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Research Report

Mental health of survivors of domestic violence in Rural Northern India: A qualitative, intersectional approach

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Mental Health of Survivors of Domestic
Violence in Rural Northern India.
A Qualitative, Intersectional Approach

Edith Gahleitner

61 FORUM



Mental Health of Survivors of Domestic Violence in Rural Northern India. A Qualitative, Intersectional Approach

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Vorwort

Die Arbeit von Edith Gahleitner ist auf den ersten Blick weder eine klassische Diplomarbeit zum Abschluss eines Medizinstudiums noch eine Arbeit, die ihre entwicklungspolitische Relevanz sofort erkennen lässt. Die Verknüpfung von psychischer Gesundheit und häuslicher Gewalt sowie die Berücksichtigung der Lebensumstände der marginalisierten Frauen sowie der Bezug zu Strategien zur Implementierung der Förderung psychischer Gesundheit bieten aber konkrete Perspektiven für den Gesundheitssektor in Nordindien. Gerade dieser interdisziplinäre Ansatz sowie die qualitativ sehr gute empirische Analyse machen die Arbeit nicht nur spannend, sondern untermauern deutlich, dass die Autorin die Situation der Frauen im Distrikt Kangra nicht nur sehr gut kennt, sondern dass sie mit ihrer Arbeit einen Beitrag zur Verbesserung der Situation leisten möchte.

Die Arbeit hat auch im Kontext mit dem Ziel drei der Sustainable Development Goals (SDGs) – nämlich „Ensure healthy lives and promote well-being for all at all ages“ – besondere Relevanz. Folgt man dem Grundprinzip der SDGs „Leave no one behind“, dann sind Fragen nach den Folgen von häuslicher Gewalt und nach Marginalisierung aufgrund von psychischen Problemen relevante gesellschaftliche Fragen. Edith Gahleitners Analyse ist somit ein wichtiger Beitrag, der eine Brücke zwischen Medizin und Sozialwissenschaften herstellt und eine Grundlage für die Präventionsarbeit zur Vermeidung häuslicher Gewalt darstellt. Die Arbeit ist ebenso ein hervorragendes Beispiel für einen ganzheitlichen Ansatz im Bereich der kurativen Medizin und der Gesundheitsvorsorge.

Der Ausbildungsweg sowie die Forschungsaufenthalte der Autorin in Indien zeigen ein starkes persönliches Engagement, das mit dieser Diplomarbeit eine hervorragende wissenschaftliche Basis erhalten hat.

Dr. Michael Obrovsky

Leitung des Bereichs Wissenschaft & Forschung der ÖFSE

Diplomarbeit

**Mental Health of Survivors of Domestic Violence in Rural Northern India.
A Qualitative, Intersectional Approach**

zur Erlangung des akademischen Grades
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PD Mag.^a Dr.ⁱⁿ Ruth Kutalek

eingereicht von
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Figure 1. A Woman and a Tree s8, 24 years¹

There's really no such thing as the *voiceless*.

There are only the deliberately silenced, or the preferably unheard (Roy, 2004, p.1).

¹ This paper is illustrated with selected drawings made by the participants of this study in addition to the interviews.

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Preface

"Violence is not merely killing another. It is violence when we use sharp words, when we make a gesture to brush away a person, when we obey because there is fear. So violence isn't merely organised butchery in the name of God, in the name of society or country. Violence is much more subtle, much deeper, and we are inquiring into the very depths of violence. When you call yourself an Indian or a Muslim or a Christian or a European, or anything else, you are being violent. Do you see why it is violent? Because you are separating yourself from the rest of the mankind. When you separate yourself by belief, by nationality, by tradition, it breeds violence. So a [wo]man who is seeking to understand violence does not belong to any country, to any religion, to any political party or partial system; [s]he is concerned with the total understanding of mankind." (Krishnamurti, 1969, p. 50)

During my first medical internship at *Nishtha* clinic in India 2011 I faced issues that made me think about, as cultural different concepts of health, bodies and shame; of being a woman; about what patients choose to tell and about what they decided to remain silent. Aware about the "unspoken", I wanted to deepen my understanding of this silence. I wanted to investigate its roots, as well as the discrimination, humiliation, and violence women face in Indian society, that deliberately silences them. As a future doctor I believe it is imperative to be aware of the obstacles women face when seeking medical and emotional healthcare, to develop sustainable strategies that ensure every woman has access to adequate therapy and to prevent them from inappropriate medical investigations. Committed to my personal engagement for women and continually curious about India, I applied for studying at the All Indian Institute of Medical Science in New Delhi and went there in 2013. Again I was faced with the precarious situation of girls and women in Indian society. Reflecting upon my experiences in India, and upon my observations in clinics around the world, I have strengthened my dedication to women's rights and global justice for survivors of domestic violence. We have to be aware not to reduce violence against women in India to a cultural issue. The exact circumstances and vulnerability of young women to multiple forms of violence in India or in any other country may vary. What I have learned from working and researching with women's associations, activists, doctors and social workers around the globe is in order to actively fight gender inequity on various societal levels we must radically combine educational reform and familial and communal vigilance to achieve social solidarity based on the protection of the most vulnerable, such as for the subjects of my study, rural marginalized women. This project marks just the beginning of my engagement in women's rights and the pursuit of an equal society for girls and women.

Abstract

Background: Domestic violence is a serious public health concern in India, having a devastating effect on women's mental health. Mental health remains a neglected field, with lack of gender sensitivity in community mental health care. Due to socioeconomic factors, and gender discrimination rural women are further marginalized and have negligible access to mental health care. It is therefore that the burden of mental disorders in rural survivors of domestic violence is presumably underrated, lacking adequate diagnosis and treatment facilities.

Objectives: This study aims to investigate the complex phenomenon of domestic violence on a community level by focusing on mental health in rural marginalized survivors of violence in district Kangra, Himachal Pradesh, North India, following a critical, intersectional approach.

Method: A qualitative approach was used, primarily utilizing participative methods, foremost in-depth interviews with 23 women facing domestic violence. Additionally, stakeholders from nonprofit organizations, physicians and social workers were involved from the beginning. Written informed consent was obtained from every participant.

Results: The overall findings indicate serious mental health challenges are present amongst rural marginalized women who face domestic violence. Mental health is found a neglected and stigmatized issue amongst survivors of domestic violence. The intersectional analysis highlights the simultaneous interaction of multiple forms of violence and underscores the need for including marginalized women's voices and realities on the ground. It is therefore essential and indispensable to build on future strategies for community mental health care and develop a methodology for sustainable prevention of domestic violence.

Zusammenfassung

Hintergrund: Häusliche Gewalt gegen Frauen ist ein ernstzunehmendes sozialmedizinisches Problem in Indien mit weitreichenden Folgen für die psychosoziale Gesundheit der Frauen. Psychosoziale Gesundheit ist ein allgemein vernachlässigtes Feld, speziell Gendersensibilität in psychosozialen, kommunalen Versorgungsstrukturen. Sozioökonomische Faktoren und die Diskriminierung von marginalisierten Frauen wirken sich nachteilig auf deren Zugang zu psychosozialen Betreuungseinrichtungen aus. Das Ausmaß psychischer Probleme von Frauen im ruralen Indien wird weitgehend unterschätzt und psychosoziale Versorgungsstrukturen sind mangelhaft.

Ziel: Diese Studie analysiert das komplexe Phänomen der häuslichen Gewalt an Frauen einem intersektionellem Ansatz folgend. Dabei wird speziell auf das Lebensumfeld und die psychische Gesundheit marginalisierter Frauen im ländlichen Umfeld im Bezirk Kangra, im nordindischen Bundesstaat Himachal Pradesh eingegangen.

Methode: Es wurden 23 qualitative Interviews mit Frauen, die häusliche Gewalt erlebt haben, durchgeführt. Interessenvertreterinnen aus Nichtregierungsorganisationen, Ärztinnen und Sozialarbeiterinnen wurden von Beginn an miteinbezogen. Eine schriftliche Einwilligungserklärung der Studienteilnehmerinnen wurde eingeholt.

Ergebnisse: Diese Studie weist auf ernsthafte psychische Probleme von marginalisierten Frauen hin, die häusliche Gewalt erfahren haben. Psychische Gesundheit im Allgemeinen ist ein vernachlässigtes und stigmatisiertes Thema unter gewaltbetroffenen Frauen. Die intersektionelle Analyse betont das Zusammenwirken verschiedenster Formen von Gewalt und die Notwendigkeit, die Lebenssituationen marginalisierter Frauen in der Planung zukünftige Strategien zur Implementierung eines adäquaten Programms zur Förderung psychischer Gesundheit zu berücksichtigen. Eine nachhaltige Präventionsarbeit zur Vermeidung häuslicher Gewalt ist notwendig.

Aims of the Study

This research aims to understand the complex interrelationship of domestic violence and its mental health consequences within a group of service-users of two nonprofit organizations in order to develop strategies for the purpose of improving community-level mental health care interventions and implementing system change.

Following an intersectional approach (Anthias & Yuval-Davis, 1989; Crenshaw, 1989), this paper will not only discuss multiple forms of violence and mental health sequelae that are inherently associated with physical health consequences, but also analyze women's strategies and agency in the context of domestic violence. Intersectionality emphasizes a context-related understanding of domestic violence and seeks to examine "how patterns of subordination intersect in women's experience of domestic violence. Intersectional subordination... is frequently the consequence of the imposition of one burden that interacts with preexisting vulnerabilities to create yet another dimension of disempowerment" (Crenshaw, 1991, p. 1249).

Focusing on the interests of marginalized rural women, the interpretive framework underlying this research project follows a critical paradigm. A critical research position puts an emphasis on how social inequities such as gender, class, race and economical circumstances affect people's lives. Critical research sheds light upon people who have been historically neglected in a traditionally paternalistic and western dominated scientific research community. The central intention of this approach is to end the "invisibility and distortion of female experience, in ways which serve to abolish gender inequalities and discrimination against women" based upon a "critical analysis of gender relationships in research and theory... an appreciation of the moral and political dimension of research... and the recognition of the need for social change to improve the lives of women" (Ussher, 1999, p. 99).

1 Introduction

1.1 Violence Against Women in India

Violence against women (VAW) is a serious public health concern and human rights violation. It is occurring in epidemic proportions and requires urgent action (World Health Organization, 2013a). VAW is seen a major obstacle to development and is a neglected priority of the international development agenda. VAW is hindering the achievement of the Millenium Development Goals (World Health Organization, 2005a). It is the most pervasive but least recognized human rights violation in the world (Heise et al., 2002) and has a traumatizing and devastating effect on women's health as well as on those who witness it - their children (Buzawa & Buzawa, 1996; Ellsberg, 2006; Garcia-Moreno et al., 2005). It is an extremely complex phenomenon, deeply rooted in gender inequalities and gender based power relations. The United Nations General Assembly Declaration on the Elimination of Violence against Women (1993) defines VAW as, "any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life". Worldwide VAW is the most commonly committed crime by intimate partners (Campbell, 2002; Garcia-Moreno et al., 2005; Martin et al., 1999b; World Health Organization, 2013a). It coerces women to bear their sufferings and remain silent about their experiences. They are socialized to accept, tolerate and rationalize these violent acts (Kumar et al., 2013). VAW pervades all social classes, castes, religions, ages, genders and geographical boundaries (Kumar et al., 2013). Both intimate partner violence and non-partner violence have a deep influence on a woman's life from childhood to adolescence and beyond (Buzawa & Buzawa, 1996; Heise et al., 1994). The World Health Organization's Multi-country Study on Women's Health and Domestic Violence against Women showed that 15-71% of women aged between 15-49 years have faced sexual or physical violence by intimate partners at some point in their lives (World Health Organization, 1997).

India has one of the highest rates of VAW worldwide (World Health Organization, 2013a). India's National Family Health Survey-III, carried out in 29 Indian states during 2005-2006, indicated that nationwide 37.2% of women had experienced abuse after marriage (International Institute for Population Sciences & Macro International, 2007). Other studies show an even higher prevalence in India, ranging from 18-70%, varying widely through diverging study methodologies (Babu & Kar, 2009; Kumar et al., 2005; Martin et al., 1999a;

Miller, 1999; Rao, 1997). Since rural marginalized women are likely to be socially deprived they are at a heightened risk of facing violence. Stress related factors such as poverty, a higher number of children and a lower educational level were found to be positively associated with domestic violence (Martin et al., 1999b). Alcoholism (Babu & Kar, 2010; Khosla et al., 2005; Kumar, 2013; Sinha et al., 2012) as well as controlling behaviour of a spouse (Dalal & Lindqvist, 2010) were found as other main promoters of intimate partner violence. On the other hand, household wealth, higher education of the wife (Kimuna et al., 2013) and social support (Sinha et al., 2012) were found protective factors. Mander criticized that the most vulnerable women who belong to the lower economical strata, Scheduled Castes² and Scheduled Tribes³, are generally left out of the recently emerged national outrage against gender violence in India (Laul, 2013).

"Violence against girls and women has existed for centuries. Unlike other forms of violence, many atrocities against women have remained invisible and neglected even though they are recognized in laws and policies" (Bhaiya, 2012, p. 41). In India, the Protection of Women from Domestic Violence Act (2005) provides the legal framework for the definition of domestic violence in India. Hence, domestic violence is specified as any act that causes harm or injury to a woman's mental and physical health including physical, sexual, verbal, emotional and economical violence. It implicates any dowry related abuse and unlawful demand and any threat or other injuries that cause harm.

VAW includes but is not restricted to, emotional and psychological violence. This implies all strategies undermining a women's self-esteem such as intimidation (yelling, threats), humiliation (mockery, harassment, contempt), abusive language (cursing) and deliberate deprivation of emotional care and isolation (Bhaiya, 2012; Garcia-Moreno, 2005). Physical violence ranges from frequent pushing and shoving to more severe forms such as beating, hitting, slapping, kicking, armed threats, torture, mutilation and murder. Sexual violence implies all forms of non-consensual sexual interaction ranging from unwanted sexual touching to forced degrading sexual practices, rape and incest. Economic violence contains all forms of strategies to control a couple's financial budget, income and property and more

² The term '*Scheduled Castes*' refers to a list of socially deprived castes listed by the British Government in 1935 and is an official term for *dalits*, the informally called 'untouchables', usually members of the lower economic strata in Indian society. The schedule of castes originally aimed on the heightening of the representation of Scheduled Caste members in the legislature, in government employment, and in university placement.

³ *Scheduled Tribes* specifies indigenous tribal populations who gain kind of the same compensatory treatment as Scheduled Castes.

subtle forms, for example, preventing the partner from any engagement in earning additional money outside of home. It also includes any form of deliberate deprivation of basic needs, such as food, by not providing money for it. Religious violence encompasses any attempt to ridicule, forbid or destroy someone's cultural or religious faith or force someone to follow certain religious practices.

Looking back at historical achievements in feminist activism, VAW was made visible in public perception by pointing to its structural causes and effects rather than at individual and isolated cases. "Violence in general is a coercive mechanism to assert one's will over another, in order to prove or feel a sense of power... Any hierarchial system of social organization, where there are categories of dominant groups and subordinate groups, is inevitably accompanied by the victimization of the latter through various means - subtle pressure, through the power of ideology, through mechanisms of socialization that reward compliance and punish noncompliance and also through open force... In fact, it is often not even necessary to actually use physical force or inflict severe injury, for the mere threat to do so is enough to subdue the subordinate person or group... [and create] an atmosphere of terror, a situation of threat and reprisal... [Any] hierarchial social structure has violence built into it." (Kosambi, 1993, p. 1)

Structural violence as such is defined by Galtung (1993) as an "avoidable impairment of fundamental human needs" through repressive social structures due to economical status, gender, caste, religion etc. "or, to put it in more general terms, the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible. The threat of violence is also violence" (p. 106). Structural violence is closely linked to social injustice, which plays an important role in economically deprived regions, such as Northern India. Farmer (2001) describes the effect of structural violence on the health of subaltern and marginalized people: "Their sickness is a result of structural violence: neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress" (p. 79).

The acquittal of two policemen by the Supreme Court in 1979, accused of raping a 14 year old tribal girl named Mathura at a police station in Maharashtra, provoked public outrage in India. At the same time, women's groups in Delhi uncovered cases of accidental deaths and suicides of some newly-married women, now denoted as 'bride-burnings'. Both incidences

were main factors in triggering of public protests around India and contributed to the fast spread of the feminist movement in India, not only in urban but also in rural areas (Gandhi & Shah, 1992). India's women's movement became strong, pluralistic and is still marked by a continuing vibrancy. Multiple forms of VAW were 'discovered' and India's women's movement became instrumental in making VAW a political issue and advocating for legislative reforms (UNIFEM South Asia Regional Office, 2003). The Fourth World Conference on Women in Beijing in 1995 marked another important historical turn; its essence being the declaration of women's rights as human rights. The Beijing conference and its resulting Beijing Platform for Action, had contributed to a policy environment in which VAW is legally acknowledged by the state as a major human rights violation. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), was introduced in 1979 by the United Nations General Assembly and set an international law for women's rights including national agendas to eradicate gender inequity. By adopting this convention, India committed itself to taking action against the discrimination of women. Women's groups and NGOs are at the forefront of holding the government accountable to international conventions, actively contribute to policy environment, and provide a fundamental agenda for empowerment (UNIFEM South Asia Regional Office, 2003).

1.1.1 Women's Life in the Context of Violence

Domestic abuse is embedded in a circle of violence as "Indian society remains firmly rooted in the patriarchal ideology, which is premised upon male supremacy and a legitimization of women's oppression" (Kosambi, 1998, p. 19). Hereby, a major problem is that VAW is viewed 'normal' in certain communities, and women are viewed as inferior to or even owned by men (Lafta, 2008). As Heise stated, violence is an extension of a continuum of beliefs that grants men the right to control women's behaviour (Heise et al., 1994).

This chapter follows the structure of a life of a woman, emphasising the overall exposure of girls and women to violence throughout their lives, from pre-birth to old age. The "socialization of Indian women is the sheer exteriority of her life; in the fact that her values, her goals and her actions are decided, not from within, but from without, by our socio-cultural imperatives. The inner voice of the Indian women is silenced, during the process of becoming a socially useful and acceptable being" (Davar, 1995, p. 164).

Starting pre-birth, sex-selective abortion following **prenatal sex determination tests** is a prevalent practice in India (Khanna, 1997; Trivedi, 2007; United Nations, 2012). Families have a strong preference for sons (Kumar et al., 2013; Trivedi, 2007). This is rooted in beliefs

that a son will carry on the family name, sons are essential for the last rituals of death in Hindu religion, and sons place no dowry burden on their family (Kumar et al., 2013). Most Indian women hope to give birth to at least one male child after marriage. Hence, women who are infertile or have not given birth to male offspring after marriage often face assault (Puri et al., 2011; Trivedi, 2007). In middle-class families (less so in families from lower economical strata), family members often force women to undergo an amniocentesis or ultrasound, not to check for hereditary diseases but to find out the sex of the fetus (Gilles & Feldman-Jacobs, 2012). In case it is a female fetus, doctors are requested to abort them. A commercial campaign promoting sex-selective abortion proved to be effective at a national level, resulting in a strongly male biased sex ratio in India due to **son preference**, which in turn resulted in increased VAW (Brooks, 2011). The enactment of the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, should prevent sex-selective abortion from happening, but its implementation remains low (Bhaiya, 2012).

At birth, when a male child is born, the family is supposed to distribute sweets. If a girl is born, she is seen as an economic and social burden from the very beginning of her life due to the daughter's immanent marriage. It is not unusual that mothers of daughters fear humiliation or even life threats because they have given birth to a baby girl. **Female infanticide** is another prevalent practice in India (Khanna, 1997; Trivedi, 2007; United Nations, 2012), despite media campaigns against femicide and despite it being an offence under Indian law equivalent to murder, emphasizing its heinousness due to the defenceless nature of a child. Female infanticide means the intentional killing of girls due to their sex in early childhood. A more subtle but prevalent form of violence is **girls neglect** (Miller, 1983), where female children are denied basic access to health care, nutrition and education (Sen, 2013). Malnutrition of girls might be the most visible form of sex-selective childcare in rural India. Usually girls eat with women after the male family members have had their food. If a family is poor and lacks food, girls and women usually have less substantial meals compared to their male family members (Ahmed-Gosh, 2004). Chronic malnutrition of girls often results in anaemia which is epidemic in rural Indian girls and women. Sex selectivity in pediatric health care is another elaborate negligence against girls in India (Khera et al., 2014). Many Indian girls are denied basic medical care for childhood ailments or their medical treatment is delayed, which sometimes results in their death. As Miller (1987), a physician, illustrated; "In one village, I went into the house to examine a young girl and I found that she had an advanced case of tuberculosis. I asked the mother why she hadn't done something sooner about the girl's condition because now, at this stage, the treatment would be very expensive. The mother

replied, 'Then let her die, I have another daughter.' At the time, the two daughters sat nearby listening, one with tears streaming down her face" (p.95). Girls are denied basic immunizations and nutrition and less money is spent on their medical treatment. Gender inequity in accessing medical health care, deliberate neglect of girls and sex-selective abortions do effect the declining child sex ratio in India (Khera et al., 2014). Census 2011 showed a child sex ratio of 919 females per 1000 of males compared to a child sex ratio of 927 females per 1000 of males in 2001. This regressive trend is also seen in the child sex ratio of Himachal Pradesh (Cohen, 2000), the area of research: In 2011 the child sex ratio was 909 females per 1000 of males, compared to 2001 it was 957 females per 1000 of males (Registrar General, 2011e).

Traditional role models are root causes that perpetuate and enable VAW. Traditionally rural girls are raised to help their mothers with household tasks. They have less spare time to play and they are likely to be denied education. From a very young age, rural girls are trained to be obedient in order to become *pativrata*⁴, good wives.

As adolescence begins, so does an extremely vulnerable period for young women in becoming victims of abuse. 'Eve-teasing', for example, is a euphemism for **sexual harassment** and molestation of women by men in public, which is a highly prevalent form of VAW starting from adolescence onwards. Its trivialization may be influenced by some popular Bollywood movies, in which the heroine usually falls in love with the hero, who then will tease her, which is considered to be fun. But the root problem is that the hero interprets a 'no' as a 'yes'. Protests by the heroine will be unheard (Bhaiya, 2012). The underlying message, transferred into reality, undermines women's acts of resistance against unwanted sexual touching. Sexual harassment includes any form of objectionable sexually loaded behaviour including words, touching, whistling, pushing, pawing, exposure to any visual violence such as obscenity and pornography that makes women feel uncomfortable. It commonly happens in the workplace and public space but also in private. It is usually inflicted by employers, persons of affluence or landowners in rural communities. The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013, seeks to protect against sexual harassment at work places, whether it is in public or private. It also includes school and college students, patients in hospitals and the high risk group of domestic workers. The success of its implementation is yet to be seen, but it provides a basis for

⁴ *Pativrata* literally derives from *pati* = husband, *vrata* = vow.

redressal of complaints.

Generally girls and women from the lower economical strata have a higher risk of facing sexual violence. Thus, girls from Scheduled Castes are extremely vulnerable and are often the target of sexual assault by upper-caste men. This contributes considerably to the high rate of **child marriages** especially among *Dalit*⁵ girls in rural parts of India. The problem is that if a girl is raped, she cannot be married off any more (Human Rights Watch, 2008). Generally, child molestation and child physical and sexual abuse is a severe problem in India. The National Crime Records Bureau (2012) reported that 12.5% (3,125) of the total female victims of rape were under 14 years of age. 23.9% (5,957 victims) were adolescent girls between 14-18 years of age.

Most marriages in traditional rural Indian society are arranged. In arranged marriages, parents would select a husband for their daughter mostly due to caste. Dowry also plays an important role in marriage arrangements. This is the main reason arranged marriages are seen to be so problematic; because women are treated like goods. The custom of an arranged marriage is nurtured by the highly valued marriage ritual of *kanyaadaan*, which is based upon Hindu mythology. By giving away their daughters as gifts in marriages, parents get rid of their sins and ensure their right to 'heaven'. As newlyweds, women have a high risk of encountering **dowry harassment** in traditional rural families (Kumar & Kanth, 2004; Kumar et al., 2013). Usually, newly married women move into their marital houses after marriage and suddenly they have to subordinate to a completely strange environment. When dowry demands are not met or the bride-price is found to be unsatisfactory, verbal assault and violence against the newly-married woman are utilized to pressure her family for more money or gifts such as a car or motor bike. In its worst form, greed for dowry can lead to **dowry killings** (Kumar & Kanth, 2004). In fact, the tradition of dowry has increased within the last decades resulting in erratic mortality and morbidity rates of married women in India (Banerjee, 2014). Various women's rights activists and reformists have condemned the dowry custom. During the seventies, women's rights groups found out about the crucial practice of dowry killings after they inquired about a wave of mysterious deaths of newly married women. Although Indian

⁵ *Dalits* is a denotation for a group of people referred to as 'untouchables' or *harijans*. This term already implies that Dalits often face social exclusion especially in traditional rural Indian society. They are often denied access to schools, public happenings, temples and even water sources. The official term for Hindu, Sikh and Buddhist Dalits is 'Scheduled Castes' (SC). Dalits are a heterogeneous group of people following different religions, speaking different languages and belonging to various communities all over India. According to Census 2011 Dalit population in India in total was 16.2%, with the second highest portion in Himachal Pradesh of 24.7% following Punjab (Registrar General 2011d).

law had already made the practice of dowry an offence in 1961 through the Dowry Prohibition Act, the dowry system turned out to occur in large and disturbing proportions in Indian society. The law was therefore altered through the Dowry Prohibition (Amendment) Act in 1984. However, its legal implementation lacks. Many women entangled in the system of patriarchy are afraid to raise legitimate complaints. India's Crime Records Bureau registered 8172 dowry murders in 2008 (National Crime Records Bureau Ministry of Home Affairs, 2008), but incidence is expected to be much higher (World Health Organization, 2012). Burning is a common method of dowry murder, as well as forced suicide (World Health Organization, 2012). Usually, the woman is first dowsed with kerosene oil and then set alight. These homicides are covered up as kitchen accidents, as women in traditional society spend much time cooking, mostly over an open fire. This was found to be the third most prevalent reason of death among 15-44 year old women in the South East Asia region (Sanghavi et al., 2009).

Domestic violence is rampant in India. 37.2% of women have experienced abuse after marriage (International Institute for Population Sciences & Macro International, 2007). It is known but not acknowledged. "It has been invisible because of the 'private' nature of the family and the personal nature of the relationship between husband and wife. Women rarely want to speak of domestic violence as it involves their own husbands or relatives, their family honour, fear of social pity and of not being believed by society." (Bhaiya, 2012, pp. 41). Non-consensual sex is another frequent form of violence within marriage. Some husbands may use restraint, but the problem lies more in women's underlying belief that they are not allowed to disobey their spouse's sex-related demands. A further problem is that there is no law that provides Indian women legal redress for sexual abuse within marriage (Bhaiya, 2012). Forced marriages, forced sexual initiation and rape in marriage is widely tolerated in India (Jejeebhoy et al., 2013). **Marital rape** is a common practice, often denied by men. It may be due to women lacking the knowledge about their right as women to say 'no', especially in low educated rural women and also about sexuality in general. In their qualitative research on different gender perceptions of violence Jejeebhoy et al. (2013) revealed huge gender disparities in the perception of marital violence. All female participants in their study were exposed to marital rape whereas male participants would deny it from happening.

Rape is seen as coercive sexual intercourse or other forms of sexual penetration through threat by physical means without consent or a person that is incapable of giving consent, such as an unconscious person or a person under influence of drugs, such as alcohol or the date-rape drug rohypnol and gamma hydroxybutyrate (Watts & Zimmermann, 2002). In contrast to

the common belief that rape is perpetuated by violent strangers, the National Crime Record Bureau reported that 98.2% of the registered rape victims in 2012 had known their perpetrators (National Crime Records Bureau, 2012). Watts & Zimmermann (2002) state that coerced sex is mostly committed by intimate partners, male family members, or other male authorities and that most incidents are not unique but continuing for years. Due to the sensitivity of the issue of rape, underreporting is prevalent. In particular, date rape reports and sexual coercion in schools or colleges are not made public because girls and young women fear reproval by their families and peers (Bhaiya, 2012). Rape victims in India fear social stigmatization tremendously. Forced suicide in Indian rape victims has been mentioned earlier. The Criminal Law (Amendment) Act, 2013 was enacted by the Indian government in response to the brutal New Delhi gang rape case December 16, 2012, which provoked again national outrage, and a call to stop VAW. The Anti-rape Bill amends the Indian Penal Code, Indian Evidence Act, Code of Criminal Procedure, 1973 and the Protection of Children from Sexual Offences Act. It allows for life imprisonment and even death sentences for rape convicts and severe punishment for other perpetrations such as acid attacks, stalking and voyeurism ("New anti-rape law comes into force", 2014). Gang rape is associated with forms of gang initiation, racism, ethnic hatred and punishment (Watts & Zimmermann, 2002). There is no separate statistic on gang rapes in India available. Since *Nirbhaya's*⁶ gang rape in New Delhi, December 16, 2012, incidents of gang rapes have found wide national media coverage in India. It was found especially threatening to Indian women that she was a well educated, middle-class woman. But as mentioned earlier, media coverage of raped marginalized women slightly is neglected in India. Another phenomenon is mass rape of women as a political weapon and strategy of war, as a means of targeting women in order to humiliate and punish the whole community. This implies the view that women are seen as their husband's property. Thus, violating this property is an effective way of harming 'his' property. During the Jammu and Kashmir conflict⁷ Indian security forces were accused of widespread use of rape against civilians. Widely use of mass rape as ethnic violence had also been reported during counter-insurgency operations in other conflict areas in northeast India, especially in Assam (Human Rights Watch, 1993). "[N]o one practices untouchability when it

⁶ *Nirbhaya* literally means 'the fearless one'.

⁷ The conflict in the North Indian state of Jammu and Kashmir is ongoing since January 1990. It is a battle between Indian security forces and armed Muslim insurgents, who strive for independence or accession to Pakistan.

comes to sex" (Pal, 2007, p. 2). The recent *Badaun*⁸ gang rape case in May 2014 of two Dalit girls in Uttar Pradesh, who were found dead hanging from a tree, triggered again a national and international condemnation of violence, especially in support of vulnerable marginalized women from Scheduled Castes and Scheduled Tribes. Rape of Dalit girls and women in rural India is a widespread phenomenon. Forced sex with village landlords or forced prostitution (*devadasis*⁹) are common among Dalits (Human Rights Watch, 2008). Iyer, a senior researcher at Amnesty International India, denounced the violence and discrimination against Dalits in India as a means of humiliation and power abuse by members of dominant castes (Gohain, 2014). Rape of poor women and women belonging to low-caste and tribal minority groups by Indian police has also been condemned by Amnesty International ("Document - India: Torture, Rape and Deaths in Custody", 1992).

Women belonging to the lower economical strata, Scheduled Castes or Scheduled Tribes, are also prone to becoming victims of trafficking. **Human trafficking** for labor or sexual exploitation including forced prostitution, violence against sex-workers, forced labour, slavery and removal of organs, is a rampant problem in India. 90% of trafficking in India takes place interstate or intrastate, only 10% of trafficking is international (Hameed et al., 2010). The United Nations (2000) defines trafficking as an abuse of power and control over women for the means of exploitation and earning profit. Threat, coercion, abduction, deception and debt-bondage are frequent methods of repression against victims of trafficking (Watts & Zimmermann, 2002). They are promised good jobs but end up being forced into slavery-like situations, sweatshop labour, forced prostitution or begging. India's low sex ratio and its resulting 'marriage squeeze'¹⁰, was found to have a negative impact on the rising trafficking of women, forced marriages, bride importation and female migration (Gilles & Feldman-Jacobs, 2012).

At the far end of the spectrum of violence against women is the intentional killing of a woman due to her gender. Most commonly, **femicide** is committed by intimate (ex-)partners following threats, excessive spousal abuse and persistent attempts at intimidation. Occasionally other family members may be involved, for example in forcing a woman to take her own life.

⁸ *Badaun* is a district in Uttar Pradesh, India.

⁹ *Devadasi* is usually a girl from a poor family, who is 'dedicated' to Hindu deities and often lands up as a 'temple prostitute'. Critical voices stresses that *devadasi* tradition supports forced prostitution.

¹⁰ 'Marriage squeeze' is a sociological term referring to a shortage of women, resulting from unequal sex ratio, that makes it difficult for men to find a bride. In societies such as India, where marriage is almost compulsory, this leads to a serious problem for men.

Sometimes rape victims are forced to commit suicide because they are considered to bring shame over the family or they fear that no one will marry them once having lost their virginity (Kumar et al., 2013). **Honour killing** is another form of VAW and is increasing in incidence. Women are punished by family members or members of their caste or their religious community due to actual or assumed breaches of social norms, such as behavioural infringement, adultery, sexual intercourse or even rape (World Health Organization, 2012). It is seen as a method to save family honour by the penalization of women who, for example, chose a man outside their caste, tribe or community. But even the suspicion of any intimate contact of a woman with a man could result in her murder (Bhaiya, 2012). Sometimes honour killing is used to disguise incest.

A lesser known form of VAW in India is **female genital mutilation** (FGM). While the Hindu community does not support female circumcision, among certain Muslim populations, such as the Bohra community, it is a common practice (Goswami, 2012). *Khatna*, the excision of the clitoris is performed on seven year old girls. Removing the *haraam ki boti*, the clitoris, is a way of controlling a woman's sexual urges and according to traditionalists, it prevents women from infidelity. The World Health Organization (2014) defines FGM as all "procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" and condemns it as a basic violation of human rights.

Acid throwing is another very repulsive form of humiliation against Indian women. It is perpetrated by men who feel rejected or ignored by young girls and women who have refused their sexual advances or marriage proposals. Men throw car battery fluid or sulfuric acid on women's faces or bodies to maim them completely. It mostly happens during the night. Many victims are also burned afterwards. The perpetrators aim to dishonour the women's families and ruin their future marriage prospects (Chowdhury, 2005).

Violence against widows or elderly women includes social stigmatization of widows and being accused of being useless in terms of work. Widows in rural India are highly marginalized, facing stigmatization, discrimination and social exculsion (Chen & Drèze, 1992). They are denied property rights, banned from marriages and other public events and have to obey certain socially restrictive customs. In many traditional families widows won't get support from their in-law family after death of their husbands. Mainly they will have to rely on the support of their children only. Their exclusive social status makes them highly vulnerable for sexual harassment and forms of violence not only but particularly through members of the marital family. A shocking and visible form of VAW is the tradition of *sati*,

in which women traditionally immolate themselves at the husband's funeral pyre to sacrifice themselves for their husbands (Jaising, 1995). *Sati* and its glorification was legally banned in India through the adoption of the Commission of Sati (Prevention) Act, 1987, by the Ministry of Women and Child Development (Jaising, 1995). Although in its extremity *sati* was legally forbidden, the subjacent concept of the moral obligation to be an obedient, docile and a self-sacrificing wife remained.

1.1.2 Legal Aspects

Mitra (2000) criticises that laws meant to protect women are also made within the context of a patriarchal system. Legislation itself will not change the situation. Thus, what is needed is a profound rethinking of cultural and social norms. "There is a wide divergence between the legal provision and the perception of those associated with its implementation. The legal system gives pre-eminence to the notion of homogeneous family, thus disregarding the subordinate status of women within the family, and of her experiences of violence that this entails." (Mitra, 2000, p. 11).

The National Crime Records Bureau (2012) specifies 'Crimes Against Women' as crimes committed directly and particularly *against* women. Indian legislation classifies them in two categories: 1. The Crimes under the Indian Penal Code (IPC): Rape (Sec. 376 IPC), kidnapping & abduction for specified purposes (Sec. 363 - 373 IPC), homicide for dowry, dowry deaths or their attempts (Sec. 302/304-B IPC), mental and physical torture (Sec. 498-A IPC), molestation (Sec. 354 IPC), sexual harassment (Sec. 509 IPC), importation of girls (upto 21 years of age) (Sec. 366-B IPC). 2. The Crimes under the Special & Local Laws (SLL): Gender specific laws which are statistically recorded are the Immoral Traffic (Prevention) Act, 1956; the Dowry Prohibition Act, 1961; the Child Marriage Restraint Act, 1929; the Indecent Representation of Women (Prohibition) Act, 1986 and the Commission of Sati (Prevention) Act, 1987.

The National Crime Records Bureau (2012) reports a continuous increase of reported crimes against women since 2008. In 2012 a total of 2,44,270 crime incidents (both under IPC and SLL) were reported showing following distribution:

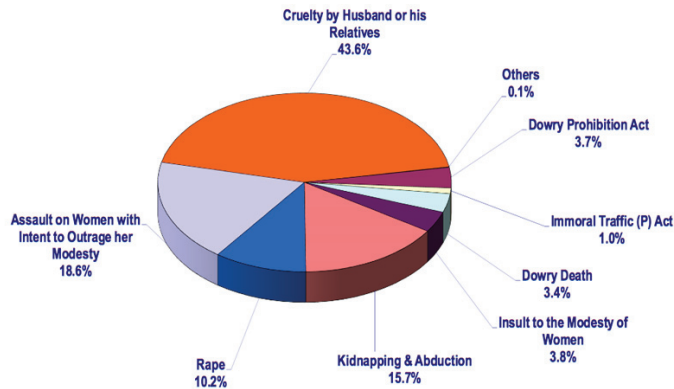


Figure 2. National Crime Records Bureau. (2012). Crimes Against Women Percent Distribution 2012

Various Indian legislations are aimed at the protection of women's rights to live free from violence. One most important legal framework is provided by **The Protection of Women from Domestic Violence Act (PWDVA), 2005**. It should protect the rights of women who face domestic violence and facilitate their access to justice. The PWDVA provides a detailed definition of domestic violence including physical, sexual, verbal, emotional and economic abuse. Key features are its focus on the protection of victims of domestic violence, specifically women and children, instead of punishing the perpetrator. It further includes mothers, daughters, sisters, widows, relations through adoption and the recognition to 'relationships in the nature of marriage', such as victims of bigamous or fraudulent marriages and 'relationships of cohabitation'. It provides immediate relief to victims in emergency cases, the allocation of women's shelter and the right to reside in shared households. New authorities and mechanisms, like a 'protection officer' as the interface between the victim and the court, shall ensure effective access to justice for victims of violence. A case filed under the PWDVA is to be disposed within 60 days of filing. Under the PWDV Act, victims may get protection orders from any act of domestic violence, residence orders (including the right to reside in a shared household), monetary relief, custody orders, compensation orders, interim and ex-parte orders. A key issue is its unambiguous recognition of the woman's right to live free from violence (Sen, 2013, p. 18).

In reaction to the Delhi gang rape December 2012, India has passed new legislations, and various amendments of existing laws have been made concerning VAW. **The Criminal Law (Amendment) Act, 2013** was passed on the recommendations of the Justice Verma committee and focuses on the protection of women from sexual or sex related offences. The amendment basically provides a broader definition of sexual assault including acid attacks,

human trafficking, voyeurism and stalking, and has included some changes to punishments. However, the exclusion of marital rape as defined sexual assaultive act in the amendment was strongly criticised by Sen (2014).

The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act (SHWWA), 2013, replaced the Vishaka Guidelines, 1997, of the Supreme Court and entered into effect in April 2013. The SHWWA seeks to protect women from sexual harassment at any workplace or any matters connected to it. Thereby, it also includes as workplaces the unorganized work sector such as agriculture, domestic work, service industry and construction work, as well as the armed forces, the government and the private sector. It further includes employees in precarious working conditions such as daily wagers, volunteers, trainees, temporary and ad-hoc employees. It provides a consistent procedure for filing a complaint against sexual harassment and has to be done within three months. Furthermore, it lays down an employer's responsibility to create a no harassment policy and a safe working environment, including preventative measures and awareness campaigns against sexual harassment in the workplace.

Despite legislative protection of their rights, female Scheduled Caste (SC) and Scheduled Tribe (ST) members are known victims of atrocities in India (Amnesty International, 2014; Human Rights Watch, 2008), found to be extremely vulnerable to becoming victims of physical, emotional, sexual and monetary depletion and violence. Caste discrimination and violation of fundamental rights is vast. Thus, many cases against Dalit women remain unregistered (Amnesty International, 2014; UNIFEM South Asia Regional Office, 2003). **The Scheduled Castes and The Scheduled Tribes (Prevention of Atrocities) Amendment Ordinance, 2014** shall amend the protection of SC and ST from atrocities, as the implementation of The Scheduled Castes and The Scheduled Tribes (Prevention of Atrocities) Act, 1989, had failed both in preventing violence from happening and the failure to punish perpetrators (Gatade, 2008).

In spite of important legal reforms, Human Rights Watch (2014) criticises several key gaps remaining in Indian law referring to the issue of VAW, such as victim and witness protection, penalization of honour killings, legal investigation of ethnic violence but also the implementation of greater safety measures for women in public spaces.

Underreporting of violence is a frequent problem in India (Watts & Zimmermann, 2002). India's National Family Health Survey-3 (NFHS-3) showed that only one in four women affected by violence may seek help to end violence, and even then most often from her own

family and rarely from institutional sources like nonprofit organizations or police (International Institute for Population Sciences & Macro International, 2007). Studies among battered women showed a widespread belief that abuse is a private matter and should be kept secret (Panchanadeswaran & Koverola, 2005). Comparing the result of the NFHS-3¹¹, that 37.2% of ever-married women have ever experienced spousal violence, to the registered cases through the National Crime Records Bureau (2008), it reveals that only 0.03% of victims of domestic violence file a case (Sen, 2013). Minor injuries might not be reported by women. Likely causes for underreporting and why women may not seek help might include; cultural values that perpetuate the subordination of Indian women in order to maintain peace, harmony and family honor (Ahmed-Ghosh, 2004), women's shame, fear of disgracing their family's honour and fear of social pity and stigmatization when reporting abuse (Bhaiya, 2012; Kaur & Garg, 2010). In addition, police investigations are poor and corruption is a widespread obstacle preventing women (especially from lower economical strata) accessing justice (UNIFEM South Asia Regional Office, 2003). Thus, the legal framework provides a basis for seeking redress, but the need for cultural and social reforms of deeply rooted patriarchic social structures is indispensable (Gilles & Feldman-Jacobs, 2012).

1.1.3 Medical Aspects

Short and long term consequences of VAW are outreaching. Physical consequences include unintended pregnancies, sexually transmitted infections (Martin et al., 1999), multiple abortions and gynecological problems such as vaginal infections, fibroids, decreased sexual desire, pain on intercourse, chronic pelvic pain, urinary-tract infections (Campbell, 2002; Heise et al., 2002; Sarkar, 2008), serious physical injuries, chronic pain syndroms, gastro-intestinal symptoms like loss of appetite, chronic irritable bowel syndrome, central-nervous symptoms such as fainting, seizures, loss of consciousness due to head injuries and strangulation (Campbell, 2002; World Health Organization, 2013c). Domestic violence is significantly associated with poor mental health (Kumar et al., 2005). Most common mental health consequences in the context of VAW are low self-esteem, depression (Fikree & Bhatti, 1999; Fischbach & Herbert, 1997; Trivedi, 2007; Varma et al., 2007), stress-related syndromes, anxiety (Fikree & Bhatti, 1999), substance (ab)use (Fischbach & Herbert, 1997; Sarkar, 2008), post traumatic stress disorders (Campbell, 2002; Pico-Alfonso, 2005; Varma et al., 2007), multiple personality disorders, somatoform disorders (Varma et al., 2007), eating

¹¹ The National Family Health Survey-3 (NFHS-3) refers to the years 2005-2006.

disorders and sexual risk-taking (Heise et al., 2002; Kumar, 2013; World Health Organization, 2013a; World Health Organization, 2013c). Spousal abuse doubles the risk for depression (World Health Organization, 2013b). The severity of VAW significantly correlates with increased psychiatric morbidity (Varma et al., 2007), possibly resulting from cumulative traumatic experiences, as women in abusive relationships are more repeatedly exposed to victimization (Pico-Alfonso, 2005). VAW undermines women's self-esteem and sense of autonomy and their ability to think and act independently (Kumar et al., 2013) often resulting in depression and withdrawal. This does not only affect women's mental health but their capability to care for their families and children. Partner violence creates an atmosphere of fear, subsequently affecting society by impairing an economically productive workforce (Kumar et al., 2013). Many women experience the psychological effects far more debilitating than the physical effects. For some women the burden of violence is so humiliating that they attempt or commit suicide (Kumar et al., 2013). Thus the suicide rate among abused women is five times higher than in the general population (Buzawa & Buzawa, 1996). Suicide is found to be a major public health issue (Jayaram et al., 2011). This shows the important role of health institutions, as abused women may tend to internalize their mental distress. Instead of sharing their mental distress women tend to seek medical help for other, more socially accepted reasons, such as chronic pain disorders (Varma et al., 2007).

India chronically lacks community mental health programmes, especially in rural India, due to a neglect of mental health in low income countries (Jayaram et al., 2011; Kermode et al. 2009) resulting in a large treatment gap. Psychosocial aspects of health are denied, despite a high number of mental disorders among India's population (Jayaram et al., 2011). Thus, implementing affordable and accessible mental health programmes on a community health care level will remain challenging advocacy work. However, the World Health Organization (2013c) also points out the importance of training health care providers, especially those working at a primary health care level, about the mental and physical health consequences of VAW in order to be able to identify and respond properly to abused women.

1.2 Community Mental Health in India

The Lancet Series on Global Mental Health in 2007, observes that mental health in most low and middle-income countries is a neglected and stigmatized field (Prince et al., 2007). 14% of the global burden of diseases are caused by neuropsychiatric disorders, mainly common mental disorders, foremost major depression and substance-abuse disorders. The disabling nature of mental illness has drawn attention to the severity of common mental disorders as a

public health agenda (Prince et al., 2007). Various physical health problems heighten the risk of mental health diseases and vice versa. Comorbidity affects help-seeking behaviour, proper diagnosis and adequate treatment strategies (Prince et al., 2007). The World Health Organization (2014) states there is 'no health without mental health', in order to address the problem of mental health neglect around the world. Mental health is greatly influenced by socioeconomical factors (Kermode, 2007). It is estimated that about one quarter of patients who use primary health care facilities in low-economic countries do suffer from mental illness (World Health Organization, 2001). Mental health is more than the absence of mental illness, defined by the World Health Organisation (2014) as "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Herrman et al. (2005) propose a framework of mental health programs on a community level, that determine social inclusion, access to economic resources and freedom from discrimination and violence as key determinants in forming the basis of intervention.

Mental Health in India remains a neglected field, especially community mental health. The burden of mental disorders is presumably underrated as the interrelationship of mental and physical health is still inadequately evaluated (Prince et al., 2007). 11% of the Indian population suffer common mental disorders, of which 3% are in need of active intervention and 1% require hospitalization (Davar, 2008). Especially in rural areas, mental health is an issue of low value. In 1982, India launched the National Mental Health Program (NMHP), which was reviewed 1995, aiming to implement community mental health programs in already existing primary health care centers, to de-stigmatize mental illness by promoting community participation and to protect the rights of mentally ill patients (Agarwal, 2003; Pujari, 2013). Critics of the NMHP condemn its prioritization of severe mental health disorders and overlooking the mental health needs of the most underprivileged and vulnerable sections of the population, like marginalized women, who are actually in greatest need of community mental health interventions (Davar, 1995; Jain & Jadhav, 2008). Instead of paying attention to the wide psychosocial factors influencing mental health and focusing on community counseling as primary intervention, NMHP favoured the use of invasive treatment methods, like medications. Davar (2008) condemns the focus on psychiatric medication in low-income countries rather than counseling as a form of colonialism and profit interest of the pharmaceutical industry. Jain & Jadhav (2008) propose that culturally adequate and sensitive mental health programs and theories for more sustainable interventions are strongly required within the NMHP.

Trained mental health professionals in India are in short supply and mostly based in urban areas, and the significant brain drain of medical professionals generally negatively affects South Asia (Thara & Padmavati, 2013). Because of the lack of public health facilities, the private sector in mental health services has grown a lot in India (Khandelwal, 2004). Additionally, various NGOs also address the issues of mental health care, focusing primarily on the needs of marginalized communities, educational and awareness campaigns and the protection of human rights in the context of mental illness (Khandelwal, 2004). Academic research in mental health is remarkably insufficient (Kumar, 2013). Thus, Khandelwal et al. (2004) strongly propose the improvement of academic training and research in mental health as well as the promotion of mental health as a serious public health concern throughout the society. For the 12th Five Year Plan (2012-2017), the Government of India had addressed the mental health agenda a first priority order problem (Planning Commission, 2011). Various study authors (Patel & Thara, 2003; Thara & Padmavati, 2013) emphasise the role of NGOs in the achievement of sustainable mental health program implementations, as NGOs are traditionally most aware about the needs of communities at a grass-roots level. In addition, Thara & Padmavati (2013) stress the importance of gaining a culture specific understanding of lay people's perception of mental health disorders for the design of sustaining mental health interventions.

1.2.1 Gender and Women's Mental Health

Women, in particular, are susceptible to mental health disorders (Davar, 1999; Shidhaye & Patel, 2010), due to their low status in society and traditionally restricted role models, dominant patriarchic ideology and domestic violence (Kermode, 2007; World Health Organization, 2001). Davar (2003) has criticized the general lack of gender sensitivity in mental health programs in India although common mental disorders (CMD) (Goldberg & Huxley, 1992) like depression, anxiety and somatic symptom disorders show a distinct distribution towards women, whereas severe mental disorders were equally distributed in both sexes (Davar, 1995; Astbury, 2002). The rate of CMD among Indian women is estimated to be around 10% (Shidhaye & Patel, 2010). Female gender, poverty and a poor education were found to be highly associated with CMD (Patel et al., 1999). In particular unipolar or major depression was found most prevalent among women (Kermode et al., 2007; Shidhaye & Patel, 2010). Depression is known to have a strong psychosocial association (Davar, 1995). The majority of women suffer mental disorders in the reproductive age between 16 - 40 years with the highest vulnerability seen in separated, divorced and widowed women (Davar, 1995).

Major stressors were identified to be marriage, family disputes, domestic abuse, child abuse and rape, socioeconomical deprivation, lack of emotional relationship with husband, domestic abuse and substance abuse of husband (Davar, 1995; Shidhaye & Patel, 2010). Social disadvantages, such as a low education level, and low economic resources as well as an older age in women were associated with a higher level of depression. Interestingly, Shidhaye & Patel (2010) could not find any association of caste with CMD. The level of depression in women was found especially high among women presenting with gynecological symptoms, foremost medically unexplained symptoms such as vaginal discharge, which is an epidemic problem of women in South Asia (Patel & Oomman, 1999). The prevalence of post natal depression, which includes a strong psychosocial etiology (Kumar, 1994), was found to be 11% among Indian mothers and significantly associated with a low socioeconomic background of the mother, the birth of a daughter (and resulting conflicts with the marital and natal family), unfavorable life events during pregnancy and lack of physical help (Chandran et al., 2002).

Raguram (2002) showed that women in rural India are less likely to get adequate mental health care, whereas non-allopathic treatment through traditional healers, astrologers or at holy temples are commonly used, mostly due to a lack of facilities. A qualitative study (Kermode et al., 2007) exploring the perceptions of women towards mental health amongst others found out that women viewed mental health primarily as the absence of stress, closely related to economic factors and social relationships. Mental health problems were determined as mental distress, occurring when a woman faces abuse or poverty. But this conception is limited, as *'the'* Indian paradigm does not exist in such an enormously culturally diverse country like India. Prince et al. (2007) suggest the implementation of holistic mental health care programs, reflecting the cultural diversity and integrating psychosocial interventions in order to ban gender inequity in access to health care.

The consideration of gender in mental health care highlights the complex interrelationship of the individual and its social environment with the inequalities and injustice that arise from social restrictions of women through strong patriarchal values that deeply influence mental health burdens. Gender, in contrast to biologically determined sex, relates to social and cultural norms influencing the perception on women, how they should be, think and act (Afifi, 2007). A progressive, transactional concept of mental health has to consider gender inequalities in access to resources, women's agency and having control over their health as main determinants of mental health vulnerability (Astbury, 2002). Addressing women's needs is the basis for helping women to express their potential to the full and allow autonomous

contribution to the development of their communities (Patel et al., 2007). Thus, "genderless mental health policy is poor policy, incapable of engaging with the specific risk factors that have to be reduced for mental health to improve" (Astbury, 2002, p. 162). For the last two decades many feminist and women's organisations in India have included the issue of community mental health into their agenda (Davar, 2003).

2 Material and Methods

2.1 Qualitative Research

A qualitative research approach (Dahlgren et al., 2007; Flick, 2007a; Flick, 2009; Ulin et al., 2005) was most suitable for the purpose of this study. In contrast to quantitative research, qualitative methods enable a greater insight into perceptions, experiences and attitudes of subjects towards gender based violence of both community and institutional facilitators like health and social care providers (Ellsberg & Heise, 2005; Tripp-Reimer & Doebbeling, 2004). Qualitative research follows a naturalistic paradigm presuming that reality is subjective rather than objective based upon individual interpretations and interactions between the researcher and participant (Dahlgren et al., 2007). The theoretical and methodological framework of qualitative research offers a systematic way of studying individual perceptions of subjects in a natural setting. Thus the researcher is provided with a deeper insight into socially and culturally constructed realities and extensive analyses of complex interrelations between individuals and their sociopolitical environment. Originally qualitative research was a method derived from the social sciences. To an increasing extent, its integration into public health research has been proposed to further explore social, economical and epidemiological impacts specifically on marginalized women's health (Moss, 2002).

A qualitative research process is referred to as an emergent design, inducing a hypothesis during the research process (Ellsberg & Heise, 2005) through constant re-interpretation and preliminary analyses of continuously emerging data. This requires a certain level of reflectivity of the researcher to make sure emerging concepts are grounded in research findings and not in preconceived ideas. Methodologically, this study follows the Grounded Theory approach whereby data collection is controlled by the originating theory (Glaser, 1978). In that way shame and distrust seemed to be key issues for this research. Thus, I decided to focus on conducting face-to-face interviews as mistrust seemed to prevent women from opening up and share their personal experiences of domestic abuse. In order to gain a deep insight into women's perception and experiences of violence, various stakeholders and key-informants agreed that in-depth interviews would be the appropriate method.

2.2 Study Site

I conducted my research from February – May 2014 in the district Kangra in the Northern Indian state of Himachal Pradesh. Himachal Pradesh is at the foothills of the Himalayas, with

many inaccessible areas due to mountainous regions, thus making it one of the states with the lowest population density. According to 2011 Census Himachal Pradesh is predominately populated by rural people 89,97% living in small villages with a high percentage of Scheduled Tribes, 25.2%, such as the *Gaddi* tribe, while 5.5% are of Scheduled Castes (Planning Commission, 2013). Both generally come from a low socioeconomic status in Indian society, and thus face discrimination. In the area of research, agriculture, slate mining and other forms of labour work are most common among the villagers. All family members have to work hard for their living (Lohia, 1998). Notably, women's involvement in agricultural work is striking. Rural women's work and traditional domestic obligations for the benefits of men are seen as invisible. Work exploitation of women in rural marriages is accepted as a tradition. Compared to men, women work more hours and face quite a few challenges and injustices (Kumar, n.d.). The child sex ration of rural Himachal Pradesh is showing a slightly regressive trend (Cohen, 2000): In 2011 the child sex ratio was 909 females per 1000 of males, compared to 2001 it was 957 females per 1000 of males (Registrar General, 2011e). This might indicate that the society in rural Himachal Pradesh follows a strong patriarchal structure. Women are only given value by giving birth to a male child, being an obedient wife and a hard-working laborer.

Himachal Pradesh has one of the higher literacy rates in India with an upward trend of 82.8% as per 2011 population census with a slightly lower literacy rate among the rural population of 81.85%, but the literacy rate among rural women is much lower 74.62% compared to 89.05% in rural men (Registrar General, 2011b).

Although Himachal Pradesh is supposed to be one of the wealthier states in India, with a good social fabric, still 8.84% of the population of Himachal Pradesh (about 529.000 people) are living below poverty line in 2011-12 (Planning Commission, 2013). The state specific poverty line for Himachal Pradesh for 2011-12 was declared by the Planning Commission (2013) as 913 Rs.¹² (11,17 Euro) monthly per capita for rural areas. The state-wise estimates of average monthly per capita expenditure in rural Himachal Pradesh for 2011-12 was 1800.62 Rs (22,04 Euro) (Planning Commission, 2013). Himachal Pradesh is highly populated by Scheduled Tribes, 25.2%, while the percentage of Scheduled Castes is only 5.5% (Planning Commission,

¹² Compared to the national poverty line of India for 2011-12, that was estimated at 816 Rs. per capita per month in rural areas (Planning Commission 2013) as the poverty line varies statewide due to inter-state price differentials.

2013), both having generally a low socioeconomic status in Indian society, facing discrimination and stigmatization.

The study area corresponded to the area of work of both NGOs that were cooperating for the purpose of this research. Both NGOs, *Nishtha Rural Health, Education and Environment Centre*¹³ and *Jagori Grameen*¹⁴ are based in Rakkar Sidhbari and actively engaged in empowering rural women in Kangra district by addressing their overall needs for health, social and legal care. Together they struggle to encourage rural marginalized girls and women to seek justice and equality and end all forms of discrimination against them. Their area of work is focused on district Kangra, divided into following blocks: Dharamsala & Kangra, Rait and Nagrota Bagwan.

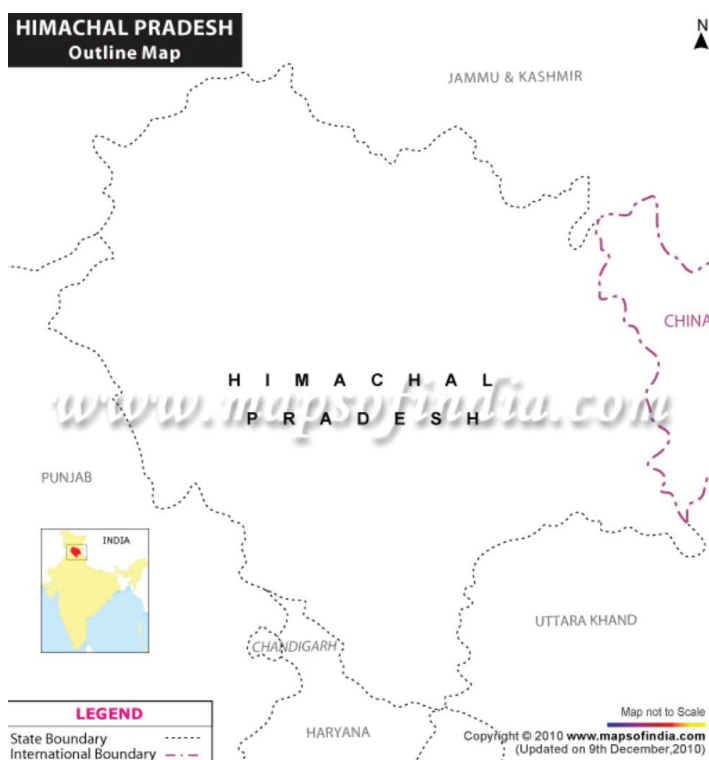


Figure 3. Maps of India. (2010). Himachal Pradesh Outline Map

¹³ <http://nishtha-hp.org>

¹⁴ <http://jagorigrameen.org>

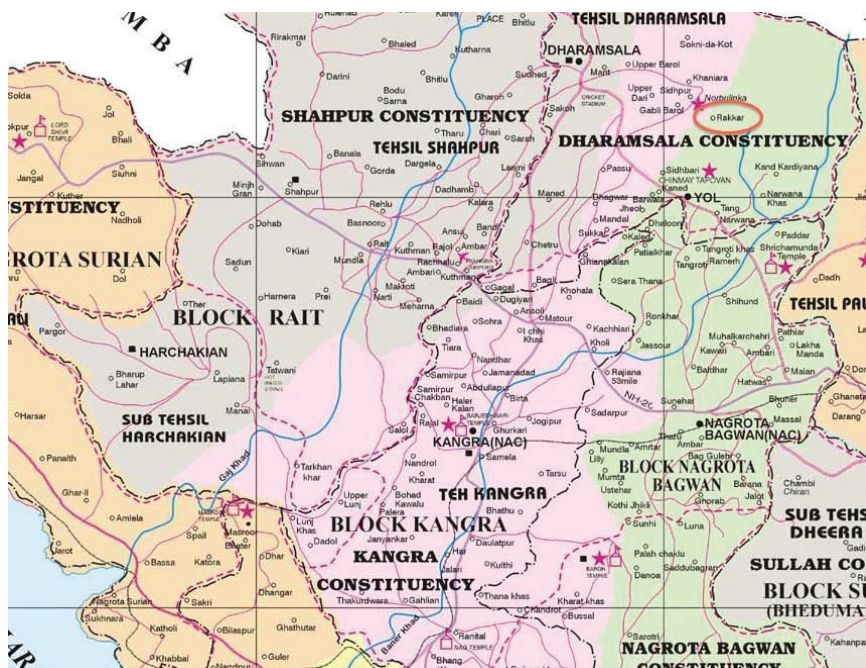


Figure 4. Himachal Pradesh Planning Commission. (2009). District Kangra

Nishtha Rural Health, Education and Environment Centre runs a health clinic based in the village Rakkar in order to provide primary health care access, free of cost, for those who have been socially and economically deprived. Twice a week mobile outreach clinics and health education programs are held in remote villages around Rakkar. Nishtha's Single Women's Program seeks to empower rural single women, a group that is most vulnerable to discrimination and harassment. Currently seven single women activists cover 92 *gram panchayats*¹⁵ in district Kangra in blocks Kangra/ Dharamsala, Rait and Nagrota Bagwan, in accordance with the study's research area. So called 'single women activists' reach out to remote villages, look for often isolated single women and provide them with essential social and legal support in the form of information about their rights, financial government support schemes and other assistance if needed. In addition they also help to organize Nishtha's mobile outreach clinics and health education programs in remote villages in order to raise health awareness among the most deprived, who are often single and elderly women.

¹⁵ 'Panchayat' is a local self-government institutions at village level. Panchayat literally means 'assembly of five' elected and respected mostly elders in a village. Panchayat functions as a legal institution on a village level, traditionally mediating conflicts between villagers. The Panchayat also has an administrative functions such as the decision making power over allocation of ration or BPL cards or the admission into MGNREGA scheme of locals.

Jagori Grameen's endeavour focus on capacity building for women's empowerment in order to build an equal society and protect the individual and collective dignity of the most marginalized by strengthening their voices. For the purpose of this study I attended the Nari Adalat, literally "women's court", as part of the Aware Women's Action for Justice Team (AWAJ) of Jagori Grameen. Nari Adalats are held on a weekly basis in Shahpur (block Rait), Rakkar (block Dharamsala) and Lunj (block Kangra). The Nari Adalat team currently consists of 4 female and 1 male legal justice activists who intend to maintain an easily accessible legal support and conflict-resolution centre for the local community. Since 2011 Jagori Grameen has been made a service provider in accordance to The Protection of Women from Domestic Violence Act, 2005, which allows them to create legally binding compromises and file cases in court. Nari Adalat aims to provide a safe space for women to raise their voice in order to address the issue of violence, gender discrimination and injustice. The Nari Adalat typically deals with domestic violence, marital and dowry issues, desertion, divorce, child custody, maintenance, compensation and land dispute. Mediating conflicts within family or community members, providing legal advice, finding a gender sensitive lawyer and help in filing court-cases in unresolved conflicts. Financial help is provided in cases of hardship.

2.3 Sampling Methods

Participants were recruited through Nishtha health clinic, Nishtha's mobile outreach clinic or at Jagori Grameen's Nari Adalats (women's courts). Respectively, 23 participants were identified using purposive sampling technique with the help of the staff of both organizations and inclusion criteria were female survivors of domestic violence, aged between 18 - 80 years, service-users of either Jagori Grameen or Nishtha. Purposive sampling technique among both nonprofit organizations was used upon the attitude that the problem of domestic violence has to be addressed collectively through both NGOs in the area of research. As I was already familiar with the team of Nishtha due to previous medical internships at Nishtha since 2011, entering the field was easy. I joined Nishtha's health clinic and mobile outreach clinic for the purpose of recruiting participants and meeting stakeholders. Nishtha's single women activists were very valuable resources and helped me to get into contact with 11 survivors of violence in remote villages in their area of work. As they had already built a good rapport, they would initially inform the women about the purpose of the study and ask the women if they want to participate in this research project. If a woman agreed to participate and her village was far off, they would coordinate the meeting with the schedule of Nishtha's outreach and health awareness programs. When the mobile outreach clinic team reached the

village, the single women's activists would already be waiting for us, in the remote village accompanied by the participant/s. The setting of the outreach clinic would enable a safe space for the interview to happen as it was away from the women's home and happens before noon, when most men would be away for work. It is the responsibility of a single women's activist to arrange a place for the outreach clinic to happen. Usually either a private house or a community building, like the *anganwaadi* center (nursing home) or the Panchayat's house (local village government), would function as temporary shelters. If a single women's activist had brought a women for an interview she would have already considered that and arranged an extra room where the interview could happen undisturbed, in privacy.

I conducted seven interviews with survivors of violence that way. If the woman lived in a village near Rakkar, she was asked by the single women's activist to come to Nishtha's health clinic or community centre or Tara Centre where she was interviewed in a separate room, in privacy. One participant wanted to be interviewed in the house of a former single women's activist, that provided a safe space for her, where she felt comfortable. One participant was immobile due to medical reasons and therefore was interviewed at her home. As she was a single woman abandoned by her husband and living alone with her child, her house was considered a safe environment for the interview. Five Interviews were made with either current or former Nishtha staff members who themselves were survivors of violence. It was made sure that the interviews took place at a suitable time and place for each woman: either in the Nishtha clinic or community centre, the Tara centre, at the interpreter's home or in one case at the woman's home, as she no longer lived in the abusive relationship and her new husband was out of house for the time of interview. In addition I had attended the Nari Adalat (women's court) sessions in Rakkar and Shahpur. When a woman who sought help at the Nari Adalat had faced domestic violence, she was asked if she wanted to participate in the study. Seven women agreed for interviews which were either held in an extra room at the Training and Research Academy (TARA) of Jagori Grameen; at Nishtha community centre which is close by, or in one case at the woman's home, while her husband was not at home during the day.

Stakeholders from both nonprofit organizations Jagori Grameen and Nishtha Rural Health, Education and Environment Centre with various professional backgrounds as feminist activists, social workers, counselors, psychologists and medical doctors were involved from the beginning. Thereby eight expert interviews were conducted in total. All interviews were recorded with a digital device, except in three interviews where participants had agreed upon taking written notes. Qualitative sampling is done until the point of redundancy, when further

interviews and observations will divulge little new information (Glaser & Strauss, 2008), which I felt I had reached after 31 interviews for the purpose of this research.

2.4 Interviews

Interviews form an essential method in qualitative research, especially for highly sensitive topics such as personal violence experiences, by providing a maximum level of privacy and intimacy. I conducted 23 semistructured interviews with the assistance of a female interpreter for Hindi, who was not part of the local community and was trained according to the strict ethical guidelines of this research. Thus, participants could be sure that no sensitive information would be shared within the community. Several times participants confirmed that they would only share this information with me, because I am not from their community. Field notes were taken during as well as after the interview. All participants were able to understand and communicate in Hindi. 18 women spoke Pahari as their native language, the common dialect in the area of this research, three women spoke Nepali and two women Gaddi¹⁶. All interviews were conducted in complete privacy, in a separate room and at a suitable time for the woman when family members would not be around and men were at work. Individual written informed consent was taken from every participant.

The semistructured interview matrix was based on the *World Health Organization Multi-Country Study on Women's Health and Domestic Violence* (World Health Organization, 2004) which had been adjusted to the local community's context with reference to experiences of both NGOs for the purpose of this research. The following themes were explored: Socioeconomic background, personal experiences of violence, mental and physical health consequences of violence, childhood experience of violence, effect of domestic violence on children, help-seeking behaviour and experiences when seeking support, personal coping strategies and resources. Emphasis was put on a positive ending of the interview, addressing the woman's strength and courage. Semistructured interviews are based on an open-ended question format with an intention of encouraging participants to talk freely in their own words. Not necessarily all questions are designed ahead of time, but certainly arise through an interview to allow for a natural flow and flexibility to probe important details. Follow-up questions and likewise probes are as fundamental as initial open-ended questions as they attempt on deepening and clarifying facts (Ellsberg & Heise, 2005; Ulin et al., 2005).

¹⁶ *Gaddi* is the language of a common tribe mainly living in the hilly areas of Himachal Pradesh and other states in North-India. Traditionally they were shepherds.

Interviews lasted between 60 minutes and 120 minutes. Compensation of 200 Rp. (2,5 Euro) for a single interview session was given to cover bus fares and time expenses of the participants. Interviews were either recorded with a digital device or written notes were taken in case participants didn't want to be recorded. Reflecting notes about the interview were taken directly after the session or, if not possible, at the end of the day. Subsequently with the help of translators the interviewes were transcribed into English and prepared for data analysis.

As also Jansen et al. (2004) explored some women in this study did not only want to disclose their stories with an empathetic interviewer but found it to be a positive experience. Those women clearly showed signs of relief after the interview by expressing their gratitude to my interpreter and me that we had listened to their story or emphasised that they would feel better now after sharing their sufferings.

Informal conversational interviews form a less systematic and comprehensive format, as they normally arise in a natural course due to certain observations or circumstances with no predetermined questions (Ulin et al., 2005). In particular Dr. Barbara Nath-Wiser functioned as a valuable field supervisor who helped me enourmously to gain access to information, served as a cultural interpreter and key informant through many informal conversational interviews.

2.5 Participant Observation

Participant observation is a core strategy in qualitative research and should provide a supplement of methodologies with the primary aim of enhancing validity of data. The researcher involves him/herself in direct interaction with people and their activities to observe and record information (Ulin et al., 2005). Social situations, involved people, activities, events, objects, verbatim comments, feelings, incongruities are noted and recorded in as much detail as possible in order to produce 'thick descriptions' (Geertz, 1973) of the research field. Ellsberg & Heise (2005) recommend to take short notes during field research and soon after leaving the field review amend them in details and substance. Systematic observation is a challenge and involves a researcher's whole presence and critical reflectivity in his/her own's role as a researcher. While the process of "going native" is seen as an important instrument in qualitative research to gain insight into a field in order to understand complex phenomena, at the same time it involves sensitivity and critical self-observation so as to not to lose the researcher's external perspective (Flick, 2009). As per definition, participant observation involves subjective interpretation and thus the capability for bias, accurate documentation is

seen as a crucial strategy enhancing rigor of qualitative research methodology. Documenting the research process by means of a field journal also includes organisational and situational descriptions of the field, notes on important decisions in research strategy, personal impressions, and emotions and experiences of the researcher. When using a Grounded Theory approach Glaser & Strauss (2008, p. 108) recommend that field notes should also contain “memos” and “codes” to constantly generate theory through intuitive illustrations for ideas.

Participating in medical internships since 2011 at *Nishtha Rural Health, Education and Environment Centre* have offered me an intimate insight into sensitive health issues of women especially in a rural Indian context. Also during my elective training at All Indian Institute of Medical Science, New Delhi, India’s major public hospital, in 2013, I could deepen my understanding of culture related health issues and symptom presentation of the socially most deprived, as the Indian government provides medical treatment for free at AIIMS. Additional training in trauma-therapy focusing on survivors of sexual and war violence further deepened my awareness and knowledge of domestic violence and its consequences.

2.6 Data Analysis

Qualitative data analysis was done with atlas.ti software version: WIN 7.0 (Build 71) according to coding principles of Grounded Theory (Charmaz, 2006; Glaser & Strauss, 2008) as it was found useful for gender research to enable extensive analysis of complex issues (Keddy et al., 1996). The conceptual approach of Grounded Theory offered a way of systematic data interpretation with the aim of inductively generating a theory (Dahlgren et al., 2007). Transcripts were coded for descriptions of the character of violence, physical and mental health consequences, factors that affected the participant's mental health status positively or negatively, coping strategies, personal resources, help-seeking behaviour and support sources. Mental health issues, including post traumatic stress disorder symptoms, were qualitatively distinguished when participants described life events or their general state of being in reliance of feelings of mental tension, depression, worthlessness, helplessness and powerlessness, fears, worries, intense crying, despair and suicidal thoughts and attempts. Collected research data was transcribed into English and characteristic information was coded. Subsequently, by the process of selective coding, important codes were clustered and transformed into categories. Identifying core categories and properties led to theoretical coding, with the attempt to analyze axes between codes and categories in order to construct concepts and a hypothesis. The final step attempted to integrate my own research findings with existing theory. The qualitative research process referring to the Grounded Theory is an

iterative process based on constant (re-)interpretation of data reading, coding, reducing and displaying. Criteria for assessing the trustworthiness of qualitative research (Flick 2007b; Ulin et al., 2005) were taken into account as follows: Triangulation of methods such as in-depth interviews, key-informant interviews and participant observation documented in my field-journal enhanced credibility. Documenting the research process by means of extensive field notes, reflections and process notes about important decisions enabled evaluation of dependability and confirmability, proving consistency within the research process and conclusions that are grounded in research data (Lincoln & Guba, 1985). The process of analytical generalization (Kvale, 2009) involved logical reasoning and judgement about the extent of transferability of qualitative research findings.

2.7 Ethical Considerations

As research on GBV is a very sensitive issue it was imperative to implement high safety, confidential and ethical standards. Thus the study was conducted by following specific ethical and safety recommendations for research on violence against women by the World Health Organization (Watts et al., 1999):

- *"The safety of respondents and the research team is paramount, and should infuse all project decisions.*
- *Prevalence studies need to be methodologically sound and to build upon current research experience about how to minimize the under-reporting of abuse.*
- *Protecting confidentiality is essential to ensure both women's safety and data quality.*
- *All research team members should be carefully selected and receive specialized training and on-going support*
- *The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research*
- *Fieldworkers should be trained to refer women requesting assistance to available sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.*
- *Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.*
- *Violence questions should be incorporated into surveys designed for other purposes only when ethical and methodological requirements can be met."*

Individual informed consent was obtained from all participants to guarantee safety and anonymity. The Informed Consent Form (ICF) was translated from English into Hindi. All participants were able to understand Hindi. Illiterate participants signed with their thumb print, a common¹⁷ practice in India. All researcher assistants had received special training according to the ethical guidelines and ongoing supervision through cooperating counseling professionals to provide basic emotional support and referral information in case a woman requested assistance. Data about study participants was replaced by consecutive numbers and so transferred into anonymized data in order to preempt subsequent identification of single participants. Research data was kept strictly confidential and safe.

Institutional ethical clearance was obtained from the ethics committee of the Medical University of Vienna, Austria (Ek-Nr: 1909/2013) and the institutional ethics committee at Dr. Rajendra Prasad Government Medical College Kangra at Tanda, India (No. HFW-H-DRPGMC/Ethics/2014/12) respectively, under co-guidance of Prof. Dr. Ashok Kumar Bhardwaj, Head of the Department of Community Medicine at Dr. Rajendra Prasad Government Medical College Kangra at Tanda, India.

¹⁷ Thumb print is a common, but to my opinion worth criticizing practice.

3 Results

The findings are divided into six sub-chapters: The socioeconomic background, multiple forms of violence, mechanisms of violence, mental and physical health consequences of domestic abuse and women's strategies and agency in context of domestic violence (DV) focusing on questions of resources and resilience factors in women, support sources and the empowerment process of survivors of DV.

3.1 Socioeconomic Background

Noteworthy socioeconomic findings are the precarious employment situation participants faced. Nine of the participants were unemployed. More than half of the participants were living below India's official poverty line¹⁸ with their families, showing that poverty, as expected, was a main issue for the majority of the participants. Castes have not been included in the questionnaire, but most participants belonged to Scheduled Tribes or Scheduled Castes, referring to the economically lower strata. Three women were financially totally dependent on their husband. On average women attended only eight years of school. Furthermore, all study participants belonged to the Hindu religion, the prevailing religion in the area of research. Buddhists, Sikhs and Muslims also lived in the relevant areas, but they were an insignificant minority.

¹⁸ *Below Poverty Line (BPL)* is a poverty threshold defined by the Indian government to identify economically disadvantaged persons and households in need for governmental support schemes. BPL for rural areas of India is based on the degree of deprivation in respect of various parameters, varying statewide such as: landholding, type of house, clothing, food security, sanitation, consumer durables, literacy status, labour force, means of livelihood, status of children, type of indebtedness, reasons for migrations, etc. BPL card holders would get rationed, cheaper priced edibles and basic essentials. It is critically remarked that some very needy persons like migrant labour workers are disadvantaged in getting a BPL card, as pre-condition is that they would have to be at least 1-2 years in a village before applying at that villages' panchayat.

Furthermore BPL card holders are part of a governmental medical health insurance scheme for the poor (Rashtriya Swasthya Bima Yojana RSBY, literally „National Health Insurance Program“). In case of any serious health event, emergency or an operation required, costs will be taken over by the government including providing 30.000 Rp. (367,6 Euro) extra for materials that have to be bought for special operations, such as heart operations etc. It is common in India that patients have to provide costs for expensive medical equipment by themselves. HIV and TB treatment in general is free for everyone. If someone is HIV-positive one is provided 800 Rp. (9,8 Euro) per month for diet costs. Sometimes BPL card holders are only prescribed available medication in a hospital. Especially more costly medication is normally prescribed only for a very short duration of time after hospital release. If constant medication is needed patients do have to provide the costs for themselves.

Code	Date	Age	Education Level (grade)	Employment status	Employment ¹⁹	Marital status	No. of children	Persons per household	Household monthly income in Rp.	Household monthly income in Euro	Below Poverty Line (BPL) ²⁰	BPL-Card	Financial Support Source
s1	05/03/2014	45	primary (7 th)	part time	agricultural work	widowed	2	1	unstable	-	Yes	No	employment
s2	06/03/2014	36	secondary (10 th)	part time	labor work	separated	1	2	3000	36,8	No	No	employment
s3	06/03/2014	48	secondary (10 th)	part time	commission based work	widowed	1	5	3000-4000	36,8-49,0	Yes	No	employment
s4	06/03/2014	35	secondary (9 th)	part time	labor work	separated	0	1	1000-3000	12,3-36,8	No	No	employment
s5	08/03/2014	35-40	illiterate	part time	labor work + domestic work	widowed	2	4	300	3,7	Yes	Yes	employment
s6	09/03/2014	40+	primary (7 th)	unemployed	unemployed	divorced	1	2	1000	12,3	Yes	Yes	widow pension + son
s7	13/03/2014	80	illiterate	retired	labor work	widowed	7	3	300	3,7	Yes	Yes	widow pension
s8	13/03/2014	24	secondary (10 th)	full time	social activist	divorced	0	4	4000	49,0	No	Yes	employment
s9	14/03/2014	42	primary (7 th)	unemployed	unemployed	married	3	5	15000-20000	183,8-245,1	No	No	widow pension + husband
s10	14/03/2014	22	secondary (10 th)	unemployed	unemployed	married	1	6	unstable	-	Yes	Yes	parents
s11	15/03/2014	32	tertiary	full time	office work	separated	1	5	10000	122,6	No	No	employment + maternal family
s12	20/03/2014	35	secondary (12 th)	part time	domestic work	widowed	2	3	500+	6,2+	Yes	Yes	widow pension
s13	20/03/2014	37	primary (8 th)	part time	labor work + domestic work	married	3	4	unstable	-	Yes	Yes	employment
s14	21/03/2014	25	primary (5 th)	unemployed	unemployed	married	0	n.m.	n.m.	-	-	Yes	parents + in-laws
s15	21/03/2014	33	secondary (12 th)	unemployed	unemployed	separated	2	6	>10000	>122,6	No	No	in-laws
s16	25/03/2014	36	tertiary	unemployed	unemployed	married	2	5	20000	245,1	No	No	husband

¹⁹ *Comission based work* included work as a post office or insurance assistant; *Manual work* meant selling self-made products; *Labor work* was commonly considered as daily labor work within *The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA)* scheme, passed in 2005 by the Indian government, refers to the right to work with the objective of "enhancing livelihood security in rural areas by providing at least 100 days of guaranteed wage employment in a financial year, to every household whose adult members volunteer to do unskilled manual work" (<http://nrega.mn.in/nrega/home.aspx> (accessed 2014, June 20). The daily wage of a MGNREGA worker is currently 138 Rs. [about 1,7 Euro].

²⁰ The specific poverty line for Himachal Pradesh for 2011-12 as 913 Rs. [11,2 Euro] monthly per capita for rural areas (Planning commission 2013) was adjusted to the number of persons per household.

s17	25/03/2014	31	secondary (10 th)	part time	commission based work	separated	3	7	4000-5000	49.0-61.3	Yes	No	employment + in-laws
s18	27/03/2014	35	primary (5 th)	unemployed	unemployed	married	2	6	3000	36.8	Yes	Yes	husband + in-laws
s19	01/04/2014	27	primary (7 th)	unemployed	unemployed	divorced	0	7	4000	49.0	Yes	No	maternal family
s20	04/04/2014	30	primary (5 th)	unemployed	unemployed	separated	3	3	500	6.2	Yes	n.m.	maternal family
s21	06/04/2014	38	secondary (10 th)	full time	social activist	divorced	1	2	3000	36.8	No	No	employment + gov. support
s22	09/04/2014	34	secondary (10 th)	part time	manual work	separated	2	4	unstable	-	Yes	No	employment
s23	15/04/2014	23	secondary (10 th)	part time	domestic work	separated	1	2	2000	24.5	No	No	employment

Table 1. Background of Interview Partners

e: Expert-Interview
s: Survivor of Domestic Violence
n.m.: Not Mentioned
gov. support: Governmental Support Scheme

Code	Date	Employment
e1	22/02/2014	medical doctor
e2	01/04/2014	social activist
e3	06/04/2014	social worker
e4	14/04/2014 10/05/2014	counselor
e5	21/04/2014	medical doctor
e6	27/04/2014	medical doctor
e7	02/05/2014	social worker
e8	03/05/2014	social activist

Table 2. Background of Expert-Interviews

3.2 Multiple Forms of Violence

Women's oppression due to their low status in society was found prevalent among study participants. Wife-battering, dowry harassment, the husband's controlling behaviour concerning the family's finances and resulting deprivation of food were found as multiple expressions of violence deeply rooted in patriarchic ideology. Alcohol consumption of husbands was found positively associated with the severity of domestic abuse.

Wife-battering was found to have the highest rate of occurrence among the types of violence experienced by the study participants.

"When he hits me or anything, there isn't any reason behind it. I don't know what's going on in his mind. One day he came home after working... He just came home, locked the door and started beating me and the kids. So what reason for that can you give? No one said anything to him. He just came in silently and started hitting. I don't know what goes on in his mind." (s22, 34 years)

Dowry disputes were found to be the second most prevalent reason for domestic abuse in the participants. Almost all participants reported the onset of domestic abuse took place shortly after marriage, most commonly related to dowry disputes.

"I was hardly married for seven days when my mother-in-law and her sister began torturing me and isolated me. They began complaining about the dowry I had brought. According to them, I hadn't brought a golden chain with me. Within a month, I had been beaten three times over dowry and was bruised all over. Still, I didn't tell anyone in my family thinking it was this only time. But it kept getting worse. They constantly demanded things and money." (s10, 22 years)

The severity of physical violence was associated with the **alcohol consumption** of the husband. Substance abuse, foremost locally produced alcohol, was mentioned to be a prevalent reason for domestic abuse.

"He used to hit me so badly, I was in such a bad condition... He would hit me with what ever would come into his hand, but only after drinking alcohol. In the morning he would be sitting there, not saying anything. But at night he would start drinking and curse badly. He was cursing me all the time." (s13, 37 years)

"He used to beat me often. He used to beat me so much, as if he wanted to kill me. He would throw me out of the house. And on 2-3 occasions, he picked up the food I was cooking and threw the hot food on into my face. He would keep drinking and if I asked him not to drink, then he would beat me... He would drink and beat me in front of his friends. He would ask lewd questions in front of his friends. He had many bad habits." (s8, 24 years)

One interviewee, whose husband was an alcoholic, faced a lot of arbitrary violence. She told how her husband felt gratification after beating her, which she experienced as very debasing,

"Every time when he used to beat me, my heart felt, that I had no self-respect for myself. How could he have hit me in front of all these people? He started fighting and beating me over small things, no matter

who was there. He never felt any shame... He used to beat me a lot. He used to get calm after beating me. He got some sort of satisfaction out of it." (s23, 23 years)

Economical violence such as controlling a family's finances, denial of money for food, medication or other basic needs and deliberate deprivation of food was reported to be a severe strain, especially in women who were financially dependent and those coming from a very low economical strata.

"She [sister-in-law] used to say I couldn't eat rice or too much food, and I could only eat one and a half *roti* [bread], even though I was the one making them. I would do all the work and make food for them, and after they were done, sometimes there wasn't any food left." (s21, 38 years)

Poverty was found to be a prevailing reason for mental distress in participants. One woman facing extreme poverty and intentional, economical deprivation by her husband, described how poverty affected her mental health,

"I have kids and I don't make that much money... I get stressed how to feed my kids, and how to buy them books for school. I feel like sometimes I am not able to provide them things that are essential for them... When I think about all this, my heart gets so heavy, I get so sad and I am not able to sleep... Sometimes we will have *roti* [bread] with *chai* [tea] and that's it, or just *roti* with salt. We will find waste to fill our stomachs. My kids eat anything, they are not picky." (s22, 34 years)

Ensuring that their children had enough food was reported to be an enormous burden on women as well.

"He doesn't take care of the kids, he doesn't give them any money... Whenever I ask him for money or if the kids ask him for money, he tells us that we should go begging. When he does these things that hurts... I am very sad, but I don't show it." (s22, 34 years)

"I take one medicine and it costs 450 Rp. He tells me, that he doesn't have money for that. He tells me to ask my mum or brother for money. " (s20, 30 years)

Women experienced violence as extremely abasing if it was centered around the topic of food. Examples of this would be preventing access to the kitchen, throwing food against wives and depraved comments on food. Meal time was found to be a critical time when husbands had violent outbursts of violence which prevented women and children from eating their food.

"Whenever I get up in the morning to get food, I get scared because I don't know what is going to happen that day. Many times we eat food before he gets home, because we are afraid what he will do when he gets home... I tell my kids to eat quickly, because if he gets home I don't know if we get a chance to eat food or not. Sometimes he will just throw the dishes." (s20, 30 years)

"When I gave him his food he spits at me... He said I can crap here if I want to." (s20, 30 years)

"When I used to come home, he had already eaten food, and he started a fight with me and not let me eat." (s21, 38 years)

3.3 Mechanisms of Violence

3.3.1 Subordination

"I was tolerating everything and he was insulting me... In our culture... once you get married you can't leave the person, there is nothing like this." (s19, 27 years)

Subordination of women was found to be a common trait in rural marginalized communities.

"[Women] try to cope up with things on their own... because they are never considered very valuable and their own self-esteem also goes low because of this constant reminder that you are not valuable, that you are not wishable, that you are just complementary to the entire scheme of things... The right to take care of one's own needs somehow seems to be non-existent... A good woman is the one who is sacrificing, who doesn't think of herself, who doesn't fight for herself, who doesn't fight for her own rights... Therefore denial of one's own needs becomes second nature. And if a woman complains of something and wants some help then it will be seen as if she was avoiding her responsibilities and goes wanting for attention... When the physical aspects of health are not taken care of, then I would say the severity of not taking care of your mental health becomes all the more great... You grow up to think being denied is the way the life is as a woman. Keeping my things on hold for infinity is my faith." (e8, 38 years)

Deeply rooted traditional values and gender role models were seen among the participants, inherited from their family and other villagers.

"You know, it's very commonly said to women that they have to take care of the household. So our society, in our village, they all tell us these things. So that naturally becomes ingrained in girls. Girls think that, 'Yes, we have to live here. We have to grow up here. We have to die here, all of that.'" (s23, 23 years)

Being selfless and tolerant of any situation in the in-laws house, no matter what, were considered to be good attitudes of married women. Several women reported that after their marriage, they had been told by elder women from the in-law's family that from now on they have to abide their husband's will and pleasure, without contradiction.

"Don't worry, just be quiet and live your life. Don't talk too much to your husband and don't talk back to him. If he says anything, just be quiet and if you get hit, there is no need to go anywhere, there is no need to separate from him. Just take the beating and stay quite. It's all your destiny.' That's what [the women in the village] used to say... I didn't want to put up with this quietly, but I also didn't have any option. If I have had some money or some hope or if I was a little bit educated... then maybe I could have gone somewhere and got a job." (s23, 23 years)

Child marriage increased subordinating behaviour in women. Four participants, that were married off as children before the age of 18, particularly noted the negative influence of the great age difference between them and their husbands on their self-esteem, that made them feeling inconsequential. All four participants who were married as children, came from very low economical strata. One woman, who estimated to be around 80 years of age, was married off by her relatives at the age of 9 as being an orphan. Her husband was about 50 years old and

had already 7 children from his first wife, who had died. She remembered her alcoholic husband to beat her from the very beginning of her marriage, not giving her any money. She said, she had to go begging in order to survive. After he died of a long paralysing illness, she felt relieved. Interestingly she noted, she had a sex life for 8 years only. Now, she reported to face violence against elders and got accused by her son of not being able to work anymore.

3.3.2 Humiliation

Humiliation was found to be the leading theme in all of the interviews. Deliberate humiliation by spouses was reported to have the most destructive influence on women's self-esteem, keeping them passive and obedient wives. Verbal abuse, degrading comments and constant mortification were found to be pervasive in all women's narratives. Verbal assault was inflicted commonly by the husband and other members of the in-law family, mostly by the mother-in-law.

"He wants to humiliate me in front of the *panchayat*²¹... He wants to disgrace me, so that I lose whatever peace and dignity I have here. He should just give me poison in front of everyone. I will die happily... As I told you earlier, as long as he wants, he can make me run around in circles... What does he want? It's obvious that he wants to humiliate and disgrace me. As long as he wants, he can humiliate a woman. A woman has no meaningful identity. She can't go anywhere." (s10, 22 years)

Extreme verbal assault and emotional violence was perceived as far more debilitating than physical violence. However, there were also physical acts with a strong symbolic connotation women had experienced as extremely debasing, such as being hit with shoes, being forced to kiss a lower caste's person's feet, being abused in public and cruelty involving fecal matters.

"I couldn't believe he was sick and I was pregnant and still he would say such things... One time, he shat in his bed pan, then he kicked it, and it landed on me." (s21, 38 years)

"On the first day when I reached his home, the house was under construction. There was a kitchen and beside that, there was a room. The dog was used to be kept in that room...They said: ...'This is your room.' When I saw the condition of the room, it was like in a cowshed... The paint of that room was also so shabby. On the windows they used bed sheets as curtains. If anybody pushed the door, it could have been opened. Then I thought, I got married here so I have to stay here." (s19, 27 years)

"He will say that I didn't respect his mum. But his mum was the one who was horrible to me, she beat me with her shoes. One time she hit me with a big stick... she said that with this piece of wood I am gonna feed you stool. She is so dirty." (s20, 30 years)

²¹ see footnote p. 33



Figure 5. A Woman and a Tree. s18, 35 years

Depraved sexual violence including forced oral sex, viewing pornography and threatened prostitution were perceived extremely disrespectful and degrading, making the women feel guilty and deeply ashamed.

"He beat me the whole night ...He had beaten me so hard over here, I had turned black and blue. And he burnt me with a cigarette too... He wasn't trying to have sex with me, he would just beat me all the time... He would force me to have oral sex." (s21, 38 years)

"A woman who keeps her mouth shut is a happy woman. If she starts pointing fingers, she gets in trouble with the society. She has no right to stand for truth and justice. All I said was I will not do this type of thing [depraved sex]. I know that after marriage, sex happens as the man demands, not as the woman wants... If I agreed, then he would beat me. If I didn't agree, then he would beat me too. When I said no, he said, 'I can get 36 prostitutes to do this to me for only 200 Rp.'" (s10, 22 years)

One woman was **forced to prostitution** through her husband with the aim of making money. He made her hair cut, a strong humbling symbol for traditional rural women, and changed her

name. Through deprivation of food and imprisonment, even in a holy temple site, her husband wanted to force her to prostitution. She finally managed to leave her husband, despite great doubts if that would be right, fearing social pity for her natal family when leaving her spouse.

"He made me cut my hair. When I used to see my hair I felt so bad about it... He said, 'Wash the cloths of my friend, and wash the socks!' Whatever he asked me to do I did that... He even changed my name... He said to me, 'If you like anyone of them, then go along with them, one can earn a lot of money from it.' ...He did not give me anything to eat... [He] said 'No, I don't have money with me. You should take food from your brother. You better agree to the work I am asking you to do!' ...He said [to his friends] 'She will listen. There is nobody to defend her. We can easily convince her.' Whenever he went out, he locked me inside the room." (s19, 27 years)

One interviewee reported she faced **sexual harassment** repeatedly in her marital home by her husband and her in-laws, at various workplaces, as well as in her natal home. These assaults ranged from vulgar and sexually offensive language and unwanted sexual touching, to unconsensual sex and even incest.

"He always tried to touch me, not even when we are alone, but when we were in a group, indirectly and directly. His behaviour was very cheap... In his mind he had only one thing, sex. And nothing else. [Those men] have no respect towards any woman. Just use women and throw them. I hate this type of man. I think I would have handled all these things if my daughter had not been there... it's because of my sister-in-law's husband... he touches every girl. His cheapness has gone beyond in his mind... If he touches her like this... she is so small, she is a newborn baby for me. So how can I avoid all these things?" (s11, 32 years)

Discrimination, respectively distinct verbal humiliation, was found particularly prevalent among those participants who had been sent to Delhi after marriage to live with their in-laws. Having a low educational level, belonging to a lower economical strata, a Scheduled Tribe or growing up in remote rural areas were found to be common subjects to mock and discrimination. But verbal discrimination was not necessarily restricted to the three participants who went to live in Delhi, but also interview partners who had stayed in the area of research.

"When I used to say anything, they used to say that I didn't know anything, that I was from the jungle and from the mountains and from a backwards community." (s21, 38 years)

"Then [my sister-in-law] said to her husband that we were living in a *kutchha* house [mud house], we live in a jungle. We are rag pickers. We do not know anything, that I was illiterate... Then I replied, 'Yes we are poor, but my parents never made us realize that we were poor.'" (s19, 27 years)

3.3.3 Stigmatization

Societal stigmatization through leaving the traditional 'subordinating wife' gender role model was a very restrictive experience for many rural women. Separation from the husband was

considered to be very stigmatizing. **Abuse in public** was experienced as severely disrespectful, leading to unbearable feelings of shame and loss of dignity in women.

"He had beaten me up in public in front of everyone in the street. Busses stopped, cars stopped... He didn't feel any bit of shame... How could he have hit me in front of all these people?... He started fighting and beating me over small things, no matter who was there. He never felt any shame. I felt like he had left me with no respect." (s23, 23 years)

Negative emotions such as anger and aggressiveness **were not considered socially acceptable** for women. Thus, the suppression of negative emotions towards their husbands or in-laws was a common pattern in participants. Only when women could not bear their abuse any more and had left their husbands, were they able to speak about their hate, anger and aggression against the perpetrators of violence.

"I feel angry that I got married. It's only after marriage that girls face these sorrows. Before getting married, I was so free. There was no one telling me what to do. My mother in-law said, I should leave my husband and sleep with another man... [There is] no happiness in marriage for a woman, only for the man... People crave for a child, and here I am, totally destroyed despite having given birth to a child. I have been accused of killing my own child. Can a mother kill her own child? Why did I keep the baby in my womb for nine months? Why did I give birth to it, if I wanted it dead? ...I am beyond anger, because he has strained all my relationships." (s10, 22 years)

Participants reported, that their **suppression of emotions** had lead to sudden irrepressible, reinforced **aggressive behaviour against oneself or others who were powerless**, like their own children.

"Sometimes when I was frustrated, when my newborn daughter was crying, I beat her... I was such a fool, I had become like my husband. I didn't understand why she was crying... I wanted to kill someone. I wanted to go home and kill my husband." (s11, 32 years)

"One time I tried to set myself on fire. My mother in-law was there and my children were also there and they got scared... At that time I was very angry." (s15, 33 years)

3.3.4 Exploitation

Whether it was reported to be sexual or labour exploitation, many women told to have felt being utilised, treated as slaves and servants by their in-laws.

"There were eight people in the house and I had to do the work for all ...I got fevers and I vomited through my pregnancy, but I still had to do the work for everyone... Even though I had a baby, ...[my mother-in-law] used to make me do all the household chores... And my operation [caesarian] wound hadn't even fully healed, still I had to do all the work." (s21, 38 years)

"My husband said, 'My aunt and uncle in-law made your marriage, now you have to keep them happy. I don't need you. You are illiterate. You are a person of the hills, so you have to do work for both aunt in-laws. In the morning by 4:00 or 5:00 a.m. you have to do all the work for them.' I used to think that I got married, now I have to listen to him all the time." (s19, 27 years)

Being assaulted because they were not able to do household work or prepare meals due to

illness or physical impairment, was commonly reported by participants. One woman was abandoned by her husband because she was physically impaired after an accident, in which she broke her leg. She narrated that initially her in-laws took care of her for one month, when she was bedridden with a newborn son and a broken leg. But after one month she was abandoned by her husband because she was found to be useless, and was told she was incapable of taking care of the household. She went back to her parent's home where she requested a small amount of land from her family. But the land's size was not big enough to build a little house on it and she had to build half of her shelter on governmental forest land. She suffered severe osteomalacia and osteoporosis, most probably negatively influenced by her extreme malnutrition, as she belonged to a very low economical strata, almost starving. After being abandoned by her husband, she broke her legs multiple times again. She had no choice but to live alone with her son, and she managed her own living with support of a nearby NGO.

Another participant was chased away by her marital family because she suffered from chronic rheumatic disease making it impossible for her to fulfill her household's duty regularly. Her mother-in-law also accused her of being useless and was adamant about seeking another woman for her son. Subsequently she was chased away by her in-laws after an illegal second wife had already lived for two weeks in the same household. Most painfully, she narrated, she had to share the same bed with her husband and his second wife. She sought help at the Nari Adalat (women's court), which helped her to make a compromise and ensure her right on returning into her marital home.

One woman was accused similarly, of not being capable of doing all household and agricultural chores, resulting in a very abusive situation, which she had fled from. At the time of the interview she was with her newborn son staying with her own family. She came to seek legal assistance at the Nari Adalat with the intent of filing a divorce case and claiming for child custody. She was extremely worried about her two daughters whom she had to leave behind, as she claimed they were in acute danger of sexual child abuse.

"I am sick, that's why he says these things. 'You can't do any housework!', he says to me. They have a cow at home. They tell me, I can't bring grass for her. He wants someone, who can do all this work. My kids are very small and no one takes care of them. I have to do everything." (s20, 30 years)

Those women who were sent to Delhi to live with their in-laws reported severe forms of exploitation including social isolation and imprisonment. All of them had faced extreme forms of abuse, almost beyond human imagination. Their strict social isolation was mentioned to be one of the root causes of suicidal thoughts and helplessness among them. All of them

were denied social contact outside their marital home. One woman was even claimed to be dead by her in-laws in Delhi, in order to exploit her. She managed, with the help of her family, to escape from her abusive marriage.

"When I got to Delhi I didn't know where to go, because my sister-in-law would never let me go outside of the house." (s21, 38 years)

"In Delhi, I did not know about anything because I was from a village. It was my first visit to Delhi. They did not allow me to go outside the house. They used to lock the door, then how to escape?" (s2, 36 years)

3.4 Mental Health

"I get very sad. How else would I feel if my husband never asks me how I am, but beats me all the time?" (s20, 30 years)

Mental health problems were found to be highly prevalent, and had a significant influence on the women's functioning and performance of daily activities. All participants reported that domestic abuse had a significant effect on their health. The most common symptoms were mental distress, depression, suicidal behaviour and symptoms related to post traumatic stress disorder (PTSD). Humiliation, helplessness, sadness and a feeling of being alone were by far the most coded emotions during the interviews, followed by feelings of guilt, anger and powerlessness.

"Happiness has gone, it won't come back... What to do in sadness?" (s12, 35 years)

The level of **depression** among interview partners was found to be high. 15 women reported symptoms of severe depression resulting from their abusive relationships. Depression in itself was not a familiar concept amongst marginalized women. Participants tended to express symptoms of depression, such as guilt, self-doubt, despair and helplessness through the commonly used and socially accepted term of '*tension hogayee*', having mental tension. Thus, **mental distress** was found to be an accepted concept, whereas feeling depressed as such was only mentioned by two women. More or less, all the women suffered from mental tension. Thirteen women explicitly used the term of '*tension hogayee*'. It was interesting to note that the women hardly focused on their own needs. The heavy workload most women had to put up with made it difficult for them to avoid their daily household duties. Women also reported that their exhaustion would have been misinterpreted by the in-law family as laziness. Thus, the loss of the ability to perform daily household tasks, a recognised symptom of depression, was rarely found in participants. Only two women described that they were not able to perform their daily activities due to depression.

"I usually don't think about these things... I am very sad, but I don't show it... When he says bad things, I do get angry but I can't do anything about it. I think what is wrong with me, that he says such things to me?... For days I would go into a depression. And I wouldn't do anything. I would spend days thinking about it, why he hit me and why he did these things to me? Now I don't think." (s22, 34 years)

"I never liked to talk to anyone, I never spoke with anyone. I never felt like going outside, I would always just stay inside the room. Some days I wouldn't even eat or drink, I would just stay in my bed, and laying in bed all day, my body had become so weak. When I got out of bed or when I tried to walk outside a little bit, my body had become so weak, that even if I tried to walk a little bit, I would get dizzy. I was in a very bad condition. But nothing extreme ever happened. So that's how I used to feel. Sometimes I used to feel that I would just die that way, just being suppressed and being suffocated." (s23, 23 years)

Fatigue could not clearly be distinguished resulting from physical weakness, as severe anaemia was common in participants or even be a consequence of the heavy workload women usually had to put up with. A local physician reported that abused women won't seek medical help because of feeling depressed. They would rather express their emotional burden in the form of somatoform disorders, primarily chronic tension headache, backache and sleeplessness. Her theory was that the struggle to earn enough money for food and basic expenses keeps women so busy, that they simply don't find time to be depressed.

"I hardly see depression; but sleeplessness, headaches... Women, who come here, are mostly women who are from lower economical strata where there is a matter of mere survival... Those women work hard, they hardly will have time for being depressed." (e6, 65 years)

Depression was rather expressed in symptoms like social isolation, withdrawal, loss of appetite, feelings of being overburdened, total helplessness, hopelessness and emotional apathy.

"He said that I am gonna sell both of these girls. I said, 'They are your kids, do what you want with them. At least they will stay in a nicer home, they will stay away from all these fights!'" (s20, 30 years)

The time after separation, when most women went back to their maternal home, was found to be a particularly vulnerable phase for severe mental depression in participants. This was described as the time when women had realized the extent of the emotional burden that the abusive relationship had on them.

"That time I lost my concentration. What I ate in the morning, I forgot it... Many times I just went without *duppatta* [shawl] and with home slippers... forgetting everything and frustrations.. My daughter said, 'Mama, I want to play with you!' And I said, 'No, I will never want to play with you!' Because I didn't forget all these things. It was so shocking for me, why all this had happened... When I was at my parents home, I couldn't reveal everything so frankly. I was always in depression. I never wanted to talk... That time I hated everything, whatever I ate, wherever I went... I didn't bath a day... I felt like doing nothing and sat at one place and blamed myself that maybe it happened because of me." (s11, 32 years)

Another woman, who had just recently left her extremely abusive relationship after several

years, talked about her severe state of depression. During the interview she exhibited PTSD symptoms such as hyperarousal alternating with emotional numbness, dissociative behaviour and severe depressive symptoms indicated through a total loss of interest.

"The whole day I would lay in bed, but still I would not be able to feel asleep... When I left my husband's home, that's when all this happened. I didn't eat anything. When I used to live with my husband they used to say you eat a lot of *roti* [bread] and food. But when I left ...I wouldn't feel hungry ...Whenever someone used to talk to me, I felt I wanted to hit him/her but I had to control myself... There were some times where I got so angry on myself that I wanted to kill myself, but then I thought that people would say, she killed herself because she did something wrong. That's why I didn't want to kill myself... [If you could gain one thing in life, what would you want that to do?] Nothing, I just want to finish learning stitching, out of that nothing. I don't want to do anything." (s14, 25 years)

Reasons for mental tension were varied. Emotional violence was generally far more debilitating than physical violence, having a greater effect on the mental health of participants. Constant verbal humiliation and emotional abuse were described as the main promoters of emotional distress in women. Total ignorance of the women's feelings and emotional needs by their spouses was experienced as additionally humiliating. Several women reported that their husbands would not apologize for their abuse. Some husbands were often very drunk when they abused their wives. Afterwards, the husbands would not remember it. Others reported that their husbands even abused them without being drunk and never apologized. This behaviour was reported to have mortified the women, leaving them feeling alone and sad. One woman narrated,

"When he is drunk, he beats me and he never feels sorry for that. He has never apologized for these things. And he never bothered about me that I got hurt." (s9, 42 years)

The most commonly cited reasons for mental tension surrounded food, shelter, children's education and, most notably, about a daughter's future or about the effect of domestic violence on their children. If their own children were abused too, participants described feelings of immense self-reproach for not being able to protect them, and great apprehension about the children's well-being and their future.

"But whenever he hits me when they are around I get scared he might hit them too. Then I get a lot of tension. They see everything that happens... My younger daughter is very smart, when she sees that happening she runs away immediately. She thinks that I am gonna run away and she will run away before me. And my older daughter watches everything. When she sees that her dad is hitting me, she hides things that her dad could hit me with so he can't hit me with them." (s20, 30 years)

"If anyone speaks to him [the older son] loudly, if I speak to him loudly or his teacher then he forgets whatever he is thinking about. They have seen the situation at home and they have seen their mum getting beaten, and now those kids cannot do anything. The little one is a little bit courageous, but the older one is always afraid and runs away... I don't know if my children will be successful." (s22, 34 years)

Failing to provide their children with food or leaving their children hungry at night was described by women as an unbearable sadness and they blamed themselves for failing to fulfill their responsibilities.

"I got a lot of pains in my head, they happen out of the sudden... I have kids, and I don't make that much money, some months I make 600 Rp. and from December to February this year I didn't make any money. So I get tension over how to feed my kids, and how to buy them books for school. I feel like sometimes I am not able to provide them things that are necessary to them such as food, sometimes we just eat rice with salt and that's it. Of course, I am having tension." (s22, 34 years)

"Yes. Many times I tried to find food from anywhere. If I don't have rice I tried to give them *roti*. But one time their father came home from work and locked himself in the kitchen... So then we just had to drink water and go to bed... I was not able to sleep all night. The whole night I thought that even I had food, I wasn't able to give them. So I woke up the next day at 5 am and made them food." (s22, 34 years)

Several women expressed their fear about the children's future education as they attributed concentration problems and lower school performance as effects of violence on the children.

"[My daughters] study but they forget everything. How can they take any exams? When they have tests he starts creating noise. My daughters would wake up in the middle of the night. I used to help them study. I am not very educated, but help them as much as I can... But whatever they learn they would forget." (s20, 30 years)

A woman described how it makes her feel sad when she sees her little son copying her husband's abusive behaviour,

"[My son] learned very bad curses from him, because my husband would say those things to me... He is just a kid repeating these things. I used to get very sad, seeing my child saying that bad curses... My son also started me slapping when my husband beat me. Then I felt so bad that my son was also learning these things by watching ...He has some bad habits, or habit of hitting people, but to a certain extent." (s23, 23 years)

Six participants disclosed that their husbands would abuse their children regularly, putting a great strain on them and in many situations leaving them in desperate helplessness due to the husband's ruthlessness.

"I had to spend so many nights outside, and then he hits my daughters. This time when I went back he beat my little daughter so much, I could hear her screaming from outside. He started to burn her hair on the stove. What kind of father is he?" (s20, 30 years)

Participants facing sexual abuse feared that their daughters would be sexually harassed. One woman reported that she suffered from increased anxiety and sleeplessness because she was greatly concerned about her two daughters,

"Everybody in the area says that your daughters are like flowers... I worry about my kids. That's a house of alcoholics. I don't know what can happen there. I can't sleep at night thinking about this... Sometimes his uncle drinks alcohol and tells me to sleep with him... If I had boys, then I wouldn't have so much tension. But I have daughters. I have so much tension because of my daughters. You know

what kind of things happen with little kids... And that's a house of alcoholics. They never stop drinking alcohol there." (s20, 30 years)

In addition, the threat to the woman's life was another major reason for constant tension.

"My daughters say to me, 'Mum if you live here, dad will end up killing you!'" (s20, 30 years)

"I don't have a day's peace. Sometimes he calls on the phone and threatens. Sometimes, he makes problems from the roadside near our house. Everyday I hear some or the other news, either from his sister or some other way. His aim is to give me so much tension daily that I become mentally unstable and withdraw the case against him. So all I want is to be rid of this man as soon as possible." (s10, 22 years)

"He brought me back to his house and on the way he wanted to kill me. I had a gut feeling something is wrong. Then he said, 'My mother wanted me to kill you!' He said sorry and we both cried. We went back to his house because I believed him and he apologized himself. Now I understand the circle of violence." (Written notes, s16, 36 years)

Several women believed that the development of dark skin discolorations was an effect of mental distress. Dark skin was found to be ugly and associated with a lower level of self-perception.

"I have a fear. You know after marriage I became black. My skin became black because of depression, because of tension." (s18, 32 years)

Key informants reported another phenomenon among battered women, which was that women would cling to their belongings. This was not mentioned by the participants, but was found widespread in the research area. Women would even go to bed, hiding all their belongings inside their nightwear.

Being prescribed psychiatric medication was only reported by a single participant. She subsequently tried to attempt suicide through taking an overdose of her medication, but her nephew prevented her from doing so. He told her that in the future, she should share her problems with him. This act brought her emotional relief, which she acknowledged in her narration of her suicide attempt,

"I had medication for anxiety, back then I had so much tension. Then I took so many pills, and my nephew came and asked what are you doing? I said I'm not doing anything. I said, I am sad with tension, I just want to die. My life is over... I said, that my husband comes home everyday after drinking alcohol and says dirty things in front of the kids... He told me... if I have any problem, to share it with him... I share any troubles I have with him... Before I had become crazy, when my husband used to beat me I felt like I was just going to die." (s13, 37 years)

Generally, not being able to share one's mental distress was found to be a great strain on the women's mental state. Most women feared to disappoint their parents, as they had interpreted their abuse as a personal failure in being a good wife. A woman who joined a *mahila mandal*, a women's group, after her husband had died explained how she felt emotionally relieved by

sharing her sadness,

"When I share my sadness with anybody, I feel better. Then my tension in my mind becomes less."
(s12, 35 years)

Symptoms of **post traumatic stress disorder** (PTSD) like intrusive memories, avoidance, negative changes in thinking or mood, emotional numbness, general negativity, lack of interest, hopelessness, memory problems, arousal symptoms such as outbursts of anger and aggression, being hyperalert and easily frightened, overwhelming guilt or shame, concentration difficulties and sleeping problems, were reported by all participants as consequences of domestic abuse. The intensity of PTSD symptoms varied among the participants. Four women were found to suffer from severe PTSD and were highly constrained in their daily activities.

Nine women suffered from **concentration problems** and memory loss due to severe physical beatings such as being hit in the head, or having their hair pulled. Injuries to the head were reported by the women to have affected their "brain work". Concentration problems were found extremely debilitating especially in young women, who had separated from their husbands and wanted to continue their education or learn some handicraft that would help them to become economically independent. Living separately often meant a sudden loss of economical stability and those women had to rely on their own abilities for earning money much more than others.

"He would catch hold of my hair and hit my head against the wall. Some men do this when drunk, but he would do it even when he wasn't drunk... If I do not concentrate, then I forget what we were talking about. So I need to focus a lot when talking to people. And at night, I sometimes wake up choking, as if I can't breathe... [Would you like to complete 12th grade?] Yes I want to, but my brain doesn't work anymore. I don't remember things. I can't give exams... I simply can't remember what I study. My brain is not as sharp as it used to be." (s8, 24 years)

"But there is some effect that remains. Before I used to be very smart in school, I could catch things very quickly, but now if someone tells me something, I forget it. If I put something somewhere I won't remember where I have put it." (s22, 34 years)

"When I have to do any sort of work, I don't remember it... [You started learning sewing right now - so you were able to remember everything of this?] Yes, I was able to, but after some days I had forget it again... He hit me quite a lot." (s14, 25 years)

Eight participants mentioned **sleeping disorders**. Either they were not able to sleep because of constant thoughts, or they feared their spouse would hit or sexually force them during the night. Several women reported their spouses would come home drunk, late at night and would beat them regularly without any reason.

"Earlier, for three to four years I just couldn't sleep. I would have nightmares about whatever happened to me in real life. I would keep thinking of the same things. Now it's better, but my body keeps aching... I couldn't sleep because I didn't know what he would do to me, when I will get beaten." (s8, 24 years)

"I have a fear that in the night he might do anything. At midnight he starts murmuring and gets angry and also watches television till 2 am in louder voice. The children have to go to school in the morning, they have to wake up early in the morning, but he does not care and does not allow us to sleep well." (s9, 42 years)

Emotional hyperarousal was another PTSD symptom often mentioned by participants. One interviewee who had just separated from her extremely abusive husband, who still threatened to kill her at her parents residence, was very stressed during the interview. She described severe PTSD symptoms of emotional hyperarousal, dissociation and extreme fear and self-harming behaviour. A non-local, highly-educated social worker involved in the work of Nari Adalat (women's court) described the difficulties of handling traumatized women during the counseling process of Nari Adalat.

"[If a woman comes that is obviously traumatized, what happens in the Nari Adalat then?] ...Normally she will already be with somebody. Very few cases come straight from their marital homes. Most times it begins after she had gone back to her parents. But that doesn't mean the trauma stops. Her parents might have already put pressure on her to go back to her husband... A lot of these women, when they first come, they just want to get rid and want to talk it all out ... So we just listen to her... Then [we] give her a sense that she is not helpless, that the law stands with her... and in case of a crisis, she knows that if ...she phones us, we will come, she is not alone any longer." (e3, 26 years)

Suicidal thoughts and suicidal attempts were found to be highly prevalent among interview partners. This was true in 18 of the participants. Suicide is considered a cultural taboo and would only be the very last, desperate option women would take. Recurrent suicidal attempts were reported by two women facing extreme forms of humiliating abuse. Women reported that they could not think of any solution. Their social isolation and deep feelings of shame and self-doubt were identified as key emotions leading to a suicidal attempt. Eight participants had attempted single or multiple suicide attempts.

"I keep thinking why all this happens only to women? Men are free no? They have no unhappiness. All sorrows are ours to bear. I feel sad. I got married but it came to nothing. I gave birth but it came to nothing. I have to hear from everyone about my future and my past. Both ways, women have to bear the pain... Sometimes I feel I should just kill myself... A woman can't live as she wishes nor die as she wishes. She just can't do anything based on her free will... A woman can do nothing. She has to hear what the world has to say, listen to their taunts." (s10, 22 years)

Considered methods for attempting suicide among participants were self-immolation, ingesting a poison, drug-overdose, jumping from a high bridge or throwing themselves in front of a train. Self-immolation is a strongly symbolic and commonly used method among Indian women. One woman, who's husband deliberately mortified her in public narrated her

multiple failed suicide attempts out of total loss of dignity she felt,

"I had taken suicide pills once and it didn't work, but then after that I would have tried again. And I tried another time after that. Because I felt suffocated in that place. I had stopped talking because I felt very shy. People talk about you behind your back. That's the atmosphere of the village... So I felt like killing myself, I thought what is left in living... That time I had even taken medicine to try to commit suicide... But nothing happened. I don't know why it didn't." (s23, 23 years)

The foremost reason that prevented women from committing suicide was the responsibility of women towards their children. Second most common reason was the fear the social stigmatization that suicide would bring over their maternal family and their children.

"Sometimes I thought of committing suicide but I did not do so for my kids as they all were small and they are girls." (s9, 42 years)

"I used to think about it a lot. I used to think I should die. In any case, he was always trying to kill me, but couldn't because other people would rush in and save me. Then I used to think I should kill myself, but then I would think of my parents. If I were to kill myself, all their efforts with me would be waste... I really wanted to die, but if I were to kill myself, my family would have a bad name, that their girl killed herself." (s8, 24 years)

One participant, whose husband as well as her brother in-law sexually coerced her and also sexually touched her five year old daughter, talked about her suicide attempt which was cut short. She realized the imminent danger of the sexual abuse of her little girl, who she would have left behind. She narrated,

"I tried two or three times, but I failed. I had a poison or washing cleaner whatever. I drunk it that time. But I thought after my death, my daughter will be alone and how will she face that husband. Then I vomited." (s11, 32 years)

"A couple of times I went to the train tracks and stood on them but I never had enough courage to kill myself... If I killed myself, then people would think that I was the one who was wrong, and there must have been some weakness in me. And then he would say to my family that I was the bad girl and they had gotten me married to him." (s21, 38 years)

Following this, one woman who painfully realized that she could not protect her daughter from child abuse, was so helplessly desperate, that she intended to first kill her daughter and then herself. She narrated that she could not think of any solution other than to die with her daughter,

"When I gave birth to my elder daughter, he beat me. She was five or six month old. He has beaten me and I went outside and I took my daughter along with me into the jungle. I thought that I won't survive that night. I thought that I would kill my daughter and then myself... Maybe she was two or two and a half years old. She said, 'Mother, why did we come here late night into the jungle?' Then I realized that my daughter is begging me. Then I came back and I stayed at my uncle in-law's place. Then I came back in the morning to my own place." (s17, 31 years)

3.5 Physical Health

Bruises, injuries and fractures as physical health consequences of spousal abuse were reported by twelve participants. Only one third of the women reported to have sought medical help for their injuries. Women tried to hide their bruises and injuries or lied about the origin of their injuries, explaining that they had been hit by a cow or fallen over. Despite the feeling of being ashamed and afraid of revealing one's abuse, women cited having no money for medical treatment, the lack of close by medical facilities, and that there was none who would have accompanied them in the dark, as reasons why they didn't seek help. Participants also reported they doubted that society would believe they had been abused, even though they had obviously been injured. One woman was actively hindered by her husband to go and seek medical help for her injuries.

"I never went to the hospital. The village I come from is a very backwards area. It would be very taboo, if a woman did something like that, if she went to the doctor. So people never go to the doctors because of such things... And then hospitals are also far away from the villages... And I probably didn't go because I was ashamed." (s23, 23 years)

"I told the doctor that I was sick and that I fell down the stairs. [Why didn't you say anything at that time?] I was young, I didn't know much, so I kept quiet." (s21, 38 years)

Glass bangles which are usually worn by a newly married Indian women and indicate their status of being married traditionally cover both forearms. Breaking those glass bangles during fights had caused deep injuries in two women.

"I have a scar here, where he hit me one time, here in my arm my bangles had cut me. I had to have them removed from here to here. And I have some scars on my back too, a lot. Here I had gotten hurt too [pointing on her nose]. I had gotten dizzy. He had given me so much tension at night." (s20, 30 years)

Medically unexplained symptoms, primarily chronic pain disorders such as tension headache and backache or joint pain were reported by nine participants. According to a local clinician, the expression of mental distress in form of somatic complaints was found a common pattern of symptom presentation among victims of violence (e6, 65 years).

Eight participants suffered from debilitating **chronic headaches**. Headache often was induced by physical violence such as pulling the hair, severe head injuries or blows into the face. Seven women reported severe head injuries through dangerous objects such as a sickle, a kitchen knife or a piece of wood with nails in it. One woman was even attacked with an axe, but her spouse was luckily hindered by her neighbour from further injuring her.

"He got up and took this wooden stick and hit me here in the head. A nail got stuck and I was bleeding". (s21, 28 years)

"He used to pull my hair. Now I can't sit without a backrest for a long time. My back starts to hurt. My neck also hurts." (s8, 24 years)

"He cut my head, so for many years I had tension in my head because there were lots of blood loss from my head." (s17, 31 years)

Dizziness was reported by seven women. In three women it was unclear whether they suffered dizziness and fainting episodes due to somatization, hysterical fits, anaemia or injury induced seizures. Physical exhaustion or **fatigue** was either a somatoform complaint or caused by severe **anaemia**, which itself was a result of chronic malnutrition through sex-selective nutrition.

"I get dizzy all of a sudden, it will happen after a year or after two years. But I don't know if its happening. I didn't have this before marriage... I start to shake but I won't know it. It will happen for two minutes and after that I will be ok... The doctors said that this sickness would get worse, the more tension I have. You can see for yourself how much tension I have... Nowadays it has gotten a lot worse." (s20, 30 years)

"He had injured my head... He pushed me from the veranda against the wall and I got hit... I feel dizzy often when there is tension. And in this portion here, there is a lot of pain... On both eyes I can't see properly. I was hit straight into my face... Any mental tension is followed by dizziness... [What's the frequency?] ...Sometimes after a week, sometimes after a month. [Do you remember the duration of that period for which you remain fainted?] 30 minutes or 10-15 minutes... Weakness and tension brings this state." (s5, 35-40 years)

Functional disorders, hysterical fits, breathing problems and pressure on the chest were other described symptoms.

"I fainted at 12 noon. Then my aunt in-law came and pulled my hair. She said, 'You were fine few times back. We do not want this drama in our home.' I was having so much pain in my chest and also breathing problem that I was not able to say anything to her ...She didn't bother about it." (s19, 27 years)

Gynecological problems were found highly related to sexual abuse. Nine women suffered from severe gynecological problems such as miscarriages, stillbirth, menorrhagia, postpartum hemorrhage, dysmenorrhoe, preterm labor, forced abortion, force sterilization, pregnancy complaints, uterine prolapse and one woman reported to have suffered from syphilis, a sexually transmitted disease, due to her husband's multiple extramarital affairs. Local medical practitioners confirmed the high prevalence of gynecological problems among abused women, another important psychosomatic pattern of symptom presentation. Referring to a local clinician, various gynecological problems, dyspareunia and frigidity were common reported problems of patients (e6, 65 years).

Pregnancy was found to be a highly vulnerable period to face abuse. **Violence during pregnancy** was experienced as especially shattering by the women.

"When I was gonna have my second daughter he still hit me. I was very pregnant and he still kept on hitting me." (s20, 30 years)

Two participants showed desperate grief over their miscarriage or stillbirth as a consequence of forcible sex and targeted beatings into the abdomen during pregnancy. One woman described this traumatic experience of the death of her newborn girl whom she had given birth to due to premature labor:

"Nine months were about to be completed. It was a girl. They wanted a boy. They won't have let me live because they wanted a boy... They were very happy that the girl didn't survive. They never wanted a girl. He said, 'Don't worry, we will make another baby!' But I knew they won't let me live. That's why I didn't go back. That's why people think I am wrong, because I chose not to go back. I delivered before time, that's why she died." (s8, 24 years)

She hardly recovered from this traumatic loss and suffered severe post-pregnancy complaints. Another woman showed many symptoms of severe PTSD while narrating her story,

"After miscarriage, I was just about 18... I kept bleeding for five to six months... It used to smell very bad. I couldn't even walk. I became swollen... I was bed ridden. It took me almost a year to recover... I had pain in my breasts also. My milk didn't stop. I had to take it out manually. I was very sick... Sometimes, I don't get my periods... I am very weak inside. Sometimes I get dizzy. My body was damaged at that time. That one year was so tough for me... He used to beat me all the time. Sometimes, he would say he wanted a boy and at other times, he would say this child is not mine. I was so young, I didn't know anything, how to make a relationship work. Tell me, what does a school girl know of these things?" (s8, 24 years)

One woman who faced brutal abuse reported her husband forced her to abort multiple times through taking an abortion pill four to five times. As a consequence she became severely anaemic and physically incapacitated due to blood loss because of the induced abortions. Her regular menstruation cycle had stopped by that time. Subsequently, her husband forced her to undergo sterilization at the age of 21. She recalled that he had even threatened the doctors in the hospital to get it done.

"I took a lot of medicine, in order to have a miscarriage... It was for abortion. He didn't want a child... Before my periods were fine, the flow was as much as it should be. After taking the pills, I became weak, because of the abortion pills I ate... I had an operation, to get sterilized... It wasn't necessary to get my operation done in such a young age, and I didn't agree either, but he forcefully got it done. After that again I became really weak. I had a lot of problem, I had anemia" (s23, 23 years)

Unwanted pregnancies for the sake of the husband, because he wished to have a son born after having only female children, were reported by two women. One narrated,

"I said I didn't want to have another kid and we should have an abortion, but he said no. He said no, because he has so much land and such a big house. He said that if we had a son, then the son could take care of the land. Then we even had a son. After two daughters we had a son, but he still was not happy. As soon as I came from the hospital he started fighting with me." (s20, 30 years)

Menorrhagia was seen as another consequence of domestic abuse in two women,

"Before you know when he used to hit me. But I don't have it anymore... I would get my period three to four times a month, and then I would not get it at all." (s14, 25 years)

One participant reported she could not breastfeed her newborn child because of a vaccination that was necessary after severe physical damage due to bites by her spouse. In addition she felt very weak due to critical anaemia.

Most of the participants were employed in precarious jobs or at home. Doing hard work till labor starts is common as there is no legal maternity protection or leave. If a woman faced pregnancy complaints or postpartum complaints she would not have been spared from her household duties. It was a common problem that women who felt sick, whether pregnant or not, were accused of being lazy. Two participants, who suffered severe pregnancy complaints, were considered to be useless by their in-laws and were threatened to be thrown out, as they needed a household worker not someone who just eats the food and needs to be taken care of.

"I didn't even know it and they said that I was pregnant. The first time I got pregnant. And then my health was getting bad, and then I wasn't able to do much work. And my sister in law would say bad things, that I am not able to do work and I am useless." (s21, 38 years)

Four women in this study were childless. They each separated from their spouses. Their childless stigma in society was reported to have a great negative impact on their mental health.

A major traumatizing event for two participants was the mysterious death of a child. Their mothers suspected each to be a victim of violence. None of those two children's death was legally investigated or provided justice. This has left a feeling of injustice and grief which was found to be a major stress factor, having a negative effect on the mental state of the participants concerned.

"We got separated when he had beaten my second daughter. Then he killed her... She was four months old. He choked her neck. He said that I am giving birth to a baby girl that is why he choked her neck... after one year of that I gave birth to the next baby girl... Then he started beating me when he was drunk complaining about me that I had given birth to a baby girl, again and again." (s17, 31 years)

"I had a baby but he died four days after being born. After delivery, when my child died, they blamed me for killing him... That was the time when he made me do all that stuff I talked about, porn... When I was pregnant, he would sexually force me... My brother-in-law dragged me out of the house. They kept me in tension and tortured me. I never got food on time. There were so many ways in which I was tortured, but the main was what he did with the mobile phone... He treated me very badly. I believe that my son died because of what he did to me..." (s10, 22 years)

Severe abuse due to giving birth to a female child was mentioned repeatedly. Women were made solely responsible for giving birth to a female baby. Humiliation, beatings and postpartum neglect, not being visited in the hospital or at the maternal home after giving birth

to a female child were reported by participants. Two women, who had already faced severe domestic abuse, feared for their lives after giving birth to a girl. Subsequently they never went back to their marital homes, but separated from their husbands.

"Then my daughter was born in the hospital by a cesarian... I was very weak, but my mother in-law didn't look after my child... I saw my mother in-law feeding my child with cold milk. During night times after the cesarian he beat me so much, because the baby was a girl." (s16, 36 years)

3.6 Women's Strategies in the Context of Domestic Violence

Though this research project follows an intersectional approach, it does not only discuss multiple forms of violence and mental health sequelae that are inherently associated with physical health consequences in rural marginalized women. It also sheds light on women's strategies and agency in the context of domestic violence and thereby empirically reconstructs how violent acts are not only witnessed or remembered, but also "how one might inhabit such a world [again], one which has been made strange through the desolating experience of violence" (Das, 2007, p.39). The following descriptions offer insights into an agency of the everyday, by women using different coping strategies. Of note, the limits of language through which pain can be addressed is acknowledged and the importance of the socio-cultural expressions of violence in resilience, denial and silencing.

3.6.1 Coping Strategies

Resilience was found to be remarkable among rural marginalized survivors of often extreme domestic abuse. A local physician (e6, 65 years) explained that facing an economically deprived situation results in an extreme survival struggle, keeping women busy with work in order to manage food and other basic expenses for housing and education of their children. This notable, **strong survival struggle** was seen in the majority of the participants, in particular those who had children and were living in very poor economic conditions. Responsibility towards their children in terms of providing them enough food and for their education expenses was found to be a major source of resilience, helping the women to leave behind their maladaptive coping behaviours of passive acceptance.

"Now at this time what is your biggest problem? To take a stand. I have to look after my children and to move on. That is the main thing" (s15, 33 years)

Rural Indian women usually have to put up with a lot of hard agricultural, household and sometimes additional labor work. This physical imposition was at the same time, for many women, a method of **distraction**. Keeping themselves busy with work or other activities was found to be a common coping pattern among participants.

"When I am in stress, I try to indulge myself in activities... There are kids and when I play with them then I forget about it and I keep it behind... I am not able to talk openly... I know if I remember all these than I will have breathing problems and chest problems." (s19, 27 years)

Anxious avoidance was found to be another coping mechanism among participants, who reported that they usually did not think about their abuse, they would just ignore it. Women said that remembering or talking about the violence they had faced would bring them great sadness. Therefore they stopped thinking about it because it was not found 'healthy'. Generally, it was striking how many long moments of silence occurred during the interviews, indicating the extent of emotional burden the participants were loaded with.



Figure 6. A Woman and a Tree. s20, 30 years

One woman reported of coping through **substance abuse** of pain killers, after her husband had beaten her.

"[After you were beaten up, was there a need to go to the doctor?] I used to eat pain killers... I felt it necessary to go [to the hospital] but I was afraid and I was not able to go." (s3, 48 years)

Denial as a coping mechanism was expressed in the common statement that the abusive situation would simply be a woman's destiny or kismet. Resignation to a fate is a traditional

and common Hindu belief that hindered participants from taking action for help. This led to denial of awareness about the impact that the abuse had on themselves and their witnessing children and the denial of the repetitive pattern of their domestic abuse. All women tended to bear the abuse for a long time. Only those women who had faced extreme abuse connected to life-threats of themselves or their children realized their denial of the abuse earlier and left their relationships after a short while. The strong use of denial as coping mechanism might be connected to that women often felt optionless and could not think of any solutions.

"No, no, no, I don't think about it anymore, I don't even want to remember that this stuff has ever happened to me... And when I think about it my head starts to hurt." (s14, 25 years)

"I know if I remember all these than I will have breathing problems and chest problems... I feel very bad about it, why it happened with me." (s19, 27 years)

Most women would use the maladaptive coping mechanism of **self-blame**, being trapped into the mode of victimization. Helplessness, sadness, feelings of being alone, guilt, anger and powerlessness were far the most coded emotions during the interviews, indicating a strong passivity and negativity among participants. Only five women were found to have overcome the mode of victimization. All of them reported that they were empowered by NGOs they were involved with, giving them courage, strength and social support. Religion was found to be another source of strength in those women.

Spirit possession is an interesting phenomenon of coping that was common in the area of research and had been witnessed several times by medical doctors engaged in the area of research. It was, however, not reported directly by participants, possibly because it is very stigmatized. In violent emotional outbursts, resembling a hysterical fit, possessed women spoke with the voice of a deity commenting on various things. If a woman got possessed she usually would disclose it with the expression "*mata aya is ke pas*", literally meaning 'the goddess came to me'. The clinicians interpreted this phenomenon of spirit possession as a traditional custom that enables subordinated, discriminated and marginalized women to overcome their state of repression and have a legitimate chance to communicate their suppressed emotions. Women from all castes could be possessed by goddesses.

"Oppressed women who cannot defend themselves suddenly get possessed by a deity. Then they can do whatever they want to, what they would not be allowed to under normal circumstances, for example pelt their husbands with cow dung. Possessed women usually get a hysterical fit. Women start to tremble in a strange way. Sometimes this phenomenon even will be performed. It's a strategy to make one's voice heard... I saw it in a Dalit woman who was banned to use a water source. She got so annoyed about it ... that she got possessed and mata [the deity] spoke through her 'What the pandits said is wrong, what the brahmins said is wrong. Water is here for everyone!'" (e6, 65 years)

"People believe, that if the goddess is asking for a demand, then it should be completed, we should listen to that... [They are] personifying goddesses or some elderly women, who are already dead. They come into their body... they will say that their body is speaking through me. Different acceptable forms of expression emerge out of suppressed emotions, because they are not supposed to be expressed. So, acceptable forms are being adopted, psychologically by the women, which are seen important... by the people and the family members... Even small needs like if they want to eat something, if they want to say no to something..." (e1, 59 years)

Religion and spirituality were other important resources among the participants. Worshipping a deity, making a pilgrimage to a holy temple site and wearing traditional religious symbols were mentioned as additional resources that helped women to survive.

3.6.2 Silencing

"A woman who keeps her mouth shut is a happy woman. If she starts pointing fingers, she gets in trouble with the society. She has no right to stand for truth and justice." (s10, 22 years)

Silencing among women was widespread. Ten women reported they did not dare to speak about their abuse for a long time. Reasons for silencing were various. Foremost, **domestic violence was seen a private matter**. Some women even were warned by their in-laws not to share their abuse with others. It was clearly communicated that it was of no business to others. Women tended to question themselves; what was wrong with them and why they were abused. They felt ashamed about being abused and feared that their domestic abuse would be revealed. Participants stressed that at that time of their lives they were very inexperienced and uneducated about how relationships work and thus accepted the situation as it was and stayed quiet.

"He took advantage of me, because I wouldn't say anything. I just stayed quiet." (s14, 25 years)

This perilous combination of **naivety and subordination** was found prevalent in rural marginalized women. Their primary aim as wives were to satisfy their husbands needs. Being beaten was interpreted as the women's failure in being a good wife. This dynamic of feeling guilty reinforced their negative self-perception, leading to extreme shame. Self-doubts and questions for what reason they had been abused by their spouses were common reaction patterns seen in rural marginalized women. It was remarkable that women remembered their own ignorance, uncertainty and helplessness as most hindering. In one woman, this dynamic was augmented. She was indoctrinated by her in-laws that being abused by her spouse was her own fault, which further increased her helplessness.

"I used to feel very bad when they used to say it is my fault... I felt helpless." (s21, 38 years)

Although women knew about intimate partner violence happening in their villages, stating that it was a 'usual' thing among village women, they felt alone and did not dare to share their suffering. Mostly women had a **fear of not being believed** despite obvious injuries like a black eye. The fear of losing child custody or property also hindered them from informing others. Participants alluded to examples of other village women who sought help and were not believed by legal institutions or other family members and even accused wrongly. These negative examples prevented them from taking their own initiative to speak out. But it was not only fear of this, but also their own tangible experiences of not being believed, women told.

"I never asked for help. I had asked *mata* [a feminine goddess] and whenever I shared my story with anyone, they thought I was the wrong... If I wanted to tell it to neighbours his relatives would always say not to tell it to other people because it was our personal matter." (s21, 38 years)

Separation and divorce were reported to be very stigmatizing acts, making the women feel deeply ashamed. **Fear of social pity and stigmatization** of their own family were major reasons. Participants narrated examples of other village women who were stigmatized or who experienced injustice and were not believed by legal institutions where they had sought help.

"You know when a woman is divorced, how people see that woman, how badly they think of her... If I talk to any man, they think surely there is an affair going on. Life is very difficult for a divorced woman... My close relatives... didn't speak to me when I came back. They had broken their ties with us because I have left my marital home... They used to say, I should have gone back to my marital home even if I had to die there. Just because I left my marital home, I am considered wrong. I really hope this doesn't happen to any other girl. This world doesn't let us live." (s8, 24 years)

In order not to make their parents unhappy, most women initially denied their abuse. Only when they could not further hide it, would they speak out. Some participants reported to have even been blamed by their own family.

"Nobody gives me support. My brother and his wife keep on saying, 'Why do you need to do this [separate from the husband]? We will be ashamed in society!'" (s20, 30 years)

One participant who separated from her husband after facing extreme domestic violence and humiliation by her in-law family, talked about the social stigmatization she feared for her family,

"My brother is getting married in three, four months... When his wife comes home, then she will have to see all this... and I have three kids... I feel ashamed." (s20, 30 years)

Another woman, bearing social isolation brought through her separation, was living separately next door to her husband's and in-law's house, having had her divorce case going on for eight years without success.

One participant who had faced extreme abasing violence desperately felt alone in her agony. Her severe depression made her completely unable to act, embedded in negative thoughts and anger about what she had to face.

"I am screaming from inside. Because otherwise people outside can hear everything and they know, her husband beats her. So I tried to not let people know that my husband had hit me or anything happened. I had a lot of injuries naturally, but I never went anywhere for that. (s23, 23 years)

Life-threats or threats to commit suicide by their spouses, in case they would reveal the abuse was another reason why two participants would not dare to seek help.

In spite of being horribly abused by forced prostitution, one of these women remained obedient. She said, she had always remembered what she was told by her aunt in-law initially at her marriage, that it is her only duty as a wife to respond to her husband and make him happy. She described how young, inexperienced and naive she had felt, with no self-confidence at all. She felt very ashamed about being forced to prostitute herself. Her father was very sick and before he died he married her off quickly, not knowing the groom. During the three hour interview she was constantly crying. Only after her husband had imprisoned her and denied her food for days, she realized she was in a life-threatening situation and escaped back to her maternal home. She was identified as one interviewee suffering from severe PTSD.

"I thought, I will reveal everything but he had already warned me. If I would do so, he will kill himself or me. I thought if you would do so, it's ok... I did not want to live my life." (s19, 27 years)

3.6.3 Finding Courage

"But I have decided that I am going to give my kids a lot of courage." (s22, 34 years)

Rural marginalized women tended to bear the abusive relationship for several years; a long time. Only in case of life-threatening violence did women separate from their husbands earlier, after some months. Two main dynamics were identified in which victims of DV seemed to break their silence. Either they were driven to **protect their children** from severe harm through physical or sexual abuse or they had the realization of imminent **danger to their own life** from their husband. Interestingly, emotional abuse was not paid as much attention to as physical beating, starvation or sexual harassment. The women always said they intuitively had known their husband would have killed them if they had gone back. Participants tended to bear the abuse for a long time, until they could not put up with it any more. The point of taking action was always triggered through a concrete threat to either the children's or the women's bodily integrity.

"I always just thought about my kids. Before he only used to hit me but then he started to hit the kids. And my little kids would get so scared about him and would run away from him. So that's when I thought that before he only used to hit me, but now he is hitting the kids and they get so scared. I got courage because I wanted to protect my kids." (s22, 34 years)

Before leaving the abusive environment completely, a few women reported to have had found courage to **fight back** in defiance of their husband's physical abuse, and the husband had reacted in surprise to that. This was not necessarily successful for every woman, but at least for some time, men would stop abusing them.

"There was one time in the kitchen... he start beating me. I had my hair open, because I was combing it. He pulled me by my hair. I didn't have anything in my hand, I wasn't able to do anything except on his pinky, but I was able to bite. I didn't let go of his finger until he felt pain. Then he let go of my hair. And he said, 'When you do that to my finger it hurts a lot.' And I replied, 'When you hit me, don't you think it hurts me?' After that he never hit me. He says a lot of things, like I am gonna do this and this and this. But he doesn't hit anymore." (s22, 34 years)

Unfortunately after a long time without being beaten, this participant's husband had recently lifted his hands against her again and severely injured her. With the help of NGO workers, she filed a complaint at the police station, lodging an FIR²².

But fighting back was not considered a socially acceptable behaviour and if publically revealed could result in malicious gossip about the self-defending woman. After women had found the courage to leave an abusive environment most of them went back to their maternal homes, having no other option.

"I think to myself why? A woman can fight back, she is not helpless. But she becomes helpless when society says that she is a bad woman. Men have all the rights, but what does a woman get? ...That's why one time I challenged him... People said, look she is supposed to take care of her husband, and now she is lifting a stick against him." (s13, 37 years)

3.6.4 Support Sources

Medical institutions as help seeking resources were attended only by participants who had severe injuries. Even then, women reported that they lied about the cause of their injuries. Doctors were considered too busy, and it was not their responsibility to take care of a women's emotional needs. Many women would instead seek medical help for organotropic or somatoform disorders. The lack of medical facilities was also a reason that was mentioned. However, two participants narrated their positive experiences with clinicians, who either encouraged them to fight back or helped them with personal effort to escape from the abusive environment, in the case of a woman who had faced malicious abuse.

²² FIR = First Information Report, which is usually a written complaint lodged with the police through a victim of a cognizable offence.

"It was a lady doctor. She asked me, how this happened and I told her everything. And the doctor asked, 'Why can't you do this also? Why do you have to put up with his beatings?' She gave me a lot of confidence and encouraged me. She was very nice. She empowered me. She said, 'When a man does things like this, why can't a woman? You can beat your husband too.' So she said things like that to me. She treated me well. (s22, 34 years)

"Only if we are awoken then other people will be awoken!" (s23, 23 years)

When they had come to seek **legal support** at *Nari Adalat* (women's court), for many women the first contact point, they were usually accompanied by family members from the maternal family. Very rarely, women came directly from their abusive environment on their own. Women reported that it was difficult to speak out about what had happened to them but the non-judging and empathic listening of some NGO workers were mentioned positively. The Nari Adalat provided help-seeking women a welcoming, safe space where they could speak out in confidence. Further steps aimed at helping the women regain self-confidence. This being the foundation of future empowering interventions to question traditional role models and patriarchic structures. But still, it was critically remarked by professionals, that solutions made through Nari Adalat were found slightly fast tracked, and that the process of empowerment didn't come from within (e2, 40+ years). Helping victims of abuse to obtain legal restitution in order to overcome their helplessness and passivity towards regressive power structures was central in the proceedings of Nari Adalat (e3, 26 years).

"If you are strong people will respect you. If you are weak, people will pity you and behind your back they will laugh at you." (s16, 36 years)

"I started coming to *Nishtha* and started getting advice about things. Then I started to get knowledge about certain things. When I used to come to Nishtha they would always ask me what happened and they would always want to help me. Before I used to hide things, if he hit me I would say, 'Oh, I fell.' But now I don't hide it anymore. I don't get tortured by what he says anymore. I know he only says it to keep me sad." (s22, 34 years)

Thus, achieving legal justice was reported to have had a fundamental influence on the mental health of abused woman. Foremost, concerns about child custody, maintenance, legal divorce, property rights and getting one's possessions back were important issues. Legal justice was rare, *panchayat* and police were not always helpful as its members were sometimes friends of the perpetrators and considered corrupt and discriminating. Verbal abuse and discriminating taunts by male members of legal institutions (especially against women belonging to Scheduled Castes or Scheduled Tribes or having a low literacy level), aimed at intimidating them and was experienced by a significant number of ten women. The majority of complaints that participants had filed, mostly with the help of the Nari Adalat or other educated persons help, remained ongoing cases for many years, letting women remain in great mental distress

about the legal decisions. It was found to be a major phenomenon that women who separated from their husbands were denied property rights. Part of the legal assistance through the Nari Adalat was to help a woman in fighting for a piece of land, written in her name. This is seen a sustainable support strategy in order to help her building up her own economic independence and identity. The emotional clinging to their property rights in the abusive marital home was notable among the participants.

"He is very proud of the land he owns. He says that I have land and you have nothing!" (s24, 30 years)

"He tries to turn my kids against me, he says... 'We will kick her out of the house.' I say, that I will die before I leave this house." (s22, 34 years)

Next to the legal redress, economical independence was seen an important empowerment issue. Thus, helping women to get a job, to encourage them to continue their education or do vocational training was part of the Nari Adalat counseling.

"Earlier I was less self-confident, because I wasn't free to move. Now I earn myself and can move around." (s5, 35-40 years)

Women tended to seek solutions within the same kind of ideological background (e2, 40+ years). Participants usually had tried to find a compromise several times, before they would go for divorce. The Nari Adalat was considered an important help-seeking institution at grass-roots level, specifically by those participants who had already had a negative experience when seeking help at other legal institutions.

3.6.5 The Empowerment Process

Empowerment of survivors of violence happened very informal and slowly, most probably due to the lack of adequate support services. The participants who found a job at an NGO were found most empowered. It was found vital to be part of a group within a supportive, openminded and caring environment and having the opportunity to go out into villages and listen to other women's suffering. **Social participation and social support**, going out on her own and even earning money for it was seen as a powerful strategy for empowerment and a major factor to help rebuild a woman's self-identity. Hearing other women's problems helped them to speak about their own abuse. Listening to others was found to be the main catalyst to sharing one's own suffering. Illiterate field workers of NGOs reported they had gained immense self-confidence by being given this job opportunity. One former illiterate woman proudly told how she had been supported to learn how to read and write through a literacy program by an NGO. She was abandoned by her husband due to her chronic illness because her walking was severely impaired due to osteomalacia and osteoporosis. At the time of the

interview she was not able to leave her home and was dependent on her only son's very little income, almost starving. In the meantime, an NGO helped her to get legally divorced. What made her extraordinary was her optimism and positivity despite the fact she had to face severe poverty and had been bed ridden for nine months. With an immense gratefulness she reported how she had been given support by an NGO that enabled her to see 'the world', as she expressed it. Coming out of her small village, just the very simple act of getting on a bus daily as a single woman on her own, made her so proud of herself. She repeatedly pointed out how grateful she was to have been given a chance to see the world and attend women's meetings.

"I used to cry all the time... Then I went outside the house. I never used to go outside. Village people don't send you that far. I didn't know anything about what the world is... By going out several times you get to learn things... Those folks gave me courage, taught me about health, getting up, sitting, talking, walking... They taught me how to travel... If I would have stayed at home, I would have cried, cried, cried... Now, I go to women's meetings, and hear the different ways people talk and listen to them... See through staying at home you don't get smart. By going out you get smart!... When I went out, I saw a lot... Delhi, Shimla, Mumbai, Gujarat... God has given me so much happiness for who knows why." (s6, 40+ years)

NGOs also provided education about women's rights, health issues (especially addressing women's needs) and *Wenlido*²³ **self-defence workshops**. All of these were perceived by participants as helpful strategies. The self-defence workshop especially created an intimate space for women to speak out about their abuse in a confidential group.

"I was doing this training [*Wenlido*] for the second time, because it builds my self-confidence and makes me feeling strong... Before he used to just hit me and I didn't know anything. I used to just put up with it. But now I know... if he holds me a certain way how I can retaliate. Having the knowledge is very important. Before... I just used to take his beatings." (s22, 34 years)

After empowerment through *Wenlido* and a safe job at an NGO, this woman gained strength and decided to not further put up with it, although she remained living in the same house.

"It used to be bad before... I couldn't do anything, I didn't pay attention to what I ate, or personal hygiene, I just sat and kept thinking and thinking. But not anymore, I have strengthened my mind and body, and decided that I will not put up with it anymore." (s22, 34 years)

Three women who escaped their abusive relationships became well respected women's activists through joining an NGO for women's rights. Their own experience encouraged them and gave them a lot of strength to engage in women's rights. One of them described the most

²³ *Wenlido* is a self-defense program for women and girls to provide them self-confidence and strength to withstand domestic violence. The intent of *Wenlido* is to provide information on practical personal safety strategies and techniques based on the types of attacks that the women will most probably encounter. For further details see: <http://wenlido-west.webs.com>

important process of empowerment was to build up her own identity, to be given a name instead of just being known as the wife of somebody.

"It was painful for me, but it gave me so much power. Which mother doesn't miss her child? This live you loose something, but you also get something. I chosed to live... I give small things and receive a lot. It is love what I give... Now people know me by my name, not as his wife. My name is my identity. I always tell it is so important to build up one's own identity." (s16, 36 years)



Figure 7. A Woman and a Tree. s11, 32 years

Another woman who became a social activist said she gained again a purpose in life. By engaging for others who suffered similar abuse, she got self-confidence and realized how important her contribution as a single women's activist was in helping other's to build up self-esteem. Asked about the advice she would give another abused woman, she replied,

"You have to struggle by yourself, no matter what it is! Someone may give us the path, but we have to walk the path on our own. If he hits you for the first time, you need to stop the violence right there. If you don't stop the violence at the first time the violence will increase... Keep on asking for help until somebody gives it to you. If an NGO is far away then ask for help from those around you... But first of all... we need to get over the obstacles in our own mind and stop thinking about what other people would say. Throw all those old beliefs behind you! And all of this stuff is build into Hinduism too. Women have to realize, when the husband is beating them, why isn't God come to help them? ...You have to help yourself." (s21, 38 years)

3.6.6 Where to go?

"I was kept like a labourer, taking care of the child, washing dishes, cleaning the house from the in-laws. I was always thinking where should I go? What is my future? Will my family accept me back?" (s16, 36 years)

All participants tended to bear the abuse for a long time. They reported to have felt **optionless** and didn't know where to go. Although most women who had separated from their spouses went back to their parents, **returning to one's maternal home** was not always an option for abused women. Participants reported their family denied shelter and would have sent them back in fear of bringing social pity, especially if there were still unmarried children in the maternal home. Having a separated women living in one's house lowers the family value for future marriage proposals for siblings. Participants were aware of this fact, so if they had a younger sibling they tended to bear their abuse and spare their own family.

"No one wants that their married sister living in their house." (s10, 22 years)

As a consequence, provided solutions were not always suitable. One abused women had asked the local *panchayat* for help, which had upheld for her the right for one room in her marital home where she was legally allowed to live, but this did not prevent her from further abuse.

„The *panchayat* provided me a room. Now I am living in that room. But the electricity for my room has been cut down by my mother-in-law and husband since eight years now. I am staying without light... And whenever he comes from Delhi he goes to his mother's and relatives' home and does not talk to me... It is going on since last eight years... Then the property which was on my husband's name, he converted it into his mother's name... My mother-in-law is threatening me 'It's my home, go away from here!'" (s4, 35 years)

Life-threats were mentioned by two women whose husbands were extremely aggressive. One respondent who faced cruel abuse was helped to flee to another village, but still she didn't feel completely safe as her husband threatens her constantly, although she thinks it's a great relief to live some distance from her marital home.

„Even here I don't feel safe... He has come here many times and created a scene... I would be very tensed... People talk here too, they wonder who I am and where I am from... But I am free, I can go where I want. It's much better than before.“ (s23, 23 years)

Several women expressed their wish for a safe place for separated or single women to live. They favored a women's shelter that would provide a safe space to recover from traumatic abuse, where women could regain self-confidence through a caring environment. A place where they could live with their children without being threatened and to allow a chance at generating an income in order to overcome economic and emotional dependency and passivity.

"[My older daughter] tells me, that we should go somewhere far away, where her dad can't reach us... and we will live together." (s20, 30 years)

4 Discussion

The following chapter discusses the findings of this research project and the analysis of its implementation values, followed by potential policy implications for developing a sustainable and holistic community mental health care program, in particular for addressing the needs of marginalized survivors of domestic violence. The overall results indicate the vast complexity of the interrelationship between domestic abuse and mental health.

4.1.1 Structural and Economic Violence

These socioeconomic findings mirror **structural violence**, based upon a fundamental gender inequality in accessing education, health, and individual agency. Such restrictions were observed to have a major impact on the mental health of women due to their limiting nature. Poverty, economic dependency and precarious employment situations of participants due to low educational level were observed as being major influences on violence experienced by rural marginalized women in Kangra district, Himachal Pradesh. A majority of the participants surveyed belonged to a lower economic strata, with a family's household's income often barely meeting basic food expenses. More than half of the participants belonged to families living below the poverty line. In particular 'single' women, who per definition (International Center for Research on Women, 2013) are widowed, divorced, separated, deserted or unmarried women above 35 years of age, are known to be at risk of facing challenging socioeconomic circumstances (Dhar, 2011). Ten women in this study belonged to this category of 'single' women. Ten more women were widowed, divorced or separated, but below the age of 35 years. The precarious situation of 'single' women in general is barely investigated, but currently the subject of research in the study area, which aims at building strong evidence for national policy recommendations (International Center for Research on Women, 2013).

Overall, participants' lives were governed by economic limits. Education, health status and nutrition, access to medical treatment, scope of actions and strategies were all affected by rural woman's economic situation. Limited employment opportunities and the resultant high unemployment rate among participants was another important observation, mirroring the economic insecurity of rural Indian women proposed by Srivastava & Srivastava (2009).

Economic pressure was found to be the main source of mental distress in rural women, specifically concerns about food, their children's education expenses, and dowry. The above concerns, in addition to expenditures on medical treatment and alcohol, were main topics

correlated with provoking violent outbursts in husbands. These findings support other authors research, which describe economic pressure as a major promoter of domestic violence (Koenig et al., 2006; Martin et al., 1999b), and also being highly associated with women's mental health (Jayaram et al., 2011; Lund et al, 2011; Patel et al., 1999), whereas Jayaram et al. (2011) found a significant association of low education level and poverty-associated factors, such as starvation and lack of resources with common mental disorders. Restricting structural factors that limit a woman's agency must be considered when developing sustainable strategies to implement an affordable and accessible mental health care program. Therefore, it is important that mental support services not create any additional costs to help-seeking women in order to avoid additional mental distress about the expenses for medical treatment, which would be contradictory to the aim of reducing the mental stress on care recipients.

Economic violence, such as withholding of food or the refusal to provide money for basic expenses, was reported as a common form of spousal abuse. Three women in this sample were completely financially dependent on their husbands with no alternative financial support services. Control over finance in various studies is referred to as determinant of women's autonomy (Blum et al., 2001; Jejeebhoy & Sathar, 2004). Sorensen, A. & McLanahan, S. (1989) stress the disadvantage of economic dependence with respect to the women's ability for individual growth and achievement. In matters of the barriers that economic dependency puts upon women's available options of agency, it could be assumed that total economic dependence may increase women's risk of victimhood.

4.1.2 Strategies of Oppression in the Context of Social Interdependence

The concept of individuality among the participants was found fundamentally interrelated to others, first and foremost the maternal family members, as they provided the most reliable source of support. Economic dependence among rural women was found to be a major determinant of interdependence. Women were seen to place great emphasis on taking care of others, fitting in a social construct, and adopting certain social values in an attempt to live in harmonious interdependence with others. Social responsibility among rural marginalized women was found to be a major constraint on women's agency and coping behavior. Thus, the fear of social stigmatization greatly confined rural marginalized women in their capacity, putting immense mental pressure on them. Davar (1995) provides interesting insights into the socialization of marginalized women, stressing the controlling external influences and the strong social interrelationships that determine marginalized women's lives. She further

condemns the discriminatory socialization of girls and women to subservience and criticizes deeply rooted patriarchal ideology that legitimizes women's oppression in Indian society. Recent developments in feminist theory (Anthias & Yuval-Davis, 1989; Crenshaw, 1989; Six-Hohenbalken & Weiss, 2011), emphasize the necessity of an intersectional and context-related understanding of domestic violence. However, an intersectional approach in mental health is found to be rare. Thus, I advocate for the consideration of intersectionality, that seeks to analyze the influence of different forms of discrimination, on the understanding of mental health in the context of domestic violence.

In the following, determinants of patriarchal ideology such as humiliation, enforced inferior ranking through exploitation, discrimination and subordination that were identified as key dynamics of the abuse experienced by participants, strongly influencing women's coping behaviours, agency and subsequent mental health, will be elucidated:

Humiliation was found to be the most effective strategy to subordinate women, making them even more passive, obedient and voiceless. Abasing verbal abuse through constant mockery and mortification pervaded all participant's narratives. Verbal abuse was mostly committed by husbands and mothers-in-law. Participants felt much more debilitated by psychological abuse than by physical violence. Acts with a strong culturally related, symbolic connotation were considered extremely abasing, such as getting hit with shoes, having one's hair cut, being forced to kiss a lower caste's person's feet in public, being abused in public and abuse involving fecal matters. The striking extent of degrading abuse experienced by participants, reveals the extent of the problem, that domestic violence is widely tolerated in Indian society, which was found by other authors as well (Davar, 1995; Kosambi, 1998; Lafta, 2008).

Thus, **subordination** and naivety were found to be a perilous combination in rural marginalized women. Women's self-abandonment and passive bearing fostered their victimhood from the very beginning of their marriages. Fulfilling the criteria of being a good wife put a great emotional burden upon the women. Child marriage and the big age difference between girls and their husbands was not surprisingly reported to have had a very negative effect on women's self-perception and promoting their feeling of being insignificant. The unwanted subordinate position of women of having to put up with everything at the in-law's house, no matter what, made women a vulnerable target of abuse. I assume that the subordination of wives may be unconsciously interpreted by abusive husbands as legitimization for the continuation of their controlling behavior. One participant underlined this fact that her husband had used her timid nature as a justification of further abuse. Another

woman shared how surprised her husband reacted when she defended herself, subsequently stopping him from beating her. In that sense, feminist scholars (Abramsky et al., 2011; Davar, 1995) proposed the transformation of gender norms and attitudes as an essential preventive strategy against domestic abuse. Astbury (2002) stressed the need for critically addressing deep inherited patriarchal values in women by enhancing women's autonomy and control, which are known factors of resilience.

A poststructuralist feminist approach criticized the simplification of the concept of violence that dichotomizes men as perpetrators and women as victims (Anthias & Yuval-Davis, 1989; Crenshaw, 1989; Six-Hohenbalken & Weiss, 2011). The findings of this study support the complex interplay of multiple social hierarchies between gender and generation as Fernandez (1997) proposed, that malicious paternalistic values were not only upheld by the men but also by women, particularly mothers-in-law or aunts-in-law. These individuals were mentioned by many participants as perpetrators and promoters of domestic abuse and abusive power-relations. Psychological, economic, and physical abuse were cited as having been committed by an elder woman from the in-law's family. Common reasons for their abusive behavior were a lacking dowry, dissatisfaction with a woman's household performance and physical impairment of the woman due to chronic diseases. As Fernandes (1997) stated, this fact refers to the intricate gender hierarchies in which the supervision of daughters in-law is devolved from husbands to elder women in the family in-law maintaining older women's generational superior position. Further, Koenig et al. (2006) proposed the intergenerational cycle of violence and the effect on social action of witnessing and experiencing violence by oneself. It can be assumed that the female perpetrators of domestic abuse may have themselves been abused in terms of power. Thus, they may unknowingly continue the circle of power-abuse and hand it on their daughters and daughters-in-law. In this respect, Buzawa & Buzawa (1996) and Heise (1998) showed that witnessing violence in childhood might have a greater effect on perpetration than on victimization. It would be worth to further investigate the motivation of female perpetrators of domestic abuse in the context of their own experiences of child abuse and domestic abuse.

Patriarchic ideology implements strong ideas about a wife's socially accepted attitudes. Suppression of socially unacceptable emotions for women, foremost anger and aggressiveness, was found to be another pattern in marginalized survivors of domestic abuse. The oppression of emotions may be influenced by the women's subordination to strong societal patriarchic values, as Davar (1995) concluded about women: "Their low self-esteem is the pathological result of a logical process of socialization, the main goal of which is the

substance of patriarchy. As no cultural routes of expression of aggression are allowed in women, they redirect their aggression against themselves and against other women, so that a unionization of women and their participation in a collective feminine identity cannot be realized." (p. 164). Total suppression of emotions in combination with PTSD symptoms may lead to destructive irrepressible, reinforced emotional outbursts of anger and hyperarousal against those who are defenseless, for example a woman's own children. As one woman described, she repeatedly had hit her newborn daughter in rage attacks as a consequence of her emotional and sexual abuse, which she did not dare to reveal. Nayak (2010) assumed that there might be a link between the aggression level in victims of violence and experienced abuse by their spouses.

Exploitation of women was found in, but is not necessarily limited to, the tradition of arranged marriages. Study participants reported to have been treated as slaves or servants and to have been even imprisoned in their marital homes. Women who were married off to Delhi, far away from their maternal homes, were found at greater risk of being exploited. Labor exploitation for the comfort of the in-law's family was found to be a common malpractice in participants who mostly belonged to the lower economic strata, Scheduled Castes or Scheduled Tribes. Sexual exploitation was reported by one woman, who was forced into prostitution by her spouse as a means of earning money. These findings underline the fact that rural marginalized women are particularly prone to becoming victims of sexual or labour exploitation, as was reported by other studies (Hameed et al., 2010; Human Rights Watch, 2008).

Stigmatization was found to be an effective method to control women and keep them deliberately silenced. Being abused was misrepresented as the women's own failure, resulting in extreme shame, as was seen prevalent in participants. As a result, the already low level of self-confidence in submissive women was further defeated. Constant devaluation and reproaches of bringing shame on one's own family nourished commonly found reaction patterns of guilt, entrapment and negative self-perception in rural abused women. Deliberate silencing through life-threats or threats to commit suicide by the husband were effective strategies to silence the women even more. Silencing and the consequent underreporting of domestic abuse is known to be a frequent problem (Watts & Zimmermann, 2002). But as the above described 'mechanisms of silencing' show, reducing it to the sensitivity of the subject as Watts & Zimmermann (2002) stated, would simplify its context. However, this research findings support other authors who outline the complexity of the issue of silencing and underreporting. According to Ahmed-Ghosh (2004), likely causes for underreporting are

cultural values that perpetuate the subordination of Indian women, whereas Bhaiya (2012) and Kaur & Garg (2010) found fear of social stigmatization and dishonoring one's family the leading cause of women's silence.

Discriminations of being illiterate, a member of a Scheduled Tribe or Scheduled Caste or belonging to the lower economic strata was found to have a negative reinforcement on the mental health of participants. Hameed et al. (2010) even proposed that social discrimination, such as belonging to the lower economic strata, Scheduled Castes or Scheduled Tribes, being separated, divorced or widowed may increase the risk of becoming a target of abusive behavior. Kumar (n.d.) stated: "The women have little identity and are not expected to have any desires for self fulfillment. From birth, she is socialized to make her life subservient to the demands of patriarchy... Girls are conditioned to not look up to men, not to talk back, work without being heard and learn to adopt their destiny from early age. She accepts discrimination against her be it food, clothing or opportunities to acquire new skills or literacy." (p. 2)

Overall, the level of self-esteem was found to be extremely low in the participants due to the strongly repressive dynamics of violence, and must be the prime intent of mental health interventions focusing on resilience, assertiveness, and identity re-building of women.

4.1.3 Mental Health

All participants reported that domestic abuse had an effect on their mental health. **Common mental disorders** were found highly prevalent among rural marginalized survivors of domestic violence, affecting their social interactions. Most prevalent symptoms were mental distress, depression, post traumatic stress disorder symptoms and suicidal thoughts and attempts. Thus, this research fosters the finding of the strong negative influence of a lifetime experience of domestic violence on the self-reported poor health of women, which was affirmed by Ellsberg et al. (2008).

Generally, the awareness about mental health problems was found to be very low among the participants. These findings support Davar (2008), who found mental health subjected to a very low value amongst the rural population in India.

The concept of a subordinating wife, that was exemplified by Davar (1995), may provide an understanding why participants in this study hardly had put their needs central. Also, the fear of being wrongly accused of laziness was mentioned by participants and prevented them from showing their mental and physical exhaustion. Fear of becoming *pagal*, the local word for

'crazy', was found in participants. *Pagalpan*, literally insanity, was found to have a very negative connotation in the local cultural context. It may be due to the **stigmatization of mental health** that mental health problems were primarily expressed as somatoform disorders, foremost chronic pain disorders like back pain, tension headache and sleeping disorders. Other authors reached similar conclusions: The expression of mental distress in the form of more socially accepted reasons like somatic complaints was found to be prevalent in Indian women (Isaacs et al., 2006; Varma et al., 2007) and may be linked to a general neglect and stigmatization of mental health issues, especially among rural Indians (Jayaram et al., 2011).

Options for adequate mental health care were non-existent, except for a very few private counselors living in the area of research, but those were barely known by the participants. All participants except one were only provided very informal counseling by other local village women with no professional or even semi-professional background. Psychiatry departments in the hospitals nearby would not be considered as a contact point for participants. Mental health as part of the official health care system, except in one woman who was married to a severely mentally ill husband, was a totally neglected topic. *Manasik svastha*, the Hindi term for mental health, was a known but commonly unused term. These findings support various authors who found community mental health in India to be an extremely neglected field resulting in underrating mental disorders (Prince et al., 2007), particularly ignoring the needs of the most underprivileged, such as marginalized women (Davar, 1995; Jain & Jadhav, 2008), and a lack of adequate treatment facilities in mental health care (Raguram, 2002).

Depression was found in two thirds of the participants, promoting other authors such as Kumar et al. (2013) or Prince et al. (2007), who found domestic violence clearly associated with a higher risk for depression. Symptoms such as fundamental self-doubts, feelings of guilt, desperate helplessness, social withdrawal, loss of appetite and feelings of being overburdened were commonly reported.

The peak of depression was reported to happen after women had separated from their abusive husband and gone back to their maternal homes. This stepping out of the circle of violence was often followed by a severe depressive phase. Women reported that this was the time when they realized the extent of their emotional burden caused by domestic abuse. Participants described this state as being unable to get out of the bed, do any chores, see anyone, talk to anyone, or as a total loss of interest even in their children. The finding that women who have recently left their abusive environment were found most vulnerable for

depression provides an important fact to be considered when working with survivors of domestic abuse.

A high level of **mental distress** was found prevalent in all participants. Suffering mental distress was commonly expressed as '*tension hogayee*', which means having tension, a socially widely accepted term among locals. Various reasons for their mental tension were reported, such as economic difficulties, worries about a safe shelter, social stigmatization of being separated and ongoing threats through husbands. Ellsberg et al. (2008) and Jayaram et al. (2011) also found mental distress to be significantly associated with spousal abuse. Ongoing verbal and emotional abuse were found to be the main causes of mental distress and depression.

Symptoms of **post traumatic stress disorder** (PTSD) were reported by all participants, varying in its intensity. Concentration problems due to severe PTSD were found particularly impairing in young, separated women, who wanted to continue their education or do a vocational training for their economic autonomy, but could not do so due to severe concentration problems. Living separate often means a sudden loss of economic stability for the women, requiring them to have to rely on their own abilities for earning money much more than others. Thus, addressing their needs, especially to help them overcome their traumatization, will be of major importance in order to help them regain their personal and economic autonomy as young women.

Interestingly, the understanding of the concept of traumatization was nonexistent among rural survivors of domestic abuse, including local women who were engaged in NGOs as social workers and activists in providing support service to victims of violence and were found to be the first point of contact for many victims. The neglect of mental health also included disregard of trauma aspects in help-seeking women. Most probably due to the lack of understanding of the concept of traumatization in local members of NGOs, there has been an observed ignorance of severe traumatization within victims of violence who had sought help at these NGOs. Thus, solutions sometimes were found to be fast tracked, and not mindful of the process of empowerment, which comes rather slowly, and from within. In my observation, basic concepts of trauma-sensitive treatment of survivors of violence were neglected in the process of consulting them for legal assistance and mediation. Experts and service providers, however, were aware about the problem of traumatization in help-seeking women, but have not yet proposed its implementation in existing support services, mainly due to lack of availability of professional counselors. 'Barefoot activists', local social workers and activists,

were found to be the first point of contact for many victims. It would be worth investigating the reasons why the concept of traumatization is not existing in the cultural context of rural North India. But essentially, we have to question the validity of applying 'western' concepts on non-western cultures. As traumatization as such is deeply influenced by societal and cultural values (Kleber, 1995), it would be illuminating to see if the concept of PTSD is applicable to rural Indian women's sociocultural dimensions.

The high prevalence of a **suicidal tendency** among three quarters of rural marginalized survivors of violence was found remarkable. This number reveals the seriousness of mental health problems among abused women in Kangra district. One third of the participants had attempted suicide. Multiple suicide attempts were reported by two women facing extreme forms of humiliating abuse. No suicidal attempts were reported after separation from their husband had taken place. Social isolation, feelings of having no option, self-doubts and hopelessness were identified as key emotional patterns leading to suicidal tendencies. Thus, it can be assumed that women had not primarily intended to kill themselves, but their attempts were desperate cries for help by women who are commonly deliberately silenced by society and offered no solutions. Friedli (2009) also found hopelessness and the feeling of being without options important risk factors for suicidal tendencies. According to Jayaram et al. (2011) and Prince et al. (2007), suicide among women is a commonly recognized public health issue in India and it is well proven that domestic abuse is strongly associated with suicide attempts (Buzawa & Buzawa, 1996; Devris et al., 2011; Ellsberg et al., 2008; Kumar et al., 2013; Pillai et al., 2009; Vachher & Sharma, 2010).

4.1.4 Physical Health

Physical health consequences effect the mental health condition in participants, and thus can't be excluded from an intersectional research approach. Physical consequences of domestic abuse was seen prevalent.

Physical injuries due to violence of varying severity were experienced by all participants, but only one third of the women had sought medical treatment for their injuries, often lying about the cause of their injuries when seeking medical help. Reasons that prevented women from seeking help were various, such as shame, fear of not being believed by society, societal pity, lack of money for medical treatment, lack of nearby medical facilities and active hindrance by the spouse. Panchanadeswaran & Koverola (2005) identified another barrier to seek help - a widespread belief that domestic abuse is a private matter and should be kept secret. Although women had not mentioned that as reason not to seek help, it can be assumed to play a role

because several participants mentioned that they had been indoctrinated by others, mostly by members of the in-law family, that their abuse was a family matter.

Foremost, **gynecological complaints** were frequently found in participants and also to be correlated with common mental disorders. Pregnancy was found to be a highly vulnerable period for abuse among participants. Respondents reported that domestic abuse during pregnancy was especially shattering for their emotional well being and also led to pregnancy complications. Consistent with previous studies (Heise et al., 2002; Jejeebhoy, 1998; Sarkar, 2008; World Health Organization, 2013c), participants reported preterm labor and ante- and postpartum hemorrhage as consequence of abuse experienced during pregnancy. Unwanted pregnancies, forced abortions, sterilization, miscarriages and stillbirths were experienced as severely traumatic by participants and a consequence of brutal coerced sex during pregnancy. Patel & Oomman (1999) and Jayaram et al. (2011) verified that gynecological problems in particular are associated with an increased risk of mental health problems in survivors of domestic violence.

The societal stigma on childlessness was reported by four women to have a strong negative impact on their mental health. The ideal of womanhood is considered to be motherhood in the Indian rural cultural context. Thus, the stigmatization surrounding childlessness is often locally referred to as somatic symptom disorders, the culturally preferred expression of mental health problems (Isaacs et al., 2006).

Medically unexplained somatic symptoms were found numerous among participants. The most common somatic expressions were chronic pain syndromes, such as back pain, tension headache, joint pain, dizziness and fatigue. Dizziness was often combined with fainting. But as health was self-reported, it was unclear whether participants suffered from somatization, hysterical fits, injury induces seizures, or anemia related symptoms. Fatigue, a very commonly reported symptom, was not necessarily related to mental prostration but often simply caused by severe anemia, a consequence of malnutrition, which was a frequent problem of participants. In Himachal Pradesh, 43.3% of all women between 15-49 years were found anaemic (International Institute for Population Sciences (IIPS) and Macro International, 2007). Prince et al. (2007) support that medically unexplained somatic symptoms are significantly associated with common mental health disorders and a frequent form of seeking help in silenced women (Isaacs et al., 2006; Varma et al., 2007).

4.1.5 Coping Mechanisms

Maladaptive coping strategies were common phenomena among participants, foremost self-blame, denial, distraction, anxious avoidance, and substance abuse. Victimization was a prevalent problem among survivors of violence, even in participants who had separated from their abusive environment many years ago.

Although a poor economic situation is known to negatively influence resilience in survivors of domestic abuse (Martin et al., 1999b), participants of this study showed that poverty is not necessarily a problem for all. Poverty and economic deprivation forced women to seek work. Even though most women faced precarious work situations as daily labors or domestic workers, the economic necessity of holding a job gave them an opportunity to leave the abusive household, and mingle with other women. Contributing to the family's economic situation was reported to be an important source of self-confidence. Most women belonged to the lower economic strata, and thus were used to hard labor, specifically agricultural and household work. Unemployed separated women self-reported the lowest poor mental health, as they felt unable to manage their living on their own and were worried about their dependency on their maternal family's good-will. Taking these findings into consideration, the high unemployment rate in rural women may have a major negative impact on the coping behaviour and mental health status of female victims of violence.

Spirituality, respectively religious customs were found to be a source of inner strength. References to Hindu mythology and religious customs were reported by a local physician to be a useful and easily understandable strategy to illustrate medical education. While Hindu mythology may provide an interesting opportunity to de-stigmatize mental health, it may also reiterate negative societal expressions of female roles. Davar (1995) mentioned that the fatalistic common concept of 'karma', accepting one's destiny passively that appeared as a hinderance to Hindu women taking action against their abuser. But she further underlined the importance that "women must be given back their capacity to experience their spirituality: their inner sense of being and acting" (Davar, 1995, pp. 165). Examining the role of religion and spirituality as a coping strategy for DV survivors may prove an interesting and important future research topic, especially within such a pluralistic religious society as India.

Empowerment through **social support and social participation** were found to be the main promoters of a good mental health state. Specifically, engagement with a NGO was reported to be an immense source of encouragement and confidence for participants. The safe environment created by NGOs allowed for women to listen to other women's sufferings and

share their own abuse. Such environments provided women with the opportunity to leave the small world of a remote village and explore surrounding villages and sometimes even other cities across India and other countries. Participants reported that such opportunities were extremely positive experiences. Most women got great strength from working with an NGO, sometimes even dedicating their life to social activism, as separated women fighting for justice and gender equality. The most important process provided by NGOs, however, was the chance to form and claim a new identity without reference to the role as someone's wife. Other authors (Friedli, 2009; Shanthakumari, 2013) also found supportive social networks to be major factors in improving resilience in survivors of violence.

Respondents and stakeholders mentioned the need for establishing a safe place for women, where they can recover from and integrate their traumatic abuse, together with their children, and receive intensive emotional and mental health care. Although according to the Protection of Women from Domestic Violence Act, 2005, every abused woman should be provided a women's shelter, implementation of **women's shelters** is severely lacking in rural areas, the area of research included.

4.1.6 Policy Recommendations and Implementation Strategies

Addressing mental health in the context of domestic violence (DV) from an intersectional psychosocial perspective requires interventions on two levels: structural and individual. The structural level aims to address the complex interdependency of structural causes of DV, such as gender inequity as promoted through a patriarchal society, poverty, and a limited access to education and health resources for marginalized women. The second level of intervention works on the individual level and has to be addressed by women on a case by case basis, placing the women's individual needs and values at the center of the intervention, with the long-term goal of improving self-confidence and understanding the structural implications of their day to day environment. The individual level also requires proper medical treatment of mental disorders if necessary. Priorities should be given to love, affection and care, as well as encouraging reinforcement that women do have the power and strength to live a fulfilled life, in safety, without discrimination and stigmatization, and with dignity and respect.

Due to the high prevalence of common mental disorders and the low awareness of mental health found in rural marginalized survivors of DV, I strongly advocate for the implementation of a basic emotional and mental health care program in district Kangra that particularly addresses the realities of rural marginalized women. Summarized, I propose the following main intervention levels.

First Level: Prevention - Education and Awareness Building

Awareness programs about mental health and the consequences of violence against women (VAW) need to be implemented among the local communities, reaching community members of all ages, gender, and educational background. Furthermore, community interventions addressing the high alcohol consumption of local men are also needed. De-stigmatization of mental health issues should happen through creative awareness campaigns addressing mental health.

Complex socioeconomic factors, such as poverty, discrimination, gender equity, and justice were determining factors in the mental health of rural survivors of violence. Furthermore, the dynamics of marginalization, the active social exclusion of rural women from education, safe employment, healthcare, and democratic participation were found to be associated with mental health in participants. Jewkes (2002) showed that among survivors of DV, an emphasis on educational, economic and social empowerment was an effective protector against future cases of abuse. Furthermore, within mental health programs, it is important to address the cultural norms and attitudes that condone VAW, foremost the social acceptance of domestic abuse. Shah et al. (2012) found a low awareness of domestic abuse as a serious health threat in Indian society. Previous studies showed that DV is most prevalent in societies where violent abusive behaviour is widely accepted (Jewkes, 2002).

Preventive interventions should therefore focus on sensitizing health and social workers in NGOs, medical and legal professionals, and teachers, to identify abused women and encourage early interventions. Awareness campaigns about DV have to concurrently provide solutions for women in need. As a rising number of youths in remote rural areas have access to and use cellphones, smartphones, and increasingly the internet, creative media campaigns designed for the technology access of rural marginalized youth should be utilized. The increasing number of mobile phones among women also from the lower economic strata should be taken into consideration when establishing emergency hotline services for women in need. These hotlines should be made public.

Basic education programs about sexuality, gender roles, women's rights, and the role of relationships and marriage in young unmarried or newly-married girls and women, will form an important strategy for a community mental health agenda. Therefore, the uncertainty of (arranged) marriages is another important point to consider. Traditionally, women leave their maternal home and move into a totally strange environment of their in-law family, the marital home. Leaving their familiar environment for a completely unknown family marks an

extremely vulnerable life time event, making women more susceptible to emotional instability. The vulnerable setting of a newly married couple living in a traditional household with the in-law family can be seen for both parties, the woman and the man, as an extremely volatile time of uncertainty in arranging new power relations. Thus, implementing preventive programs against DV in newly-married women will be another important strategy for a community mental health agenda. Most participants reported that the onset of violence took place shortly after their wedding. The typical age of newly-married women in the area of research was reported to be around 20 years of age. Remarkably, several participants mentioned their sexual inexperience at the beginning of their marriage. Hence, the starting point of preventive interventions against DV has to be set up at the very beginning of relationships or even before that. Educating girls and young women about women's and sexuality rights, including aspects of DV, will be essential strategies. It is equally important that young men and boys be included in domestic violence awareness programs with the aim to address the underlying cultural beliefs and social structures that are perpetuating VAW.

As poverty was found one of the root causes of violence, the limited economic resources of rural women must be taken into fundamental consideration when planning a mental health program. Therefore, the congruent implementation of sustainable income generating projects or livelihood skills training for girls and women in combination with counseling sessions, may be a powerful tool for female empowerment.

Second Level: Early-intervention - Training of Professionals

The value and understanding of mental health among the survivors of domestic violence (DV) was low. Although experts were aware of the concept of traumatization in victims of DV, it was found to be nonexistent among the local women who were engaged as social workers and social activists in NGOs providing support to DV survivors in the area of research. As a result, aspects of traumatizations in victims of violence were totally neglected. The severe traumatization of four participants was not taken into consideration adequately in their support strategies through NGOs. Without an implemented concept of traumatization and with a lack of professional counselors and mental health specialists, mental support can only be provided at a very basic level. Therefore, improving the knowledge about basic concepts of mental health, including the concepts of traumatization and re-traumatization of survivors of DV, in professionals working in NGOs, educational institutions, and medical and legal support services is paramount. Often, such professionals are the ones responsible for identifying victims of violence, therefore education of these professionals about a trauma-

sensitive approach is essential in order to ensure early intervention strategies. Before that, further transcultural trauma research is strongly requested to prove the validity of the finding that the concept of traumatization is nonexistent among rural women or if it is a colonial attribution of a disease concept.

The high prevalence of suicidal tendency among the interview partners further highlights how essential it is to have a well-founded, culturally embedded mental health program in order to prevent such acts of desperations in abused women.

Further more, physical medical assessment has to be an integral part of a sustainable, holistic mental health program. The found correlation between physical consequences of domestic abuse and mental health reiterates the importance of designing a rural mental health care system that combines physical health care service, in particular reproductive health care and community mental health service to successfully allow for early-intervention in addressing DV. Such a system was also proposed by Stephenson et al. (2006). It will remain a great challenge to implement effective community mental health program easily available for women in need.

Enhancing resilience among professionals working in NGOs, legal and medical support centers, specifically by providing internal support services to them, is another important part in a holistic community mental health care program, and must not be ignored and undervalued.

Third Level: Rehabilitation - Establish a Women's Shelter

Support services for cases of domestic violence (DV) must be enhanced in addition by creation of easily accessible safe spaces where women can go and seek shelter and assistance for emergency as well as long-term stays. Such a women's shelter would provide a safe place from threats to women and their children, and allow them to recover from the trauma faced from DV. It should also include intensive rehabilitative mental health services and small income generating opportunities with the aim of supporting women to become economically independent. Many women continued to bear domestic abuse for a long time, because they did not know where to go and they did not want to economically and socially burden their maternal family with their return. Ideally, a women's shelter in a nearby area would be of advantage. Concentration problems, a PTSD symptom, in young, separated women who wanted to continue their education or do a vocational training for their economic autonomy, was found to be a direct consequence of DV and a key issue that has to be addressed within rehabilitative mental health services. Establishing such a women's shelter and a community

that women can belong to and relocate themselves within, physically and conceptionally, is a crucial component to a sustainable and holistic rural mental health care program.

Fourth Level: Advocacy Work on a Structural Level

In order to address the needs of rural, marginalized survivors of violence, advocacy work including resource development, utilization, networking and legal reforms will be fundamental.

Due to the complex interrelationship of DV and the neglected field of mental health in rural Indian women, I support the recommendation of the World Health Organization (2013a, 2013b, 2013c) to conduct more research and develop research coalitions, in order to increase the capacity for disseminating research findings and advocating for policy reforms and an appropriate allocation of resources. Further methodologically well-planned research is required in particular to explore the underreporting and underidentification of mental health issues.

It is our responsibility as global women to recognize where violence is happening around us, where fundamental women's rights are being violated, and which cultural values, traditions and perceptions are perpetuating it. We have to act as global women and strive to end VAW. Without this global support, women will remain silent about violence against them because they are left with little choice but to bear their suffering silently. If support is not provided to them to overcome their trauma and become economically independent, women will remain in the vicious circle of violence (Kumar et al., 2013). Sometimes one has to help just a little bit to unfold the resources that are inherent in women. I had witnessed an enormous strength in rural marginalized women and I advocate the creation of a supportive mental health programme that allows women to become dignified and respected members of the society, harnessing their strength and inherent autonomy.

5 Strengths and Limitations

The strength of the study's evidence lies in integrating marginalized women's voices in reference to mental health, enabling insight into a highly neglected perspective of mental health of rural Indian women in the context of domestic abuse. In addition to having a large number of interview participants, the quality of interviews and study results were greatly enhanced by the unique and excellent bond that the NGO's that mediated the contacts had with the conductor of the study and the interview participants. Triangulation of methods, such as in-depth interviews, key-informant interviews and participant observation, further enhanced the credibility of the findings.

This study is an initial attempt to analyze the complex problem of mental health in survivors of DV in rural North India. The complexity and sensitivity of DV may require a much deeper involvement in the community. DV is a traumatic experience, so it might be difficult for many women to share their experiences. Even though many participants mentioned they could share details of their live with me only because I am not part of their community, I assume it may be difficult for them to share all the details of these traumatic experiences with an unknown person. As domestic abuse is such a taboo topic, I decided to do a purposive service based sampling of participants. This means that women in abusive relationships who had not yet found the courage or need to seek help were not included in this sampling. This may have an effect on the results. Mental health was self-reported, thus, according to the low value of mental health problems among rural women it may be assumed that its incidence is even higher. Language barriers might have played a role in establishing rapport with the participants. Although all participants were able to understand and communicate at a basic level in Hindi, it might have been easier for some to express very emotional and delicate details in their native languages and dialects, mostly Pahari. Furthermore, interview quality have varied due to multiple interpreters I was relying on. Further, quality of transcripts may vary because I sought help of multiple translators. Readers must keep those limitations in mind.

6 Annex

6.1 Acronyms

APL	Above Poverty Line
AWAJ	Aware Women's Action for Justice
BPL	Below Poverty Line
CEDAW	The Convention on the Elimination of All Forms of Discrimination Against Women
CMD	Common Mental Disorder
FGM	Female Genitale Mutilation
GBV	Gender Based Violence
IIPS	International Institute for Population Sciences
IPC	Indian Penal Code
MNREGA	Mahatma Gandhi National Rural Employment Gurantee Act
NFHS-3	National Family Health Survey-3
NMHP	National Mental Health Program
NGO	Nongovernmental Organization
NPO	Nonprofit Organization
PTSD	Post Traumatic Stress Disorder
PWDVA	Protection of Women from Domestic Violence Act
Rp.	Indian Rupee
SC	Scheduled Caste
SLL	Special and Local Laws
SHWWA	The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act
TARA	Training and Research Academy
UN	United Nations
UNIFEM	United Nations Development Fund for Women
USD	US Dollar
VAW	Violence Against Women

6.2 List of Figures

Figure 1. A Woman and a Tree by s8, 24 years [drawing] (2014).

Figure 2. National Crime Records Bureau. (2012). Crimes Against Women Percent Distribution 2012 [Circle graph]. In *Crime in India 2012* [Governmental report]. p.85. Retrieved from <http://ncrb.gov.in>

Figure 3. Maps of India. (2010, Dezember 9). Himachal Pradesh Outline Map [Map]. Retrieved from <http://www.mapsofindia.com/maps/outlinemaps/himachalpradesh.htm>

Figure 4. Himachal Pradesh Planning Commission. (2009). District Kangra. [Map]. Retrieved from <http://hpplanning.nic.in/HDR-Kangra.pdf>

Figure 5. A Woman and a Tree by s18, 35 years [drawing] (2014).

Figure 6. A Woman and a Tree by s20, 30 years [drawing] (2014).

Figure 7. A Woman and a Tree by s11, 32 years [drawing] (2014).

6.3 List of Tables

Table 1. Background of Interview partners

Table 2. Background of Expert-Interviews

6.4 List of Nonprofit Organizations

Jagori Rural Charitable Trust

VPO Rakkar Sidhbari

Tehsil Dharamsala, Distt. Kangra

Himachal Pradesh, India 176057

phone & fax: +91 1892 234974 or +91 9816 579397

email: jagorihimachal@yahoo.com

<http://jagorigrameen.org>

Nishtha Rural Health, Education and Environment Centre

V.P.O. Rakkar - 176057

Distt. Kangra, Himachal Pradesh

India

phone: +91 1892 236597

email: contact@nishtha-hp.org

<http://nishtha-hp.org>

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