CHAPTER -4

Violence and Mental Health: Perspectives on Mental Health Sequelae of Violence against Women

In pursuance of the core argument that the cause of mental disorder may be located in one's social context and not necessarily triggered by bio-genetic factors, the present chapter focuses on the study of violence, a significant social stressor, as a causal factor of mental disorder particularly among women. In the recent times, violence has emerged as a major public health concern. Several research works on violence have indicated at the same as an important cause of morbidity and mortality across the globe. According to an estimate made by World Health Organization (2002), 1.6 million people have died in 2000 as a result of violence. Violence has been associated with poor physical health, suicide, mental health problems, reproductive health problems, somatic symptoms, and several medical conditions, such as cancer and ischemic heart disease, either as a provocative or as a risk factor. The impact of violence on global burden of disease is considerable, so much so, that in the year 2000 interpersonal violence ranked 31st in high-income countries, and 21st in low and medium income countries (LAMIC), as one of the main causes of disability-adjusted life years (DALYs) (Rebeiro et al., 2009**).**

4.1 Violence, Women and Mental Health

Violence against women is a pandemic social malaise that poses serious threat to their physical, mental, sexual, and reproductive health in other words to their overall well-being. The United Nations Declaration on the *Elimination of Violence against Women* defined violence against women 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 in private life" (1993, A/RES/48/104 cited in Garcia-Moreno and Stockl, 2013, 2). The spectrum of violence against women is broad and inclusive of physical, sexual and psychological violence, including battering, sexual abuse, dowry-related violence, rape - including marital rape, female genital mutilation, sexual harassment and intimidation at work, trafficking and forced prostitution and violence related to exploitation (Garcia-Moreno and Stockl, 2013).

Violence against women is embedded in the overarching framework of gender inequality. It is argued here that violence against women has a structural component, and is rooted in the patriarchal ideology that legitimates the use of violence either as a disciplinary tool or as a controlling mechanism in the hands of the men to retain their power (Rebeiro et al., 2009). Violence, therefore, is a manifestation of unequal power division in society and also a mechanism to sustain the same. Davar, in this context forwards the view that, "women globally, and Indian women, live in a social environment where violence is an immediate reality, overriding socio-demographic differences of cultural background, class, education, occupation, etc." (1999, 98). Women grow up in an environment of fear and violence; violence meted out by the men, as mentioned above, is a sanctioned socio-cultural contrivance to put bridle on women's behavior and sexuality. Feminist perspective on violence, "proposes that violence against women is perpetrated by international agents in situations of control to manipulate and obtain specific, often but not always sexual, goals by the use of actual or implied threats to well-being or even survival of those in less endowed situations: Within feminist concerns, the international agents are usually men, and the victims, usually female" (ibid.). Though reprehensible women, across cultural spaces, are socialized to suffer violence with equanimity; nevertheless, violence has the most devastating impact upon women's mental (also physical) health and accounts for the prevalence of common mental disorders among them. Violence, therefore, is the most dominant stressor on women's mental health (ibid.). In spite of the humungous proportion in which violence is carried out against women, many forms of violence suffered by women are considered by them as shameful aspects of their lives and therefore remain under-reported (Garcia-Moreno and Stockl, 2013). Therefore, the data on violence against women is only indicative of the magnitude of the issue rather than an actual representation.

Women of the low and middle income countries, as established by several studies, are at greater risk of facing violence whether at home, public places or workplace for that matter. The conservative patriarchal structure of these countries fosters an

unpropitious climate for the women and endorses their victimization (Ceballo et al., 2004 cited in Rebeiro et al., 2009) Violence, as mentioned earlier, is a broad concept and may be perpetrated at psychological, physical, sexual and economic levels. Whatever the nature of violence committed, the same has the potential to trigger common mental disorders, alcohol and drug misuse and suicidal ideation. Women's victimization may occur at any time of their lives, however, having to face violence at sensitive phases of life, such in childhood or pregnancy, has been observed to have far-reaching implication on the women's physical and mental health. Maternal experience of violence is a major public health concern as it is associated not only with negative neonatal outcome (Ferri et al, 2007 cited in Rebeiro et al., 2009) but also mental health problems among the children (Bordin et al., 2009; Fleitlich and Goodman, 2001 cited in Rebeiro et al., 2009) .

Though violence against women is pervasive globally, local socio-cultural dynamics determines how the same is played out in a given context. Context specific dynamics of gender relation, moral values as well as cultural attitude towards violence determines the nature and extent of violence prevailing over a given society. Cross-cultural applicability of the definition of violence is rather problematic; anthropologists and women's health advocates have pointed out at the fact that what constitutes violent behaviour is variable across time and space. Universal classification systems cannot fully account for the cultural variance of the concept of violence, therefore, any study on violence has to be embedded in its particular context (WHO, 1996 cited in Niaz, 2013). Societies across the globe have reflected variable attitude towards violence ranging from bare tolerance to open endorsement. It may be worthwhile to recall here, Sanday's (1981 cited in Kalra and Bhugra, 2013) account of rape-free and rape-prone cultures which, as he explains, are shaped by the sociocultural values endorsed by a society. While the former is reflective of an egalitarian society where the rate of violence against women is low, the latter conjures the image of a hostile society adversely disposed towards women. In the context of the latter, male violence towards women is culturally endorsed therefore acts of violence such as rape abound therein. As an extension of this argument, one may draw from Otterbein (1994 cited in Kalra and

Bhugra, 2013) who, having studied a wide range of cultures, forwarded the view that cultures with rigid sex-role systems fan higher sexual violence. Cross-cultural anthropological and ethnographic studies of violence against women have dwelt upon the role of social and cultural mores, particularly those concerning gender relations, in the furtherance of violence against women. Cultures that endorse hyper-masculinity associated with dominance, aggression and male honour were found to be more hostile towards the women and reflected higher incidence of violence against the same (Campbell, 1985 cited in Niaz, 2013). Certain cultures reflect an outright support towards violence committed by husband to ensure that wives do not deviate from their socially designated duties (Dobash et al.,1992 cited in Niaz, 2013). "The sociocultural theory, thus, explains sexual violence in terms of social expression of male power or patriarchy. If one agrees with this hypothesis, it would mean that patriarchal societies will witness more sexual violence compared to the gender-equal societies" (Kalra and Bhugra, 2013, 248).

Patriarchal societies like that of India are built on the notion of male superiority over females. Manu, the ancient legal commentator on Hindu philosophy advanced the premise that women lack intelligibility and are morally frail; therefore, they ought to be under the perpetual guidance of their male counterparts i.e. their fathers, husbands and sons. The dictum of Manu enjoins women to revere their husband like God even if he were devoid of any merit. Under the dominant patriarchal ideology women's autonomy, authority and aspirations are severely curtailed. Other major religions of South Asia, whether Islam or Buddhism also promote an unfavourable culture of dominance and regimentation for the women and harp on male superiority, physical and spiritual. (Niaz, 2003). Thus, within a patriarchal set up male prepotence is well grounded which systematically disempowers women and makes them susceptible to male control whether through ideology or through application of brute force.

It has been observed that more women suffer from post-traumatic stress disorder and common mental disorders like depression, anxiety disorders etc. which is reflective of the morbific social circumstances women find themselves trapped in. Whether

domestic or otherwise, women remain vulnerable to violence which definitely has a deleterious impact on their physical as well as mental health. Studies focusing on the physical health effects of violence have indicated at victimization as a major health problem (Coker et al., 2000 cited in Jordan et al., 2010). The impact of violence on women's mental health is well established and, most forms of major nonorganic mental distress and disorder have been linked with interpersonal victimization of women (Jordan et al, 2010). The impact of violence is not limited to the individual alone but is palpable at the community and social level through secondary victimization, enhanced fear of crime, economic costs, and other indirect costs that impair quality of life (Crowell and Burgess, 1996 cited in Jordan et al., 2010). At this juncture, it may be relevant to draw attention to the sheer magnitude of the problem to gauge the global threat that violence against women poses. World Health Organization in its multi-country study on women's health has revealed that 15-71% of women (aged 15-49 years) have been subjected to physical and sexual violence by intimate partners at some point in their lives (2005, 2013 cited in Kumar, 2013). Similar studies in the Indian context is sparse, nevertheless, the small body of work on the subject concerned have yielded that 22-60% women have been victims of violence along the course of their lives (World Health Organization, 2005; Mahajan, 1990 cited in Kumar, 2013). In a study conducted in five districts of Uttar Pradesh (one of the largest states of India), 18 to 45 %, men admitted to have physically abused their wives (Narayana, 1996 cited in Niaz, 2013). Another study conducted in 1999 by Fikree and Bhatti, revealed that 34% of women were physically abused, 15% had been physically abused whilst pregnant and that 72% of the physically abused women were depressed (Niaz, 2013).

This chapter is an endeavour to study violence against women and the impact it has on their mental health. The mainstay of the present work is the argument that the incidence of common mental disorders among women can be traced to factors embedded in their social environment. In line with this argument, violence is being studied as a social stressor that has the potential to negatively impact mental health. In this chapter, the line of thought traversed is that exposure to violent episodes, whether physical or psychological, may be traumatic to the concerned individuals (in the present

context, the women who occupy the centrestage of the study) and therefore weigh upon their mental health. For conceptual clarity, it may be mentioned at this juncture that the researcher's understanding of violence has been guided by the definition of the same provided by the United Nations (1993) which encompasses the physical, sexual and psychological dimensions of violence. It would be rather myopic to envision violence as simply an act of abuse, without bringing within the purview of consideration its physical, sexual and psychological dimensions (Jordan et al., 2004 cited in Jordan et al., 2010). Recent works on violence against women have reflected sensitivity towards all the three dimensions of violence in order to gain a holistic understanding of the same. Violence against women may assume one of the following forms *viz*. physical assault, sexual assault, stalking and psychological aggression (Tjaden & Thoennes, 1998 cited in Jordan et al., 2010).

Physical violence may be defined in terms of behaviors such as pushing, shoving, slapping, hitting, kicking, biting, choking, burning, the use of weapons, or other form of aggression that may result in injury or death of the victim (Crowell and Burgess, 1996 cited in Jordan et al., 2010). Sexual violence as defined by the Centers for Disease Control and Prevention (Basile and Saltzman, 2002 cited in Jordan et al., 2010) and the World Health Organization (Jewkes, 2002 cited in Jordan et al., 2010) refer to sexually violating behaviours that may not qualify as crime in legal parlance, nevertheless, has deleterious effect on the individual's wellbeing. The term sexual assault, however, indicates at acts of unwanted sexual penetration or touch committed by the use of force, threat of force, or when the victim has been incapacitated or otherwise unable to provide consent (Koss & Achilles, 2008 cited in Jordan et al., 2010).

The scope of psychological abuse is vast and evades concise definition (Follingstad, 2007 cited in Jordan et al., 2010). While physical and sexual violence have physical parameters defining their nature and scope, the spectrum of psychological abuse is rather complex and obfuscates both professional and lay understanding of the juncture at which interpersonal interaction passes over into the terrain of psychological abuse. Unlike other forms of violence against women, psychological abuse "may require

several components to concur for the behavior to be labeled as abuse: (a) some type of objective consensus that the action in and of itself constitutes abuse; (b) some determination that the initiator intended maltreatment; (c) the perception of the recipient (that would include an idiosyncratic analysis incorporating context and relationship history); and (d) a determination that the action possesses the potential to psychologically harm the recipient" (Jordan et al., 2010, 610). To obtain some clarity on the matter one may fall back on the definition provided by Murphy and Cascardi which is pretty comprehensive and seems to incorporate most of the elements that constitute psychological abuse. They forward the view that psychological abuse is non-physical in nature and "...consists of coercive or aversive acts intended to produce emotional harm or threat of harm." (1993, 105 cited in Jordon et al., 2010).

The argument mooted in this chapter is that exposure to violence results in mental trauma which then weighs on one's mental health. In the context of the study, trauma is understood as the emotional response to a violent incident; further that trauma is a subjective experience, unique to the individual(s) concerned is also taken cognizance of. The word trauma is derived from the ancient Greeks which means wound. Trauma in medical parlance generally indicates a physical injury, however, trauma may well be understood as emotional or psychological wound. Trauma may be triggered by a violent event one has witnessed or personally lived through; its unique feature being that it causes far reaching effects that continue to exist long after the events that ostensibly caused the same cease to exist.

While different scholars have different takes on the onset, nature and definition of trauma, it is largely the subjective experience of an individual that determines what is traumatic for her/him. Nonetheless in an attempt to understand trauma, the following stands of thought may be referred to. Trauma may be viewed as a situation of extreme stress that overwhelms the traumatized person's ability to cope with the same (Giller, 1999). Trauma may also be understood as a situation when an individual experiences a threat to life, bodily integrity, or sanity. (Pearlman and Saakvitne, 1995, cited in Giller, 1999). Trauma experience has a subjective as well as an objective reality, the violent

events which one has had to encounter constitutes the objective reality while the emotional response or reaction to these events or incidents constitute the subjective reality. Jon Allen, a psychologist at the Menninger Clinic in Houston, Texas and author of *Coping with Trauma: A Guide to Self-Understanding* informs us that,

> It is the subjective experience of the objective events that constitutes the trauma...The more you believe you are endangered, the more traumatized you will be...Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness. There may or may not be bodily injury, but psychological trauma is coupled with physiological upheaval that plays a leading role in the long-range effects. (1995, 14 cited in Giller, 1999)

This argument harps on the idea that trauma is a subjective reaction; therefore, the same is not amenable to sweeping generalizations. What is traumatic for one may not be quite so for another. Trauma may be triggered by one time incidents such as accidents, natural disasters, crimes, surgeries, deaths, and other violent events or by chronic or repetitive experiences such as child abuse, neglect, combat, urban violence, concentration camps, battering relationships, and enduring deprivation. Trauma may also be triggered by natural catastrophe or by violence perpetrated by man (Giller, 1999). Whether one has experienced violence once in their life time or has lived through recurring episodes of violence, whether one has been on the throes of natural calamity or violence perpetrated by man, the experience may be traumatic for the concerned person. Women's social vulnerabilities expose them to traumatic episodes of violence, both in their personal as well as public lives, which bear upon their mental health. In this chapter, two aspects of violence have been studied to establish their link with common mental disorders prevailing among women.

The two aspects of violence chosen for the study include,

- ✓ Domestic violence and
- ✓ Sexual violence

Exploration of the present subject entails narrative enquiry, for which cases have been collected from Tezpur sub-division of Sonitpur district.

4.1.1 Domestic Violence and its Impact on Women's Mental Health

Domestic violence also termed as intimate partner violence (the two terms are often used interchangeably) may be succinctly explained as verbal, emotional, physical, or sexual abuse of, most commonly, women by their partners. This form of violence, whether actual or threatened, is all pervasive cutting across economic and ethnic status and socio-cultural barriers, and accounts for victimization of 10-69% women across the globe (Pico-Alphonso et al., 2006). WHO defines domestic violence as "a range of sexually, psychologically and physically coercive acts used against adult and adolescent women by a current or former male intimate partner" (1997, WHO/FRH/WHO/97.8 cited in Satyanarayana and Chandra, 2009, 15). According to the tenets of gender theories, domestic violence connotes the idea of male dominance wrapped within the larger ideological framework of patriarchy (Robertson and Murachver, 2007 cited in Alejo, 2014). Generally understood as violence perpetrated by male against female (Kishor and Johnson, 2006 cited in Alejo, 2014), domestic violence may as well imply violence perpetrated against men and also needs to be acknowledged in the context of lesbian, gay, bisexual and transgender relationships (Alejo, 2014). Though cognizant of the expanding domain of domestic violence, the researcher explores the subject with reference to male violence against women as the same befits the scope of the study.

World Health Organization (2009) surmises that domestic violence is a regular feature of societies that promote patriarchal values such as male dominance, regulation of women's autonomy and agency etc. (Keeling, 2014). The experience of domestic violence as well as the response towards the same varies across cultural, economic and political contexts , however, invariant remains the fact women are subjected to domestic violence in all societies and at all times. Alejo (2014) refers to the worldwide study undertaken by World Health Organization (2006) which conducted surveys in fifteen (15) sites in ten (10) countries from 2000 to 2003 to determine the prevalence of

domestic violence against women and revealed that in most sites 30% to 60% of women had been victims of domestic abuse; the absolute range being from 15% to 71%, with physical and sexual violence featuring as the most common. The study found that domestic violence against women is a common phenomenon across the globe , that women are more commonly abused by a partner than by an unknown perpetrator, and that domestic abuse, more often than not, tends to be severe and frequent (Garcia-Moreno et al., 2006 cited in Alejo, 2014).

In the Indian context, domestic violence is a social malaise that has spread its vicious tentacles all over and has wrought far reaching consequences. The following statistics provide an insight into the magnitude of the problem in the country. Studies conducted in India have revealed that 37 % of women in Tamil Nadu and 45 % in Uttar Pradesh have been subjected to physical violence by their husbands (Jejeebhoy and Cook, 1997 cited in Simister and Makowiec, 2008). In a study conducted in rural Gujarat, two-third of the women surveyed admitted to experiencing physical, psychological or sexual abuse in their lives (Visaria, 1999 cited in Simister and Makowiec, 2008). The practice of male violence in the Indian context is enrooted in the larger cultural ethos that legitimizes and rationalizes violence as an instrument of control, one that may need to be exercised in order to ensure that women do not fail the patriarchal ideals that strive to shape their lives, identity and social status (Delsol et al., 2003; Rao, 1997 cited in Simister and Makowiec, 2008). A recent study on Domestic Violence and its Mental Health Correlates in Indian Women by Kumar et al. (2005) report mental health correlates of domestic spousal violence based on a household survey method in both urban and rural areas of seven cities. About 40% of the sample reported experiencing violence in their marriage. They in turn were at increased risk for poor mental health. In spite of the fact that domestic violence is pretty common in India, very little data exists to support the claim. In fact the bulk of literature in this domain is provided by research conducted by developed countries. Poor orientation towards research coupled with the concern for family honor which prevents many a woman from disclosing their predicament are two important causes that account for scant data available on domestic violence in India (Satyanarayana and Chandra, 2009).

Bhargavi Davar (1999 cited in Kumar et al., 2005) in this context throws light on the rigidly defined roles of Indian women that hinders them from expressing their stresses and conflicts; these barriers ensure that their mental health needs remain neglected. In recent times several systematic endeavours have been launched, such as the population-based multi-centre collaborative project, the Study of Abuse in the Family Environment (India-SAFE), to generate adequate data on the magnitude of domestic violence in the country (Kumar et al., 2005).

Domestic Violence has emerged as a bane in the lives of women and has lent a telling blow both on their physical as well as mental health. Impact on physical health maybe accounted for in terms of cuts, bruises, bite marks, concussions, broken bones, penetrative injuries such as knife wounds, miscarriages, joint damage, loss of hearing and vision, migraines, permanent disfigurement, arthritis, hypertension heart disease, and sexually transmitted infections including human papillomavirus, which can lead to cervical cancer and eventually death (Abbot and Williamson, 1999; Coker, Hopenhayn, DeSimone, Bush and Crofford, 2009; McCaw, Golding, Farley and Minkoff, 2007 cited in Alejo, 2014). However, the impact on mental health warrants attention as it can presage the most deleterious effect on women and their lives.

Mental health problems that generally occur as a result of domestic violence include depression, alcohol or substance abuse, anxiety, personality disorders, post-traumatic stress disorder, sleeping and eating disorders, social dysfunction, and suicide ideation (Abbot and Williamson, 1999; Gerlock, 1999; Howard, Trevillion, & Agnew-Davies, 2010; McCaw et al., 2007 cited in Alejo, 2014). Garcia-Moreno and Stockl, 2013 refers to a systematic review published in 2012 to bring to fore the fact that women exposed to intimate partner violence were at 2 to 3 times increased risk of major depressive disorder and 1.5 to 2 times increased risk of elevated depressive symptoms and postpartum depression than women not exposed to the same. Further, it was revealed that 9–28% of major depressive disorder, elevated depressive symptoms, and postpartum depression could be attributed to lifetime exposure to intimate partner violence (Beydoun et al., 2010). In the context of India, a study of female psychiatric

outpatients with history of intimate partner violence, 14 % were identified as having PTSD (Chandra and Satyanarayana, 2009 cited in Herbeshetter and Math, 2014), in another study on urban women, 22.3 % of them were found to have suicidal thoughts and 3.4 % had actually attempted suicide (Vachher and Sharma, 2010 cited in Herbeshetter and Math, 2014). However, the paradox of the situation is that in clinical setting where physical symptom of women battered by intimate partners may be addressed, their mental health issues often remain undiagnosed and therefore evade proper treatment (Jackson, 2011). In this context, it may be worthwhile to note that while depression, anxiety, PTSD and dissociation are common psychiatric syndromes, associated with violence, in some cases, psychological or emotional disturbances may not amount to a syndrome; instead, sub-threshold symptoms may be apparent (Chandra, 2003 cited in Satyanarayana and Chandra, 2009). Nevertheless the sub-syndromal symptoms may in course of time blow into full-fledged pathology; therefore, the same also warrants attention.

Mental health squealae of domestic violence is significant; however, the same may not be triggered by the physical component of violence as much as by the psychological component of the same. Psychological violence may precede, follow or occur concurrently with physical violence and much of the mental anguish women suffer is owing to the latter (Delera, 2016).While the physical injury inflicted does take its toll on physical health; psychological violence wreaks havoc on mental health. Therefore, both the physical and psychological aspect ought to be accorded equal weightage in analyzing the impact of domestic violence on mental health. The cases studied in this chapter mull on both the physical and psychological aspects of violence in gauging how domestic violence impacts mental health.

To validate the argument that domestic violence negatively impacts mental health of the victims two cases are analyzed hereunder. Both the women are victims of domestic violence and reflect depressive symptoms. One of the common mental health consequences of domestic violence particularly that which stems from physical abuse is mood disorder, a condition in which one experiences persistent or episodic exaggeration

of mood state (Diagnostic and Statistical Manual of Mental Disorders, 4th edition, 2000 cited in Delara, 2016). Studies have revealed that victims of physical domestic violence were more likely to report mood disorder (Okuda et al., 2011 cited in Delara, 2016). One common form of mood disorder that has been observed in women who are victims of physical domestic violence is depression.

Case Illustration 2

Shilpi Das is a young girl of 18 years who was handed over to the NGO, North Eastern Regional Multipurpose School and Handicapped Training Centre at Balipukhuri, Sonitpur District by Gingia Police Station. Since then she has been an inmate of the NGO's shelter home. She is undergoing treatment at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur for depression and is relatively stable at present.

Hailing from an impoverished background she was married off at an early age. However, much to her chagrin her husband turned out to be an insensitive and boorish man. Within a few months of marriage he started assaulting Shilpi, verbally and physically. He was a demanding man who was critical of Shilpi's attributes, efficiency at housework and everything she did or said. She felt that she could never live up to his expectation, never be able to please him in spite of all her efforts. He was particularly abusive after consuming alcohol which, however, he did frequently.

Shilpi conceived early on in her married life. However, the continual abuse she faced from her husband had turned her into a wreck of nerves, as per her own admission. She lived in an appalling fear of her husband which turned worse during her pregnancy.

"*I was very sad during my pregnancy… I received no compassion or sympathy from him. I wanted to run away… but where would I go… I could not go back to my parents and shame them. With every passing day I became weak, but there was no respite for*

me… no time to rest. Sometimes I wanted to escape… but I had nowhere to go. I only prayed that my child would be delivered safely"

Eventually Shilpi gave birth to a girl. The baby was born with low birth weight; post-partum, Shilpi herself was frail. After the birth of her daughter, she received little support from her husband who continued to assault her physically and verbally. The worst incident to befall her was the death of her daughter within two months of her birth. As she recalls the incident her eyes well up with tears and she fails to speak any more. In subsequent interactions, it was learnt that the death of her daughter filled her with a feeling of guilt for not being able to take care of the little child. She recalls the incident as the end of all her hopes to live. Her life, she says was shorn of all purpose and meaning. She slipped into a state of depression and finally walked out of her husband's house. She was found wandering about by officers of Gingia Police Station who had then left her with the NGO personnel. After being handed over to the shelter home of the NGO, Shilpi is relatively better but has not been able to overcome her depressive symptoms completely. The feeling that she failed to protect her daughter gnaws her from within, she refuses to go back to her husband. Her father-in-law had come to visit her a couple of times, even tried to persuade her to go back but she refuses to go back to the house where her daughter had to die an untimely death.

An important aspect of the present case is that it calls attention to the adverse effects of violence during pregnancy, which has been associated with a wide range of risks such as threat to health and risk of death of the mother, fetus, the baby or both. Further, abuse during pregnancy has been associated with infant outcomes such as preterm delivery, fetal distress, antepartum haemorrhage, pre-eclampsia, and low birth weight (Campbell, 2002).

Jordan et al. (2010) explain that domestic violence precipitates a wide range of negative emotions such as dissociation, somatization, cognitive disturbances such as hopelessness, low-esteem and suicidality. Physical violence is concomitant with psychological violence, an interaction of both exercises the most unfavourable influence

on mental health as is evident in the case studied. Shilpi's depressive state may be traced to the volley of onslaughts she suffered in her marital life which had led her into a state of abysmal hopelessness, exacerbated particularly by the death of her child. The psychological onus of violence is experienced more palpably during sensitive phases such as pregnancy and post-partum, when women experience a range of emotions and stresses. In Shilpi's case, the physical abuse she suffered at the hands of her husband had already wrecked her and negatively affected her self-perception. Further, the death of her daughter overwhelmed her with guilt and hopelessness, a compendium of these emotions weighed upon her mind so much that she had sunk into a state of depression. As is apparent in the context of the present case, depression in battered women deepen as the violence they face interacts with other life stressors (Warshaw et al., 2009). Depression is one of the most common mental-health sequela of intimate partner violence. Depression that sets in on exposure to violence may exacerbate with subsequent episodes and result in greater disability and dysfunctionality over time as is evinced by Shilpi's case, whose prolonged exposure to violence intensified her depressive state.

Case Illustration 3

Ruma Nath, a woman in her 30s, was identified through the superintendent of the NGO, North Eastern Regional Multipurpose School and Handicapped Training Centre. She is presently residing in the shelter home of the NGO. Ruma was married to an alcoholic and abusive husband. Ruma's husband owned a tea-stall and spent a sizeable portion of his income on his drinking habit leaving a meager portion of the same for household expenses. Physical assault by her husband had become a routine affair of her life. The birth of her two sons had increased the demand on her husband's income and the husband and wife would always biker about the management of household expenses. Drinking habit of Rupa's husband had drained the resources of the house. Managing two square meals for the children was in itself a huge stressor, to top it the regular violence she faced from her husband made life doubly stressful for her.

"*Everyday abuse made me feel like an animal. I had given him two sons… yet there was no respect. He had no concern for the upbringing of our sons. It was a routine in the house… he would close shop in the evening , sit with his friends for drinks and come back home to beat me. Slightest protest on my part was not tolerated… my body would hurt all the time from the beatings… how much more would I tolerate. It was better to be on the streets than to be with him. I am angry with life…why did I have to face so much trouble in life."*

Rupa was not keen on expanding the family further owing to the perpetual financial crisis she was steeped in. However, her husband would force himself on her and she became pregnant for the third time. At this juncture, Rupa's mental health started deteriorating. She started having frequent and violent anger outbursts. As her behavior started reeling out of control, she was sent to her natal home. Her mother and sister brought her to LGBRIMH for treatment but never turned up to take her back. As her mental condition stabilized, she was handed over to the NGO where she delivered her third child, a daughter. Rupa is very much her former self, post treatment, however, she continues to have sporadic anger outbursts as conveyed by the superintendent of the NGO.

People who suffer from depression manifest symptoms of overt or suppressed anger. Depression has also been conceptualized as a kind of self-directed anger that reflects a propensity towards hatred and hostility. Anger is a common distress manifestation that has been observed in patients with depression (Fava et al. ,1997 cited in Sahu et al., 2014) In sync with this claim, many studies have recorded a positive association between the severity of depression and levels of hostility and anger experience. Several studies have revealed that patients with anger outbursts are significantly more depressed, anxious and nurture ideas of hopelessness (Sahu et al., 2014). In Rupa's case her anger outbursts can be attributed to the depressive state of her mind.

Further, studies have shown that the adverse effects of domestic violence reflect on one's esteem; trapped in the vicious cycle of violence women are morally shaken and

more often than not, perceive themselves in a negative light. Self- perception has a significant effect on mental health and several studies have pointed out that the association of domestic violence with depression can largely be attributed to low self-esteem, feelings of powerlessness, hopelessness, loss of control and coping responses (Delara, 2016). Further, control and coercion experienced by women in abusive relationships thwarts their autonomy and undermines their self-confidence (Harne & Radford, 2008 cited in Keeling, 2014). Learned helplessness, a situation where women perceive themselves as utterly helpless in the face of violence inflicted upon them and accept their lot as something they cannot escape from, is yet another dimension that merits consideration while attempting to explain the connect between domestic violence and mental disorder (Stewart and Cucutti, 1993 cited in Keeling, 2014 . The argument posited here holds water in the cases explored above and offers a framework for understanding how the two women's mental health was affected by the infelicitous circumstances of their lives.

The burden of psychological distress is further compounded by certain unfavourable factors of social environment such as poor health status, and reduced access to critical resources, all of which can create an unfavourable atmosphere for the women (Ruzek et al., 2007; Warshaw, 2001 cited in Warshaw, 2009). Scholars have identified certain risk factors that interact with the phenomenon of domestic violence to deepen its effect on women's mental health. Some of the risk factors include:

1. **Poverty**

   Empirical research has emphatically shown that lower income individuals experience more stressors and therefore are relatively more vulnerable to mental health difficulties, such as anxiety and depression than higher income individuals (Carbone-Lopez et al., 2006 cited in Delara, 2016). Women in poor households are economically dependent on their husbands, which increases the threat of physical assault in their lives (Romito et al., 2005; Pavao et al., 2007; Byrne et al., 1999 cited in Delara, 2016). These women are faced with enormous

social, physical and economic stressors, which in combination with domestic violence they are subjected to, are likely to increase their vulnerability to mental morbidities (Patel et al., 1999 cited in Kumar et al., 2005). Heise (1998 cited in Kumar et al., 2005) postulated that poverty probably acts as a marker for an array of social conditions that associated with domestic violence enhance the distress experienced by women and have the potential to culminate in PTSD, depression, and other emotional difficulties (Delara, 2016).

2. Education

Women who are poor and less educated are also found to be at greater risk of poor mental health as they lack the resources and defenses to insulate themselves against violence. Women without education experience greater sense of helplessness in their lives and are more exposed to a range of vulnerabilities including domestic violence. It has been found that higher levels of education of both the woman and her husband acted as a protective buffer against poor mental as the same inculcates better skills in coping with and dealing with stressful situations. Studies have revealed that low academic achievement is one of the risk factors predicting physical abuse of women by men (Moffitt and Caspi, 1999 cited in Kumar, 2005).

3. Alcoholism

Alcoholism has been shown, by several studies, as a risk factor for partner violence across varying settings (McCauley et al., 1995 cited in Kumar et al., 2005). Many researchers have forwarded the view that alcohol increases the likelihood of violence by reducing inhibitions, clouding judgement and impairing an individual's ability to interpret cues (Flanzer, 1993 cited in Kumar et al., 2005). Many women who are subjected to domestic violence have explained how their husband’s alcoholism was at the root of their violent behavior.

4. Social Support

> Social support is a significant determinant of mental health, (Coker et al., 2003 cited in Kumar et al., 2005) found that higher levels of emotional support can modify the effect of intimate partner violence on health. However, victims of domestic violence particularly from the low socio-economic rungs generally lack social support and therefore miss out on the favourable forces that could mitigate the effect of domestic violence in their lives.

The lives of the two women discussed here reflect all the attributes mentioned above e.g. the women are uneducated, are economically impoverished, lack social support and are married to alcoholic husbands. These negative factors therefore comingle to exacerbate the experience of violence and exercise a negative influence on mental health.

Next to depression, yet another mental health problem that, as suggested by existing literature, commonly occurs in women who have been victims of domestic violence is anxiety disorder (Meekers et al., 2013 cited in Delara, 2016). The disorder is characterized by fear and worry without reason (Wingood, 2000) and may manifest itself as post-traumatic stress disorder (PTSD). Women subjected to extreme physical and psychological trauma develop symptoms which are clubbed under the umbrella term, post-traumatic stress disorder (Walter et al., 2010). In this condition, the victim responds as though the traumatizing event or threat perseveres, long after the same ceases to exist, and therefore lives through haunting flashbacks and taunting memories of the same. In the face of traumatizing recollections the victim, as argued, manifests hyper-arousal symptoms (Koyama et al., 2005; Leibner et al., 2007, cited in Delara, 2016). Traumatic events leave behind psychic scars and mental wounds (Luckhurst, 2008) which linger long after the somatic wounds have healed. Freud (1920 cited in Luckhurst,2008) terms this as ‘repetition compulsion’, in which the “psyche constantly returned to scenes of unpleasure because, by restaging the traumatic moment over and

over again, it hoped belatedly to process the unassimilable material, to find ways of mastering the trauma retroactively" (Luckhurst, 2008, 9). According to Freud, traumatic events are wounding intrusions on the psyche and PTSD or the compulsion to repeat is viewed as a rearguard action to address the traumatic impact. Walter et al. (2010) articulate that due to traumatic experiences, "many patients suffer from prolonged complex disruptions of their somatic and mental functions, which are summarized under the concept of post-traumatic stress disorder (PTSD)" and that in PTSD "due to the neurobiological proximity and similarity of processing mechanisms of physical and psychological pain stimulation and extremely negative emotions, the patients often suffer from persistent pains even after the somatic healing process is completed" (465). PTSD, as Walter et al. infer, is more acute if the violence perpetrated is man-made which accounts for higher prevalence of PTSD among women who are particularly vulnerable to domestic violence or other forms of violent assaults such as rape. The nature of the traumatic event and 'reactivity' (Briere, 2004 cited in Delara, 2016), which is the self-perception of the victim, impact upon mental health outcome. It has been observed earlier in the chapter as well that severely traumatic episodes which strike a heavy blow on the self-esteem of the victim often lead to psychoses such as PTSD (Delara, 2016). Some studies have shown the comorbidity between PTSD and other disorders such as depression, which increases distress and disability of the victim and reduces the possibility of recovery (Shalev AY, Freedman S, Peri T, et al., 1998 cited in Hossain et al., 2010).

In the following case illustration, the narrative of a victim of domestic violence manifesting PTSD symptoms is discussed.

Case Illustration 4

Suranjana Devi is a woman in her late 50s who was identified though Tezpur District Mahila Samity (women's association). She has been living in the hostel of the Samity for the last four-five years. Suranjana is a married woman with two sons, who had an abusive marriage. Married at a young age, Suranjana had to live through

enduring turbulence all though her married life. Her husband, as told by her, was never attached to her as he had an extra-marital affair. She had never wanted to end her marriage and had put up with a lot of abuse in order to remain in the relation. Her husband would become extremely violent towards her and assault her so much that her body would bleed. Yet she hung on to her marriage as she had no place to go with her little sons. As narrated by her, she was desperate to make her marriage work, so much that she gave up her free will and followed every order of her husband, bore his assault without a word and performed all household tasks without complaining. In spite of all her efforts she failed to save her marriage. To her utter dismay, her husband eventually married the women he had an extra- married affair with. Even then she implored him to let her stay in the house as she had no means to support her children. Eventually Suranjana and her children were thrown out of the house.

"*I had borne all the assault without complain, I dared not oppose him when he brought the other woman home. I even put up with the beatings… all I wanted was to stay in his house with the kids. I had nowhere to go and, being uneducated, no means to sustain myself. My worst fear was to be turned out of my husband's house … to be left alone in the streets with my children, and that is precisely what I eventually had to face. I had become so helpless…so ashamed of myself. I gave up all my social ties…I did not want people to laugh at me. Had it not been for my sons, I would have given up my life."*

Suranjana on being turned out, found a rented accommodation and did petty jobs around the town to sustain herself and her sons. Her sons, with the passage of time got married and set up their homes and left their mother on her own. "*They are like their father*…", she ruefully commented to the researcher. Over the years, Suranjana has developed PTSD and somatic symptoms. Particularly at night, the memories of the yore haunt her and she screams out in pain. In fact, the other women who reside with her in the Samity's hostel complain of her screams at night. She visits Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, though not regularly, and has been prescribed medicines which help her provided she takes them on regular basis. Owing

to paucity of money, her visits to the institute of mental health are sporadic. Further she complains of abdominal and lower limb pain, clearly somatic symptoms, which according her has not subsided even after treatment. Suranjana's PTSD and somatic symptoms are the result of the assault meted out by her husband, memories of which have been etched in her mind and continue to haunt her. Her somatic symptoms could also be a reflection of the pain in her heart which seeks to resolve itself though bodily complains.

A striking aspect in this case which merits attention is the reclusive nature of the researched. Even in the hostel, she remains reclusive and incommunicable as conveyed by the other hostel residents. Interpersonal violence has been observed to impact sociability, openness to experience, dependency, assertiveness and trust and fosters negative emotions such as helplessness, anger, alienation, isolation (loneliness), and changes in beliefs and values (e.g. loss of invulnerability, lack of predictably) (Jordan et al., 2010). Many of the cited attributes manifest in Suranjana, which may be explained as the brunt she bears because of the violent past she has lived through.

Anxiety disorder may also be manifested as obsessive compulsive disorder (OCD). The subsequent case illustration exemplifies how psychological violence, perpetrated within the ambit of domestic violence may lead up to mental disorder, in the present case to OCD. Psychological violence can engender as much anguish as physical violence and, as evinced by several studies, has caused depression and anxiety disorders among victims of the same (Pico- Alphonso et al., 2006). However, the impact of psychological violence often evades clarity owing to "the subjective nature of the experience, the occurrence of it within interpersonal interactions and relationship contexts, the frequent co-occurrence of physical violence, and problematic measurement" (Jordan et al., 2010, 614). Maiuro (2001 cited in Jordan et al., 2010) provides a framework to explain the expanse of psychological abuse in which he hypothesizes the mental health outcome of the same as, (a) denigration of one's partner, intended to result in damage to self-esteem/self-concept, possibly leading to depression or anxiety; (b) withholding affection and nurturance, contrived at damaging

self-esteem (which is also a manipulative ploy aimed at producing submissiveness, probably leading to depression, learned helplessness, and/or a passive personality); (c) threatening actions, intended to frighten/intimidate, thus leading to anxiety, compliance, and passivity; and (d) restriction, intended to control the partner's actions, potentially leading to depression, passivity, and lack of sociability. Also termed as emotional abuse, it may be understood as a non-physical behavior or attitude intended to control, subdue, punish, or isolate another person through the use of humiliation or fear (Engel, 2002 cited in Karakurt and Silver, 2013). Psychological abuse may entail verbal assault, dominance, control, isolation, ridicule, or the use of intimate knowledge for degradation (Follingstad, Coyne, and Gambone, 2005 cited in Karakurt and Silver, 2013).

Marshall (1996) unravels six patterns of psychological abuse which include:

I. Severe violence but without denigration or control of finances
II. Moderate violence and sexual abuse
III. Low on abuse but enforced isolation
IV. Low level of violence with overt criticism and several types of control
V. Several types of overtly dominating and controlling abuse and lower levels of sexual aggression
VI. Similar to cluster V but with different patterns of help seeking

The case discussed here is a paragon of the impact of psychological violence on mental health. The effort in analyzing the case has been to reflect on how violence can be perpetrated at the psychological level which, even in the absence of overt physical harm, may have a traumatizing impact on the individual concerned and may very well result in mental disorders that encumber one's life.

Case Illustration 5

Aradhana is a 62 years old woman who was introduced to the researcher by a friend outside the Out Patient Department of Lokopriya Gopinath Bordoloi Regional Institute of Mental Health. A Resident of a small town in southern Assam, she had come to Tezpur on a visit to her brother's house. She visited the OPD of the institute with her

daughter, who was keen on a psychiatric consultation for her mother. It was learnt in the course of the interaction with the latter that Aradhana reflected symptoms of obsessive compulsive disorder. In her case, it was her obsession with washing herself clean, she would take bath several times a day… for prolonged hours to ensure she was clean enough.

Aradhana is a short and stocky woman married for the last 40 years to a doctor employed in a government hospital. She has a daughter from her marriage. Aradhana has been an overweight woman for much of her life which provoked much criticism from her husband. Her husband, as communicated to the researcher, was unhappy with her physical appearance especially her weight and subjected her to ridicule and scathing criticism owing to the same. After the birth of their daughter, Aradhana's husband became totally indifferent and neglectful towards her. He had a transferable job and would not take her along with him. Aradhana had spent most of her life alone with her daughter.

"*I have spent most of my life on my own. My husband wanted me to be slim…. But I could not lose weight. He would avoid taking me out with him… overtime even I felt hesitant to interact with his friends. I limited my social interactions… I developed an aversion towards my own self. A woman is worth nothing if she cannot please her husband…I was worth nothing because I failed to keep my husband happy*"

Aradhana sometimes faltered in narrating the events of her life. At this juncture her daughter would chip in to complete the narrative. Her relationship with her husband was strained. His constant ridicule of her appearance had taken a toll on her self-esteem. Though she craved for her husband's love and attention, her husband remained cold and distant. He never treated her with warmth, rather made it clear that he could barely tolerate her. The distance between Aradhana and her husband kept growing. With passing years Aradhana suffered great consternation as she realized that owing to her physical appearance she could never gain her husband's love and respect. However, the hardest blow inflicted on Aradhana was when her husband got embroiled in an

extramarital affair with a nurse he worked with. Her mental health started deteriorating from that point. She developed an obsession to keep herself clean and was driven by the compulsion to take bath over and over again least any speck of dirt remains on her body. It so appeared to the researcher that, Aradhana had developed a negative attitude towards her body owing to her husband's constant criticism of her physical appearance and that she was driven by the obsessive thought to wash off the perceived ugliness of her body.

Though her husband has come back to live with her after his retirement, Aradhana has not been able to overcome her obsession which has debilitated her life to a large extent. She has desisted psychiatric consultation so far. The visit to Lokopriya Gopinath Bordoloi Regional Institute of Mental Health was her first attempt to seek medical help. However, it is not known if she has continued with the treatment initiated at the institute.

Aradhana is an exemplar of the impact of psychological abuse on mental health. The criticism of her physical disposition, the lack of warmth in her husband's attitude towards her, her expulsion from the core of her husband's life and the overall dejection she experienced resulted in OCD in her case. Research, over the years, has shown how psychological abuse can negatively impact psychological well-being of victims so much so that psychologically abused women may tend more towards loneliness and despair than physically abused women (Loring, 1994 cited in Karakurt and Silver, 2013). Follingstad (1990 cited in Karakurt and Silver, 2013) identified five forms of psychological abuse *viz*. threat of ridicule; jealousy; threats to change marriage; restriction; and damage to property. Ridicule, as observed, is the worst form of abuse as it hurls a cruel blow on the victim's sense of self than any other form of abuse; such an abuse in all likelihood would shatter the victims sense of hope and security in the relationship leading to depression, low self-esteem and alienation from self and others (Sackett and Saunders, 1999 cited in Karakurt and Silver, 2013) Ignoring is also a serious form of abuse as it sends most negative signals about self-worth; it makes the one ignored feel as if she/he does not exist (Karakurt and Silver, 2013). Aradhana, as

revealed by the narrative, faced ridicule from her husband for her physical disposition and was also ignored by him. Drawing from Follingstad's argument, it becomes evident that ridicule and the feeling of being ignored by her husband were at the core of the mental travails she experienced. Aradhana's case is reflective of the dejection and despair one may experience as a result of psychological abuse and how these negative emotions experienced over time may culminate in neuroses.

Having attempted an exploration of the mental health sequelae of domestic or inter-personal violence, the next section deals with the impact of sexual violence on women's mental health.

4.1.2 Sexual Violence and its Impact on Women's Mental Health

Violence against women has assumed pandemic proportions (World Health Organization, 2011 cited in Keeling, 2014) and calls for attention of academicians, field interventionists and policy makers owing to the physical, sociological and psychological damage it causes to the victims. In this section the researcher studies the impact of sexual violence on mental health of women. The World Health Organization (WHO) defines sexual violence as "any sexual act or an attempt to obtain a sexual act, unwanted sexual comments, or advances, acts to traffic or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim in any setting, including but not limited to home and work." (2002, 149 cited in Kalra and Bhugra, 2013). Globally, approximately one in three women have been physically assaulted, abused or coerced into sex at some stage in their lives, by a known perpetrator in the majority of incidents (United Nations Human Rights, 2011 cited in Keeling, 2014). In the Indian context, National Crime Records Bureau, in its recent publications, has revealed that a crime is recorded against women every three minutes. Every hour, at least two women are sexually assaulted (Harbishettar and Math, 2014).

Violence against women is less of a simple casualty and more of a social phenomenon with patriarchal, misogynist, and gender-shaming undertones (Kalra and

Bhugra, 2013). Burt (1980 cited in Kalra and Bhugra, 2013) described rape as the psychological extension of a dominant-submissive sex-role stereotyped culture. Implicit in sexual violence are the elements of power, control, humiliation and domination; the collective impact of the same is pertinent in conceptualizing the harm caused by sexual violence to mental health. Mental health sequelae of sexual violence includes debilitating disorders such as depression, post-traumatic stress disorder (PTSD), anxiety disorders, suicidal tendency and sleep disorder (Dillon et al., 2013 cited in Harbishettar and Math, 2014). Somatoform disorders (such as headache, back pain, neck pain, joint pains or stomach cramps) also develop in victims of sexual violence, through which victims seek cure for their impalpable emotional distress routing the same through physical complaints (Harbishettar and Math, 2014).

Several studies have mulled on the possible outcomes of sexual violence, however, the fact remains that each victim responds in her unique way in the aftermath of the violent episode (Briere & Jordan, 2004 cited in Yuan et al., 2006). The unique response of the victim is shaped by the nature of the violence, personal attributes of the survivor, social support the victim is able to garner and the resources at her disposal; in other words, the distress experience of a victim is affected by a configuration of personal, social and circumstantial factors. Sexual violence may have short and long term psychological consequences. The immediate consequences may include shock, fear, anxiety, confusion, and social withdrawal (Herman, 1992 cited in Yuan et al., 2006), while long term consequences may manifest in PTSD symptoms such as flashback memories, sleeping disorders and emotional detachment (Rothbaum, 1992 cited in Yuan et al., 2006). Post-traumatic stress disorder (PTSD), a common fall out of sexual violence, is often comorbid with other mental health concerns such as depression, anxiety, somatoform disorders etc. Assault characteristics associated with PTSD symptoms include threat to life and injury (Resnick et al., 1993 cited in Yuan et al., 2006) and substantial use of verbal and physical force (Bennice, Resick, Mechanic, & Astin, 2003 cited in Yuan et al., 2006), which heighten the burden of trauma in the victim. While PTSD is one prominent manifestation of the harm done to the mental

health of the victim, depression, anxiety and other disorders are also recorded as residuum of sexual violence.

In the following section of the chapter, the researcher sets out to illustrate three cases of women who have developed mental disorders following their exposure to sexual violence.

Case Illustration 6

Lata Munda is an 18 year old girl who was offered shelter by the NGO, North Eastern Regional Multipurpose School and Handicapped Training Centre at Balipukhuri, Sonitpur District of Assam after she was handed over by Sadar Police Station to the same. She has been undergoing treatment at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur since then. At the time she was handed over to the NGO, Lata manifested depressive symptoms with intermittent anger outbursts. Though Lata has shown improvement after her treatment commenced at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, she still remains sad and depressed as was observed in the course of interaction with her.

Lata was studying in a school in Shillong, the capital of Meghalaya when she fell in love with a boy in her locality. The two had known each other for a year when the boy proposed marriage and coaxed her to elope with him. Deeply infatuated with her boyfriend, Lata gave in to his proposal and eloped with him to Guwahati. Much to her chagrin, her boyfriend's attitude changed towards her once they landed at Guwahati. Soon after reaching Guwahati, she was handed over to a group of boys. Abandoned in a land of strangers with a gang of abusers, Lata was confounded and terrorized about what was to follow. She was locked in a room for days as her abusers violated her; sometimes shifted from one place to another, her ordeal went on for days till one fine day she was abandoned on a solitary road by the abusers.

As Lata narrated her story, she recounted the pangs of betrayal she suffered for having been let down by someone she trusted blindly, the shock at the turn of events in

her life, the pain of being sexually abused by strangers. In the teeth of the violent event Lata, as per her own account, entered into a state of shock. It seemed like she developed situation specific amnesia, which is a temporary loss of memory due to a severely stressful event and is a common feature of PTSD.

"My mind went black…. I lost consciousness of time, place, and my sense of self…..where I came from….and where I would go. A dark cloud had covered my mind…I lost my ability to perceive the events surrounding me…I did not know what was happening ….I did not want to know. I wanted darkness to cover me… to cover my shame… my consciousness".

Upon being left on the streets, Lata wandered about without a sense of purpose or direction till she was picked up by police at Tezpur and handed over to the NGO. Lata had recoiled into a state of depression and would be hounded by memories of her abuse. Much after her treatment was initiated at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, was she able to recollect the address of her home. In the subsequent visits to the NGO, it was learnt that after persistent treatment Lata's mental condition stabilized and she was re-united with her family.

Lata, in the course of the interview would blame herself for her lot. According to her, had she not eloped with her boyfriend she would not have had to live through the ordeal. She kept repeating how her recklessness ruined her life and brought shame upon her parents. There is a prevailing sense of mistrust, loss of confidence, guilt, shame and feelings of helplessness particularly when the perpetrator of abuse is a closely associated person (Harbishettar and Math, 2014) which was clearly evident in Lata's account. The feeling of guilt she suffered from and the burden of negative emotions harbored deep within herself seemed to exacerbate her mental condition.

How survivors mentally process their experiences of sexual trauma is also related to mental health consequences (Halligan, Michael, Clark, and Ehlers, 2003 cited in Yuan et al., 2006). Many victims succumb to self-blame which leads to maladaptive beliefs

about ongoing life experiences (Koss and Figueredo, 2004 cited in Yuan et al., 2006). Victims often blame themselves for stepping into the trap of deception or for not having been able to escape the exploitative situation. Such maladaptive beliefs compound the distress experience of the victim and prevail heavily upon their mental health, as has been observed in Lata's case. Situations, such as sexual assault, which are perceived by victims as beyond their control are generally more distressful and evoke a process of blaming that would assume one of the following forms:

- ✓ Behavioural self-blame, when the victim levels blame on her behavior for the traumatic event
- ✓ Dispositional self-blame, when the victim blames her own personality traits for the traumatic event
- ✓ Vicarious control, when the victim perceives that some other person or entity had control over the occurrence of traumatic event (Frazier, 2003 cited in Chivers-Wilson, 2006)

Attributing blame to either or all of the above has been shown to have a potentially negative influence on mental health. In Lata's case her self-blaming attitude contributed to her distress experience and may be inferred as one of the compelling causes of her depression.

Case illustration 7

Bani is a young girl of 15 years, born to parents who are daily wage labourers. She along with her twin sister Buli lived with their parents in a small village in Sonitpur District. The sisters dropped out of school owing to poverty and the parents were keen on finding some employment for them. The girls' parents were approached by an agent who found the job of house maid for one of the girls in Siliguri. Buli, then 12 years old, was sent with the agent to Siliguri, on the assurance that she would get to visit her home at least twice a year and that her salary would be sent home every month. After a brief period at Siliguri, Bani was sent to serve another family at Delhi.

In the initial one year or so of Bani's employment at Delhi no problem was evident, however, with the passage of time the payment became intermittent and the family eventually lost contact with Bani. In the meantime Bani's twin sister Buli, having contracted jaundice, passed away. Bani's life on the other hand had taken an unprecedented turn when her employer started sexually abusing her. Any resistance on her part courted harsh beatings from the employer. As communicated by Bani, she was bound to the most inimical of circumstances; along with the burden of domestic work she had to shoulder and meager food she had to sustain herself on, she was regularly raped by the employer. The employer's wife being childless had to face the ire of her husband and would remain a mute spectator to her husband's abusive behavior towards Bani. Bani was continually intimidated by her employer, who needed the slightest provocation to thrash her, as she conveyed to the researcher. Stranded in a distant land with no one to fall back on, Bani had lost all hope in life. Mentally shattered and physically frail, Bani was finally able to steal some money from the employer and escape. Bani's mother recounted how saddened she was to see Bani in her present state. Bani had turned to a bag of bones and her personality had changed over the years. She seemed to be shrouded in a perpetual state of fear and avoided social interaction. She would frequently experience bouts of paranoia when she would fall on the floor, cry out as if someone was beating her and writhe in pain.

Further, Bani's mother shared her daughter's concern that the society would not treat her with respect owing to the fact that she was sexually violated. The conservative structure of the India society allows little space to victims of sexual assault. It has been observed, particularly in the context of South Asia, that the victims of sexual assault are further persecuted by the society which, more often than not, finds fault with the victims than the circumstances or the perpetrator. Sexual purity, so to say, is crucial in traditional societies like that of India. A violation of the same causes one to fall from grace and face social isolation. Bani's perception that society would persecute her further for her past added to her consternation and impelled her to withdraw from social interaction.

"*My daughter…infact both of my daughters were sociable. Once Bani came back, she was just a shadow of her former self…she had withdrawn into her cocoon and avoided interaction with others. She helps me in the domestic chores… but never ventures out of the house. She is always sad… teary eyed. If pushed too hard she prolapses into a state of paranoia. It is most excruciating for a mother to witness her child relive the pain she was in….. I curse the man that did this to my child…*"

Bani did not open up to the researcher completely; the snippets that she provided were largely supplemented by her parents to complete the narrative. However, it became evident that she was always in a state of fear, always wary of people who visited her house and always sad. The death of her sister further weighed upon her mind and intensified the feeling of desolation that shadowed her life. Though a lot more calm than what she was in the initial days of her return, Bani continued to be haunted by her past which had altered the course of her life forever. Her parents are planning a visit to Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, though at the time of interview no treatment had been initiated.

Bani's symptoms clearly align themselves with that of PTSD which is a condition caused by traumatic event such as trafficking, the memoirs of which continue to hound the victim over time. PTSD is diagnosed when symptoms last longer than one month (Saporta and Kolk, 1992 cited in Chivers-Wilson, 2006). Cognitive factors (such as a sense of defeat and confusion, negative appraisal of emotions and symptoms, avoidance and perceived negative responses from others) substantially influence the onset, severity, and outcome of PTSD after sexual assault (Derogatis L, Savitz, 2000 cited in Chivers-Wilson, 2006). If the survivor of sexual assault believes that others have failed to react in a positive and supportive manner towards her, there is a greater risk of PTSD (Breslau, 2002 cited in Chivers-Wilson, 2006). In the present case Bani's withdrawal and social avoidance was triggered by her perception that the society would fail to treat her with honor, which in the long run debilitated her social and psychological life.

Trafficking, a notorious global malaise that fosters sexual violence, is a bane that has particularly affected South Asia. UNICEF has indicated that the number of trafficked individuals from Asia (particularly South Asia) accounts for half of the trafficked individuals worldwide (Rasheed, 2004 cited in Eleni, 2011). Further, it has been revealed by studies that the prevalence of trafficking is more in Asia as depicted by the figures provided by the U.S Department of State (2010) which states that, whereas the prevalence of trafficking victims in the world is 1 per 1000 inhabitants, prevalence in Asia and the Pacific is 3 per 1000 inhabitants (Eleni, 2011). Some other records have brought to fore the fact that Asia reports the maximum number of trafficking cases a year, followed by former Soviet Union and Eastern Europe (Miko and Park, 2002; Watts and Zimmerman, 2002 cited in Eleni, 2011).

Being trafficked is a ravaging experience that leaves behind an indelible scar on the psyche of the victim. It has been argued by some researchers that sexual violence, which is integral to trafficking, is a harrowing experience and that trafficking and sexual abuse commonly cause PTSD (Farley and Barkan, 1998 cited in Eleni, 2011). Trafficking, it has been suggested, poses much more threat to mental health than singular acts of violence owing to the prolonged period over which the victim is exposed to traumatic events. The trafficked individual is exposed not just to sexual violence but also to chronic abuse, which typically includes threat on life; persistent stress and exposure to chronic danger (Zimmerman et al., 2008, Basoglu et al., 2005, Moisander and Edston, 2003 cited in Eleni, 2011). The burden of this experience is clearly palpable on the victim's mental health as in the case of Bani.

A compendium of sexual and psychological exploitation, trafficking causes untold distress to the victim. Sexual violence in itself is a devastating experience which is usually enforced through psychological control stratagem including intimidation, threats, lies, deception, and imposition of unsafe and unpredictable events in order to keep the victim insecure about the present and future and making the same compliant to the trafficker's demands (Zimmerman et al., 2008 cited in Eleni, 2011). The psychological coercion the victim is subjected to is analogous with the mental

manipulation employed by totalitarian regimes. Zimmerman et al. (2006) outline the stages in which the trafficked women are mentally broken. As articulated by them, the trafficked women are initially put through extreme survival conditions and forced to the brink of death; at a second stage they are physically drained of all energy through prolonged exposure to harsh working environment. Shorn of all physical and mental strength, the woman is mired in her situation, physically and psychologically (ibid.). Mentally defeated, dehumanized and disempowered, the victim is left with no option but to resign herself to the dictum of the trafficker, even if the same portends an end to her life (Logan et al., 2009 cite in Eleni, 2011).

The case discussed above also merits an exploration through the perspective childhood sexual abuse (CSA) which has been defined as sexual activity between a "child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person" (WHO, 1999, 62 cited in Vezina et al., 2013). CSA covers victims below 18 years of age and is found to commonly result in PTSD or dissociation (Vezina et al. 2013). Finkelhor and Browne (1985 cited in Vezina et al. 2013) propose a four factor traumagenics model to account for the manner in which sexual abuse distorts the abused children's self-concept and worldview and mediates their cognitive and emotional response towards the world. The four dynamics that affect the child's psychology and behavior include:

1. Traumatic sexualization, which is how the sexuality of a child, subjected, to abuse is distorted and shaped, often in an inappropriate and dysfunctional manner. These dynamics are, however, pertinent only to CSA and not any other kind of childhood trauma.
2. Betrayal, which the loss of trust in the perpetrator and other adults who are perceived as not having protected the child from being abused in the first place or not having supported her upon disclosure
3. Powerlessness, which is the feeling of frustration that overwhelms the child victim at not being able to alter the situation despite knowing that the same is a

gross violation of personal space. It is the state of disempowerment the child experiences as she/he is controlled by threats of injury and annihilation. The feeling of powerlessness is heightened when the victim lives through repeated and undesired invasion of the body through threat and deceit.

4. Stigmatization, which is the internalization of negative perceptions, reinforced by the perpetrator's manipulative discourse or by the negative attitude of the society towards the victim.

It may be therefore inferred that in Bani's case the interplay of these four dynamics have distorted her self-conception as also her attitude towards the world which thereafter manifested in social avoidance, a dysfunctionality that is distinctly palpable in her.

Childhood victimization, as claimed by research in this domain, results in poor mental health in adulthood. However, this association is mediated by a host of physiological (e.g., allostatic load), psychological (e.g., self-esteem), social (e.g., social support), behavioral (e.g., substance use), and structural (e.g., socioeconomic status) factors (Kendall Tackett 2002; Springer et al. 2003; Watts-English et al., 2006 cited in Hill et al., 2010). Two important mediating factors that merit mention here include social support and self-esteem.

Some studies have shown that perceived social support is a significant mediator of the effect of childhood victimization on depression, nonspecific psychological distress, and post-traumatic stress disorder in adulthood (Runtz and Schallow 1997; Shaw and Krause 2002; Vranceanu et al., 2007 cited in Hill et al., 2010). Social support towards the victimised may exercise a buffer effect on the psychological consequences of childhood abuse by encouraging positive psychological dispositions (e.g., self-esteem) and stress appraisals (e.g., from knowing that one has a support network), and by promoting constructive coping strategies (e.g., problem focused coping) and behaviors (e.g., support-seeking) (Cohen and McKay 1984; Cohen and Wills 1985; Wills 1985; Thoits 1995, 1999 cited in Hill et al., 2010). Arguably, social support through the

mechanisms cited above has the potential to lessen or even counteract the lingering impact of traumatic experiences, interpersonal problems, and/or feelings of powerlessness and worthlessness (Hill et al., 2010). In Bani's case the perceived lack of social support, as already explained, negatively impacted her self-esteem and proved inimical to her mental health.

Studies also establish the connection between childhood victimization and poor self-esteem in adulthood (Bradley et al., 2005; Brown, Craig, and Harris, 2008; Banyard, 1999; Briere and Runtz, 1990; Gold, 1986; Griffing et al., 2006; Mullen et al., 1996; Sappington et al., 1997; Stein, Leslie, and Nyamathi, 2002; Turner and Butler, 2003 cited in Hill et al., 2010). The memories of childhood victimization leave behind feelings of humiliation and shame (Banyard, 1999; Brown, Craig, and Harris, 2008; Turner and Butler, 2003 cited in Hill et al., 2010) which in the long run may make the victim feel worthless and unlovable (Kendall-Tackett, 2002; Irving and Ferraro, 2006; Shaw and Krause, 2002 cited in Hill et al., 2010). The burden of negative emotions, thus experienced, may result in poor self- esteem. Studies consistently have shown that self-esteem is associated with better mental health (Thoits 1995, 1999 cited in Hill et al., 2010), and that poor self-esteem is an important predictor of mental disorder. Whereas positive self-esteem may be able to alleviate the feelings of worthlessness and shame that are often associated with victimization in early life, absence of the same may stimulate common mental disorders such as depression and anxiety disorders. In Bani's case the connection is self- evident; her perceived lack of social support impacted her self-esteem which thereafter brought about behavioural dysfunctionality in her in the form of social avoidance.

Case Illustration 8

Ankita Hajong is a married woman in her early 30s who was handed over to the NGO, North Eastern Regional Multipurpose School and Handicapped Training Centre by Department of Psychiatric Social Work – Lokopriya Gopinath Bordoloi Regional Institute of Mental Health. Since then she has been in the shelter home of the NGO

where the researcher met her. Ankita had come across as an attractive and lonely young woman.

Ankita had been married for a few years and had a son. She had occasional fights with her husband, who after consuming alcohol would sometimes thrash her. After a spat with her husband over his drinking issues she walked out of their house and headed towards her natal home, where her mother and sister rebuked her for leaving her husband's house. Ankita narrated how, spurned by her mother and sister and not keen on returning to her husband's house immediately, she was wandering along the desolate streets when a Central Reserve Police Force (CRPF) vehicle forcefully picked her up. She was taken to the CRPF camp and locked inside a room for months. Thus began her ordeal, when day and night she was raped by the CRPF jawans.

"*At first I could not fathom what was awaiting me. I had never thought that such would be my plight… I pleaded with them to let go of me…all my pleas… my tears fell on deaf ears. At any time of the day and night…they would come and do bad things with me. After fighting in vain for long I became numb… I closed my eyes… I let darkness swallow me…I let things be. I was no longer Ankita…. I was an object…a material they wanted to enjoy"*

Ankita, during her captivity, was kept under vigil and always threatened with guns least she attempted to escape. She was held hostage for almost two months before she was released. She was left on the highway, she says, where she had wandered aimlessly for days till she was picked up by the police. The Superintendent of the NGO told the researcher that Ankita was delirious when the police took her in their custody, therefore she was handed over to Lokopriya Gopinath Bordoloi Regional Institute of Mental Health where she had undergone treatment before being handed over to the NGO. She would get hysterical at the least provocation and behave in an erratic manner as communicated by the Superintendent of the NGO. It is important to note here that Ankita had been impregnated during her abuse and was five months pregnant when the NGO took her in. In course of time she gave birth to a girl.

The incident left its dent on her physical and mental health and she continues to be depressed and unreasonably anxious, even though her treatment at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health has stabilized her to quite an extent. Ankita had expressed her desire to unite with her husband, who was thereafter contacted by the NGO. However, he refused to take her back since she was sexually violated and had borne an illegitimate child. Rejection by her husband struck a hard blow on her already battered condition. Though stable to a good extent, Ankita remains depressed and reflects sporadic outbursts of anger.

Rape is one of the worst forms of sexual onslaughts and has far reaching repercussions on the victim's mental health. Studies have revealed that high rate of depressive disorders prevail among rape survivors (Dickinson et al., 1999 cited in Yuan et al., 2006). The mental health effects of rape have been a preoccupation with many scholars; nevertheless, it is difficult to fathom how devastating it could be to the victims' emotional well-being (Campbell, 2002 cited in Campbell, 2008). Many a woman experiences trauma owing to the fundamental betrayal of their sense of self, identity, judgment, and safety they experience in a rape situation (Janoff-Bulman, 1992; Koss et al., 1994; Moor, 2007 cited in Campbell, 2008). Studies conducted in the West have shown that between 31% and 65% of rape survivors develop PTSD, and 38% to 43% meet diagnostic criteria for major depression (Kilpatrick and Acierno, 2003; Kilpatrick, Amstadter, Resnick, and Ruggiero, 2007; Koss et al., 2003 cited in Campbell, 2008). These sequelae are largely brought about by the trauma associated with rape, nevertheless, the impact of rape on mental health is modified by the co-occurrence of other negative life experiences such as severity of assault, lack of social support, economic instability etc. In the case of Ankita, the incident of rape was not a one-time traumatic event, rather she lived through the horror of repeated sexual assaults for two months. Further, the birth of the illegitimate child and the rejection from her husband added to the bulk of negative life events which crushed her morale and pushed her to the brink of emotional breakdown.

The psychological distress experienced by victims of rape may include damaged sense of worth, feelings of objectification, and self-blame (Goodman, Koss and Russo, 1993; Herman, 1992; Kimmerling and Calhoun, 1994; Rothbaum et al., 1992 cited in Wasco, 2003) which impact the recovery process of the victim. Ankita had undergone a grueling experience which made her feel no more than a commodity of pleasure and had obviously dealt a blow to her sense of self-worth, which was further exacerbated by the outright rejection she received from her husband. In addition to psychological and emotional aspects of distress and shame, rape may cause harm to physical and sexual health as well (Campbell, Sefl and Ahrens, 2003; Golding, 1994, 1996 cited in Wasco, 2003). Ankita was reeling under the dual impact of rape on her physical as well as mental health. Brutalized by a throng of jawans and rejected by her husband, Ankita was mentally devastated; to add to her woes she became pregnant and subsequently gave birth to her daughter who was no more than an illegitimate child in the society's perception. These compounding stressors, all of which were beyond her control, steeped her into deep depression. Frazier (2003 cited in Yuan et al., 2006) found that survivors' perceptions of past control (i.e., control over the assault), present control (i.e., control over recovery process), and future control (i.e., control over future victimizations) were related to post-trauma distress. Women who perceived having less or no control over any or all of the three aspects tend to wallow up in an overriding feeling of helplessness and therefore experience a heightened sense of distress.

Rape trauma syndrome (RTS), which occurs in the aftermath of rape, is characterised by three phases (Antonopoulou, 2006 cited in Chivers-Wilson, 2006). The acute phase occurs immediately after the assault when the survivor is steeped in crisis and experiences a volley of turbulent emotions. These reactions may be categorized as 'expressive', such as shaking, crying or yelling; or 'controlled' such as flattened affect, appearing outwardly calm and subdued. The second phase is 'outward adjustment', when the survivor focuses away from the assault, often with a high level of denial, and submerges herself in normal daily activities. The final phase is 'long term reorganization', in which the survivor integrates the assault into her self-perception and resolves her feelings about the assailant. During all these phases the interplay of shame,

guilt, anxiety or depression experienced by the victim and the support from family, friends or authorities determine the distress experienced by the victim (Breslau, 2002).Positively configured, these can reduce the distress experienced and negatively configured, the same, play a counter-productive role. In the case of Ankita, no support seemed to be forthcoming from her husband or her natal family. However, the NGO is providing her with the support she requires and is aiding her towards recovery. It is hoped that in the absence of family support, the empathetic and congenial environment provided by the shelter home of the NGO offers her the much needed opportunity to make peace with her past and to reorganize her life. The treatment she is undergoing and the consultation she is receiving at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health would perhaps be able to assuage the negative emotions she is experiencing at the moment and support her towards active rehabilitation.

Summation

In an attempt to understand how social factors affect mental health, the present chapter has studied violence as a stressor one needs to reckon with, as the same is laden with the potential of negatively impacting mental health. Women are more vulnerable to violence owing to the patriarchal structure of societies across the globe. In the context of India, women are particularly vulnerable to violence because of the structural factors that are unfavourably disposed towards them. Two aspects of violence *viz*. domestic violence and sexual violence have been studied in relation to mental health. A range of mental disorders have been discussed e.g. mood disorders like depression and anxiety disorders like post- traumatic stress disorder and obsessive compulsive disorder. It has been argued that violence causes mental disorders, particularly among women who are exposed to a host of vulnerabilities that makes them victims of violence. Common disorders resulting from an exposure to violence have also been dwelt upon in this chapter; however, it is to be noted that the disorders triggered by exposure to violence may well be beyond the range studied here. The variability and complexity of response to violent situation issues out of complex interaction of personal, structural and psychological factors, therefore an accurate prediction of the same is not plausible. The

next chapter studies the manner in which mental distress experienced by women is communicated by them through dissociative behaviours, as an extended exploration of socio-cultural influences on mental health of women.

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