Phua KH, Yap MT, Pocock NS *et al.* (2011). "Health and Health-care Systems in Southeast Asia: Diversity and Transitions", *Lancet*, vol. 377, No. 9763, pp.429-37.
- Culyer AJ, Meads A (1992). "The United Kingdom: Effective, Efficient, Equitable?", *J Health Polit Policy Law*, Vol. 17, No. 4, pp. 667-88.
- Datta, D(2008). *Teen suicides*, Retrieved from:
- De Maio, F (2014). *Global Health Inequalities: A Sociological Perspective*, London: Palgrave Macmillan.
- Desjarlais R, Eisenberg L, Good B, *et al.* (1995). *World Mental Health: Problems and Priorities in Low-income Countries*, Oxford: Oxford University Press.
- DeSouza, Kand Shastri, S (2009). *Indian Youth in the Transforming World*, Sage: Thousand Oaks, California USA.
- Friedman, J (2008). 'Global Systems, Globalization, and Anthropological Theory', in Rossi, I. (eds.) *Frontiers of Globalization Research: Theoretical and Methodological Approaches*, New York: Springer.
- George, V (1998). "Political Ideology, Globalisation and Welfare Futures in Europe", *Journal of Social Policy*, Vol. 27, No. 1, pp. 17-36.
- Giddens, A (1990). *The Consequences of Modernity*, Polity: Cambridge.
- Giddens, A (1991). *Modernity and Self-identity: Self and Society in the Late Modern Age*, Cambridge: Polity Press.
- GoreFM, BloemPJ, Patton GC, Ferguson J, Joseph V, Coffey C, Sawyer SM, Mathers CD (2011). Global Burden of Disease in Young People Aged 10-24 Years: A Systematic Analysis, *Lancet*, Vol. 378, No. 9790, pp. 486.
- Gururaj, G and Isaac, M K(2001). *Epidemiology of Suicides in Bangalore*, Bangalore: National Institute of Mental Health and Neuro Sciences, Publication No 43.
- Hall, S (1988). "Brave New World, ' the New Times Issue of Marxism Today", In P. Jones, 2003, *Introducing Social Theory*, UK: Polity Press, p. 159.
- Harvey, D (1989). 'The Condition of Post-modernity', in United Nations (2003) *World Youth Report 2003*, UN, Department of Economics and Social Affairs, p. 292.

- Held, D and McGraw, A (2007). *Globalization Theory: Approaches and Controversies*, London: Polity Press.
- Huntington, S (2007). "The Clash of Civilizations Revisited", *New Perspectives Quarterly*, Vol.24, No. 1, pp. 53-59.
- ILO (2015). *World Employment and Social Outlook*, Geneva: ILO.
- ILO (2017). *Global Employment Trends for Youth 2017: Paths to a Better Working Future*, Geneva: ILO.
- ILO (International Labour Organisation) (2010). *Global Jobs Pact – Policy Brief No. 14*, available at <http://bit.ly/1dgT2kF> (accessed 23 July 2018).
- King, S (2017). *Grave New World: The End of Globalization, the Return of History*, Yale: Yale University Press.
- Kirmayer L. J, and Minas I. H (2000). "The Future of Cultural Psychiatry: An International Perspective", *CanaBeckdian Journal of Psychiatry*, No. 45, pp. 438 -446.
- Kwong, J (1985). "Changing Political Culture and Changing Curriculum: An Analysis of Language Textbooks in the People's Republic of China", *Comparative Education*, No. 21, pp. 197- 208.
- Lassi Z.S, Salam R.A, Das J.K, Wazny K, Bhutta Z.A (2015). "An Unfinished Agenda on Adolescent Health: Opportunities for Interventions", *Seminars in Perinatology*, No. 39, pp. 353-360.
- Lee, K (2000). "The Impact of Globalisation on Public Health: Implications for the UK Faculty of Public Health Medicine", *Journal of Public Health Medicine*, No. 22, pp. 253-262.
- Lin, J. (1993). *Education in Post-Mao China*, Westport, CT: Praeger.
- Lopez D. A, Mathers D. C, Ezzati M, Jamison T. D, and Murray J. L. C (2006). *Global Burden of Disease and Risk Factors*, New York: Oxford University Press.
- Manning, N and Patel, V (2008) "Globalisation and Mental Health: A Special Issue of Global Social Policy", *Global Social Policy*, Vol. 8, No. 3, pp. 299–300.
- Mari JdJ, Razzouk D, Thara R, Eaton J, Thornicroft G (2009). "Packages of Care for Schizophrenia in Low- and Middle-Income Countries", *PLOS Medicine*, Vol. 6, No. 10, pp. e1000165.
- McMichael, A. J and Beaglehole, R (2000). "The Changing Global Context of Public Health", *Lancet*, No. 356, pp. 495–9.
- Meesen, B and Bloom, G (2007). "Economic Transition, Institutional Changes and the Health System: Some Lessons from Rural China", *Journal of Economic Policy and Reform* Vol. 10, No. 3, pp. 209-231.
- Mokdad AH, Forouzanfar MH, Daoud F, Mokdad AA, El Bcheraoui C *et al.* (2016). "Global Burden of Diseases, Injuries, and Risk Factors for Young People's Health During 1990–2013: A Systematic Analysis for the Global Burden of Disease Study 2013", *Lancet*, Vol. 387, No. 10036, pp. 2383–401.
- Mooney G, Hall J, Donaldson C, and Gerard, K (1991). "Utilisation as a Measure of Equity Weighing Heat?" *Journal of Health Economics*, No.10, pp. 14475–480.

- NCRB (2007). *Accidental Deaths and Suicides in India*, Retrieved from: [http://ncrb.nic.in/CD-ADSI2009/ADSI 2009-full-report.pdf](http://ncrb.nic.in/CD-ADSI2009/ADSI%2009-full-report.pdf)
- NCRB (National Crime Records Bureau) (2005). *Accidental Deaths and Suicide in India*, Retrieved from:
- Patel, V (2001). Poverty, Inequality and Mental Health in Developing Countries, in D. A. Leon and G. Walt (eds.) *Poverty, Inequality and Health: An International Perspective*, pp. 247-62, Oxford: Oxford University Press.
- Patton GC, Coffey C, Cappa C, *et al.* (2012). "Health of the World's Adolescents: A Synthesis of Internationally Comparable Data", *Lancet*, Vol. 379, No. 9826, pp. 1665-75.
- Peters DH, Garg A, Bloom G, *et al.* (2008). "Poverty and Access to Health Care in Developing Countries", *Annals of the New York Academy of Sciences*, No. 1136, pp. 161-71.
- Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips M. R, *et al.* (2007). "No Health without Mental health – A Slogan with Substance", *Lancet*, Vol. 370, No. 9590, pp. 859-77.
- Reidpath, D and Allotey, P (2007). "Measuring Global Health Inequity", *International Journal of Equity in Health*, Vol. 6, No. 1, pp. 9-16.
- Saha, D (2017). "Every Hour one Student Commits Suicide in India", *Hindustan Times*. Retrieved from: [http://www.hindustantimes.com/health-and-fitness/every-hour-on e-student-commits-suicide-in-india/story7UFFhSs6h1HNgrNO60FZ2O.html](http://www.hindustantimes.com/health-and-fitness/every-hour-on-e-student-commits-suicide-in-india/story7UFFhSs6h1HNgrNO60FZ2O.html).
- Saxena S, Thornicroft G, Knapp M, Whiteford, H (2007). "Resources for Mental Health: Scarcity, in Equity and Inefficiency", *The Lancet*, No. 370, pp. 878-89.
- Sironi, M (2018). "Economic Conditions of Young Adults Before and After the Great Recession", *Journal Fam Econ*, Vol. 39, No.1, pp. 103-116.
- Stiglitz, J. E (2002). *Globalisation and its Discontents*, New York: W.W. Norton & Company.
- Teon, A (14th March, 2017). "The Traditional Roots of Parental Pressure and Academic Success in China, Hong Kong and Taiwan", *The Greater China Journal*, <https://china-journal.org/2017/03/14/the-traditional-roots-of-parental-pressure-and-academic-success-in-china-hong-kong-and-taiwan/> (accessed on 5 August 2018).
- UN (2005). *World Youth Report 2005*. Retrieved from:
- UN (United Nations) (2015). United Nations Sustainable Development Knowledge Platform, Transforming our World: the 2030 Agenda for Sustainable Development, Sustainable Development Knowledge Platform 2015 <https://sustainabledevelopment.un.org/post2015/transformingourworld> (accessed August 9, 2018).
- UNAIDS (2018). *UNAIDS Data 2018*, Geneva: UN.
- UNESCO (2013). *Adult and Youth Literacy: National, Regional and Global Trends 1985-2015*, Montreal, Canada: UNESCO.
- UNFPA (2014). *State of the World Population 2014: The Power of 1.8 Billion*. UNFPA.
- WHO (2004). *Prevention of Mental Disorders: Effective Interventions and Policy Options*, Geneva: WHO.

- WHO (2005). *Mental Health Atlas*, Geneva: WHO.
- WHO (2009). *Mental Health, Poverty and Development*, ECOSOC Meeting, Addressing Non-communicable Diseases and Mental Health: Major Challenges to Sustainable Development in the 21st Century, WHO Discussion Paper, July 2009.
- WHO (2018). *Global Health Estimates 2016: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2016*. Geneva: World Health Organization. (http://www.who.int/healthinfo/global_burdenofdisease/estimates/en/index1.html).
- WHO (World Health Organization) (2000). *Preventing Suicide: A Resource for Primary Health Care Workers*, WHOMNHMBD/00.4, Geneva: WHO. Retrieved 19 April 2011 from, http://www.who.int/mental_health/media/en/59.pdf.
- WHO, (2017). *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, Geneva and Washington (DC): World Health Organization and the International Bank for Reconstruction and Development/The World Bank; 2017 (<http://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng.Pdf?sequence=1>, (accessed 14 August 2018).
- World Bank (2007). *World Development Report 2007: Development and the Next Generation*, Washington DC: The World Bank, DOI: 10.1596/978-0-8213-6541-0.
- Wortley, H (2006). *Depression, a Leading Contributor to Global Burden of Disease*, Washington, DC: Population Reference Bureau. Retrieved 23 Feb. 2011 from, <http://www.prb.org>.