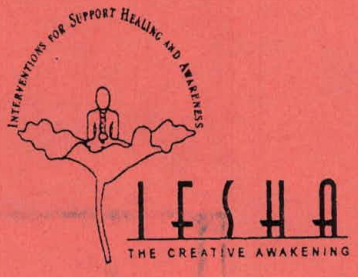
A REPORT OF A MEETING ON WOMEN, VIOLENCE, AND MENTAL HEALTH

India Habitat Centre, New Delhi

April 11TH & 12TH, 1999



Interventions for Support, Healing & Awareness

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Interventions for Support, Healing & Awareness

A Report of Meeting on Feminist Research Methodologies
Prepared by IFSHA (INTERVENTIONS FOR SUPPORT, HEALING & AWARENESS)
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IFSHA (Interventions for Support, Healing & Awareness) is a Delhi-based NGO working with and for victims of child sexual abuse and sexual violence, through counseling, research, training, and awareness raising programs.

The witness 'Sakshi' is the genesis of 'IFSHA'. IFSHA, which means the 'creative awakening', or 'to dawn' in Urdu, captures the creative consciousness born in journeying through the NGO 'Sakshi'. 'IFSHA' is about healing, about looking at women's lives as a whole world of infinite possibilities, about making men partners in recreating that world, and moving the feminist world view from the periphery to the mainstream. IFSHA is therefore a spatial relocation of the perspectives intrinsic to 'Sakshi'.

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Introduction:

IFSHA's first international conference on Women, Violence and Mental Health was held in New Delhi on April 11th and 12th, 1999, involving researchers, mental health professionals, NGO activists, and academicians. The main purpose of this meeting was for IFSHA to table a report based on a three year long research on this subject, and thereby begin a dialogue with the various institutions and functionaries directly involved in women's mental health.

The need for dialogue and an exchange of perspectives was apparent through the course of our research project. Violence as a life event of women goes unrecognized by most institutions women come in contact with, and therefore its effects on their mental health remain invisible. As an NGO, and as researchers we came to recognize and acknowledge the many expressions of women's anger, pain and frustration at their violent and stifling lives. Research and clinical practice in the West has already acknowledged and created interventions to address the significant impact violence has on women's behaviors, emotions and thoughts, but in India this has rarely been a focus of inquiry from within the mainstream. Therefore, this meeting hoped to bring together professionals who could discuss and debate the impact of violence on women's mental health, and collaborate on improving services for women clients.

This report summarizes the presentations and deliberations made at this meeting. All presentations have been condensed, and the issues raised for discussion after each presentation follow in brief. The report is organized into four parts.

- **Part I** deals with presentations and discussions around research on violence against women, and women's mental health.

- **Part II** incorporates interventions that have been made from around the world, either in the form of therapeutic techniques and initiatives, or community programs, or screening procedures, to detect and address violence against women.

- **Part III** deals with the recommendations and suggestions for collaboration that were made at the meeting.

- **Part IV** encapsulates the evaluations of the conference made by the participants.

PART 1: PERSPECTIVES ON WOMEN, VIOLENCE AND MENTAL HEALTH

Integrating Feminist Ideas within Mental Health Practice and Advocacy

Dr. Bhargavi Davar

This presentation, based on existing research and academic writing both from India and abroad, examines the negotiations between feminist perspectives on mental health and psychiatric practice from a macro point of view. The gendered reality of violence and women's experiences of mental health and ill health within mainstream psychiatry are looked at through a feminist lens. The broad goals of this work are to:

- Examine gender bias within the mental health profession
- Question diagnostic practices relating to women, to shift the discussion from women's 'madness' as a form of protest, to understanding the role of diagnosis within the larger context of mental health practice.
- Reconstruct women's own experiences of body, mind and soul using a feminist phenomenology to describe women's distress.
- Sensitize mental health services to empower women rather than control them.

So far, the feminist movement has been able to achieve, and is still working towards, some shifts in perspectives on mental health. There is a move to demystify the existing psychiatric practice, and conceptualize mental health/ill-health based on:

- A focus on common mental disorders, which affect women much more frequently, and are much more common in the population. Most resources are channeled to severe mental disorders.
- A social etiology of mental health/ill-health, as opposed to a bio-medical etiology.
- An interdisciplinary approach to mental health including public health and epidemiology, consumers' rights perspectives, human rights, community mental health etc.

- Psychology, rather than the medical profession Psychiatry.

Feminists have studied and critically examined the prominence of violence in women's lives. Violence is seen as a larger social, political problem rather than a clinical issue. The social, cultural, and legal sanctions for male violence are so deeply entrenched in our society's collective unconscious, that the prevalence of violence and its far-reaching effects on women's mental and physical health create numerous problems for interventionists. Male violence has not been viewed in its context therefore leading to a number of lacunae in therapy: men don't feel subjective distress at being violent; there is no sense of responsibility for the violence; and it is seen as an inherent part of their masculinity. The downside is that mainstream interventions target the- more pliable-women, diagnose their responses (often to male violence), and leave them to face the medico-legal and social consequences of diagnostic labeling.

The questioning of diagnostic procedures and paradigms from within the women's movement is riddled with debate. The feminist movement has questioned the process of diagnosis, which exists in a vacuum without a mental health advocacy program that addresses policy makers and the law. The movement has tried to enable women to recognize their experiences of the body and emotion as "normal" by creating safe spaces. At the same time, the movement has not been open and accepting to diagnosed women per se. The global shift towards recognizing common mental disorders as needing more intervention in terms of prevention and care, has led to a range of behaviors now being open to labeling. While CMDs are an important gender issue within the profession, the flip side has to be recognized as well. Diagnosis has not been sensitive to realities of gender, thereby moving in to appropriate behaviors that were once thought to be culturally acceptable. For example, it was once thought to be of great importance and pride for an Indian woman to have a clean and neat home; now, this behavior could be labeled as an Obsessive Compulsive cleaning Disorder, for which even drug therapy is being advocated. What are the criteria for diagnosis based on? Are they culturally relevant and "scientific"? The socio-political and market driven issues surrounding the emphasis on CMDs also needs to be recognized; drug companies have a great deal at stake in this particular issue. Therefore, diagnostic procedures have to be placed in their social, political, and economic context.

Feminist questioning and analyses vis-à-vis mental health advocacy so far have pointed out the loopholes in the Mental Health Act, which ignores the rights of the mentally ill, especially in admissions, discharge, power of the mental health officer etc. Ethics in mental health are institution-based and are not established norms yet. And there is little state support for the community mental health movement.

Involving mental health professionals and activists in a national level mental health advocacy program may ameliorate the situation. Systems and structures for transparency, protocols for screening, policy level support, a shift towards community based initiatives, and a social etiology within mental health practice and service delivery, are some of the outcomes that may be achieved by such an integrated consultative process.

Discussion:

1. The labels and ignorance that diagnosis spawns: As opposed to a changing, dynamic sociological diagnostic process that is culturally rooted and sensitive to gender realities that is being advocated here, Psychiatry's link with medicine has led to the medicalization of illness and diagnosis. Diagnosis cannot be wished away, and that is not the debate at present. It is more to examine the process of diagnosis and recognize where it needs to be improved and informed. It is important to strike the balance to know what 'symptoms' are sociological in origin, and those that are medical- "medicalization as humane"

2. There is a need for community based allied services that will ease the load on a small, and struggling population of 5000 mental health professionals for a country of one billion people. If common mental disorders should move away from the domain of psychiatric diagnosis, there have to be more grassroots health workers who are equipped to address the prevention and care of common mental disorders in the population.

Women and Depression

Dr. Rajesh Sagar

The prevalence of depression in women has to be seen in context of their inequality in society and the many stresses that operate in women's lives. This process of inequality begins in childhood where girls and boys are socialized differently, and girls' status is seen to be dependent on alliances with men. The direction of self-esteem is therefore external. Such lifelong inequality creates dilemmas and conflicts in marriage, family relationships, reproduction, child rearing, divorce, aging, education, and work. Violence in the form of sexual and physical abuse and coercion also create a great deal of self-blame, shame and stress for women. The alienation and powerlessness that these situations create have been shown to underlie mental ill health for women.

The examination of women's illness and help-seeking behavior also indicates why they may be more prone to a diagnosis of mental illness. Gender-specific behaviors complete this picture, which according to Gold (1998), reflect *real* differences. Women are generally more sensitive to any discomfort, and tend to translate (and label) their specific feelings of distress into physical/emotional problems. They are more likely to consult a health professional for their problems and are generally more willing to talk about their symptoms, often being able to recall and elaborate upon details of even minor health complaints.

The factors associated with depression in women are:

1. Biological Factors

- A genetic vulnerability for affective disorders.
- Use of oral contraceptives increases the risk for depression.
- Female sex hormones influence the central nervous system structure and functioning, resulting in changed behaviour.

2. **Personality Profile: Increased risk for depression in women who:**

- Have difficulties in adapting to change.
- Have a tendency towards anxiety in the face of threats, which leads to ineffective coping behaviors.
- Have an increased level of interpersonal sensitivity.
- Have decreased resilience factors to negotiate risks, and act as a protective factor.

3. Life Stress and Social Vulnerability

- Women's status and social reality in Indian society may exacerbate life stressors.
- Gender based discrimination results in helplessness, dependency, low self- esteem and low aspirations, and ultimately the risk for depression.
- Learned helplessness: Expectations of powerlessness, and the inability to control one's destiny prevents effective action.
- According to Brown and Harris (1970), there are four vulnerability factors: lack of a satisfying marital relationship; lack of employment outside the home; presence of three or more children under that age of 14 years; and parental loss before the age of 17 years.

[These life stress factors are not adequately represented in assessment scales commonly in use. The scales focus on personal stressors, while women tend to view their stressors in terms of significant others. Direct stressors such as violence are usually not included in such scales. Additionally, life stress scales emphasize discrete and acute changes and events rather than chronic conditions such as poverty, discrimination, health problems etc.]

4. **Marriage, Family Roles & Relationships**

- Marriage per se could act as a protective factor, whereas marital discord puts women at risk.
- Women working within the home only feel unchallenged, undervalued, and have no alternate sources of gratification.
- Women who work outside the home have excessive demands and have to accomplish multiple roles and tasks.

5. **Violence**

- Women are extremely likely to experience physical or sexual violence at any point in their lives, within the family, and such victimization may predispose them to mental health problems later in life.

6. **Reproductive Roles and Events, and Depression**

- Pregnancy is a critical role transition, motherhood represents a major change at a biological, psychological, social and cultural level.
- Pregnancy losses due to abortion, miscarriage etc. could result in a loss of status and self-esteem, and represents a (symbolic) loss of the future. This could result in anger, feelings of inadequacy, guilt, marital, and sexual disturbances.
- Post Partum blues, and Post Partum Depression -a bio - psycho - social model of etiology.
- Disorders arising out of the mother-infant relationship: delayed attachment, obsessional thoughts of hostility, rejection of the infant, neglect, infanticide.
- Pre-menstrual Syndrome.
- Infertility and the cultural beliefs that condemn women for being barren, infertile etc.
- Hysterectomy and the unique stress associated with the loss of reproductive organs that have connotations for female sexuality and feminine identity.
- Other gynecological illnesses.
- Menopause and the changes in self-perception, cultural beliefs and attitudes etc.

Discussion

1. Women's access to mental health care limited to when there is a total breakdown of all capabilities. Therefore, how is 'help seeking behavior' defined and evaluated in clinical practice?

Spouse Abuse and Depression in Women - An Etiological Approach to Depression in Women

Dr. Thomas John

There is enough evidence to suggest that there exist connections between stressors in women's lives and depressive illnesses. Within the marital relationship, women are subject to significantly greater stressors, and marriage per se can be both a putative risk factor as well as a protective factor. Western studies do imply that marital violence affects the mental health of the wife more adversely.

1. Aims of the Study:

- To evaluate the significance of spouse abuse as a possible etiological factor in the causation of a depressive episode in a married woman, and assess its prevalence and severity.
- To assess the factors that make a woman more vulnerable and those empower her.

2. The Methodology:

- The sample included 30 cases that were married for at least 6 months and had come to the Psychiatry department OPD with a depressive illness, as well as 30 controls matched for age and socio-economic status from the same community as the cases.
- Women with a history of depression, or with psychotic symptoms, or other psychiatric/medical co-morbidity were not included in the sample.
- The scales of measurement used were a socio-demographic profile, Hudson's Spouse Abuse Performa, and the Hamilton and Beck Depression Scale. The research design was cross-sectional and descriptive
- Chi-Square/t Test/Pearson's Correlation/ ROC curve and Bivariate Analysis were used in the statistical analysis of the data

3. Results & Discussion:

- The cases and controls were socio-demographically similar

- There was a significant difference in the husband's abuse of alcohol and extra-marital affairs between cases and controls, and a significant level of spousal abuse in the cases as compared to the controls.

4. Risk Factors for Abuse and Depression:

- Lower socio-economic status
- Husband's use of alcohol and involvement in extra-marital affairs, and his unemployed status
- Lack of other social supports for the wife

5. Empowering/Protective Factors:

- Women's employment outside the home
- Women's possession of independent finances

6. Limitations of the Study:

- Reporting biases.
- Halo effect.
- Small sample size.
- Methodological and subject issues.

Discussion

1. This is one of the few studies on women's mental health and violence that has been conducted within a mainstream teaching hospital in India. According to psychiatrists, research on violence against women is rarely taken up by mainstream institutions because of the following reasons: there are few culturally relevant tools, procedures and theories; most time is spent in dealing with patients with severe mental disorders; psychiatrists rarely take on proactive roles that cases of violence against women necessitate; a lack of time and numbers of patients are overwhelming; and, the underreporting of violence by women.

2. Spousal abuse is the 'best known secret', and is rarely seen in mainstream assessment and screening procedures because it's effects are not recognized as a serious health issue. It was the feminist movement that first began to recognize domestic violence and is trying to mainstream it in clinical procedures and therapies.

3. An important training aid that could be further developed is the creation of videos that compare techniques of screening, intake, and assessment by psychiatrists and NGO counselors since the experiences and techniques are so different.

4. While there is qualitative data on women and violence, there is no large survey based on hard numbers. Statistics of domestic violence in India will be available shortly, after the INCLEN (International Clinical Epidemiology Network) study is completed. It includes a survey of 8400 women in India.

5. The reality of violence against women cannot be undermined by media portrayals that reflect social prejudice; a number of movies, docu-fictional pieces, and media reporting depict women as perpetrators of violence. This is an unhealthy trend and an inappropriate time for a backlash when the enormity of the problem in India has not yet been acknowledged.

Women's Experiences of Mental Violence in the Family

Ms. Anjali Dave

The recognition of violence against women has been half-hearted in that the physical effects and signs of violence are the only forms of violence against women that are recognized by the legal and medical professions. Validating psychological and emotional abuse of women is extremely difficult in a court of law, where violence is perceived as physical assault, rather than control and coercion as well. 57% of women accessed in this study, conducted at the TISS (Tata Institute of Social Studies) run crime cells in police stations, spoke of their life experiences and the preponderance of mental violence, which was defined as verbal abuse, restriction of a woman's sexuality, and reduced access to economic resources.

The main aspects of this form of violence were:

- The romanticization of a heterosexual union-marriage-as a relationship that will be a panacea for all ills, and the stifling confines of the natal home. This is often not the case when the husband is physically and emotionally abusive. The woman has always believed that she would 'love her husband so much that he would never beat her'. The violence begins very soon after marriage and during sexual initiation. This comes as a rude shock, and is the death of her dream.

- The husband and in-laws can be emotionally and verbally abusive making the woman feel demeaned.

- The husband indulges in extra-marital affairs and does not create the 'perfect' home the woman is looking for. There is no companionship or emotional bonding between husband and wife.

- If the woman is unable to produce a male child, or is infertile, it is a cause for more ostracism and abuse from within the family.

- There is psychological control underlying the supposedly "loving" and "intimate" words and situations that are used by the husband creating confusion and a double bind for the woman.

There is a lack of therapeutic and legal interventions that recognize and address this form of violence, leaving women feeling that their experiences have not been validated.

Discussion

1. *How can mental and emotional violence be classified and categorized for the purpose of screening, testing etc.?*

If this is seen as a "soft" aspect of violence, it has to be understood in its socio-cultural context. A socio-psychological perspective has to be incorporated into testing and diagnostics for these cases by operationalizing what mental cruelty and emotional abuse mean. This would call on the skills and experiential understanding of different groups of professionals, like activists, NGO counselors and mental health professionals. This multi-disciplinary effort is essential when we are working with a social reality like violence that is so enormous in its proportions. There would need to be generalized systems of testing and assessment, which would have to be used even in specific instances. These are the dilemmas of working within an imperfect situation and within imperfect systems, so some solutions are bound to be imperfect before they evolve into ones that are more efficacious.

2. The only way to recognize the effects of mental violence is proactive research that validates women's experiences. This would also be a process of creating and refining existing tools and procedures for assessment of violence in women's lives. Research from the United States shows that the psychological effects of emotional violence are great, and in comparison to a war veteran, a DV survivor is just as likely to experience the horror of the situation even years after the abuse.

The Diagnosis of Posttraumatic Stress Disorder (PTSD) in Domestic Violence

Dr. Mary Ann Dutton

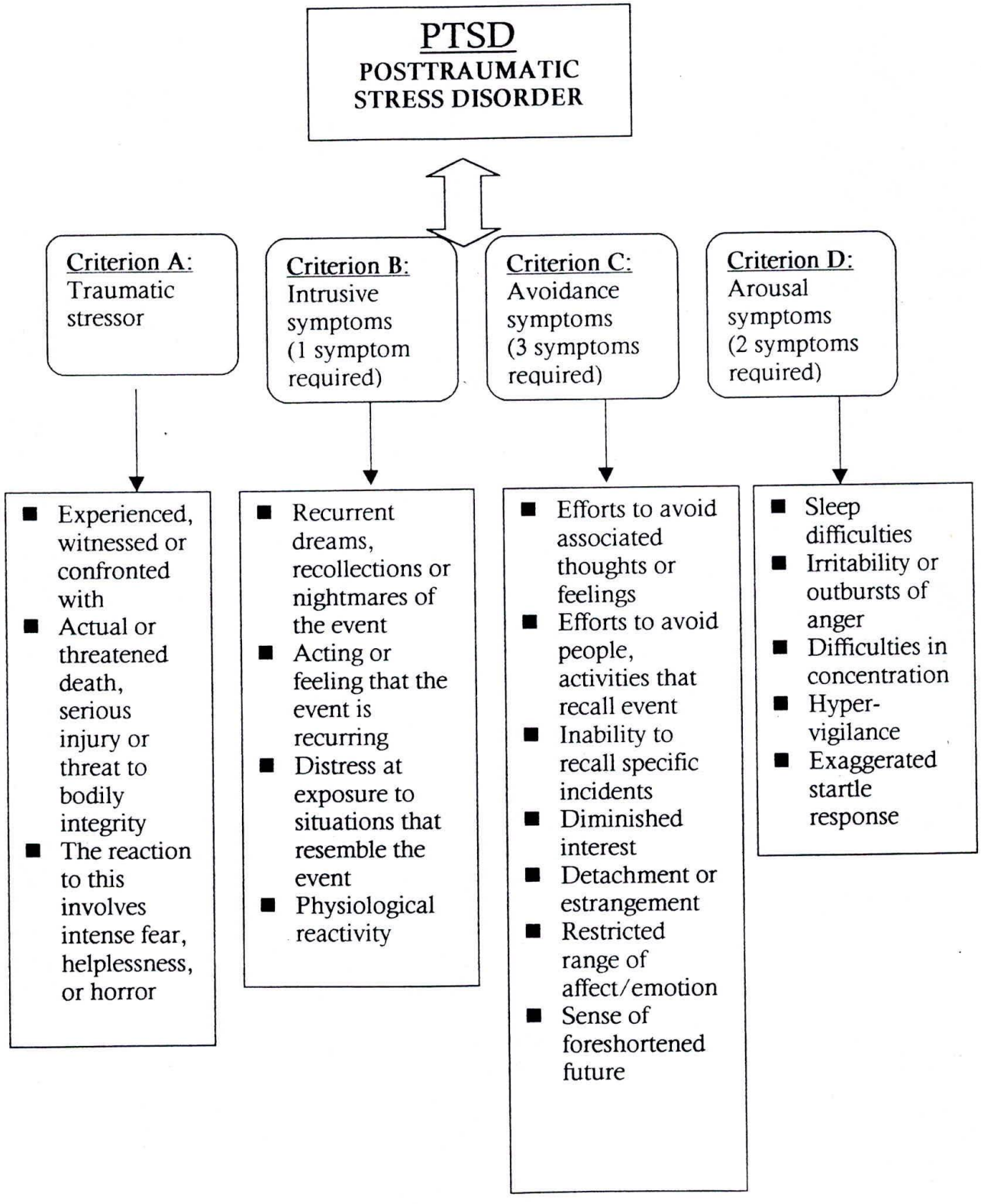
The conceptualization of sexual and domestic victimization as trauma is over a decade old in the United States, and is perhaps the most concrete way developed so far to validate women's experiences of violence. PTSD or Posttraumatic Stress Disorder was first developed to describe the fall-outs of combat situations of war veterans, and later used to show the similarity of women's reactions to domestic and sexual violence. Such a diagnostic category places the etiology of psychological symptoms with the traumatic event rather than personal psychopathology, which was how reactions to DV were initially classified. The diagnosis is also inclusive enough to incorporate the effects of multiple types of trauma. The main trauma related diagnoses used in practice are:

- Posttraumatic Stress Disorder (PTSD).
- Acute Stress Disorder.
- Dissociative disorders like depersonalization, derealization, amnesia and multiple personality disorder.
- Complex PTSD- Disorders of Extreme Stress Not Otherwise Specified (DESNOS).

The impact of trauma resulting from intimate partner violence is:

1. Intrusion of thoughts related to the traumatic event(s), and avoidance of situations that resemble the traumatic situation, and symptoms of physiological arousal.
2. Depression, anger and anxiety.
3. Self-dysfunction such as low self-esteem, self–harm, and sexual dysfunction

The diagnostic criteria that have to be met before a diagnosis of PTSD is made are described in the diagram below.



What we do know about trauma disorders is that the more severe and chronic the stressor, the greater is the likelihood that a diagnosis of PTSD will be relevant. Also, the experience of a prior trauma increases the vulnerability to PTSD upon exposure to a new trauma. In cases of PTSD, social support is a key factor in healing. Despite the advantages of using the diagnosis of PTSD, there is a caveat:

- It bestows upon the patient the stigma of a psychiatric diagnosis.
- PTSD is associated with other labels that may be harmful to victimized women, like 'Battered Woman Syndrome', which may in fact confound the healing process, by suggesting that there is something inherently 'wrong' with the woman because she is labeled as such.
- The field of trauma studies is rapidly evolving and therefore it is important to keep abreast of the latest developments in order to be up to date.

Discussion:

1. In making a diagnosis of PTSD, one has to be aware of the other symptoms and illnesses that could either accompany it, or confound the diagnostic process. For example, there is an overlap between the diagnosis of PTSD and depression. Additionally, confusion could occur between the manifestation of the dissociative symptoms of PTSD and psychosis, which could interfere with the diagnostic procedure. It is also significant that a diagnosis such as psychosis can be so damning and yet be so easily confused with PTSD.

2. Different interventions for treating PTSD have been developed, such as: medication for sleep difficulties; behavioral techniques to address phobias and panic; EMDR. One of the most effective techniques has been to let victims come to terms with the trauma by telling their stories, either in a public forum, or just to vocalize their experiences. This form of a 'public testimony' was used with survivors of the Bosnia crisis, who found it very therapeutic to have their emotions validated. Counseling for PTSD is also commonly used in clinical practice in America, and began with therapy for war veterans, and the same techniques have been extended to include victims of interpersonal violence.

3. The use of the PTSD diagnosis in India and South Asia: it is a more common diagnosis in situations of disasters, as at the time of the Latur earthquake of 1994, or war situations as in Sri Lanka's decade old ethnic conflict. It was not used at the time of the Bhopal Gas Leak tragedy, but would have been relevant. PTSD is not used in clinical practice to describe the effects of intimate partner/sexual violence because it is "not really within the consciousness of the system."

4. PTSD as a diagnosis is broad enough to include different kinds of family violence such as elder abuse, or to describe the effects of communal violence and terrorism. While there is no epidemiological data in this area, it would be relevant to use the diagnosis in all these different situations because of the nature of trauma per se.

5. The legal implications of a diagnosis: can a diagnosis of PTSD be a legal liability for a victim of Domestic Violence (DV)? In the United States, there is more awareness of the PTSD diagnosis and there are specific laws to protect the therapy/counseling documentation and its use in court in a DV case. For example, unless the woman victim herself wants to use the material from counseling sessions, it cannot be demanded by a court of law for perusal. The legal system's general lack of awareness and understanding of mental health issues is apparent in the situation in India where a label "of unsound mind" can be the ground for an ex-parte divorce. There is no qualification of this term, there is no medical evaluation or ratification of this criterion, so it is often used against women to prevent them from getting custody of children, access to property, employment etc. This general lack of awareness is applicable to any diagnosis that is made, even if it is one that recognizes her trauma, such as PTSD. The legal system has also not set a precedent of asking professionals to appear in court and clarify these issues in an individual case. In the United States, it is common practice to hire a testifying psychiatrist to make an evaluation of the case in question. In the United States there is dilemma regarding people who are on medication; if the individual is not on medication, he is said to be "of sound mind", but that would make him/her liable to criminal or civil penalties. If the individual is on medication, he/she will be seen as lacking in credibility because of the label "of unsound mind". This is how the rights of the mentally ill can be violated in the legal system. The question of diagnosis and labeling arises in the case of the term 'Battered Woman Syndrome'. It is not used in cases going through the legal system anymore, because the connotations of the term suggest that the woman herself is sick, based on personal psychopathology. Her reactions because of domestic violence are ignored and the focus is on traits that are supposedly within her. Therefore, the diagnosis PTSD is favored for its etiological focus on the traumatic event(s).

6. Re-traumatization of victims within the legal system: The effects of the legal system on trauma victims are a cause for concern. The legal process is often extremely harrowing and can even re-traumatize the victim. Though counseling and therapy may help 'shift' and move the client emotionally and psychologically to a safe space, the entry into the legal system can undo everything. Court procedures, prejudice, gender bias, and ignorance within legal procedures and systems often force the victim to re-live the trauma. In the United States there are Victims' Advocates whose role it is to prevent the possibility of re-traumatization as far as possible, to ameliorate the effects of the court process, and help victims make their way through the labyrinth of the law. So, when the legal system *does* work in favor of the victim it can be an immense source of validation, but in India, there is a paucity of systems and understanding to assist victims of violence.

Contextual Issues of Mental Health in Domestic Violence

Dr. Nimesh Desai

The mental health professional dealing with victims of domestic violence has a number of professional and professional dilemmas to address, including the nature of the therapeutic relationship. The standpoint that the professional takes in dealing with a DV victim is also open to debate. Psychiatrists are trained in the medical model where the power dynamics and privileges are clear, so moving into an 'interpersonal' space with a client is problematic, as is bound to happen with victims of abuse. With victims of domestic violence there is an impact on the mental and emotional well being of both client and service provider.

Some forms of psychological dysfunction occur due to chronic violence. Somatoform disorders are common in women survivors of domestic violence. Depression is prevalent in abused women owing to the effects of DV as well as alcohol abuse in the husband. It is also possible that the personality of a woman will be seriously affected to the point of change, due to abuse, making her excessively angry, bitter and cynical. Substance abuse is another common problem amongst violence survivors, especially tranquilizers; a recent global study confirmed that 227 per thousand abused women take tranquilizers in excess.

Different perspectives on mental health/ill-health provide different models to explain the action and impact of abuse. The social ecology model seeks answers and explanations in the socioeconomic-cultural reality of the individual. In this context, common mental disorders (CMD) are prevalent in DV victims. Long term exposure to domestic violence can result in severe morbidity for both somatic and mental illnesses. Within abusive relationships, the model of circular causality is currently in use to describe the nature and effects of the relationship. In rehabilitating the victims of a recent fire disaster in a large Delhi slum cluster in the Yamuna Pushta area, it was found that there was a very high rate of domestic violence and it was closely linked to their social-economic realities. The differing realities of women need to be evaluated in context of their political realities as well. In a needs assessment survey conducted in Kashmir, it was expected that levels of PTSD (Posttraumatic Stress Disorder) would be very high owing to political unrest and militancy. Poverty was found more of a relevant stressor in the perception of the women than the loss of a spouse to militancy, or domestic violence.

Discussion

1. **Batterers in Therapy:** Men and couples do approach the psychiatrist for help in cases of domestic violence, and it is important to remember that the batterer is also "in pain". The experience is that couples do change in terms of the levels of violence that decrease. In working with a batterer, it is therapeutically relevant to see them as 'diagnosable' with a mental illness, but this may be at odds to the established fact that abusive men are often 'normal'. Thinking of batterers as 'ill' would also imply that approximately 50-60 % of men in the society are mentally ill. The experience of some NGOs has been that when a man is indeed diagnosable, he does not believe that there is anything wrong with him and resists visiting a psychiatrist.

2. According to some NGOs the "insensitivity" of mental health professionals is reflected in clinical practice and is reinforced by the absence of gender sensitivity in medical training. It was also noted, by psychiatrists themselves, that perhaps the mental health professionals at the meeting are not really the ones who need 'exposure', because they have shown interest in attending such a meeting, but there is a large population of clinicians who are in need of training. There is a need for a "flavoring of gender in medical curricula" because there are lacunae in psychiatrists' responses to victims of violence. According to a psychiatrist in the group, the process of exposure and sensitization may lead to a 'backlash' amongst the professionals who are more aware and sensitive.

Issues of Assessment of Common Mental Disorders in Lower Income Urban Women with Gynecological Morbidity

Dr. Surinder Jaiswal

This study sought to assess women's experience of gynecological morbidity, and the presence of common mental disorders in women who report symptoms of gynecological morbidity. Women with gynecological morbidity did experience distress but did not receive treatment, either because they sought help only when the problem was chronic, or because health workers did not carefully examine women's reports, leading to even greater distress in women at not being heard. Gynecological morbidity includes conditions like PID (Pelvic Inflammatory Disease), white discharge, reproductive tract infections, and urinary tract infections etc.

Sensitive issues about women's health reporting and help seeking behavior, lead to a culture of silence, which entails the development of carefully designed tools for data collection. Since the study would use women's own accounts of their experiences, the tools would also have to record their feelings and thoughts in their own language. It was considered important to derive emic tools that were based on women's experiences, which would lead to the development of (culturally centered) etic tools, rather than impose constructs from existing Western or etic tools. The tools used were participatory which would be respondent driven, rather than more formal or structured; this would also allow emic data to be recorded. Narratives and Case Studies were used to record women's voices, along with the use of Freelisting, Ranking, and Body Mapping. .

The study used SRQ-20 (The Self-Report Questionnaire), in which some categories have been validated in the local language (a derived etic). ICD-10 was used to diagnose CMDs, which is an imposed etic, for its criteria of anxiety and depression are Western. Different methods were used to re-validate the in-depth interviews/case histories (triangulation).

Findings

- Gynecological and psychiatric morbidity were not associated with respondent's and spouse's education, family monthly income, and sterilization history of respondent

- Both morbidities were associated with the presence of a major illness in respondents

- 17.9 % respondents reported minor psychiatric morbidity

- 27.5 % and 21.3 % of the respondents who reported at least one or two gynecological morbidity symptoms also reported psychiatric morbidity.

- Psychiatric morbidity was associated with respondent's age (36-45 years), religion, and employment (not employed).

- Gynecological morbidity affected: women's physical health; changed their sense of self-worth and personal dignity; and affected their social mobility.

- Respondents felt that gynecological morbidity was part of womanhood that had to be quietly endured, and they feared that the morbidity was terminal.

- Women respondents felt alienated from the health provision system, and had often been told that there was 'nothing wrong with them', even while the illnesses did exist.

The intersection of gynecological conditions with other major illnesses and common mental disorders is widespread and largely goes unaddressed. Standard assessment procedures, when used, do not inquire about the woman's health situation in a "complete" manner, as she experiences it linked to many aspects of her life. Gynecological symptoms are addressed in isolation, the situations that create them, and the subjective distress caused by them is ignored. If the health provider were to ask the crucial question that would provide an opportunity for the woman to talk about her problem holistically, she would do so.

In Search of her Spirit: A Presentation on the Report on Women, Violence and Mental Health

Ms. Indira Ganesh (IFSHA)

The case study of the client, who brings with her a history of violence and discrimination and resultantly low self-esteem, inconfidence and fear, is the exemplar of trauma that all women are vulnerable to. It is within the context of gender that violence is a baseline experience. From birth throughout the life span, a woman has to virtually battle for her survival; the very basics of existence are denied young girls, from food to education to emotional and physical security. This perspective on gender is central to the rehabilitation and counseling provided for victims approaching IFSHA for assistance. A woman victim of violence will speak out only when the situation is beyond control or physical endurance. Rehabilitation from domestic violence or child sexual abuse means that her entire life has to be reconstructed and recreated, from addressing her scarred psyche, to the very essential necessities of physical relocation.

Counseling victims of violence focuses on understanding patterns of behavior and making connections with her history of violence. Deflection, denial, suppression, and projection, are some of the mechanisms violated women use to make sense of what they experienced and how they reacted, and to 'manage' rather than 'resolve' feelings of guilt, shame or fear. In this process, there were women who displayed behaviors that were difficult to address, like excessive crying, extreme suspicion, over-talkativeness etc. While there is an intellectual understanding of the emotions and trauma underlying the behaviors, practical *and* sensitive measures were not always available. Additionally, family members, police, lawyers, and neighbors would call her mad, or crazy based on these expressions. Considering that violence is pandemic, if only a thousandth of the population of traumatized women approached a small NGO, where did the others go? The answer came in the form of clients who had already accessed the entire range of available mental health professionals, before finding that their services were in some way inadequate. They largely felt un-understood, were often medicated for their behaviors called 'symptoms', which led to their suppression rather than resolution. They were led to believe that there was something innately wrong with their own functioning, which caused their varied reactions to trauma and even the trauma per se.

These clients found that the NGO experience gave them more space to express their trauma in a non-judgmental space, work towards rehabilitation, and source the pain and fear. The two differences in the approach to the violated woman led to the crystallization of the aims of the research:

- The connections between the psychology of violence and mental illness (our definition of violence is described in Box 1).
- The prevalence of abuse in mentally ill women.
- The manifestations of sexual and domestic trauma.
- To dialogue with mainstream mental health professionals on the experiences of abused and diagnosed women, their understanding of trauma and behavior and its treatment, and the problems in mental health practice and service delivery.

Methodology

Tools

- Biographic details of the client, onset of illness, symptoms, and treatment measures for which the medical records were consulted
- In-depth interviews with women clients on their life histories of violence and illness.
- Semi-structured questionnaires for interviews with psychiatrists

Sample & Sampling

To avoid any biases, the population of clinically diagnosed women was found to be the most suitable, rather than studying NGO clients; additionally, as an NGO we did not possess the facilities or expertise for diagnosis either.

Since each in-depth interview took 1-2 hours, and at least three interviews per client were essential, there was pressure to have a large sample. Nevertheless with 300 respondents there was enough data that could be generated. To make the sample more representative of the diversity of India, five centers for data collection were chosen: Delhi, Bombay, Calcutta, Tezpur, and Bangalore. We accessed diagnosed women from government hospitals, private clinics, and halfway homes. The final sample of the research is outlined in Box 2.

Box 1

Definition of Violence:

In the natal home:	In the marital home:
- Child sexual abuse	- Domestic violence
- Child marriage	- Sexual coercion
- Physical abuse	- Reproductive burden
- An alcoholic father	- Abusive in-laws
- Male child preference and related discrimination.	

Box 2

Sample:

Total number of cases not used in analysis (either organic disorders Or where no diagnosis has been made): 17

Total number of cases where respondents were incoherent due to medication:

38

Total number of cases used in analysis with violence as a primary or secondary factor:

245

300

Number reporting violence as secondary factor in life history (Prior to illness):

88 (35.9 %)

Number reporting violence as primary factor in life history* (Prior to illness): 157 (64.1 %)

Of this
Anxiety: 46 (29.3 %)
Depression: 65 (41.4%)
Psychosis: 46 (29.3 %)

Main Findings

The Women Respondents:

Since the data was largely qualitative and in the form of narratives, it was analyzed accordingly. The findings briefly outlined here relate to the sample recording violence as a primary factor. *

* These were the respondents who reported violence as a primary source of stress and upheaval in their life histories; women who reported violence as a secondary factor were unable to share the details of their own lives because of a recent crisis in the family, or who were incoherent on the 2-3rd interview due to medication

Women with Depression:

- Prevalence of depression highest in ever married sample (41.4 %)
- The connection between the theoretical underpinnings of depression and women's experiences of violence in marriage comprising low self-esteem, feelings of powerlessness, learned helplessness, and a nihilistic view of the future.

Women with Anxiety-Neuroses:

- Prevalence of anxiety generally lower in the sample, with distinctions relating to specific categories of violence
- Identical levels of anxiety neuroses in child marriage and child sexual abuse cases, and a similar link in cases of sexual coercion in adults and children rather than depression
- Anxiety related illnesses correlated with loss of control, as opposed to depression which was correlated with hopelessness.
- More diagnoses of somatic disorders in women with early histories of sexual trauma, displaying more unexplained pain and somatic complaints.

Women with Psychoses:

- Highest level of child sexual abuse in the entire sample in the group of women diagnosed with psychoses.
- Hardly any assessment or psychological testing was used in cases of psychoses; diagnosis was made on the basis of symptomatology and the accompanying informant's reports.
- Diagnosis of psychosis does not always acknowledge the occurrence of violence in women's lives.
- 98 % of treatment measures adopted for all forms of psychotic illness was medication, psychotherapy was hardly visible

Main Findings

The Psychiatrists

- 102 clinicians were interviewed, and most of them ran private clinics and their clientele was generally middle/upper middle class. The clinicians from government hospitals, where most of our clients were from, refused to be interviewed for reasons of client-confidentiality. Additionally, private clinicians had more scope and resources to use a range of assessment and treatment procedures that was the main focus of the interviews

- 60 % of clinicians believed that child sexual abuse was a significant issue for mental health, but only 8 % routinely checked for it in practice

- 43 % of clinicians interviewed believed that domestic violence was a significant issue for mental health, but only 12 % routinely checked for it.

- The stark differences between the high perceived significance of these two forms of violence, and the extremely low prevalence in practice reveals a contradiction; it underscores the lack of emphasis on inquiry around women's experiences of violence

- Common mental disorders are most prevalent in a given population, and 58 % of the sample felt that CMDs were most amenable to psychotherapy, but only 15 % used psychotherapy regularly in treating CMDs. 23 % reported that the progresses in pharmaceutical technology would make psychotherapy redundant.

Questions

1. Are the assumptions underlying diagnostic frameworks culturally sensitive, and relevant?

2. A diagnosis such as PTSD captures the effects of sexual and domestic victimization, but has hardly been used in this country. Why?

3. The connotations implied by diagnosis for women viz. that it affects life, liberty and personal well being of women have never been seriously considered, and go largely unrecognized by the mainstream. Why?

4. How is medication as the only form of effective therapy in cases of violence against women?

5. How does the language and practice of medicalization of illness affect women victims of sexual trauma?

Recommendations

- Partnerships with mainstream mental health practitioners, and other NGOs in assessment, research, and therapeutic interventions for women
- A sustained effort towards developing Feminist Therapy in India.

Discussion

1. A certain number of cases of women who were diagnosed with organic disorders (mental retardation and epilepsy) were not included in the analysis of data, which was challenged on the grounds that it amounted to exclusion of an important segment of women, who are usually ignored in most research anyway. This situation has to be viewed in light of constraints and hurdles that the research process had to contend with, as well as the location of IFSHA in its context as an NGO. Access to institutions, and communication with the mainstream was so limited, largely due to IFSHA's position as an NGO researching a "mainstream" issue. With deference to recognition and incorporation of the research in the mainstream, a more conservative and safe approach was adopted, and the exclusion of these cases signified that a condition such as mental retardation would introduce more variables than could be addressed within the scope of the research.

2. The intensity and enormity of the experience of violence can often make a clinician feel overwhelmed by her inability to tangibly make a difference, given her tools and resources. In this regard, without it being as a defense for the use of medication, it is perhaps the only 'active' way to alleviate the symptom. "At least the woman sleeps better a night."

3. According to some clinicians, the apparently direct connection that was made between violence, and mental illness requires further research, and the varied perspectives and inputs of different disciplines and professionals could be incorporated in such a research. Other social and community issues that operate beyond the individual's personal experience have to be explored as well.

4. The gendered experience of violence in this research, according to clinicians, ignores the violence that men experience at the hands of women, or that which is perpetrated by women on each other. In this context, the ground realities of the prevalence and effects of violence against men and women have to be recognized, and the differences in how men and women are violated are equally important. The relationship between the perpetrator and victim and the effects of intimate partner violence comes more within the lived reality of women rather than men.

5. The origins of psychiatry and psychology in medicine have led to the medicalization of psychological illnesses, and the often-excessive use of medication as treatment. Nevertheless this does not imply that counseling or psychotherapy is the only suitable form of treatment for mental illnesses, as was thought to be the point of the IFSHA research and presentation. The expectation of clients also follows here, that they generally expect to be 'cured' soon by a pill or drug. Clients do not always accept 'talking' as a form of therapy because the origin of dysfunction is constructed as being biological. In response to this, it was suggested that "wellbeing" as a concept could be kept central, and the most effective form of therapy be advocated in keeping with the situation of the individual client.

PART 2: INTERVENTIONS IN ADDRESSING WOMEN'S MENTAL HEALTH

The Identification and Assessment of Domestic Violence in Health Care Settings

Dr. Mary Ann Dutton

Health care providers can play a significant role in identifying domestic violence in their women clients. The prevalence of violence in the lives of psychiatric inpatients underscores the need for better assessment and care for survivors (as shown in the box).

- 100 Consecutive adult female admissions
- History of childhood abuse

- 95% childhood physical abuse
- 96% childhood sexual abuse
- 97% childhood emotional abuse

20-56 years (M = 39 years, S.D. = 8.2)

- Race/Ethnicity: 88% Caucasian, 10% African-American
- Education

- 37% college and/or graduate or professional degree
- 43% some college education
- 10% high school diploma
- 10% less than high school education

The effective identification of violence and abuse in a clinical setting means that there would have to be universal screening procedures, for any woman could be a victim of violence. For want of time and resources the identification procedure would have to be quick, therefore questions would have to focus on specific behaviors. If the clinician feels that there is a need for a more in-depth assessment of the woman's violence situation, some procedures could be used viz.

- *Narratives*: Asking the woman to tell her story the ways she feels most comfortable.
- The Scenario Interview method where the woman is asked about the sequence of specific incidents.
- *Structured Protocols*: To assess physical, sexual and psychological abuse or violence, stalking etc.) like: the Conflict Tactics Scale-2 (CTS-2), the Spouse Abuse Index, and the Psychological Maltreatment of Women Inventory.

Assessment procedures can help identify the extent to which the client is at further risk of victimization, which assists a health care provider in planning the entire process of healing and rehabilitation. The risks women face in situations of violence as determined by the batterer's actions, are significant: physical and psychological harm, risks to the children, family and friends, risks that threaten the relationship, loss of financial and other tangible resources etc.

There are two scales used to assess the intensity and nature of risks battered women face: *The Danger Assessment Scale, and the Spousal Assault Risk Assessment Guide.*

There are a number of issues for health care providers to be aware of when dealing with women survivors of violence:

- *Universal screening and identification by the health professional.*
- *Follow-up violence and risk assessments.*
- *Safety-planning with the client for the immediate situation.*
- *Coordinated communities response-working with agencies in the community that also have a role to play-the police, legal system, shelters etc.*
- *Sensitivity to ecological context and the context of violence, and the factors that impinge on a woman's responses.*
- *Secondary prevention through information and education, and for the prevention of revictimization.*
- *Ongoing professional education and training to deal with secondary traumatic stress and continued developments in field*

Discussion

1. Revictimization in women survivors of CSA: There are a number of theories that outline the processes underlying revictimization. The psychological processes in revictimization operate in conjunction with unique socio-cultural patterns and perceptions. For example, the experience from Mexico was that CSA victims are considered "impure" and "defiled", thereby forcing them to marry the abuser, since no one else will. Psychoanalytic theory which assumes that there are gender differences in how there is identification with the abuser/abuse, leading to boys becoming aggressors themselves, and girls becoming vulnerable to further abuse

2. Assessment protocols: the need to develop different procedures and protocols for different socio-economic classes because of women's different responses to violence.

Reaching the Un-reached: An Approach to Develop Mental Health Care for Women in Distress

Dr. R. S. Murthy

Before examining the status of mental health in India, the history of the infrastructural developments needs to be recognized. The mental health profession is inadequately resourced in terms of human capacity and physical infrastructure. The British built all existing mental hospitals, and after 1966, there were no more mental health centers. There are only 20, 000 psychiatric beds for approximately 14 % of a population of 1 billion who are mentally ill, and only 5000 mental health professionals to address them.

In a four-village study conducted by NIMHANS over a nine-month period, 80 % of the depressed population were women, and despite the availability of mental health services, 50 % were not treated. For three months, the NIMHANS team provided improved services, development etc., resulting in clinical and economic improvement, but there was 20-30 % of the community who did not access mental health services. What does exist at present are improved assessment methods, different forms of therapy, changes in the diagnostic procedure, and drugs are cheaper and more accessible. The mental health profession today is centralized, over-professionalized, and the quality of care is de-humanizing. The negative connotations in this scenario need to be transformed to a more positive stance. This process plus the resource crunch makes it most logical to suggest a public health approach and interventions in mental health. The process of change will have to therefore incorporate a holistic view, and medication or counseling alone cannot ameliorate women's mental health, but social change is also, if not more, crucial. Public health interventions and de-professionalizing the practice has begun in some measure by NIMHANS, where treatment procedures have undergone change. Mental health services have become more innovative, simplified, and broad-based as some PHCs (primary health centers) in a district of Karnataka have been trained to address common mental health problems in the community. Specifically, it is a 'partnership with families' that is sought in this process. The specific groups/issues who have been addressed through educational manuals and training programs are:

- Caregivers
- Medical professionals
- Social activists
- Primary health centers
- Working women

Such community resources include educational materials, training, focussing on social etiology, minimizing gender stereotypes, and creating spaces where the client feels empowered rather than victimized. The development of protocols for better clinical practice is another step that can be worked towards. The main aim of such community approaches to mental health is to make the shift from 'mental ill-health' to 'mental health'.

Discussion

1. If the aim of community mental health is to broadbase service delivery by 'de-professionalizing' the existing mental health system, who are the caregivers, apart from psychiatrists, who will take it on? Many individuals claim to be mental health professionals, but often don't have the requisite training, experience, skills etc. The distinctions between non-professional and para-professionals in the mental health system have not been clearly defined either. The hierarchies in the mental health profession are very clearly established. Protocols of assessment, treatment, and the purview of these caregivers do not exist. In light of these ground realities, how ethically viable is it to call upon these diverse groups to participate in the community mental health movement?

Theoretical and Methodological Issues in Therapeutic Interventions for Women and Children in Domestic Violence: The Feminist Approach

Dr. Irma Saucedo Gonzalez

Domestic violence is pandemic and its effects on victims' psychological, emotional, sexual and physical health are significant. Such victimization also has a profound impact on victims' worldview and constructions of themselves, and human relationships. The theoretical and methodological issues underlying therapeutic interventions emphasize a new meaning and approach to the emotional turmoil resulting from intimate partner violence. This re-definition of beliefs is central to recovery. Rather than focus on a medical, reductionist approach to the individual's health and psyche, it is important to address the contextual issues of self and self-image that keep victims in violent situations, or that prevent recovery from abuse. The centrality of power and the entrenchment of power relations as they exist are reviewed through a feminist lens in these new interventions. Culture and scientific disciplines produce and reinforce knowledge about the concept of power relations, the construction of gender identities, and the culturally fashioned meanings of masculinity and femininity in specific contexts. These have never been subjected to deconstruction and analysis from a feminist perspective for the purpose of therapeutic interventions. Deconstruction of power and gender systems throws light on how and why traditional psychological theories have played a significant role at normalizing women; on the cultural contexts that construct masculinities and femininities with violence and coercion as regulators of these constructions; and, the normalization and acceptance of male violence.

Knowledge about women's responses to, and recovery from, domestic violence can be re-constructed from a feminist perspective. For example, the Stockholm Syndrome Theory can be useful in understanding the way in which women can de-construct the emotional bond that exists between themselves and the aggressor. When clients themselves develop a consciousness about their behavior, they are able to re-construct more positive emotional bonds, and allows them to feel more secure when they take important decisions, such as leaving the violent relationship. This re-constructive approach to knowledge also enables therapists to understand the anguish and setbacks that women face in therapy, and when they try to distance themselves from the violent relationship.

Approaches to re-constructed knowledge such as this underlie the 'reflection groups', the specific therapeutic intervention for DV victims. These groups are for women to identify with each other and to engage in discussions on the relationship between violence, socially approved femininity, and the feelings of terror and pain. The emotional fallout of violence is diminished by the deconstruction of individual beliefs regarding its cause.

Thereon, it is possible for women to construct a new meaning to the feelings they experienced due to violence, and begin to design strategies to protect or free themselves from a violent situation. The reflection group process allows women to make connections between violent acts and femininity as being obedient, sexually constrained etc. Results of this process show that women do change and are able to deconstruct the concepts of femininity, sexuality, and motherhood that exacerbated situations of violence. Additionally, this group work has shown that the symptoms that women experienced reduced or completely disappeared. Reflection groups are not support/encounter groups, they are a source of emotional support, but not necessarily rehabilitation. There is more of an emphasis on discussing relevant themes, and not necessarily on behavior change per se. Coordinators who are trained to engage the participants in the process of analyzing and deconstructing power imbalances in their immediate relationships run the groups.

The relationship between the mental health professional (the 'specialist') and the client (woman) often replicates the power structures existing in society, between partners etc. The specialist takes on a position of resolving the violent situation without the client being able to control her own destiny, or design her own strategies which are validated (or not) through trial and error. Empowerment can occur when women victims have the intellectual and psychological latitude to analyze and deconstruct the power imbalance that exists in specialist-client relationships.

Domestic violence is a complex phenomenon. Its complexity shows that is not easy to talk about "ending it" in the near future. However, we can begin to de-structure the mechanisms that guarantee its reproduction.

Discussion:

1. Problematic issues in running reflection groups: in forming these reflection groups, the main problems have been middle class women's resistance to taking domestic violence from the private to the public sphere. The power of silence is often the starting point for the process of deconstruction of power relations. Other NGO experiences have found that class differences make it essential to organize women of similar classes together. Yet, once there is a structure in place that recognizes these issues, they have run extremely smoothly.

2. By entering a support/reflection group, a woman has to re-look at herself and take stock of her situation. This can be an emotionally rigorous experience, and a very isolating one. The group becomes the main source of affection, friendship etc., but is not always effective in providing an 'alternate supportive community' for a battered woman. The process of introspection is a painful one and there are multiple pressures to address: isolation from the partner, self-doubt, distance from other social relationships linked to the spousal one, and a total lack of understanding or empathy from anyone except the NGO.

3. The power dynamics between the facilitator (of the reflection groups) and the client are also a concern. The existing dynamics are registered and observed, and are incorporated into the themes the group takes up. The dynamics are recognized rather than ignored, which is often a preventive check on relationships within the group becoming imbalanced.

4. Non-medicalization of domestic violence: what this means is that a case of DV is not immediately referred to the mental health center. Treatment per se is not the only way to address DV, and this is what the reflection groups try to emphasize. The Mexican experience with these reflection groups has led to the suggestion that medical and mental health settings should make provisions for reflection group style processes.

Mental Health Matters Too: Expanding the scope of Reproductive and Women's Health Research

Dr. Vikram Patel

This presentation aims to highlight the need for reproductive and women's health research in developing countries to incorporate psychosocial factors and mental health as an integral component of its agenda. The intersection of reproductive and mental health has been rarely researched although there is growing evidence that mental illnesses play a significant part in the disease burden of developing countries. Common Mental Disorders (CMDs) such as depression and anxiety, in particular, have been identified as one of the commonest and most disabling disorders and women are at a higher risk to suffer this disorder. Being economically weaker, and having little or no education, which women often are, increase an individual's vulnerability to CMDs. CMDs, by virtue of their seemingly innocuous manifestations, are not commonly diagnosed, are dismissed, or are seen as sleeping disorders that are treated with the ubiquitous 'tonic'. A consistently ignored CMD often becomes chronic, leading to greater problems for the woman. The presentation reviews the existing research evidence to demonstrate the relevance of mental health by examining six key areas:

- Gynecological/reproductive symptoms and psychological disorder.
- Postnatal depression: The cultural ethos underlying childbirth in India is geared towards a celebration of the child and its survival, rather than the mother. There is very little space for women to express the emotions related to childbirth, so there is little space for them to access any form of support.
- Adolescent sexuality and mental health: adolescent suicide attempts are one of the top three causes for hospitalization in India.
- Violence and women's mental health: Apart from the impact of violence on the women's psyche, it has also been shown that DV translates into reproductive symptoms as well.
- Treatment of common mental disorders with counseling and antidepressants.
- The mental health of older women: the myth of the cozy joint family is debunked by the prevalence of elder abuse, and older women are even more disadvantaged by their poor social, health, and economic status.

Using this evidence, a range of research questions and hypotheses and their implications for reproductive health services and policy can be suggested. The broad basing of service delivery and inclusion of health workers to address CMDs is an important step towards prevention, enhanced care, effective services etc. There is not enough data from developing countries that show how prevalent certain conditions are, or how effective different kinds of treatment are; there is no 'truth' about assessment, planning, treatment etc. that can be passed on to health workers.

There is still a trial and error method used when it comes to addressing these mental health issues. It also suggests that mental health issues need to be incorporated into reproductive and women's health programs at a governmental level. In conclusion, this work undertaken by Sangath aims to broaden the scope of reproductive health research by acknowledging that it is inextricably linked to mental health.

Discussion:

1. The benefits and costs of counseling and pharmaco-therapy for mental illnesses: The benefits of both can be argued for, but there are opposing views on how they can or should be compared, if at all. At one level, the two approaches appear to be so totally different, to the extent that comparisons are impossible. A differing view is that if counseling versus pharmaco-therapy is at the heart of the conflict, then a scientific experiment would have to establish the advantages of one over the other.

Addressing Violence against Women and Children in Family Therapy

Dr. Apurva Shah

Within the psychoanalytic tradition, addressing family violence means that the concepts and skills that guide therapy will diverge from other schools of thought in psychiatry, and in family therapy specifically. So, it is important to recognize the different context that psychoanalysis operates in, and the different data and experiences it generates. The different languages and beliefs within different schools of psychology and psychiatry lead to knee jerk reactions; essentially, difference is to be recognized and respected.

In the case of domestic violence, the psychoanalyst enters a therapeutic alliance with the entire family. Psychoanalytic therapy is a long-term process with families and the clients are encouraged to attend the entire process, so there is enough time for them to establish a level of comfort to disclose and open up. This occurs by the 25th to 30th session. After this, the therapist works with the abuser on slowly reducing the level and frequency of violence in the marital relationship, by entering a moral contract with him. The analyst does not, except in rare cases, try to stop the violence completely. On the other hand, in cases of violence against children, the analyst takes a definite stand that violence has to be stopped immediately.

As a clinician, it is essential to remain truly non-judgmental in such cases as it may interfere with the helper's role. For example, NGO spaces for women victims are non-judgmental because the counselors take moral stands on violence, the victim, the abuser etc. Perpetrators of violence have to be addressed in as non-judgmental a fashion as possible, for they experience helplessness and loss of control as well. Just as the victim should not be classified as 'mad', the perpetrator should not be classified as 'bad'. In the process of psychoanalysis, one method of empowerment is locating the locus of control internally, within the self. If the outside situation cannot change, at least the victim can be empowered to deal with the violence.

While therapy, research, and interventions are important in cases of DV and CSA, there is a larger goal that cannot be ignored. Social problems such as violence against women and children are based on a reigning cultural ego ideal that shapes and is shaped by the media, popular culture etc. This in turn affects how domestic violence and child sexual abuse are viewed. In this regard, in working with children and communities psycho-education is particularly useful.

[Discussion following this presentation was not possible owing to time constraints.]

PART 3: RECOMMENDATIONS & SUGGESTIONS FOR COLLABORATION

This section summarizes the suggestions and recommendations made by the group towards collaboration on mental health issues and practice. While collaboration per se may seem the most logical outcome of such a colloquium, what it means at a ground level needs to be thoroughly debated first, where there must emerge a sense of ownership of the process. The alleged 'confrontational' attitude of NGOs is more a myth than reality; the differences in the bodies of knowledge based on mainstream practice and NGO experience have to be respected for what they are. And a process of collaboration is based on un-learning and re-learning of attitudes, perspectives, skills, and practice.

A panel of NGO representatives, academicians and psychiatrists made the following recommendations:

Recommendations from NGOs

Ms. Jasjit Purewal (IFSHA, New Delhi)
Dr. Bhargavi Davar (Bapu Trust, Pune)
Dr. Surinder Jaiswal (TISS, Mumbai)

1. Awareness-raising on gender issues within the mental health community

2. A 'support community' of mental health professionals and NGOs to provide training, exposure etc. for institutions/individuals working with violence victims.

3. Research partnerships between mainstream mental health clinicians and NGOs on issues of violence against women and mental health

4. A 'de-professionalization' of skills and perspectives used both within and outside of mainstream clinical practice, and the inclusion of ideas and practices from other allied professions. The intellectual and professional seclusion that mental health practice enjoys needs to open up for alternative perspectives in light of the varied experiences of other groups working on women's health.

5. The development of assessment protocols for cases of abuse that can be incorporated in mainstream clinical practice

6. Ethical committees to vet research done by NGOs and clinicians on women's mental health and violence.

7. The de-stigmatization of mental illness, through media campaigns for example, based on collaboration by mental health practitioners and NGOs.

8. A working group of clinicians and NGOs on issues of violence against women for debates, training, exposure etc.

Recommendations by Psychiatrists:

1. Dr. R. S. Murthy (NIMHANS, Bangalore)

- n intellectual and emotional shift away from a qualitative judgment that views perpetrators of violence as "bad"

- Research conducted by NGOs, specifically the raw data of the IFSHA report 'In Search of her Spirit: Women, Violence & Mental Health', should be reviewed by psychiatrists who were not interviewed in the study, to see if they would react in quite the same way as the psychiatrist-respondents did.

- A joint session including psychiatrists and NGOs to discuss perspectives in the assessment and treatment of women victims of violence under the aegis of a forum such as the Delhi Association of Psychiatrists, or the Indian Association of Psychiatrists.

- Mainstreaming the assessment and treatment of common mental disorders to ensure that non-mental health/para- professionals can take on the care of CMDs.

- Different methods and interventions in cases of abuse can be developed jointly by NGOs and clinicians and would need to be thoroughly evaluated before being implemented.

2. Dr. Nimesh Desai (Institute of Human Behavior and Allied Sciences, Shahdra, New Delhi)

- More dialogue between mental health clinicians and NGOs on addressing violence against women. This process might lead to the development of alternate models and perspectives within which DV, CSA etc may be viewed, in order to prevent an unilinearity of perspective that currently exists.

- More research on women's mental health and violence.

- The inclusion of DV, CSA etc. in education, training, assessment and training procedures as a form of collaboration at the service delivery level.

- A space for professionals to reflect and introspect on the nature of clinical practice, treatment philosophies etc., and to increase awareness about gender issues. Within a specific institution such as IHBAS, Shahdra, the post graduate program should include gender issues in the curriculum.

3. Dr. Mohan Isaac (NIMHANS, Bangalore)

- Since different professionals use differing languages to communicate similar themes related to women's mental health, it may be useful to evolve a "common language" to ensure communication that is reality-based and valid.

- Documentation of the process of therapy, assessment etc. by non-mainstream groups like NGOs in addressing violence victims for periodic assessment, review and training.

- Debating the legal implications of mental health issues, and working towards concrete interventions.

- A directory of NGOs and mental health professionals organized city-wise for the reference of both groups, and networking.

PART 4: EVALUATIONS

Though there was space for participants to share their experiences of the conference, we provided a written evaluation form as well, which is reproduced here. There were a number of issues that we felt could be elaborated upon through a written evaluation form. Generally, the participants had a number of ideas to share, extended offers to work together, and were impressed by the level of debates and lateral thinking that the conference stimulated.

Questions in the written evaluation form:

1. How would you feel about a collaborative effort between yourself and any other agency/individual working in a different professional sphere i.e. psychiatrist, clinical psychologist, activist, feminist therapist? What areas, if any, would you like to collaborate on?

2. What are the key areas that came up in this meeting that need further inquiry, examination, application etc.?

3. Are there any issues that you think should have been included/elaborated upon

4. Other comments?

5. Would you like to attend any other meeting by IFSHA?

Participants' Responses:

A broad overview of the written evaluations shows that participants were able to specify the issues that either needed greater inquiry, or collaboration, rather than share their views, apprehensions, and ideas about collaborative efforts. Of 45 participants who attended the conference, we received only 18 evaluation forms, so the views listed here cannot be assumed to be representative of the entire group.

1. The areas that participants' would like to collaborate on are:

- Research: sharing research and psychiatrists wanted to conduct research with activists; working on joint projects on law and mental health.

- Therapeutic Interventions: developing 'reflection group' style interventions for battered women; for elder abuse, and violence against children in the family; begin groups for domestic violence victims with the assistance of IFSHA; developing specific counseling techniques for domestic violence; developing the concept and practice of feminist therapy in India; a collaboration on a case-by-case basis for therapy and evaluation.

- Education & Advocacy: incorporating gender issues and violence against women in undergraduate and postgraduate medical education; mainstreaming disability issues in gender and mental health; advocacy for legislative awareness and change.

2. Areas that participants felt need more examination, inquiry, and application:

- Research: creating a qualitative and quantitative database on violence against women; the need for scientific data aimed at influencing policy; the scientific rigor of the IFSHA research; gender specific and gendered research methods; women's resilience and coping mechanisms; the interface of domestic violence and mental illness.

- Therapeutic interventions: sharing different practices; intervention and assessment protocols for violence cases; developing training curricula for mental health professionals; organizing a community based task force on violence against women comprising a team of professionals; defining and examining counseling as therapy

- Education & Advocacy: gender-sensitization of mental health professionals; mainstreaming an understanding of feminism; disability issues in mental health of women; mainstreaming the care of CMDs into allied disciplines like primary health care settings, or gynecology services.

3. Issues that participants felt were left out of the meeting:

- Working with and researching perpetrators' behavior and construction of masculinity
- Descriptions of community based services working on women's issues and violence
- The credibility and competence of NGOs to work in the absence of mental health professionals
- The needs and services of rural women
- The role and inputs of psychologists and psychiatric social workers in addressing violence against women
- Violence at a state level, communalism, terrorism etc.
- Disability issues in women's mental health
- What feminism is and how it is practiced, and its role in mental health care
- Relationships between children and parents coexisting in situations of violence
- Questioning the gendered sensitivity of mainstream mental health research
- The Depth Psychology of the victim of violence
- The overlaps and intersections between child sexual abuse and domestic violence
- The role of illiteracy and poverty in preventing women from dealing with violence.

The preceding sections signify that the conference threw up a number of issues for intellectual debate, discussion and further working relationships. As IFSHA, this is in fulfillment of our aims in organizing this workshop. Other comments from participants show that they enjoyed being part of this forum and gained many useful ideas, and insights, and that they looked forward to more meetings organized by IFSHA. It also makes us more hopeful that women's experiences could gain visibility in mental health forums and practice. The level of debate, involvement and passion at such a meeting was of very high quality, and reinforces our commitment to collaboration on women's mental health. It is also significant that we were able to organize a gathering of diverse professionals to discuss and share points of convergence and difference towards the larger goal of gender justice.

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Dr. Apurva Shah: has trained at the Albert Einstein, and New York City in psychiatry, child psychiatry, psychoanalytic psychotherapy, and systemic family therapy. Dr Shah is in private practice in Ahmedabad, and is director of Antarnad Foundation (Ahmedabad), a non-profit organization whose activities include: a three year graduate training program in psychotherapy, a low cost psychotherapy clinic, community outreach programs, a therapeutic nursery for autistic children, and a psychoanalytically oriented film club.

Dr. Bhargavi Davar: is a Ph.D. in the Philosophy of Psychiatry from the Indian Institute of Technology in Mumbai. Her Post Doctoral work comprised of: 'Project work on women and mental health in the Indian context – some secondary data and review'; writing on consumer perspectives in mental health; advocacy and policy research; feminist psychology and women's mental health. Presently she is a trustee for Bapu trust, a forum interested in the sociological aspects of mental health practice, policy and advocacy related issues. Dr. Davar has published two books: *Psychoanalysis as a Human Science: Beyond Foundationalism, and Mental Health of Indian Women: A Feminist Agenda*

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Dr. Thomas John: is an alumnus of the Christian Medical College and Hospital (CMCH), Vellore, India, where he currently works at the Department of Psychiatry.

Dr. Vikram Patel: is a psychiatrist and epidemiologist working with an NGO in Goa- *'Sangath'*, which focuses its activities on emotional and developmental health problems affecting children and families. He has been the recipient of a number of research awards including the Rhodes Scholarship. Dr. Patel is a MacArthur Foundation Population Program Fellow, and holds an appointment as Senior Lecturer at the Institute of Psychiatry of Kings College, London. He is currently writing, *"Where There is no Psychiatrist"*, a manual for village health workers.

WOMEN, VIOLENCE & MENTAL HEALTH MEETING
INDIA HABITAT CENTRE, APRIL 11-12, 1999

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WOMEN, VIOLENCE AND MENTAL HEALTH

April 11 – 12, 1999
The India Habitat Center New Delhi

Agenda

DAY ONE	11/04/1999
08:30 a.m.	Registration
09:00 a.m.	Introduction to the Workshop: IFSHA
SESSION I	
CHAIRPERSON	Dr. Mary Ann Dutton
09:30 a.m.	Ms. Indira Maya Ganesh: *'In search of her spirit: Women, Violence & Mental Health'* A Report by IFSHA. Followed by discussion.
10:30 a.m.	Dr. Bhargavi Davar: *'Impact of Violence on Women's Mental Health: Research Findings'.* Followed by discussion.
11:30 a.m.	Tea/Coffee
11:45 a.m.	Dr. Shubhangi Parkar: *'KEM's Interventions with Women Clients: Associating Violence with Mental Health Issues.'* Followed by discussion.
12:30 p.m.	Lunch

SESSION II

CHAIRPERSON	Dr. R. S. Murthy
2:00 p.m.	Dr. Sagar: '*Women & Depression*'. Followed by discussion.
2:30 p.m.	Dr. Mary Ann Dutton: *'Using Measurement Scales to Identify Domestic Violence'*. Followed by discussion.
3:30 p.m.	Dr. Thomas John: *'Assessment of Domestic Violence and its Correlation with Depression.'*. Followed by discussion.
4:00 p.m.	Tea/Coffee
4:15 p.m.	Open Session

DAY TWO 12/04/1999

SESSION III

CHAIRPERSON	Ms. Irma Saucedo - Gonzalez
10:00 a.m.	Dr. Mary Ann Dutton: *'Posttraumatic Stress Disorder. Affectivity in Cases of Domestic Violence'.* Followed by discussion.
11:00 a.m.	Tea/Coffee

11: 15 a.m.	Dr. R. S. Murthy: *'Reaching the Unreached - Approach to Develop Mental Health care for Women in Distress'.* Followed by discussion.
11:45 a.m.	Dr. Nimesh Desai: *'Contextual issues of Mental Health in Domestic violence'*, Followed by discussion.
12:15p.m.	Dr. Surinder Jaiswal: *'Common Mental Disorders in Low Income Urban Women with Gynecological Morbidity'* Followed by Discussion
	Dr. Anjali Dave: ' *Mental Violence in the Family'* Followed by Discussion
1:00 p.m.	Lunch

SESSION IV

CHAIRPERSON	Dr. Mohan Isaac (NIMHANS)
2:00 p.m.	Ms. Irma Saucedo – Gonzalez: *'Theoretical and Methodological Issues in Therapeutic Interventions for Women & Children in Domestic Violence: The Feminist Approach'.* Followed by discussion.
3:00 p.m.	Dr. Vikram Patel: *'Development & Evaluation of Psychological and*

	Pharmacological Interventions for Common Mental Disorders in General Health: Addressing Gender Issues'.
3:30 p.m.	Dr. Apurva Shah: *'Addressing Violence against Women & Children in Family Therapy'.*
4:00 p.m.	Tea/Coffee
4:15 p.m.	Discussion on presentations

SESSION V

MODERATOR	Ms. Jasjit Purewal
4:45 p.m.	*Recommendations: Chalking out a Course of Action.*
5:15 p.m.	*Outstanding Issues*: Issues that participants think should have been included in this process.
5:45 p.m.	*Evaluating the Process*.
6:15 p.m.	*Vote of Thanks from IFSHA.*