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RESEARCH ARTICLE

Psychiatric correlates of child marriage before age 15: A case-control study from Turkiye

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ABSTRACT

Objective: Child marriage gives rise to a wide range of problems for young girls whose psychosocial development is incomplete at the time of marriage. The objective of this case-control study is to compare a sample of girls who married at an early age with two control groups (i.e., unmarried peer adolescents and adults who married after 18 years of age) in terms of sociodemographic characteristics and psychiatric diagnoses.

Method: A total of 120 female participants were included: the child marriage group (CM; n=40), adolescent peers (CG1; n=40), and adults married at ≥18 years (CG2; n=40). Psychiatric diagnoses were assessed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL). Participants completed the Beck Depression Inventory, Brief Symptom Inventory, State-Trait Anxiety Inventory I-II, Coopersmith Self-Esteem Inventory, and Multidimensional Scale of Perceived Social Support.

Results: The CM group exhibited higher rates of lower parental education, lower family income, and a greater prevalence of extended/fragmented family structure compared with both control groups ($p<0.05$). The CM group also showed significantly higher rates of major depressive disorder (MDD) and post-traumatic stress disorder (PTSD) compared with CG1 ($p=0.022$; $p=0.012$) and CG2 ($p=0.004$; $p=0.012$). Postmarital suicide attempts were more prevalent in the CM group than in the CG2 group ($p=0.002$).

Conclusion: Child marriage was associated with lower socioeconomic and educational status, a higher prevalence of MDD and PTSD, lower self-esteem, lower perceived social support, and higher rates of suicidal behavior. These findings underscore the importance of preventive strategies, targeted mental health interventions, and strengthened social support systems for girls at risk of early marriage.

Keywords: Adolescent mental health, child marriage, early marriage, psychiatric disorder

INTRODUCTION

Child marriage, defined as marriage before the age of 18, remains a major global public health and human rights concern (1). It is regarded as both forced and premature, even in cases where it appears consensual, as children are not developmentally capable of fully comprehending the physical, emotional, and social

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consequences of marriage (2). Each year, more than 12 million girls marry before age 18; recent global estimates indicate that 19% of women aged 20–24 years were married before 18 and 4% before 15 (3). Approximately 650 million women and girls are currently living with the consequences of child marriage, with rates varying substantially across and within countries (4). The prevalence is particularly high in South Asia, Sub-Saharan Africa, and parts of the Middle East (3).

Under Turkish civil law, the legal marriage age for both men and women is 17, although under exceptional circumstances, marriage at 16 years may be permitted by judicial decision (5). In cases where one of the parties involved in marriage is under the age of 15, the marriage is considered a form of child abuse (6). Despite these legal frameworks, sociocultural norms in some regions of Turkiye sustain the practice (7). Based on the latest data from the Turkiye Demographic and Health Survey (2018), among women aged 25–49 years, 14.7% were married before the age of 18 and 2% before the age of 15 (8). In 1998, the same survey reported that 7.6% had been married before age 15, decreasing to 5.0%, 4.4%, and 4.0% in 2003, 2008, and 2013, respectively (8). Despite the declining prevalence of early marriage in Turkiye, it remains a prominent practice in certain regions.

Early marriage interrupts a critical period of childhood development and deprives children of fundamental rights such as living with their parents, freedom of expression, opportunities for play, and social interaction with peers (9). Entering marriage at a young age imposes adult responsibilities, including housekeeping and childcare, and often leads to school dropout, which in turn results in social isolation and reduced life satisfaction (10–12). Consequently, child marriage is associated with a high likelihood of severe mental health problems (2). While prior research has mainly focused on social, sexual, and reproductive outcomes, fewer studies have systematically examined the psychological impact of child marriage (13, 14). Existing literature has linked early marriage to depression, anxiety disorders, post-traumatic stress disorder (PTSD), suicidality, and diminished life satisfaction (15-17). Studies from diverse contexts—including the United States, Iran, Niger, and Ethiopia—demonstrate that women who married before 18 report higher rates of psychiatric disorders compared to those who married later (18-21). However, the majority of studies have relied on self-report questionnaires, lacked standardized diagnostic interviews, or did not include control groups. Moreover, the literature has focused more extensively on marriages under the age of 18 than on those under the age of 15, despite the fact that the latter may potentially result in more substantial challenges.

The present study aims to address these gaps by comparing girls married before age 15 with unmarried adolescent peers and adult women married at or after 18 years, in terms of sociodemographic characteristics and psychiatric disorders, using structured interviews and standardized psychometric tools. We hypothesize that (i) girls married before the age of 15 will have significantly higher rates of psychiatric disorders compared to both control groups; and (ii) sociodemographic risk factors such as parental education and low socioeconomic status will differentiate the early marriage group.

METHODS

Participants

This cross-sectional case-control study was conducted at Gaziantep Cengiz Gokcek Maternity and Children's Hospital, a tertiary referral center that also receives judicial referrals of underage marriage cases for forensic psychiatric evaluation. Data collection was conducted between January 2013 and December 2014.

The study was designed with three groups (n=40 each) to allow comparisons addressing the primary aim—characterizing the sociodemographic and psychiatric profile of girls married before age 15—against both adolescent and adult controls. The child marriage group (CM group) comprised girls who had married before the age of 15 and were under 18 years old at the time of psychiatric evaluation; all were referred for forensic psychiatric assessment following a legal notice regarding underage marriage. The first control group (CG1) included healthy adolescent volunteers aged 15–18 years who were unmarried and recruited from patients attending the same hospital for routine medical examinations. The second control group (CG2) consisted of healthy adult women aged 18 years or older who had married at or after the legal age, also recruited from patients visiting the hospital for routine medical examinations. Participants were included in the study if they met the age and marital status criteria for their respective group, volunteered to participate, and were able to complete the assessment tools. Individuals were excluded if they

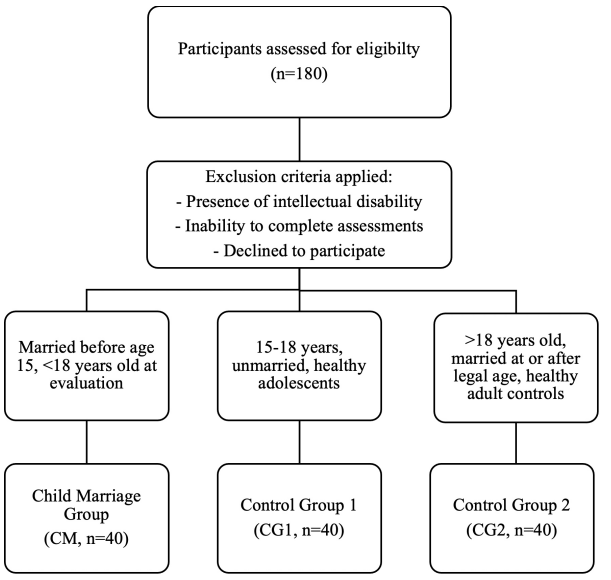

Figure 1. Flow diagram of participant selection.

had an intellectual disability, a psychotic disorder, a current manic episode, or an inability to complete the measures due to literacy or language barriers. Figure 1 shows the flow diagram of participant selection.

Procedure

This study was approved by the Ethics Committee of Gaziantep University (Approval number: 255, date 04.06.2012), in accordance with the Declaration of Helsinki. All participants, and, for those under 18 years of age, their parents or legal guardians, provided written informed consent prior to participation.

Participants in the child marriage group were referred to the hospital by judicial authorities following a legal notice regarding underage marriage. These cases were evaluated in the Child and Adolescent Psychiatry Outpatient Clinic as part of a forensic assessment process. Control groups were recruited from female patients attending the same hospital for routine medical examinations to ensure similar sociodemographic characteristics. All diagnostic interviews were conducted face-to-face by a child and adolescent psychiatry fellow (MD) trained in structured diagnostic assessments, under the supervision of a board-certified child and adolescent psychiatrist.

Each participant first completed a sociodemographic data form, after which they underwent a detailed psychiatric evaluation. For the child marriage group (CM) and adolescent peers (CG1), psychiatric diagnoses were established using the Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) version was used, as data collection was conducted before the Turkish validation of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) version became available. Although the K-SADS-PL is originally validated for ages 6–18, it was also administered to the adult control group (CG2) with minor wording adaptations to ensure methodological consistency and comparability of diagnostic assessment across all study groups.

Following the diagnostic interview, all participants completed the Beck Depression Inventory (BDI), Brief Symptom Inventory (BSI), State-Trait Anxiety Inventory I-II (STAI-I/II), Coopersmith Self-Esteem Inventory (CSEI), and Multidimensional Scale of Perceived Social Support (MSPSS). The age validity ranges of these instruments were confirmed based on Turkish adaptation studies. In instances where measures were used outside their original validated age range (e.g., CSEI in CG2), their use was justified to ensure comparability across groups.

Measures

Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL)

The K-SADS-PL is a semi-structured diagnostic interview designed to assess current and past psychiatric disorders in children and adolescents aged 6–18 years, based on DSM criteria (22). The Turkish reliability and validity study was conducted by Gokler et al. (23).

Beck Depression Inventory (BDI)

The BDI is a 21-item self-report measure that assesses the severity of depressive symptoms (24). Total scores range from 0 to 63, with symptom intensity categorized as follows: normal (0–9), mild (10–15), mild to moderate (16–19), moderate to severe (20–29), and severe (30–63). The Turkish validity and reliability study was conducted by Hisli (25).

Brief Symptom Inventory (BSI)

The BSI is a self-report instrument developed to assess a broad range of psychological symptoms across nine subscales (26). The Turkish adaptation was validated by Sahin et al. (27). The BSI was formulated through studies conducted using the Symptom Checklist-90-R. A modified version of the original

Table 1: Sociodemographic characteristics of the CM group and control groups (CG1, CG2)

Variables	CM group (n=40)	CG1 (n=40)	CG2 (n=40)	p	
				CM vs. CG1	CM vs. CG2
Age, years (Mean±SD)	15.72±0.90	16.03±1.10	22.37±1.87	0.182	**<0.001**
Education level, n (%)				**<0.001**	**<0.001**
Illiterate	27 (67.5)	0 (0)	1 (2.5)		
Compulsory education	11 (27.5)	4 (10.0)	13 (32.5)		
Further education	2 (5.0)	36 (90.0)	26 (65.0)		
Mother's education, n (%)				**<0.001**	**<0.001**
Illiterate	29 (72.5)	5 (12.5)	16 (40.0)		
Compulsory education	11 (27.5)	17 (42.5)	9 (22.5)		
Further education	0 (0)	18 (45.0)	15 (37.5)		
Father's education, n (%)				**<0.001**	**<0.001**
Illiterate	11 (27.5)	2 (5.0)	9 (22.5)		
Compulsory education	25 (67.5)	16 (40.0)	10 (25.0)		
Further education	4 (10.0)	22 (55.0)	21 (52.5)		
Family type, n (%)				**0.001**	**0.001**
Nuclear family	19 (47.5)	34 (85.0)	30 (75.0)		
Extended family	9 (22.5)	4 (10.0)	10 (25.0)		
Fragmented family	12 (30.0)	2 (5.0)	0 (0)		
Family income, n (%)				**<0.001**	**0.018**
Minimum wage or below	35 (87.5)	14 (35.0)	26 (65.0)		
Above minimum wage	5 (12.5)	26 (65.0)	14 (35.0)		

Bold indicates statistical significance (p<0.05). CM: Child marriage; CG1: Control group 1 (healthy adolescents); CG2: Control group 2 (healthy women married after age 18); SD: Standard deviation.

scale was employed, consisting of 21 items (21). The scale comprises nine subscales and global indices. The nine subscales include somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and additional items; the three global indices are the Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST).

State-Trait Anxiety Inventory I-II (STAI-I/II)

The STAI consists of two 20-item self-report scales measuring state anxiety (STAI-I) and trait anxiety (STAI-II) (28). The reliability and validity of the Turkish version were tested and verified (29). While the scale is primarily recommended for individuals above the age of 14, it can be used with individuals whose literacy skills are above the middle school level. The total score for both scales ranges from 20 to 80, with a threshold score of 45. Higher scores on the scale indicate a greater degree of anxiety.

Coopersmith Self-Esteem Inventory (CSEI)

The Coopersmith Self-Esteem Inventory, developed by Stanley Coopersmith in 1967, is a scale designed to evaluate attitudes toward the self in different domains (30). The reliability and validity of the 25-item short version of the scale in Turkish were confirmed by Piskin (31). Higher scores are associated with greater self-esteem.

Multidimensional Scale of Perceived Social Support (MSPSS)

This brief scale is designed to assess the perceived sufficiency of social support. It was adapted from three different sources and aims to evaluate perceived social support through relationships with family, friends, and significant others. The total score is determined by summing all subscale scores. Higher scores on the scale indicate a greater perception of social support (32). Reliability and validity analyses of the Turkish version of the scale were performed for the 12–22 age group (33).

Table 2: Clinical psychiatric characteristics of the CM group and control groups (CG1, CG2)

Variables	CM group (n=40) n (%)	CG1 (n=40) n (%)	CG2 (n=40) n (%)	p	
				CM vs. CG1	CM vs. CG2
Psychiatric disorders (any)	20 (50)	20 (50)	23 (57.5)	0.501[2]	1.000[2]
Major depressive disorder	15 (37.5)	4 (10.0)	6 (15.0)	**0.022**[2]	**0.004**[2]
Bipolar disorder	0 (0)	0 (0)	0 (0)	NA	NA
Anxiety disorders	16 (40)	16 (40)	19 (47.5)	0.499[2]	1.000[2]
PTSD	7 (17.5)	0 (0)	0 (0)	**0.012**[1]	**0.012**[1]
Psychotic disorders	0 (0)	0 (0)	0 (0)	NA	NA
OCD	2 (5)	4 (10)	3 (7.5)	1.000[1]	0.675[1]
Eating disorders	1 (2.5)	0 (0)	0 (0)	1.000[1]	1.000[1]
ADHD	2 (5)	1 (2.5)	1 (2.5)	1.000[1]	1.000[1]
Elimination disorders	3 (7.5)	0 (0)	3 (7.5)	1.000[1]	**0.241**[1]
Tic disorders	0 (0)	0 (0)	1 (2.5)	1.000[1]	NA

Bold indicates statistical significance (p<0.05). [1]Fisher's Exact Test; [2]Chi-square Test. CM: Child marriage; CG1: Control group 1 (healthy adolescents); CG2: Control group 2 (healthy women married after age 18); PTSD: Post-traumatic stress disorder; OCD: Obsessive-compulsive disorder; ADHD: Attention-deficit/hyperactivity disorder; NA: Not applicable.

Statistical Analysis

SPSS for Windows version 22.0 was used to perform statistical analyses. Percentages, means, and standard deviations for each scale were calculated as the main statistics. The Shapiro–Wilk test was conducted to assess the normality of the data. For mean comparisons, a t-test (vs. Mann–Whitney U test) was used when the data were normally (vs. non-normally) distributed. Correlations for normally distributed data were computed using the Pearson correlation coefficient. The values were not adjusted for multiple testing, and the statistical significance level was set at p<0.05.

RESULTS

A total of 120 participants were included (n=40 per group). Mean ages were 15.72±0.90 (CM), 16.03±1.10 (CG1), and 22.37±1.87 (CG2). Within the CM group, 15% of the participants were illiterate, 27.5% had completed primary school, 52.5% had dropped out of primary school, and 5% had dropped out of high school. In CG1, 25% of the participants were high school graduates, while the remaining 75% were currently enrolled in high school. In CG2, 32.5% had completed primary school, 32.5% had dropped out of high school, and 32.5% were high school graduates. The CM group had significantly higher rates of parental illiteracy compared with both control groups (maternal illiteracy: 72.5% [n=29]; paternal illiteracy: 27.5% [n=11]; p<0.05). Sociodemographic characteristics of the participants are presented in Table 1.

Psychiatric diagnoses assessed by the K-SADS-PL for the CM and control groups are presented in Table 2. The CM group had significantly higher rates of major depressive disorder (MDD) (p=0.022) and PTSD (p=0.012) compared with adolescent peers, with no significant differences observed for other disorders. Compared with CG2, the CM group also showed a significantly higher prevalence of MDD (p=0.004) and PTSD (p=0.012), while other diagnoses were similar between the groups. Furthermore, suicide attempts were more prevalent in the CM group, with 10% (n=4) occurring before marriage and 22.5% (n=9) after marriage, compared with 5% (n=2) and 0% in CG2, respectively; postmarital suicide attempts were significantly higher in the CM group than in CG2 (p=0.002). Suicidality characteristics, including suicidal ideation and suicide attempts before and after marriage, are presented in Table 3.

Finally, scale score comparisons revealed that the CM group had significantly higher Beck Depression Inventory scores (z=-2.732, p=0.006) and lower Coopersmith Self-Esteem Inventory scores (z=-2.030, p=0.042) compared with CG2. Furthermore, the CM group exhibited lower Multidimensional Scale of Perceived Social Support total scores, as well as diminished scores on the "friends" and "significant others" subscales, compared with both CG1 (t=-3.039, p=0.003) and CG2 (t=-4.607, p<0.001). Scale score comparisons for all groups are presented in Table 4.

Table 3: Suicidality characteristics of the CM group and control groups (CG1, CG2)

Variables	CM group (n=40) n (%)	CG1 (n=40) n (%)	CG2 (n=40) n (%)	p	
				CM vs. CG1	CM vs. CG2
Suicidal ideation during evaluation				**0.003**	**0.013**
No	29 (72.5)	39 (97.5)	38 (95.0)		
Yes	11 (27.5)	1 (2.5)	2 (5.0)		
Premarital suicide attempt				0.116	0.675
No	36 (90.0)	40 (100.0)	38 (95.0)		
Yes	4 (10.0)	0 (0)	2 (5.0)		
Postmarital suicide attempt					
No	31 (77.5)	–	40 (100.0)		**0.002**
Yes	9 (22.5)	–	0 (0)		

Bold indicates statistical significance (p<0.05). CM: Child marriage; CG1: Control group 1 (healthy adolescents); CG2: Control group 2 (healthy women married after age 18).

Table 4: Psychometric scale scores in the CM group and control groups (CG1, CG2)

Variables	CM group (n=40)	CG1 (n=40)	CG2 (n=40)	p	
				CM vs. CG1	CM vs. CG2
BDI	16.00 (5.00–28.00)	12.50 (8.00–22.75)	7.00 (2.50–13.00)	0.859*	**0.006***
CSEI	60 (42.50–73.75)	62.00 (56.00–71.00)	68.00 (61.00–75.00)	0.377*	**0.042***
STAI-1	43 (28.50–56.25)	43.00 (29.25–51.00)	40.00 (32.75–47.00)	0.394*	0.220*
STAI-2	46.6±12.14	45.37±9.79	44.41±7.03	0.621**	**0.036****
BSI					
Depression	5.50 (2.25–12.00)	3.50 (1.00–7.50)	3.50 (1.00–7.50)	0.885*	**0.031***
Anxiety	4.00 (2.00–15.00)	3.00 (1.00–8.50)	3.00 (1.00–8.50)	0.779*	0.078*
Psychoticism	3.00 (1.00–8.00)	2.00 (0.00–6.75)	2.00 (0.00–6.75)	0.147*	0.349*
Somatization	5.00 (2.00–10.75)	5.00 (1.00–6.00)	5.00 (1.00–6.00)	0.791*	0.238*
Obsessive-compulsive disorder	5.00 (2.00–13.00)	5.50 (2.00–11.00)	5.50 (2.00–11.00)	0.059*	0.661*
Interpersonal sensitivity	5.00 (2.00–10.75)	4.00 (2.00–10.50)	4.00 (2.00–10.50)	0.776*	0.584*
Hostility	4.00 (1.00–9.00)	4.00 (1.00–6.00)	4.00 (1.00–6.00)	0.242*	0.643*
Phobic anxiety	4.00 (1.25–7.75)	2.00 (0.25–4.75)	2.00 (0.25–4.75)	0.688*	0.100*
Paranoid ideation	5.50 (2.00–11.00)	6.00 (1.25–11.75)	6.00 (1.25–11.75)	0.802*	0.927*
Additional items	4.00 (2.00–10.00)	1.00 (0.00–6.00)	1.00 (0.00–6.00)	0.442**	**0.012****
Global Severity Index	29.00 (14.24–42.75)	25.00 (11.25–32.00)	25.00 (11.25–32.00)	0.348*	0.238*
MSPSS total score	42.03±15.53	53.22±16.70	59.80±17.20	**0.003****	**<0.001****
Family support	20.00 (16.50–26.00)	27.00 (20.00–28.00)	27.00 (20.00–28.00)	0.146*	**0.003***
Friends support	9.00 (4.00–18.00)	20.00 (12.00–26.00)	20.00 (12.00–26.00)	**<0.001***	**0.001***
Significant other support	6.00 (4.00–14.50)	16.00 (13.00–27.00)	16.00 (13.00–27.00)	**0.001***	**<0.001***

Data are presented as median (IQR) or mean±SD (standard deviation), as appropriate. Bold indicates statistical significance (p<0.05). *: Mann–Whitney U test; **: Independent t–test. CM: Child marriage; BDI: Beck Depression Inventory; CSEI: Coopersmith Self–Esteem Inventory; STAI: State–Trait Anxiety Inventory; BSI: Brief Symptom Inventory; MSPSS: Multidimensional Scale of Perceived Social Support.

DISCUSSION

Child marriage represents a major public health and human rights concern that requires preventive efforts (1). The findings of the present study indicate that the child marriage group faced a dual burden, consisting of increased psychiatric morbidity—including MDD, PTSD, and suicidality—as well as significant social disadvantages, reflected in disrupted education, lower family income, parental illiteracy, and less supportive family structures.

Socioeconomic disadvantage is a well-documented determinant of child marriage. Prior studies have shown that the likelihood of early marriage is more than twice as high among families living in poverty, where daughters are often perceived as an economic burden and marriage is viewed as a means to reduce financial responsibility (34). Low parental education has similarly been linked to increased risk, consistent with our observation that most mothers in the case group were illiterate and had never attended school (35). In addition, participants in the case group were more likely to come from fragmented or extended families, where economic hardship and limited resources may further facilitate early marriage. Comparable results have been reported in previous studies, which found a higher prevalence of child marriage among girls with less educated parents and identified multiple socioeconomic correlates, including welfare dependency, educational level, and place of residence (36, 37).

Marriage at an early age also implies the interruption and premature termination of schooling. In our study, all participants in the child marriage group dropped out of school before completing compulsory education. The low educational level of women functions both as a cause and as a consequence of child marriage (38). Prior research emphasizes a bidirectional relationship: lower parental and individual education increases the likelihood of early marriage, while child marriage itself restricts educational opportunities and perpetuates educational disadvantage (15). This cycle not only limits the educational attainment of affected girls but also perpetuates socioeconomic vulnerability across generations, transferring the risk of early marriage to their offspring. Due to the adverse consequences linked to early marriage, prevention efforts should monitor young girls whose schooling gets interrupted and support them in continuing their education. Several studies in the literature have pointed out that encouraging young girls to attend school, especially during secondary education, serves as a protective factor against early marriage (39, 40). Taken together, these findings emphasize the importance of improving access to education, supporting vulnerable families, and implementing awareness programs that target communities with low socioeconomic resources to prevent child marriage.

In addition to sociodemographic correlates, our study also examined psychiatric disorders in the child marriage group, revealing significant associations with trauma-related and affective disorders, as well as suicidal behaviors. The prevalence of PTSD was higher among participants in the child marriage group (17.5%) compared with both adolescent and adult controls. Studies have shown that the incidence of PTSD is higher among those who married without individual consent, lived with extended family after marriage, were exposed to physical and emotional violence from the husband, were not acquainted with the husband before marriage, or had an unemployed husband (e.g., military service, criminal conviction) (16). These findings are consistent with reports from South Asia and Sub-Saharan Africa, where child marriage has been linked to intimate partner violence and post-traumatic symptomatology (19, 20). Nevertheless, most participants in our study did not report marriage as traumatic to the extent of developing PTSD, reflecting the role of sociocultural norms in shaping perceptions of early marriage (34). In Turkiye, early marriage is often socially normalized and arranged by families; yet even in this normative context, premature separation from parents, marital conflict, and early sexual initiation can increase vulnerability to trauma-related psychopathology (7).

Within this framework, multiple and chronic traumas, such as taking on responsibilities for caring for a family, home, and children before being ready; experiencing unplanned and unintended pregnancies; having low social support; and facing economic difficulties are thought to result in MDD and adjustment disorder rather than PTSD. In line with this, our findings demonstrated higher rates of MDD, lower self-esteem, reduced social support, and more frequent suicide attempts in the child marriage group compared with controls. Self-report scales broadly aligned with the diagnostic findings: relative to control groups, girls married before 15 endorsed higher depressive symptoms on the BDI and lower scores on the CSEI. On the BSI, elevations were observed for the Depression subscale and Additional Items, whereas the Global Severity Index did not differ, suggesting a selective internalizing burden rather than pervasive psychopathology. These results are consistent with prior studies showing that child marriage is associated with increased vulnerability to internalizing disorders and trauma-related symptoms (9, 41). Given that psychiatric disorders emerging during adolescence can have lasting impacts into adulthood with significant functional impairment, interventions aimed at early detection and prevention of depressive symptoms in at-risk groups are critically needed.

Our results also indicate a higher prevalence of suicidal ideation in the child marriage group compared to both adolescent and adult controls. Importantly, while premarital suicide attempts were comparable with the adult group, postmarital attempts were significantly more frequent among the child marriage group, suggesting that stressors specific to early marriage contribute to increased suicide risk. Research has shown that the frequency of suicidal thoughts, plans, and acts in adolescents is greatly increased by the experience of psychological trauma (17, 42). Therefore, numerous studies in the literature have focused on the link between sexual abuse and suicidal behavior, but insufficient attention has been given to the relationship between suicidal behavior and child marriage. Our findings underscore the need to recognize child marriage as a contextual risk factor for suicidality and highlight the importance of implementing measures during legal procedures and psychiatric treatment to monitor and prevent suicidal behavior.

In terms of perceived social support, children who married at an early age reported receiving less support compared to adolescent peers and adults who married after the age of 18. Specifically, support from friends was notably lower in the case group, which may be related to obligations of living with in-laws, separation from peers due to interrupted schooling, and limited opportunities to maintain social networks (2). Prior research has shown that social support is a protective factor against the negative mental health consequences of child marriage (20). Although our study did not include a detailed statistical evaluation of these associations, the findings suggest that insufficient social support, together with broader sociodemographic vulnerabilities such as poverty and low educational attainment, may contribute to the psychological burden of early marriage. These interrelated factors likely interact, with disadvantage both increasing the risk of child marriage and compounding its adverse mental health effects. Taken together, these results underscore not only the importance of preventing child marriage but also the need to strengthen peer relationships, educational continuity, and social connectedness as protective factors for young girls' mental health.

The present study contributes to the limited literature by examining multiple aspects of the mental health correlates and risk factors associated with child marriage, using two distinct control groups (peer adolescents and adults married at or after 18 years of age) and semi-structured diagnostic interviews to assess psychiatric disorders. However, several limitations should be acknowledged. First, the cross-sectional design restricts the ability to make causal inferences. Second, the relatively small sample size may limit statistical power and the generalizability of the findings. Third, the involvement of legal procedures in recruiting participants for the child marriage group may have influenced their responses during psychiatric evaluation. Finally, some of the psychometric measures and the semi-structured interview used have established reliability and validity only for certain age ranges; although they were applied across all groups for comparability, this may have introduced measurement bias. Future research should employ larger, community-based samples and longitudinal designs to clarify temporal relationships and strengthen causal interpretations.

CONCLUSION

In conclusion, lower socioeconomic status, extended or fragmented family environments, lower parental education levels, and discontinuation of compulsory schooling were identified as factors associated with child marriage. The findings indicate that marriage at an early age is linked to a higher likelihood of developing major depressive disorder, post-traumatic stress disorder, and suicidal behavior. These results emphasize the importance of recognizing child marriage not only as a legal or social issue but also as a significant mental health concern, warranting early identification, targeted prevention strategies, and comprehensive psychosocial interventions for those affected.

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