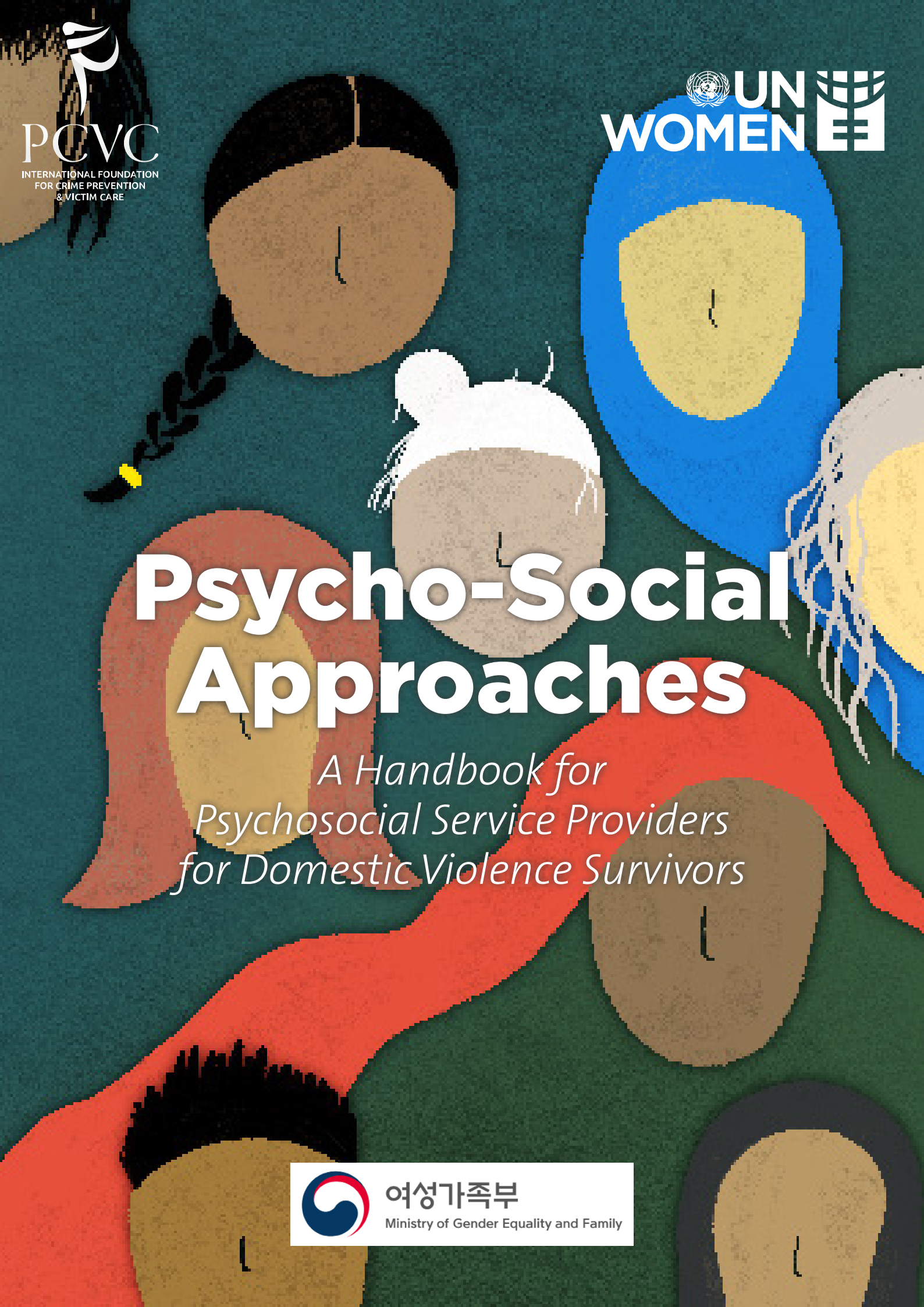

PCVC
INTERNATIONAL FOUNDATION
FOR CRIME PREVENTION
& VICTIM CARE
UN WOMEN
Psycho-Social Approaches
A Handbook for Psychosocial Service Providers for Domestic Violence Survivors
여성가족부
Ministry of Gender Equality and Family

Developed by
International Foundation for Crime Prevention and Victim Care (PCVC)

With support from
UN Women, Office for India

Suggested citation:
Psycho-Social Approaches: A Handbook for Psychosocial Service Providers for Domestic Violence Survivors, International Foundation for Crime Prevention and Victim Care (2023).

Layout and cover design by Skillskapes Pvt. Ltd.

Typeset in TheSans and Gotham.
Layout and cover design by Skillskapes Pvt. Ltd.

Publication Year: 2023

Psycho-Social Approaches:
A Handbook for Psychosocial Service Providers for
Domestic Violence Survivors

This handbook is dedicated to
all survivors of gender-based violence
who are entitled to a life free of violence

and all service providers who work so very hard
to ensure that that becomes a reality.

Foreword

Globally 1 in 3 women are subjected to sexual or physical violence in their lifetime by their partner/non partner and this data has unfortunately remained unchanged in the last decade (WHO, 2021).Domestic violence is also a significant issue in India, with many women experiencing it but few reporting it. It has a severe impact on their mental and physical health, making it essential to have empathetic support services available at all times. However, during the pandemic, it became clear that apart from uninterrupted availability, these services also needed to be customized to meet the specific needs of women and queer individuals.

To address this gap, in 2022 UN Women partnered with the International Foundation for Crime Prevention and Victim Care (PCVC) on strengthening response and service provisioning for gender-based violence in Tamil Nadu, as part of the Ministry of Gender Equality and Family, Government of South Korea funded "Gender-responsive COVID-19 recovery in India" programme. As part of the project, UN Women supported in creating two handbooks and a support services directory to provide survivors with information about domestic violence, legal rights, psycho-social support and other available support services.

The handbooks are easy to understand and will help empower individuals on how to address domestic violence and provide information on how to offer support effectively by service providers, family, friends, community members, faith-based leaders, and others to survivors and those at risk of violence. Both the legal and psycho-social handbooks act as a handy and ready reference for firsthand responders. The handbooks' questions are based on the lived experiences of survivors and service providers, ensuring that the content is relevant and helpful.

The directory provides district-wise details on service providers in the state. I am certain that it will benefit survivors and will become a handy resource for various stakeholders working with violence against women and girls.

PCVC was among the very few organisations that was able to keep its shelters open and fully operational during the pandemic. PCVC's best practices, shared through the handbooks and directory, were crucial during the pandemic when many support services were unavailable. I thank them for sharing their knowledge and expertise with all stakeholders, especially service providers and families, through the handbooks and the directory.

Supporting survivors of domestic violence requires empathy and sensitivity. I hope that the handbooks will allow service providers and firsthand responders to reflect on their own practices and empower family and community members to intervene at a personal level. By building a crisis-resilient and sensitive support network across the country, we can create an enabling environment for women to speak up and report violence and access the help they need to rebuild their lives.

Thank you.

Susan Jane Ferguson

Country Representative, UN Women India

Contents

1

Setting the Context: An Introduction to the Handbook

1.1. Who We Are: An Introduction to PCVC

The International Foundation for Crime Prevention and Victim Care (PCVC) was founded in 2001 in Chennai, Tamil Nadu to create and extend support services for women affected by domestic and interpersonal violence. PCVC is a rights-based organization that strongly believes in a survivor-centric approach. Women drive the process and make all decisions regarding their life with the full and unconditional support of a team of social workers, psychologists and welfare officers.

Over the past 2 decades and more, the organization has evolved to provide both emergency support and long term rehabilitative support to women and queer survivors. The prime focus at PCVC is to ensure that we employ a gender-just, DV-informed, trauma-informed, rights-based lens to our work and create an enabling environment for survivors that will facilitate more equal and just interactions with patriarchal family and societal structures and institutions so we can all live violence-free lives.

PCVC's work as a specialized domestic violence service provider has informed the creation of this handbook and many of the strategies and tools shared in this resource is a direct output of the work we have done with survivors for the past 22 years.

1.2. Why a Handbook

Domestic violence is a significant public health issue and one of the most prevalent forms of gender-based violence against women (NFHS-5, 2019-2021). Supporting the development of healthy, respectful, and nonviolent relationships can reduce the occurrence of domestic violence and prevent its harmful and long-lasting effects on individuals, families, and the communities where they live. Addressing domestic violence within communities and providing robust support services is also a crucial element in such prevention efforts.

If we look at the service landscape today, most service providers offer broad-based support that cover a range of issues that impact women and to a much lesser extent, queer individuals. However, the particular concerns of women and queer individuals subjected to intimate partner violence or family violence or both are not adequately addressed by the system. Specialized and targeted services for domestic violence are largely absent and the nuances of how domestic violence manifests, operates and impacts survivors is not taken into account when services and interventions are built.

Service providers across TN, whether it be the police, OSC, CSO, DSLA or protection officers offer psycho-social support to survivors who reach out to them, often in the form of counseling. There is a lacunae when it comes to training and understanding of psycho-social support across service sectors which needs to be addressed. There is a need to go beyond counseling and look at psycho-social support in a holistic manner to strengthen services. Here, psycho-social support looks at psychological, legal, medical, social, spiritual and cultural factors that influence the experience of violence and provide a range of services that meet the critical needs of survivors and help in promoting well-being , social support and connectedness, efficacy and sense of safety.

Survivors experiencing violence often reach out to family, friends, community members, religious leaders and a range of other personal support systems before reaching out to service providers. By the time they reach out to service providers, they have exhausted many avenues of support and may be emotionally and physically traumatized and feeling helpless and vulnerable. They require understanding, care and support

and this handbook supports service providers in offering that care.

Footnote

"Queer individuals are those who do not conform to traditional societal norms of gender identity, sexual orientation, or sexual behavior. As noted by the American Psychological Association, "queer is an umbrella term for sexual and gender minorities who are not heterosexual or are not cisgender" (American Psychological Association, 2019). This term includes individuals who identify as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and other non-binary identities. Some members of the LGBTQ+ community have reclaimed the term "queer" as a way to resist heteronormativity and express their non-conforming identities.***"American Psychological Association. (2019).***

1.3. Intended Audience of the Handbook

This handbook is primarily for service providers working with women and queer persons who have survived or are experiencing domestic violence and was conceived as a resource that might help plug the gap and allow various service providers - CSO's, police, protection officers, OSC's etc. - to adapt existing services and modes of approach to addressing the needs of survivors of domestic violence sensitively. This handbook is not focused only on counseling and looks at psycho-social support as a front-line support that can be offered by various stakeholders in the service ecosystem.

Although this handbook has been developed for domestic violence service providers, the following group of people are likely to find this handbook relevant and helpful:

- Women and queer persons who may be survivors of domestic violence and would like to understand and contextualize their own experience and the kind of care they are entitled to receive.
- Family and friends of survivors who would like to understand what their loved one is going through and available resources for support.
- Healthcare staff who are often the first points of contact for many domestic violence survivors (survivors are more likely to seek medical support before reaching out to other institutional support mechanisms). This handbook might support in understanding domestic violence and its signs so that early identification and referrals for support is possible.
- Social workers/NGOs working in other spheres who want to embed domestic violence response within their work.
- Legal professionals who work on cases of domestic violence.
- Policy makers who would like to understand domestic violence response.

1.4. What to Expect from the Handbook

The handbook serves as a resource for service providers to develop their understanding of domestic violence - its causes, manifestations and impact and reflect on their own practice and how to provide care, improve access to resources, connect to necessary services in a way that upholds the rights and choices of the survivor.

This handbook offers information and suggestions on how to respond effectively and provide appropriate. The handbook covers the following:

- Awareness about Domestic Violence
- Barriers to Support
- Introduction to the Psychosocial Approach
- First-line Support and Beyond
- Understanding Service Flow
- Domestic Violence and Mental Health
- Collective Care and Self Care

By the end of the handbook, you should be able to:

- Understand the forms of violence and how it impacts an individual's mental health and well-being.
- Understand the barriers to accessing support and how to overcome these challenges.
- Learn basic skills and strategies to support people experiencing domestic violence.

There are a few guiding principles to remember when going through the handbook.

Person-centred Care: Empowering people to take charge of their health and well-being. The person's views, input and experiences inform the intervention. This requires providers to give priority to the person's lived experiences and maintain a collaborative and respectful approach.

Rights-based Approach: People are born with fundamental rights including the right to live a life free from violence and the right to make their own decisions. A human rights–based approach is about empowering people to understand and claim their rights and strengthening the capacity and accountability of people and institutions that are responsible for respecting, protecting and fulfilling rights. This approach prioritises those who are marginalised, excluded and discriminated against and ensures they not only receive requisite care but participate freely and meaningfully in the intervention.

Sensitivity: Existing power dynamics determines how people treat one another and their access to resources. Providers must be aware of the power imbalance that perpetuate violence against women and queer persons.

A note on the terminology used in the handbook

Throughout this handbook, the term 'person' or 'people' have been used to describe individuals who identify as women or queer. The pronouns used are 'they' because it encompasses different identities and is the most inclusive language choice available. However, sexual and gender identities are fluid (Fontanella et al., 2013), and it is impossible to ascertain if people would continue to identify with the language used in the handbook. If labels have been used, they have been used purely to categorize and understand unique needs of different communities with the caveat that they should not be considered permanent or fixed.

2

What We Need to Know About Domestic Violence

2.1. Gender-Based Violence: An Introduction

The United Nations, in its Declaration on the Elimination of Violence Against Women (1993), defines 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". It is rooted in discrimination and inequality and existing power dynamics that is skewed in favour of men. Gender-based violence (GBV), or violence against women and girls, is a global pandemic with one in three women affected by it across their lifespan (WHO, 2013).

Women and queer persons have less power than men in different spheres of their lives, including their bodies, decisions, and resources. Society condones men's use of violence as a form of discipline and control. This reinforces gender inequality and perpetuates gender-based violence.

GBV takes numerous forms: intimate partner violence, sexual and physical violence, child marriage, female genital mutilation, trafficking for sexual exploitation, female infanticide and 'honour' crimes. It also includes denial and discrimination of opportunities of services on the basis of gender.

2.1.1. Domestic Violence: Intimate Partner & Family

Domestic violence (DV) is the most common form of violence against women. It can be explained as a pattern of behaviour in a relationship that is intended to establish control and fear of the woman through violence (Kaur & Garg, 2008). This violence can take the form of physical assault, psychological abuse, financial abuse, or sexual assault, and these often overlap. The frequency of the violence can be on and off, occasional or chronic and can take place between couples, within families, households or communities.

The violence experienced within an intimate relationship (married, unmarried or live-in) that causes harm to those in the relationship is defined as Intimate Partner Violence (IPV) (WHO, 2002). IPV occurs across different socioeconomic, cultural, and religious groups. Although women can be violent in relationships with men, often in self-defense, and violence sometimes occurs in same-sex partnerships as well, the most common perpetrators of violence against women are male intimate partners or ex-partners. By contrast, men are far more likely to experience violent acts by strangers or acquaintances than by someone close to them (WHO, 2002).

Intimate partner violence is conceptually different from domestic violence. Domestic violence includes all types of family violence such as elder abuse and child abuse; however, IPV is limited to acts of aggression between intimate partners (Cunradi, 2010).

Queer individuals are deeply impacted by family violence because of their identity - not conforming to expected gender boundaries, refusal to marry, seeking gender affirmative procedures - and invites punitive action in the form of threats, intimidation, forced marriage, corrective rape and conversion therapy. Domestic violence occurs in same-sex and opposite-sex romantic relationships, as well as in relationships in which one or both partners identify as transgender or genderqueer (National Coalition of Anti-Violence Programs [NCAVP], 2012). When it comes to queer relationships, the person may become their source of validation for their identity and for reducing the sense of isolation. LGBTQIA+ (lesbian, gay, bisexual, transgender) abuse in intimate relationships is regarded as rare. Bisexual and lesbian relationships are

often idealised as being peaceful and utopian (Barnes, 2010). Such a stereotype, among many others, can be an obstacle to lesbian persons in recognizing that a partner's behaviour is abusive (Seelau & Seelau, 2005). When abuse doesn't follow gender normative scripts, it can increase isolation and make it much more difficult to identify harmful dynamics of control. Research suggests that queer persons face barriers to seeking help that are unique to their sexual orientation and gender identity (Brown & Herman, 2015). These obstacles are listed below:

- Legal definitions of domestic violence exclude same-sex couples
- Dangers of 'outing' and the risk of rejection and isolation from family, friends and society
- A lack of awareness about available queer -specific resources
- Potential queerphobia from service providers
- Low levels of confidence in the sensitivity and effectiveness of law enforcement and court officials for queer persons

2.1.2. Scope of the Problem

In 2021, the National Crimes Reports Bureau (NCRB) reported that 318,000 cases under crimes against women were recorded under the Section 498A of the Indian Penal Code (IPC) within the category of 'Cruelty by husband or his relatives'. The increasing number of cases of domestic violence in 2020, particularly during the lockdown, was also highlighted by the National Commission for Women (NCW). Additionally, in the same year, it found that every 9 minutes a woman died by suicide, and the leading cause was reportedly family problems.

The National Family Health Survey (NFHS- 5, 2019-2021) reported a 24% increase in physical and sexual intimate partner violence in the last 12 months. Tamil Nadu, alone, experienced a 16% increase in crimes against women in 2021. The most commonly reported crimes against women in the state include dowry death, female infanticide, trafficking and acid attacks. Domestic violence impacts millions of women worldwide. It infringes on their fundamental human rights and has devastating consequences for their health and well-being.

The NCRB data also indicated an underreporting of cases of domestic violence. Only 507 cases were registered in the country under the Domestic Violence Act in 2021- 0.1% of the total cases of crimes against women. Underreporting occurs for various reasons, both personal (shame fear of retaliation, economic dependency) and societal (imbalanced power relations, victim-blaming/punishment). Furthermore, social norms governing the sanctity of the family unit and the institution of marriage encourages silence. The tendency to value family privacy, and prioritise the status of the family over individual dignity perpetuates the acceptance of abusive behaviour. It also prevents persons from seeking outside help, where social systems influence legal systems to prioritise the reputation of the family over the victim's well-being (Choudhary, 2022). This creates a climate of tolerance that reduces inhibitions against violence, makes it more difficult for women to come forward and promotes social passivity (Shrader & Sagot, 2000).

Family violence and intimate partner violence among queer persons is doubly invisible due to stigmatizing and pathologising of queer identities. The few studies on IPV among queer couples that have been conducted are largely limited to the Western population and it is apparent that IPV among queer couples requires further investigation in the South-Asian context. The few studies from the West, revealed the existence of DV among lesbian and

gay couples, and its incidence is comparable (Turell, 2000), or higher than that among heterosexual couples (Messinger, 2011; Kelley et al., 2012). FV toward queer individuals is sanctioned by society and community and is found permissible in ways that lead to institutional stakeholders and service providers re-victimising queer individuals and denying them their rights to a life of their choice.

2.1.3. Forms of Violence

The forms of DV can be largely categorised as physical, sexual, emotional/psychological and financial abuse (UN, 2020).

Physical Violence

Physical violence refers to the use of physical force against an individual that causes harm or injury to the body. It includes:

- Hitting, slapping, punching, kicking, biting, shoving
- Choking or strangling
- Burning
- Damaging personal property (for instance, throwing things)
- Using physical restraint (for instance, holding the person against a wall)
- Forcing drug or alcohol use
- Hurting with a weapon
- Refusing medical care, controlling medication and/or withholding help when the person is sick or injured (for instance, denying food)
- Locking the person in a space

Sexual Violence

Sexual violence refers to the violation of a person's body through forced sexual acts without the person's consent. It includes:

- Forcing sexual contact against the person's wishes
- Unwanted touch including penetration (oral, anal or vaginal) or touching (stroking, kissing, licking, sucking or using objects on) any part of the person's body
- Forcing a person to participate in unwanted sexual activities including stripping, pornography, prostitution (to have sex with other people)
- Hurting a partner during sexual activity
- Preventing the use of contraceptives and/or forcing abortion
- Pursuing sexual activity when the person is unable to make an informed decision about involvement because of being asleep, intoxicated, drugged, disabled, too young, too old, or dependent upon or afraid of the perpetrator
- Making fun of a person's sexuality or body, making offensive statements, insulting, or name-calling in relation to the person's sexual behavior/passing sexual comments or remarks
- Spying on a person when they are engaged in private activities (for instance, bathing, undressing etc.)
- Withholding sex from the person as a way to control them

> *People find it difficult to talk about their experience of sexual violence because of shame and guilt. They may perceive sexual activity within a relationship, especially marriage, as their duty and be unaware that they can be sexually assaulted or raped by their intimate partners.*
>
> *(Yadav, 2018)*

Emotional/Psychological Violence

Emotional/psychological violence is behaviour that targets the person's psychological well-being and sense of self. It causes emotional suffering and trauma. It includes:

- Insulting/criticising/shaming a person to undermine their self-confidence (for instance, calling them 'crazy', 'stupid', ugly')
- Humiliating the person in public
- Withholding approval, appreciation or affection as punishment
- Threatening to cause direct or indirect distress or harm (for instance, threaten to harm or hurt themselves or a family member or a pet)
- Confusing/manipulating the person with lies and contradictions (also referred to as 'gaslighting')
- Consistently ignoring or neglecting the person's requests and needs
- Isolating a person from their family and community
- Rejecting or not valuing the person's beliefs, thoughts, ideas and opinions
- Controlling the person's behaviour and movements
- Extreme anger outbursts, for example, destroying property to scare the person
- Stalking including reading mails/messages, following the person's activities throughout the day

Financial Violence

Financial violence involves making a person financially dependent as a way to control them. This includes:

- Preventing/forbidding the person to work and earn a living
- Injuring the person to prevent them from going into work or taking up a job
- Engaging in behaviour that will cause the person to lose their jobs
- Preventing/forbidding the person to pursue an education
- Having control and/or withholding access to financial resources
- Providing a small, often unrealistic allowance
- Misusing the person's name for financial reasons
- Forcing the person to sign documents against their will such as bank & loan documents, taxes, immigration papers or other important documents
- Stealing money, cards, property or other assets
- Gambling jointly earned money
- Demanding access to financial accounts

Unique Elements of Abuse in Queer Relationships

Queer individuals face family violence due to non-acceptance of their identities. For queer couples, one or both partners may also experience violence based on the perception of being non-heterosexual (homophobia) or being transgender or gender-non-conforming (transphobia).

- Forced marriage and corrective rape to change a person's identity or orientation.
- 'Conversion' therapy to 'change' or 'correct' a person's sexual orientation or gender identity—a deeply violent act that subjects queer individuals to non-consensual medical and mental health interventions, forced hospitalisations, forced sedation/medication etc.
- 'Outing' or threatening to reveal a partner's sexual orientation/gender identity to work colleagues, family or friends.
- Misgendering a partner, for instance, using offensive pronouns such as 'it' to refer to a transgender partner or telling a person identifying as trans that they are not a 'real' man or woman and ridiculing their identity.
- Dead naming (using the name associated with the gender that the person no longer identifies with) or Comments made towards the person's body that further intensifies feelings of 'gender dysphoria'

> *This is not an exhaustive list of all the forms of violence but provides an idea of the ways a partner may control and harm a person. You may also refer to the 'Power and Control Wheel' developed by the Domestic Abuse Intervention Project in Duluth that describes various behaviours that people may use to gain power and control (Pence & Paymer, 1993).*
> *Additionally, not all forms of domestic violence are criminalized in India - marital rape for example is not yet recognized by criminal law (Sachdev, 2022).*

2.1.4. Risk Factors

Domestic Violence is the result of factors occurring at the individual, family, community, and wider society levels that interact with each other to increase or reduce the likelihood of violence happening. The factors that increase the risk include the ones listed on the following page (CDC, 2004; Gerino et al., 2018; Semahegn & Mengiste, 2015; Mahapatro, 2012; Stith et al., 2004):

> *Queer couples face existing marginalisation and discrimination based on their sexual orientation and gender identity. They do not follow the heteronormative script and are not equally valued. For instance, queer couples have to often pretend that they are 'not a couple' but are 'just friends'. Their realities are ignored, and their stories of togetherness or dispute are unlikely to attract interest or empathy. This, when interacting with the following factors, make their experience of violence complex and invisible (Ranade et al., 2022).*

Individual Factors

- Low self-esteem
- Low education and/or income
- Age
- Caste
- Religion
- Alcohol and drug use
- History of experiencing sexual, physical and emotional abuse
- Low social support (family and friends) and isolation from the community
- Poor physical and/or mental health

Family/Relationship Factors

- Witnessing family violence including parental violence/ intergenerational violence
- Emotional dependency/insecurity
- Financial dependency/ Economic stress
- Family size
- Number of children
- Low family income
- Type ('arranged'/'love') and duration/length of relationship
- Presence of relationship tension and conflict
- Partner's age, educational status, occupation and substance use

Societal Factors

- Belief in traditional gender roles and norms (for example, men should make the decisions, women should stay at home)
- Attitudes towards intimate partner violence (normalisation of violence)
- Low willingness of the community to intervene
- Weak legal sanctions against intimate partner violence
- High rate of unemployment, poverty and crime

A combination of individual, relational, community and societal factors contribute to the risk of experiencing DV. Examining DV/IPV through an intersectional lens can help identify how different systems and structures contribute to violence. A society where there is prevalence of discrimination on the basis of caste, religion, sexuality, economic standing etc is more prone to violence, including inter-generational violence. Understanding these interplays is key to categorising DV/IPV as a social issue, thereby transferring the burden of care from the individual to society.

2.1.5. Protective Factors

Protective factors are conditions that reduce the impact of DV risk factors, and support the safety, recovery and well-being of people experiencing violence. The socio-ecological model considers the interplay between individual, relationship, community and societal factors, and suggests that in order to prevent violence, it is necessary to act across these multiple levels of the model at the same time. This approach is more likely to sustain prevention efforts over time and achieve population-level impact WHO, 2020).

The protective factors may be at the individual, relational, community or societal level. Individual factors focus on promoting attitudes, beliefs and behaviour that prevent violence and developing skills related to conflict resolution, life skills training and socio-emotional learning. At a relational level, it includes family-focused interventions, peer mentoring programs and problem-solving skills, to name a few. Prevention strategies at a community level focus on creating and building safe spaces for people to live, learn, work and play, and addressing conditions that give rise to violence including poverty and high density of alcohol outlets. Lastly, prevention at a societal level includes strengthening household financial security, education, employment opportunities and creating policies that aim to reduce inequality. Protective factors can also be categorised according to the following:(Browne & Ung, 2019)

- **Concrete support:** Physical and mental health services, restraining orders, safe housing, transportation, financial assistance and links to jobs
- **Affiliative support:** Friendship, companionship and connection with others who share similar circumstances
- **Emotional support:** Non-Judgmental advice, empathy and validation of self-worth.
- **Informational support:** Parenting guidance, recommendations for health care services or child care and education
- **Cultural support:** Shared identity, norms, traditions, a sense of community and ways of understanding the world

Service providers need to look at the different avenues for intervention that can help a person experiencing abuse. It must be highlighted that protective factors can be strengthened even under adverse circumstances, and the growth in one of the factors can be the foundation of growth in others.

2.1.6. Impact of Domestic Violence

People can face ongoing and challenging effects after enduring abuse. It can take time for a person to adjust to living in a safe environment, especially if the abuser was severely violent and/or committed the actions over an extended period of time (*Madhavan et al., 2022; OWH, 2019; Kalokhe, 2017*).

Physical Health Effects

- Scratches, bruises, cuts, sprains, fractures
- Chronic fatigue
- Shortness of breath
- Muscle tension
- Changes/disturbances in eating and sleeping patterns
- Sexual-health related issues including sexually transmitted diseases, disturbance in menstrual cycle etc.
- Urinary tract infections
- Forced pregnancies or abortions
- Frequent experience of illness
- Aches and pains without a clear medical cause
- Chronic pain, fatigue & exhaustion
- Disability
- Death

Mental Health Effects

- Feelings of shame, guilt and loneliness
- Drastic mood swings
- Emotional detachment/Numbness
- Social withdrawal
- Feeling hopeless and helpless
- Low self-esteem
- Difficulty trusting others
- Fear of intimacy
- Experience of flashbacks
- Self-harm
- Suicidal ideation
- Substance abuse
- Engaging in impulsive, high-risk behaviour
- Anger outbursts
- Hypervigilance and fear
- Denial and/or minimization of the abuse

Some of these effects become coping mechanisms for people. For example, some people may look to alcohol to lessen the pain of abuse. Unfortunately, these also act as barriers for people who want help or want to leave their abusive relationships.

Thus, the prevalence of violence increases the risk of mental health concerns. Similarly mental health concerns can lead to a greater risk of violence. This leads to a vicious cycle that is difficult to break out. It is also to be noted that medical conditions such as Tuberculosis or any sexually transmitted diseases can also stigmatise individuals and increase incidence of violence against them in the family setting. Service providers can serve as the catalyst that helps them address or escape violence.

Unique Life Stressors in Queer Lives

Queer persons are forced to live on the margins of society which makes them vulnerable to a number of stressors that adversely affect their health and well-being. They may already experience challenges due to societal and familial rejection including low self-esteem, anxiety, and the inability to lead a fulfilling and meaningful life. It is therefore important for service providers to keep in mind the minority stress framework while addressing their mental health concerns. Some of the concerns queer persons experience are described below (Ranade, Chakravarty & Shringarpure, 2022):

- **Difficulties with self-acceptance:** Queer persons grow up in a society that stigmatises and rejects non-heterosexual sexualities and identities. For instance, homosexuality is perceived as perverse, pathological or 'a phase that will pass'. queer persons may internalise these beliefs and struggle with their sense of self. When it comes to a trans person, they may experience distress from a body that feels 'not right', and from people who refuse to see them as the gender they identify with. This experience is referred to as gender dysphoria.
- **Coming out:** The assumption is that we are all born heterosexual. The responsibility is placed on queer persons to acknowledge their sexuality and identity and tell others. This may have violent consequences because of the stigma associated with queerness, for instance, forced marriage or house arrest. They may struggle with shame, anxiety and isolation.
- **Invisibility:** Queer persons, because of their lack of privileges, are often forced to live double lives, hiding their identity from people to escape violence. Not having access to resources and role-models that affirm their sexuality and identity can cause a deep sense of disconnection and loss.
- **Discrimination and Harassment:** Education institutions, work spaces, law enforcement and legal systems, hospitals and the medical system, and families become sites for harassment and violence if the identity and sexuality of the person becomes known.

The effects of domestic violence extend to the family and community. It can lead to the break-up of families, homelessness, frequent relocation and increased mental health issues among family members, including children.

> **Impact on Children**
>
> *The biggest predictor of children growing up to become perpetrators of domestic violence is growing up in a household where there is abuse. Studies show that in homes where there is intimate violence, on average 40% of children are also abused. Growing up in a household with domestic violence has devastating implications for the health, well-being and development of children. This can have lasting impact throughout the life cycle (Buckley et al., 2006).*

2.2. Activities

Activity 1

Instructions: *Here are a few statements on domestic violence. Are they myths or facts? In the space below, provide an explanation of why you think it is a myth or a fact.*

- Only physical violence counts as domestic violence.

- Domestic violence is a pattern of controlling and abusive behaviour. If there is no intervention it may get worse.

- Domestic violence is a learned behaviour.

- If a person is in real danger, they would leave. If they haven't, it isn't that bad.

- Alcohol use or abuse is not a cause of domestic violence but it can contribute to making the violence worse.

- Domestic violence only occurs in poor, uneducated families.

- People make false claims of domestic violence or exaggerate how bad it is.

- Domestic violence is a deep-seated issue and is not just caused because of anger issues.

- IPV is rare, and does not occur often in queer relationships.

- Domestic violence is a private family matter.

- Couples therapy is not the ideal solution for people in abusive relationships.

- It is easier for queer persons to leave abusive relationships than it is for cis-heterosexual, married people.

Activity 2

Instructions: *Below are 4 case vignettes of women experiencing different types of concerns and challenges. Please read the descriptions and answer the questions mentioned below.*

Case Example 1

Saroja is a 30-year-old woman who has been experiencing headaches for the last few weeks. Whenever she visits the health center, she has bruises on her body. She mentions that her partner is prone to drinking. Her partner comes home and hits her whenever he is drunk. Right before her partner comes home, she experiences heart racing and shortness of breath . She also feels a sense of dread. Her partner comes home and often tells her that she's weak and doesn't know how to deal with anything.

1. *What are some of the abuses Saroja is experiencing?*

2. *How are these experiences affecting her physical and mental health?*

Case Example 2

Varsha, a transwoman, is married to a cisman. She has been married for about a year. She does not feelsecure with her partner. Her husband lost his job and began blaming her for their financial problems. She does not feel any joy doing anything and has lost her appetite in the last 2 months. He

also keeps telling her she is not a real woman and that he is not attracted to her.He often threatens to out her to neighbours and co-workers who may not be aware of her identity. She does not have any family support, so she feels like she has nowhere to turn for help.

1. *What are some of the abuses Varsha is experiencing?*

2. *How are these experiences affecting her well-being?*

Case Example 3

Tanvi is a bisexual woman. She was in a relationship with a woman. She felt that her partner was controlling her by reading her messages and monitoring when she left the house and where she was going. She told her she would like to end things. Now, the woman has started following her to her workplace. She told a colleague about this, but the colleague does not believe her and thinks she is being dramatic. She now lives in a constant state of fear that something bad is going to happen. She is also worried that the colleague might reveal her identity to others. She is unable to sleep.

1. *What are some of the abuses Tanvi is experiencing?*

2. *How are these experiences affecting her well-being?*

Case Example 4

Meghna works as a software engineer. She says that her husband forces her to sleep with him. Every time this happens, her body becomes tense and she experiences pain. She also experiences nightmares. She describes that it is getting worse and worse. She told her family about it, and they told her it was her duty to meet her husband's needs. She is having thoughts of ending her life.

1. *What are some of the abuses Meghna is experiencing?*

2. *How are these experiences affecting her well-being?*

Warning Signs to Identify Domestic Violence

Warning Signs

For Support System

If you are a friend, family member or co-worker who is noticing changes in your loved one and are concerned, **Here are a few signs to look out for to identify domestic violence**

- Seems alert and anxious to listen to and please their partner
- Frequently reports their whereabouts to their partner
- Receives harassing phone calls
- Are restricted from having contact with others
- Rarely seen outside in public
- Have limited access to money
- Is isolated and closed off from others
- High levels of control from their partner
- Person uses different survival strategies to cope, for instance, deny, minimize or rationalize the violence
- Have frequent injuries which they describe as 'accidents'
- Dress in clothing designed to hide marks and bruises
- Show changes in behaviours, personality (have low self-confidence when they previously displayed higher self-confidence)
- Have mental and physical health problems
- There is a general atmosphere of uncertainty and tension

For Survivors of Domestic Violence (UN, 2022)

Questions to ask yourself if you think your relationship may be abusive:

Does your partner...

- Insult, embarrass or make fun of you in front of your friends or family?
- Put down your accomplishments?
- Make you feel like you are unable to make decisions?
- Use intimidation or threats to gain compliance?
- Tell you that you are nothing without them?
- Treat you roughly—grab, push, pinch, shove or hit you?
- Call you several times a night or show up to make sure you are where you said you would be?
- Use drugs or alcohol as an excuse for saying hurtful things or abusing you?
- Blame you for how they feel or act?
- Pressure you sexually for things you aren't ready for?
- Make you feel like there is "no way out" of the relationship?
- Prevent you from doing things you want – like spending time with friends or family?
- Try to keep you from leaving after a fight or leave you somewhere after a fight to "teach you a lesson"?

Do you...

- Sometimes feel scared of how your partner may behave?
- Constantly make excuses to other people for your partner's behaviour?
- Believe that you can help your partner change if only you changed something about yourself?
- Try not to do anything that would cause conflict or make your partner angry?
- Always do what your partner wants you to do instead of what you want?
- Stay with your partner because you are afraid of what your partner would do if you broke up?

3

How Difficult is it to Reach Out for Help?

3.1 Gender-Based Expectations, Cultural Beliefs and Stigma

Domestic violence is interlinked with our social structure and the complex set of values, traditions, customs, habits and beliefs that govern a woman's role in the family and community Sabri & Young, 2022; Choudhary, 2022; Stephens & Eaton, 2020; Rakovec-Felser, 2014). Some of these beliefs are:

- Women must be submissive to male family members in all aspects of her life. Additionally, men are expected to exercise coercive control and have the right to discipline women for 'incorrect' behaviour (normalisation of violence).
- Marriage is an important life goal and is for life. Therefore, the individual must accept whatever happens within the marital relationship.
- Women should understand that their primary role is that of a 'caregiver' and they must continue in this role regardless of the violence they endure.
- Violence that occurs in a family is considered a private matter and seeking outside help is not acceptable. Talking about family matters publicly will bring 'shame' to the family.
- Lower divorce rates are celebrated and treated as a cultural win but at the cost of abused women who are stuck in an abusive marriage (Mehra, 2019). They may receive pressure from family and friends to 'work it out'. This along with the stigma of being a divorced-single woman force women to stay in violent relationships.

> *One should keep in mind that domestic violence victims constantly evaluate their own safety and risks of future danger for themselves and their loved ones. A person may make an informed and rational decision to not seek active intervention; if the person does so, it does not mean that they lack credibility or that domestic violence never took place.*

3.2 Barriers to Support

About 70% of domestic violence is not reported (Guram & al., 2020). Society often asks survivors why they do not leave abusive relationships, instead of asking why the perpetrator abuses or why society accepts relationship violence.

There are many barriers that stand in the way of a person leaving and reporting an abusive relationship (Whiting, Cravens & Aamar et al.,2015 ; Hasselle et al., 2019).

- **Danger and fear:** One of the most important reasons women and queer persons don't leave abusive relationships is because it can be dangerous. Separation from an abusive partner is often thought to be the solution to ending violence; yet, abuse and the risk for lethality often escalates following separation (Campbell et al., 2003; Stark & Hester, 2019; Zeoli et al., 2013).
- **Isolation:** A form of domestic violence includes isolating the partner and weakening their connection to family, friends and colleagues. It makes it all the more difficult for people to seek support during times of distress and leads to increased dependency on the abusive partner.

  They may also fear that the people in their lives will judge them or decide to cut ties.
- **Shame and low self-worth:** Women often feel shame, guilt and embarrassment when experiencing abuse. They may believe it is their fault and feel like they are the only ones that experience violence. They may also feel worthless about themselves and hopeless about their situation. The person may depend on their abuser for their sense of self and support.
- **Saviour complex:** Many people have a deep desire to help their partners. They may love their partners and hope for change. They may also value their commitment and put their partner's needs above their own.
- **Children:** People may choose to stay in abusive relationships for their children. They may also fear for the safety of their children, if they were to leave.
- **Financial constraints:** People may also depend on their partner financially - to pay bills or meet their basic needs. They may fear losing their home or joint property. This also makes survivors further vulnerable to other forms of violence.
- **Difficulty with the justice system:** Women and queer persons experience stress throughout the process of reporting and seeking action. They may find it hard to prove violence has been committed against them, and fear being disbelieved. They may also be blamed for causing the problem, airing personal issues in public and bringing shame to the family. Domestic violence cases are rarely treated seriously and in most cases, little or no action is taken that holds the perpetrator accountable. Additionally, coercive control cases typically require evidence through texts, emails and voice messages. Reliving and sharing this evidence can be traumatic for victims because of its personal or intimate nature.
- **Difficulty with the medical system:** Seeking medical help can also be a challenging process; these institutions are often not sensitised enough to respond empathetically to crimes against women and queer persons. For instance, medical workers might avoid conversations about violence or not know that the person's concerns may have been caused by domestic violence (Girshick, 2002). Additionally, the survivor might feel judged by the medical workers.
- **Lack of awareness:** People are unaware of what may constitute violence. They may not recognize certain behaviour as abuse and normalise them (Dempsey, 2003). Even if they are able to identify the violence, they may not know or lack access to professional help.

Cycle of Violence and Trauma Bonding

There tends to be a cycle of behavior, known as the cycle of violence, in abusive Relationships (Walker, 1979). That cycle includes the tension-building, explosive, and tranquility/honeymoon stages. The tension-building stage involves abuse, like pushing, insulting, coercive behaviors, and escalating demands for control, and is often volatile and unpredictable. People may feel that they are 'walking on eggshells' and worry about the situation deteriorating. The victim of abuse tends to try to appease the abuser in an attempt to limit the abuse. The acts of abuse increase to a severe level during the explosive stage. The abuser may release tension by engaging in, more overt and serious acts of abuse and control, like slapping, punching, constraining, or raping the person. . Following this, during the tranquility or honeymoon stage, the abuser will take steps to re-establish connection with the person. They may feel remorseful or ashamed for their actions. They may apologize for the abuse, provide affection and make promises that it will never happen again, and blame it on alcohol, stress, drugs etc. The tension reduces and both partners may deny how bad the abuse was. Episodes of abuse followed by gestures of remorse and love cause a trauma bond to become cemented (Porter & Fuller, 2022)

This gives the abused person hope that their suffering will end and that they will one day receive the love or connection that the perpetrator has promised. The person experiencing the abuse may see suffering as a price to pay for kindness. Remorseful behavior may also cause the abused person to feel grateful, particularly if they have become accustomed to poor treatment. In this stage, the abuser may also overtly or covertly blame the victim for triggering the abusive behaviour leading to the abused person looking at their own actions more critically and extending the

benefit of the doubt to the abuser. This reinforces an unhealthy bond (Walker, 1979).

The bond that forms is referred to as a trauma bond. It is a psychological response that happens when an abused person develops an unhealthy attachment to their abuser (Zoppi, 2020). They are rooted in our basic need for attachment and security. The abuser holds power and control. This along with the shame and embarrassment a person experiences, makes it difficult for them to leave. Additionally, if the abuser is a comforter or caregiver, the emotional pull to stay can be intense. The person may struggle to separate love from a trauma bond(Jhonson, 2022).

It is common for domestic violence patterns to persist and breaking the cycle may take time and effort. Survivors may leave and return several times before permanently separating from their abusive partner. It is important for service providers to understand the complexity and persistence of this pattern, and provide consistent and long-term support (McAdams, 2017).

Example:

- A man comes home intoxicated more frequently and talks rudely (tension building phase)
- He beats his wife following an argument (explosive incident/violence)
- The wife has had enough of this and wants to return to her parents' house
- Husband is apologetic, displays affection towards the child, gifts her, promises to drink less and not hit her again (amends, apologies, excuses)
- Wife believes that he only hit her because he was intoxicated and that he will make amends this time. She continues the relationship in the hope that things will change (honeymoon phase).

Survivors and others may think alcohol as the reason for experiencing domestic abuse. There is a strong correlation between alcohol consumption and domestic abuse(Parekh et al., 2021; Nayak et al, 2010). However, this may lead to the belief that the violence may stop if alcohol use discontinues and this is often not the case. Violence is learned behaviour and may persist regardless of alcohol use - however it may worsen when alcohol is in the mix.

Additional Barriers for Queer Persons

The challenges experienced by queer persons, specifically those of discrimination and harassment , make it all the more difficult for them to speak out about violence.

- **Difficulty with acceptance:** This is especially concerning for people who are transitioning from their gender assigned at birth to their gender identity that aligns with their personal experience. For example, a heterosexual cisman in a relationship with a transman may feel that their identity as a straight man is being challenged. Additionally, family members may force lesbian and bisexual women to marry and have a family as a way to 'get over' their sexual orientation Ranade et al., 2022).
- **Fear of being outed:** Domestic abuse may be exacerbated by ex-partners or family members informing the wider community about the individual's sexual orientation or gender identity, resulting in them experiencing hate crimes (Calton, 2016).
- **Lack of information:** Available information about domestic abuse often refers exclusively to heterosexual relationships and there is a general lack of information about domestic abuse in same-sex relationships (Bornstein et al, 2006; Donovan & Hester, 2011). queer persons may be unaware that violence can occur in same-sex relationships, and therefore not acknowledge their experience as abuse (Donovan, 2011).
- **Fear of being shunned:** The person may also try to hide the abuse because of the fear of being shunned by the community and losing their primary connection to the community. They may also avoid tarnishing the image of the LGBTQIA+ community (Harvey, 2014).
- **Internalised stigma/hatred:** Queer persons may also have unresolved guilt and self-hatred about being queer, making it difficult to accept that they are deserving of support.
- **Fear of discrimination and harassment by service providers:** LGBTQIA+ people's fears of experiencing homo/bi/trans-phobia from service providers is grounded in their past experiences of societal discrimination ((Rolle et al., 2018)and psychological and physical trauma, including family rejection, hate speech, hate crimes and bullying (Ard & Makadon, 2011). For example, stereotypes include the idea that rape would be less traumatic for gay men than heterosexual men or women (Meyer, 2020); that trans people are sexually predatory (Todahl et al, 2009) and that they deliberately "deceived" the perpetrator about their supposed "real" gender. Lesbian and bisexual women reported to Donovan & colleagues (2011)) that when they had been raped by a woman, service providers found it "difficult to envisage" a female perpetrator.
- **Exclusion from medical treatment:** Trans people may be excluded from services because of their gender history, for example being excluded from a women-only service because they were assigned male at birth - this may include lack of access to contraceptives, abortions, affirmative care during pregnancy etc .

Intersecting Barriers

- Queer persons from minority backgrounds may be more vulnerable to experience violence, for instance, by law enforcement.
- Young queer persons are particularly vulnerable to domestic abuse for a number of reasons: they may view their first relationship as affirming their identity; they don't have any models for what a positive same-sex relationship should be like; their relationship is embedded within their queer friendship networks, and they lack resources to seek help.
- Queer persons accessing these services experienced higher levels of substance use and mental health problems than heterosexual victims of domestic abuse)Green & Feinstein, 2012). This suggests that their needs are more complex and may cause them to seek help at a delayed stage.

Coping with Violence

People may use the following coping strategies in domestic violence situations (Garcia-Moreno, 2005; WHO, 2002; Heise et al., 1999):

- Minimise or deny the violence.
- Take responsibility for the violence.
- Use alcohol or drugs as a numbing effect.
- Use self-defense.
- Seek help.
- Remain in the abusive relationship to avoid escalation of violence.
- Initiate violence as a means of gaining some control.

Normalisation of Violence

Women and queer persons in domestic violence situations fail to recognize and define their own experiences as violence. Living with an abusive partner changes their interpretation and understanding of violence. They normalise violence, and perceive the relationship as a manifestation of their own failure. Most people are reluctant to identify themselves as a 'victim' and the partner as an 'abuser'. As a coping strategy they tend to define the violence as 'caring', 'love' or 'normal'. Research has shown that only after the woman has left the violent relationship, when she no longer faces isolation, control and risk of further violence from her former partner, the process of 'denormalisation' of violence begins, which enables her to identify her experiences as violent (Messinger, 2021; WHO, 2002; Wood, 2001)

Few Things to Keep in Mind

Leaving a significant relationship is not easy. People may experience a loss of identity and a range of emotions including grief, euphoria, anxiety, disorientation, and loneliness. It may be overwhelming, contradictory, and unexpected. Along with this, people may experience physical reactions such as sleep disturbances, nausea, menstrual and weight changes, to name a few. It is a time of change, there is no expected way for people to think, feel or behave (WDVCAP, 2020).

- Always reassure those affected by violence that they are not at fault or responsible for the violence that is happening to them. It is essential to keep reminding people to avoid self-stigma and challenge social ideas that place the blame on the people experiencing violence instead of the perpetrator.
- When identifying a possible case of domestic violence, ask if something is wrong rather than waiting for the person to disclose concerns. This shows that you understand her situation , and it helps to build trust.
- Listen to the person's experience of violence. Show genuine concern and support to people experiencing violence.
- Do not pressure people to act in a way you think is best. Do not tell them what to do.
- Ask them rather than assuming a person's gender orientation or sexuality.

This will be further expanded in the next section of the handbook.

3.3 Activity

Activity 1

Instructions: *Below is a description of a series of interactions between a husband and his wife. Please describe which actions and behaviours would be in the tension-building stage, the explosive stage and the honeymoon stage. You can refer to the cycle of violence description to answer this question.*

Yeshoda and Raja have been married for 4 years. Raja lost his job because of the Covid 19 pandemic. He is now at home more than he used to be. He started becoming irritable at home. He blamed Yeshoda for his lack of a job. If she asked him about the job situation or brought up any home-related expenses such as groceries or rent, he would yell at her. She is scared to discuss anything related to finances with him. Raja notices that Yeshoda is keeping a distance from him. He begins to taunt her. One evening, she had prepared dinner. Raja was unhappy with the food and asked her why she had made rice instead of chapathi. She explained that there was no flour at home. He began questioning her angrily. She explained that since they were short on expenses, there was already rice at home and she didn't feel that they needed to spend on flour for the week. Raja yelled at her and asked her if she was humiliating him by pointing out the money situation. He then slapped her twice across the face. Yeshoda was shocked and began to cry. Raja j left and went into the bedroom and locked it. The next morning, Raja is silent. He is sulking at the table. He apologizes to Yeshoda after she serves him breakfast. He says he is the worst husband, and he should not have hit her last night. He feels guilty, upset, and inadequate since he cannot provide for the family. Yeshoda feels bad for her husband and the pressure he is under. She tells him that it is alright, and that she forgives him. She feels calmer and sits down beside him. They then begin talking about other things in their lives.

Activity 2

Instructions: *Below are case vignettes of people in abusive relationships and the different barriers to seeking support. See if you can identify the different barriers and how they are affecting them. You may refer to the above section to answer the questions mentioned below.*

Case Example 1

Rohini is a 30-year-old woman who has been married for 6 years. From the very beginning of her marriage, her husband has been hitting her. Lately, things have escalated to such an extent that she has started sustaining a lot of injuries. In the beginning, she felt she had to deal with it by herself and not make it into a big issue. However, when she could not bear it any longer, she told her family about the incidents and asked for support. They told her that it is part of a marriage and she has to adjust. They also indicated that it might be because she is doing something wrong and asked her to not pick fights and be more accommodating to her husband's needs. She has started believing she is not being a 'good' wife. Rohini, now, feels anxious and is constantly worrying about every action she takes. She also feels like she cannot speak to anyone and feels alone and helpless.

1. *What are the barriers Rohini is facing?* .....

.....

.....

2. *How are they affecting her?* .....

.....

.....

Case Example 2

Asha is a 42-year-old lesbian woman and is in a relationship. . She often has visiblebruises and scratches on her body. She tells those who ask that she had an accident or jokes about how clumsy she is. When things escalate with her partner, she goes to a clinic to get her injuries checked. The doctor does not ask her how she got the injury. He assesses the injury and tells the nurse to dress the wound. The nurse asks her about the injury. After much hesitation, Asha tells her that her partner sometimes hits her. The nurse does not understand how 2 women can be in a relationship ('it is not normal'), and also does not consider this as abuse. She tells Asha that maybe she should go to a temple and pray over her choices. Asha feels sad after leaving the clinic. She does not know whom to spek to about her experiences. She feels that no one will ever understand and she will have to keep silent about this.

1. *What are the barriers Asha is facing?* .....

.....

.....

2. *How are they affecting her?* .....

.....

.....

Case Example 3

Poongodi is a 30-year-old homemaker. Her husband is a doctor in a government hospital and is an influential person having contacts with politicians, police, and lawyers. Recently, he slapped and pushed her during an argument causing serious injuries. As this had happened many times in the past and although he always promised not to do it anymore but there were no signs of change, she decided that she must not be silent any longer. She reached out to her friends and family members who were supportive and encouraged her to file a police complaint against her husband. She approached the police for support and filed a complaint to report the incident. During the investigation, Poongodi made it clear about filing for divorce while her husband wanted to reconcile and promised to change yet again. He also mentioned that she argued too much and did not understand the high pressure life of a doctor. The police spent many hours convincing her to go back home to her husband as she is young and have children and she must consider their future. They also repeatedly told her that she is lucky to have married a doctor and should not nag or argue with him. They did not file any complaint on her charges of physical abuse.

1. *What are the barriers Poongodi is facing?*

2. *How are they affecting her?*

Case Example 4

Tamilarasi is 19 years old and has been a victim of online abuse and harassment. She had been dating a boy for 3 years with whom she broke up recently because she caught him cheating on her. He did not take the break-up well—he began by apologizing to her and trying to win her back by begging and pleading, sending gifts, emotionally blackmailing her saying he would end his life etc. When she was firm in her decision, he started to threaten her and said that he would leak all her intimate images on the internet which she had sent him while they were dating. She is scared that her parents, relatives, friends, and neighbors will come to know about this and her life would be ruined. She did not want to reach out to the police as she was worried about how they would react and whether they would inform her family. She reached out to a local CSO in her area for support. The CSO staff were very rude to her and asked her how she could send such pictures—they asked her if she had no shame and spoke among themselves that they are wasting their time on things like this instead of helping those in actual need. . They let her know they have to inform her family as she is young and unmarried.

1. *What are the barriers Tamilarasi is facing?*

2. *How are they affecting her?*

4

Psycho-Social Approach

4.1. Introduction to the Psycho-Social Approach

In the context of domestic violence, it is important to adopt a psycho-social lens when examining the experiences of women and queer persons. The person may not only experience psychological concerns such as loss of self-worth and depression, but also feel like a burden to the family if she cannot 'fulfill her role as a caregiver'. psycho-social support is crucial to help people counter the social conditioning from themselves and others, that risks portraying the incident as 'all their fault'; and to support survivors prioritise the well-being of themselves and their children , build their self-esteem and confidence and create an enabling environment where they can exercise their agency to lead an independent life free of violence.

4.1.1. What is the psycho-social model?

The psycho-social model advocates that the health and well-being of a person depends on a range of psychological and social factors. Psychological factors are related to the person's way of thinking, feeling and behaving, including their mental health concerns and social factors are related to their identity, economic background, relationships, cultural context etc.

The psycho-social approach looks at the interplay between the psychological factors and the social environment, and the effect on people's mental and physical health, including their ability to function. This model is applied in a number of helping professions in health and social care settings.

The aim of the model is to:

- Alleviate the person's distress
- Enhance the person's functioning

Rationale

In DV, the person's decision to leave the perpetrator has been the focus for behavior change. However, someone else- the perpetrator is responsible for the problem behaviour of violence. Change is not solely an individual endeavor, but takes place in the context of a relationship in which the action of the individual may result in a perpetrator's violent or abusive counteractions or reactions (Anderson, 2003; Brown, 1997). For instance, leaving the abusive partner may seem like the most obvious way for a person to reduce their exposure to abuse and violence, departure typically is difficult and may not result in increased safety. For this reason, there has been a recognition that leaving may not be the healthiest action for a given person at a given time.

The focus of interest has turned to the variety of specific safety-seeking behaviors that women employ, both while in the abusive relationship and when attempting to leave (Peled, Eisikovits, Enosh, & Winstok, 2000). Looking at multiple avenues of action may lead to successful resolution from the person's point of view.

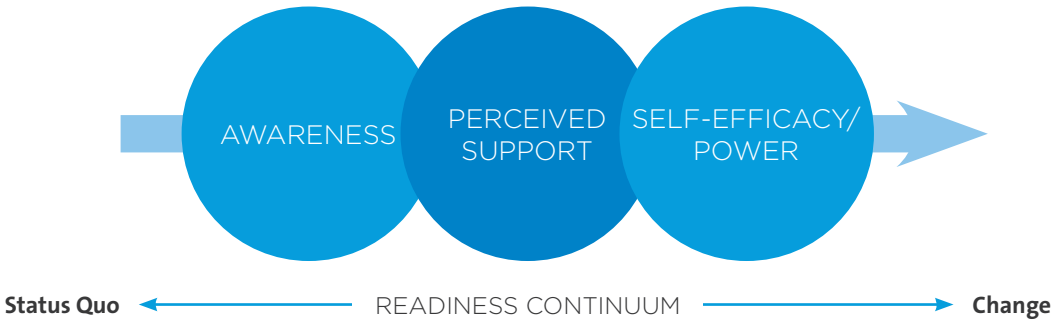
4.1.2. Psycho-Social Readiness

Psycho-Social Readiness Model

The psycho-social readiness model describes the dynamic balance of internal and external factors that affect a person's readiness for change (Cluss et al., 2006). The model focuses on 3 internal factors:

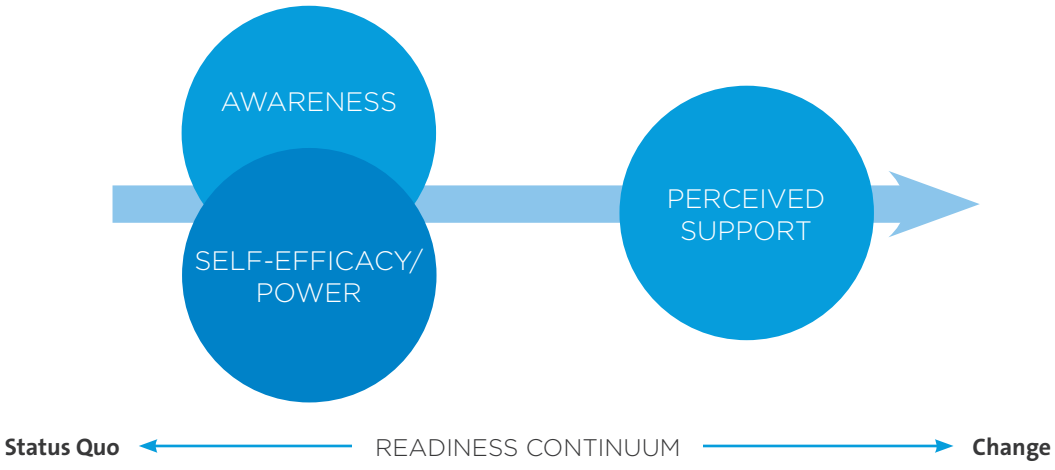
- **Awareness:** This refers to the awareness of abuse in the relationship.
- **Perceived support:** This refers to how individuals perceive friends, family members and others as sources available to provide support during times of need.
- **Self-efficacy/perceived power:** This refers to how the person feels about their ability to be successful if they try to make a change.

The balance of internal factors along the continuum affects the likelihood of movement toward change.



Example:
Yeshoda believes they have support from family and friends in times of struggle. They meet them every week and they encourage Yeshoda to keep herself busy with work. Yeshoda thinks that the way their partner behaves towards them is normal and they deserve it. Yeshoda tells their friends that they will never leave their partner. For Yeshoda, she has high perceived support but low awareness and self-efficacy. Therefore, her readiness for change is closer to the status quo end (where things remain the same).

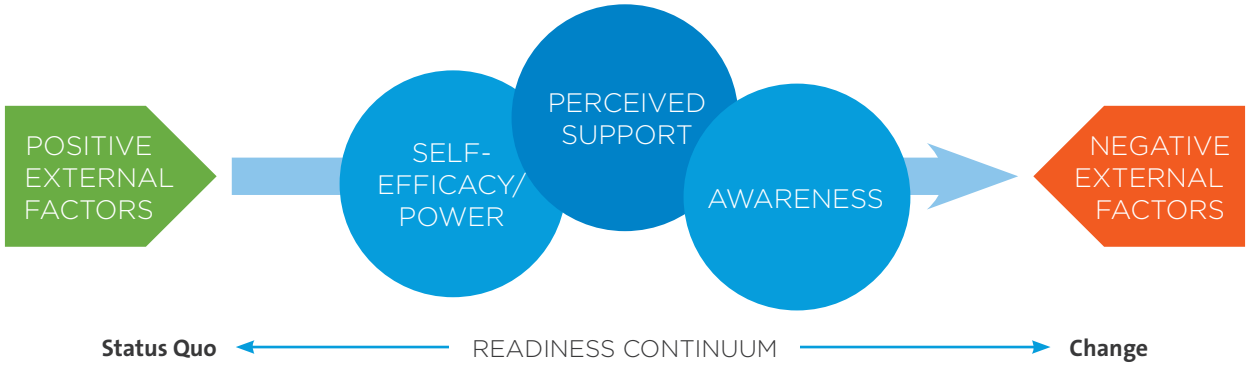
(Adapted from Miller & Rollnick (2002)'s case example)



The model also describes the role of external factors that prevent or facilitate change. It thinks of readiness as a continuum along which people experiencing domestic violence move toward and away from change.

Example:
Yeshoda's close friend lives near them. The friend told Yeshoda she would be happy to take her to work on a daily basis and if she needs help getting around elsewhere, she can help (influencing perceived support and self-efficacy). Yeshoda doesn't need to depend on their partner to take them around. One time, they stayed in a shelter for abused women and queer persons. There were a lot of arguments that took place. They did not feel comfortable being there and went home (influencing self-efficacy). Yeshoda's sister also confronted their partner without asking them. It made things worse at home for Yeshoda (affecting perceived support). Yeshoda's partner was also diagnosed with cancer. Yeshoda feels sorry for their partner and does not feel right leaving their partner (influencing self-efficacy). All these different external factors affect's Yeshoda's movement along the continuum of change.

(Adapted from Miller & Rollnick (2002)'s case example)



The model allows for a complex understanding of the processes that enhance and inhibit positive change for people experiencing domestic violence. By looking into these three factors, intervention strategies can be developed that help support people and move them towards safety. It is an empowering approach and provides validation for the many forms of active change that women and queer persons make, even when they choose to remain with the abuser.

It is important to look at various factors, internal and external, that influence a person's thoughts, feelings and behaviour. By taking a psycho-social approach, service providers will be better able to support people experiencing abuse.

4.2. Activity

Activity 1

Instructions: *Below is a case vignette of a woman's relationship with her partner. Please read the description and answer the questions mentioned below.*

Case Example 1

Sanjana constantly felt that something was not quite right in her relationship with Roshan. She read Roshan's text messages and found out that he had cheated on her. Roshan hit Sanjana when she confronted him and abused her for looking through his phone. Sanjana discussed these concerns with her neighbour. Her neighbour told her this is not alright and this behaviour is abusive. Sanjana then realized that she was right all along. She has now taken up another job on the side to keep her busy and away from home. She is saving up money to move out and rent a place of her own.

Sanjana doesn't have many other friends. Her friends are people she mostly met through Roshan. She is scared that if she leaves him, she will end up alone. Her employer also told her that they may have to let her go because they do not have the money to pay for her salary. On the other hand, Roshan is not always abusive - he is sometimes very loving and pampers Sanjana with gifts. Sanjana is unsure if she is making a 'big deal' out of it and her relationship is not actually abusive,

1. *Is Sanjana's awareness low or high? Why do you think so?* .....

.....

.....

.....

2. *Is Sanjana's perceived support low or high? Why do you think so?* .....

.....

.....

.....

3. *Is Sanjana's self-efficacy low or high? Why do you think so?* .....

.....

.....

.....

4. *Illustrate where you think Sanjana's internal factors lie on the readiness continuum.* .....

.....

.....

.....

5. *What are the different external factors that are mentioned?*

6. *How do you think each external factor is influencing her internal factors? Describe below.*

5

First Line Support and Beyond

5.1. Introduction to First Line Support

Survivors of domestic violence have to overcome a lot of individual, familial, social, cultural and institutional barriers before reaching out for support as discussed in Chapter 3. The effort it takes to overcome these barriers and access help is enormous. When the individual reaches out to any service provider offering DV support, be it the police, one stop centers, state run helplines or civil society organizations, the provision of first line support is crucial to addressing the crisis and connecting the survivor to long-term support.

The WHO (2014) in its clinical handbook on 'Health care for women subjected to intimate partner violence or sexual violence' states that "First line support provides practical care and responds to a woman's emotional, physical, safety and support needs without intruding on her privacy."

The handbook (WHO, 2014) outlines 5 tasks that first line support entails:

> ***Listen:*** *Listen to the woman closely, with empathy, and without judging.*
>
> ***Inquire about needs and concerns:*** *Assess and respond to her various needs and concerns—emotional, physical, social and practical (e.g. childcare)*
>
> ***Validate:*** *Show her that you understand and believe her. Assure her that she is not to blame.*
>
> ***Enhance Safety:*** *Discuss a plan to protect herself from further harm if violence occurs again.*
>
> **Support:** *Support her by helping her connect to information, services and social support.*

This is a simple and effective way to respond to the immediate needs of survivors, connect them to further services and protect them from harm. Providing the right kind of first line support may make the difference between a survivor accessing further support or getting into protracted cycles of violence. Now let us look at how this looks in practice and some of the principles and strategies that will support us in delivering this care.

5.2. Ethical Principles to Service Provision

Fundamental ethical principles underlying the provision of support services to survivors of domestic violence and other kinds of gender-based violence UNW, UNFPA, WHO, UNDP and UNODC (2015), CEHAT (2016):

Rights-based:

Violence against women, girls and queer individuals which is directed at them because of their gender and sexuality is a fundamental violation of their human rights. As service providers, we need to look at the delivery of services to survivors of violence from a rights-based lens. The work we do to provide support must facilitate upholding their rights to live a life free of violence.

When survivors approach us for support and we look at the violence they have undergone and the solutions we can potentially offer them from the prism of family and the importance of keeping the family together rather than the rights of the individual, we fail to take into account the safety and freedom of the individual and the options and choices we can offer them narrow significantly. It is important to remember that families are only happy, safe and secure as long as every member of that family is happy, safe and secure and has the right to express their feelings and exercise their choices.

Intersectional:

Survivors of violence may face multiple marginalizations due to social locations informed by caste, class, gender identity, sexuality, religion, disability, linguistic differences etc which exacerbate their experience of gender-based violence and make them vulnerable to intersecting forms of violence. Front line services that account for the diverse needs of the most vulnerable will have the capacity to address the needs of all survivors.

The incidence of gender-based violence and domestic violence occurs across socio-economic groups. However, the discrimination and violence that an individual may be subject to due to their caste or due to their disability will compound the experience of domestic violence and make it much harder to move towards solutions. As a service provider, if you can see the ways in which these experiences make them more vulnerable and reduce their access to justice systems and increase social barriers that prevent them from breaking out of the situation, you will be better able to work on removing/reducing these barriers within your institution and address diverse needs that support them in mitigating violence in all its forms.

Survivor-centric:

Front line services must center the voices, needs and wants of survivors. Services should be driven by and respond to the unique experiences and needs of each survivor. Services should ensure that survivor rights and choices as articulated by them are at the forefront of any front line effort and treat them with respect and dignity.

Prescriptive approaches to service delivery that are driven by social conditioning and that attempt to tell survivors what to do or decide on next steps on their behalf, coerce or pressure them into taking particular courses of action, are not survivor-centric. They cause more harm than good. Support services are meant to adapt to the survivor's choices rather than try to force fit survivors into existing models and processes.

Do no harm:

A core tenet of any first line service is to cause no harm, to the individual or to the larger community. The purpose of service delivery is to facilitate positive change and anything that detracts from the choices and rights of survivors may cause them further harm. First line services should take into account risks to the safety, security and freedom of individuals accessing their support by perpetrators or service providers themselves.

Re-victimization of survivors causes irreparable harm. When services that are meant to protect and uphold rights, instead are inaccessible, intimidating or coercive, the survivor faces insurmountable odds in breaking out of violent situations and it has grave consequences for their safety, well-being and mental health.

Maintain Confidentiality & Privacy:

Maintaining the confidentiality and privacy of survivors is foundational to any service provider - beneficiary relationship. It builds trust and maintains the integrity of the service provision process.

While confidentiality is often considered a cornerstone of any counseling process, it is not something that only needs to be applied by counselors. Law enforcement, protection officers and other kinds of service providers who may not be strictly bound by the principles of confidentiality given the nature of their work, also have an ethical duty to understand consent and how, when and what information can be shared to ensure the safety of survivors, especially when dealing with high risk cases of domestic violence.

Violence is Non-Negotiable:

In providing first line services to survivors of violence, we operate with the understanding that violence is not justifiable under any circumstances. The goal of first line services is to alleviate distress by offering psycho-social and legal support and it rests on a fundamental belief that no one should be subject to violence because of who they are or the choices they decide to make.

To suggest to survivors that it is their behavior, clothing, decisions etc that has invited violence or triggered the perpetrator to attack them is victim-blaming. To tell survivors that if they change themselves, deny who they are, comply with the decisions of perpetrators because it fits into the dominant, conditioned narrative of society is re-victimizing survivors. Neither are signs of a sensitive or effective service.

Perpetrator Accountability:

First line services must work to enhance survivors' knowledge about their legal rights, increase their access to justice systems and work to eliminate barriers that prevent them from pursuing justice. Services must hold perpetrators accountable for their actions and where possible, ensure that legal remedies are applied.

Treating domestic violence as a family issue and not applying the rights-based, legal framework means that perpetrators do not face any consequences for their behavior and actions. Service providers that look at violence as a family issue and propose solutions from that lens end up being a punishing process for survivors. Counseling, mediation, negotiating with family and community structures etc should not override the survivor's needs and asks for justice and accountability.

Advancing Gender Equality and Empowerment:

Recognizing that deeply rooted, patriarchal attitudes, beliefs and norms lead to violence against women, girls and LGBTQIA+ individuals is necessary to frame support services from the lens of equality and empowerment. The purpose of first line services is to advance the rights of individuals to live lives free of violence and recognize their agency to imagine a self-determined future for themselves.

To enable and facilitate positive change with the people who seek our support, it is imperative that we not only look at individual circumstances but also the wider social movements and structures that inform oppression. As a service provider, there has to a be commitment to question injustice and cultural and social beliefs that lead to the acceptance and perpetuation of violence.

5.2.1. Activities

Instructions: *Below are case vignettes of people experiencing violence. Read the description and answer the questions mentioned below.*

Case Example 1

Gomathi is an Architect. She has two children and her husband is an influential businessman. Her husband convinced her to quit work a few months after their marriage and asked her to take care of the household since he is earning more than enough for the family. She was unsure but complied with his wishes. However, she found over time that he was not involving her in any of the financial decisions regarding the family and the lack of financial independence was making her feel very insecure. After the children were born, there were even fewer opportunities to get back to work. He constantly belittles her at home and in front of others. When she tries to involve herself in financial decisions, he asks her to look into matters of the household and children only. They are having more arguments around this and during one such argument, he slapped her. He immediately apologized and promised her it would not happen again. She was shocked and did not know how to react. She was not seriously hurt but was very shaken about the incident. She reached out to her friends and family members but everyone advised her to forgive him and move on for the sake of the children. When she spoke to a counselor at an NGO, they advised her that since this is the first time he has done something like this and that he is taking good care of her and the children and she should not make a big deal out of it. She is confused about what to do next.

1. *Do you think this violates any of the fundamental principles of service provision? If yes, explain why.*.....

.....

.....

.....

2. *As a service provider, how will you handle it if this client approaches you for support?*.....

.....

.....

.....

Case Example 2

Aparna is 22 years old and is studying Mechanical Engineering. She lives with her family. She met Varun on an online dating app and they have been seeing each other for a year. He is 24 years old and working in the same city. In the beginning they would chat a lot and they slowly grew close to each other. They began sharing intimate pictures with each other and also took some pictures when they met up. They mutually agreed to delete all pictures once they have seen them. However, over time she realised that he had many intimate pictures of her and whenever she said no to anything, he threatened her with them. With increasing verbal abuse, digital abuse and sexual coercion she found herself unable to break up with him as he told her that he would post the pictures online and disclose them to her family and friends. She is scared that her parents, relatives, friends, and neighbors will come to know about this and her life would be ruined. She reached out to the cyber cell and requested them for support in handling this issue without involving her family. The officer there shamed and berated her for sharing intimate pictures and having a

sexual relationship before marriage. He asked her many insensitive and intrusive questions which made her uncomfortable and scared. She was told that they would help her but she would have to bring her parents as she is unmarried.

1. *Do you think this violates any of the fundamental principles of service provision? If yes, explain why.*

2. *As a service provider, how else would you handle it if this client approaches you for support?*

Case Example 3

Reena is 27-years-old and identifies as a lesbian. She met her girlfriend in college and they are in love and want to live together. She tried to explain her lack of interest in men to her parents but they brushed it aside and forced her to get married and she now has a 1 year old child. She is experiencing a lot of distress in having to engage in a sexual relationship with her husband. As the child is over a year old now, she is unable to avoid intimacy and her husband is frustrated that she is refusing him. He has begun to verbally and emotionally abuse her.

She disclosed her sexual orientation and decision to leave the marriage to her brother but he shared it with their parents and they were extremely angry and spoke to her very abusively. Unable to bear the abuse from all sides, she left her child with her husband and moved in with her partner. Her marital and natal families are threatening to harm her and her partner and a missing complaint has been registered. At the station, the family counselor and the cops told her that this was abnormal and two women cannot live together. They asked a lot of intrusive and derogatory questions about their sex life and slapped her partner several times. They also shamed Reena for leaving her child behind and asked her what kind of mother would do this. They forced them to separate and sent Reena home with her parents.

1. *Do you think this violates any of the fundamental principles of service provision? If yes, explain why.*

2. *As a service provider, how else would you handle it if this client approaches you for support?*

Case Example 4

Prem is 25-years-old and identifies himself as a transman. He has been experiencing physical, verbal, and emotional violence from his parents since he revealed his identity to them and refused to get married as per their wishes. Prem explained to his family that he had always thought of himself as male and reminded them about the clothing and hair style he has preferred right from childhood to explain how he felt. His family failed to understand his identity and took him to a psychiatrist for treatment and to several religious spaces to perform rituals in order to change him. The psychiatrist had no knowledge about gender dysphoria and how these feelings are natural and no treatment can change or fix them and diagnosed Prem with a mental disorder. He was admitted in the hospital forcibly and kept under heavy sedation. The psychiatrist advised the family to get him married and said that this is just a phase and his thinking will change after marriage. Prem's family continues to keep him heavily medicated and has started looking for grooms.

1. *Do you think this violates any of the fundamental principles of service provision? If yes, explain why.*

2. *As a service provider, how else would you handle it if this client approaches you for support?*

Case Example 5

Archana is a 24 -years-old domestic worker. She was forced to get married to Navin at a very young age due to financial constraints in the family. There is a gap of 7 years between her and her husband. Navin is an auto driver and doesn't go to work regularly and whenever he does he uses that money for alcohol. Whenever he is drunk, he hits her. She tried talking to him about his behaviour and action when he consumes alcohol and the impact it has on her but there was no change. The violence has increased and he now abuses her even when he is not drunk. He forces her to have sex and refuses to use protection.

She is now pregnant. Given the uncertainty around her future with Navin and the lack of financial stability, she decided to get an abortion and approached the nearest primary health care Centre. The nurses in the hospital yelled at her for taking this decision and asked her to think about the many women who are unable to get pregnant. They advised her to have the child and claimed things would change after the baby arrives. They also told her that a child is a gift from God and it is a sin to abort. They asked her to bring her husband and mother-in-law along if she still wishes to have the abortion and they would not move forward without his signature.

1. *Do you think this violates any of the fundamental principles of service provision? If yes, explain why.*

2. *As a service provider, how else would you handle it if this client approaches you for support?*

5.3. Institutional Characteristics for Effective Service Delivery

First Line Care & Beyond: How to deliver quality services to women, girls and queer individuals who have been subject to violence

When we consider the ways in which our services can be strengthened to meet the needs of survivors of domestic violence and other kinds of gender-based violence - it is essential to consider the individual and institutional steps that need to be taken to improve capacity and provide the kind of care that is supportive, non-victimizing and empowering.

At the institutional level, the UNW, UNFPA, WHO, UNDP and UNODC (2015) Essential Services Package for Women and Girls Subject to Violence - Core Elements and Quality Guidelines outlines some of the essential characteristics of first line services that ensure the delivery of high quality services.

Core Elements & Quality Guidelines for First Line Services
Availability Essential health care, social services, justice and policing services must be available in sufficient quantity and quality to all victims and survivors of violence regardless of her place of residence, nationality, ethnicity, caste, class, migrant or refugee status, indigenous status, age, religion, language and level of literacy, sexual orientation, marital status, disabilities or any other characteristic not considered.
Accessibility Accessibility requires services to be accessible to all women and girls without discrimination. They must be physically accessible (services are within safe physical reach for all women and girls), economically accessible (affordability) and linguistically accessible (information is provided in various formats).
Adaptability Essential services must recognize the differential impacts of violence on different groups of women and communities. They must respond to the needs of victims and survivors in ways that integrate human rights and culturally sensitive principles.
Appropriateness Appropriate essential services for women and girls are those which are delivered in a way that is agreeable to her: respects her dignity; guarantees her confidentiality; is sensitive to her needs and perspectives; and minimizes secondary victimization.
Prioritize Safety Women and girls face many risks to their immediate and ongoing safety. These risks will be specific to the individual circumstances of each women and girls. Risk assessment and management can reduce the level of risk. Best practice risk assessment and management includes consistent and coordinated approaches within and between social, health and police and justice sectors.
Effective Communication and Participation by Stakeholders in Design Women and girls need to know that she is being listened to and that her needs are being understood and addressed. Information and the way it is communicated can empower her to seek essential services. All communication with women and girls must promote their dignity and be respectful of them.
Data Collection and Information Management The consistent and accurate collection of data about the services provided to women and girls is important in supporting the continuous improvement of services. Services must have clear and documented processes for the accurate recording and confidential, secure storage of information about women and girls, and the services provided to them.
Informed Consent and Confidentiality All essential services must be delivered in a way that protects the woman or girl's privacy, guarantees her confidentiality, and discloses information only with her informed consent, to the extent possible. Information about the woman's experience of violence can be extremely sensitive. Sharing this information inappropriately can have serious and potentially life threatening consequences for the women or girls and for the people providing assistance to her.
Linking with Other Sectors and Agencies through Coordination Linking with other sectors and agencies through coordination, such as referral pathways, assist women and girls receive timely and appropriate services. Referral processes must incorporate standards for informed consent. To ensure the smooth navigation of the different essential services for victims and survivors, protocols and agreements about the referral process with relevant social, health and justice services, including clear responsibilities of each service, need to be in place.

5.4. Effective Service Delivery

At the individual level, the following section outlines the essential characteristics and skills one must possess/cultivate to provide effective services.

5.4.1. Essential Characteristics of Effective Service Providers

People may feel anxious or uncertain when they come to talk to a provider for the very first time. They may be unsure of how this intervention may help them or what is expected of them. Establishing an effective relationship is essential for the intervention to work (Anand et al., 2013). The goal of the relationship is to make the person feel that the provider is someone who can be trusted, will take their problems seriously, listen to their fears, doubts and ideas with acceptance, and help them find solutions to their problems. The relationship must be collaborative so that the person feels involved, plays an active role in counseling and expresses themselves freely (Rogers, 1957).

Building an effective relationship is a continuous process. To do this, it is important for providers to cultivate the following characteristics (Velleman et al., 2014):

Genuineness

To be genuine is to be yourself, and not put on an act as a provider. It is to be sincere and display consistency in words, actions and feelings. This does not mean that the provider expresses all their feelings. The goal is for the provider to say things that might be helpful to the person and to ensure that what is expressed is real and honest.

Warmth and Understanding

Sharing difficulties with a stranger is challenging; therefore, if a provider is warm and understanding, it helps a person share their concerns more openly, and view the provider as a person who is friendly and approachable. Providers may express warmth and understanding by greeting the person, smiling while speaking to them, speaking in a calm manner, nodding their head to show understanding and engagement.

Non-Judgmental Attitude

Being non-judgmental is being open and accepting of the person's thoughts, feelings and behaviors so that they are encouraged to open up. If the provider is judgmental and begins finding faults, the person is unlikely to be free and open when they talk.

Empathy

Being empathetic is to understand the person's perspectives and emotions as if they were our own. The provider attempts to see the person's experiences through their eyes.

5.4.2. Essential Skills

Some of the essential skills required in a services provider are as follows (Velleman et al., 2014):

Building Rapport

Rapport means a harmonious relationship that is based on understanding and open communication. Establishing a good rapport means to work towards building a relationship based on these values. This is the foundation of an effective relationship.

Using Appropriate Language

It's helpful for providers to use simple and nontechnical language, and speak in a way that is easy for the person to understand.

Listening Actively

Active listening is a way of listening that lets the other person know that the provider is listening and paying attention to whatever they are sharing with them. This can be demonstrated in the following ways:

- **Maintaining eye contact**
- Paying attention to body language (when their voice trembles or if their leg shakes)
- Avoiding distractions and interruptions ('thinking about other things and noises in the background)
- **Using verbal statements and sounds** ('aha', 'right', Mm-hmm')
- **Reflecting and paraphrasing** (repeating what they are saying in the provider's own way)
- **Respecting silences** (assure them of support until they feel ready and comfortable to share)

Asking Questions

Asking questions indicates to the person that the provider is interested in them and their concerns. They may ask open-ended questions. These questions require thought and reflection, and are useful in getting honest and free responses. For instance, 'Could you explain this in more detail?' or 'How are you feeling today? Close-ended questions can be answered more straightforwardly, with a simple "yes" or "no"; "more" or "less"; "sometimes", "often" or "not at all". These questions can work well to engage a person who may not like to talk much on their own and also helps to get specific details from them. For instance, "Did it work out okay for you?" or "Can your friends help you with this?".

Summarizing

Summaries are useful to confirm if a topic has been accurately understood by the provider. Summaries can also help the provider to focus on the important areas of discussion and make transitions to other topics.

Building Hope

Building hope is a way of giving the person courage and confidence that the provider will support them. Providers must build hope for problems that are manageable, and not provide hope in situations that are beyond the person's control. For instance, telling the person 'Don't worry; everything is going to be alright'. This may not be realistic. It is important for providers to judge in which situations to provide hope and reassurance.

Providing positive feedback and encouragement

Giving positive feedback and encouragement to the person helps them feel supported. The provider may express sincere appreciation for the person's efforts and strengths and avoid inflated or false praises.

Validating

Validating another's experience means letting the person know that we are listening attentively, that we understand what they are saying, and that we believe what they say without judgment or conditions. Recognizing that someone's feelings and thoughts make sense can show that we are listening without judgment and can help build stronger relationships.

Respecting ambivalence

Ambivalence is having mixed or confused thoughts and feelings, for instance, wanting to leave the relationship but also being in love with the person. Providers are encouraged to be comfortable with contradictory information. The provider must avoid forcing the person to 'pick a side' or confront her with these contradictions, and instead gently describe them to them.

5.4.3. Essential Considerations

There are a few things providers can keep in mind that would help them provide the best kind of support to the person experiencing abuse.

- Set up the space and keep it as quiet and private as possible so that the person feels safe to share
- Prepare for the session and keep necessary materials ready
- Greet the person and introduce yourself to the person
- Maintain session structure
- Set up a time to speak
- Set the agenda (what providers will be covering that session)
- Manage the time of the discussion
- Speak in the language the person is comfortable with
- Explain the purpose of the discussion.

Characteristics & Skills	Examples
Genuineness	"It sounds like right now you are feeling overwhelmed in managing your problems. Let us work on it together." "We have not made as much progress as we hoped, but I will do my best to help you." "I'm not sure about what you have asked, but I will speak to my supervisor a`nd get back to you."
Non-judgmental Attitude	"No problem is too small; and you are not making a big deal about it. We should be able to talk about the things that affect us in any way without judging ourselves just because we are feeling sad about it." "Thank you for sharing your problem so openly with me. I see how stressed you are about it."
Warmth and understanding	"How are you doing?" "Do you need a few seconds before we begin?" "Are you comfortable right now?"
Empathy	"This sounds like it's been very difficult for you." "That must have been hard." "I can understand why this was hurtful."
Asking Questions	"What would you like to talk about?" "How do you feel about that?" "Could you tell me more about that?" "Can you explain that again, please?" "Is there anything that you need or are concerned about?"
Paraphrasing and reflecting	"You mentioned that you feel very frustrated." "It sounds as if you are feeling angry about that..." "You seem upset." "It sounds like you may need a place to stay." "It sounds like you are worried about your children."
Summarising	"You seem to be saying that...."
Providing positive feed-back and encouragement	"I know that it's not easy at all to talk about these issues but I'm glad that you're trying."
Validating	"Anyone in your situation would have felt the same way." "It is but natural to feel angry when someone you trusted let you down."
Building hope	"You are doing a lot. You are sharing difficult things and coming to speak to someone. I'm sure we can find ways to help you better manage your concerns."
Respecting ambivalence	"Sometimes it can be confusing. The experience itself is confusing—to have someone you love doing something like this to you." "I understand that you feel a mix of emotions. It makes sense."

Important statements providers can use to provide validation and respond sensitively:

- "It's not your fault. You are not to blame."
- "It's okay to talk."
- "Help is available." [Say this only if it is true.]
- "What happened has no justification or excuse."
- "No one deserves to be hit by their partner in a relationship."
- "You are not alone. Unfortunately, many other women have faced this problem too."
- "Your life, your health, you are of value."
- "Everybody deserves to feel safe at home."
- "I am worried that this may be affecting your health."

5.4.4. Activities

Activity 1

Instructions: *Reflect and answer the questions below.*

1. Can you think of a time you sought help from someone when you were facing a problem?.....

.....

.....

.....

2. Why did you seek help from this person?.....

.....

.....

.....

3. What made them approachable? What drew you to them?.....

.....

.....

.....

4. What did you think of before approaching this person?.....

.....

.....

.....

5. How did you feel during the interaction?.....

.....

.....

.....

6. What are some of the ways this person helped you?.....

.....

.....

.....

7. How did you feel after the interaction?

8. How do you think a service provider differs from a trusted person you go to for help?

Activity 2

Instructions: *Reflect and answer the questions below.*

1. What characteristics do you think will be easy for you to demonstrate? Why do you think so? Can you provide an example of a situation in which you exhibited the characteristics?

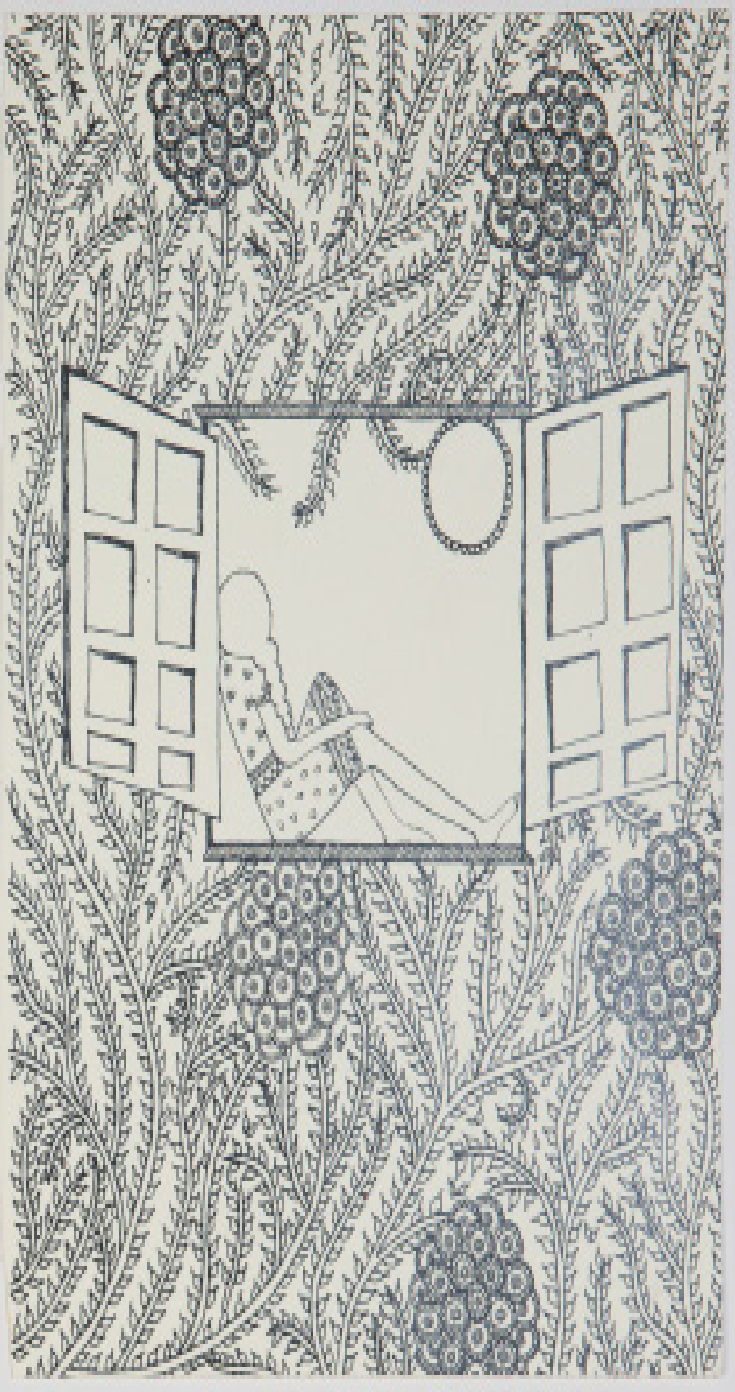
2. What characteristics do you think will be difficult to demonstrate? Why do you think so?

3. What skills do you think will be easy for you to demonstrate? Why do you think so? Can you provide an example of a situation where you exhibited the characteristics?

4. What skills do you think will be difficult to demonstrate? Why do you think so?

6

Understanding Service Flow



6.1. Environment

When survivors of abuse reach out for support, having a warm, welcoming environment to receive them is important in establishing safety and trust. First line services should be non-intimidating and easy to access.

- Offer water and a place to sit when they walk in. Enquire if they have had a meal, if not arrange for food to them and make sure they have had their fill.
- If they are accompanied by infants or children, offer milk/snacks/toys/adult supervision to keep the children distracted.
- Ensure there is a private space to share their feelings. If you are not a direct counseling service and dont have an immediate need or set-up to do so, once you identify the individual as a survivor of abuse, offer them a private space to share their experiences.
- Even within the constraints of space and resources that most front line services may operate within, a few small touches can make a difference even if the infrastructure doesnt support separate spaces. For example, one can use curtains and sectionals to set up semi-private spaces with minimal resources.

6.2. Sensitivity

At the first point of contact, it is important to listen to the survivor with empathy and without judgement. Survivors who are reaching out to share their experience for the first time, may be anxious and stressed about the kind of response they might get. They may also have previously experienced a dismissal or rejection of their thoughts and feelings. They may get triggered by events and places that consciously or unconsciously remind them of their initial traumatic event.

These are a few things providers can keep in mind:

- Avoid leaving the person in a room without informing them of the reason
- Do not label the person's feelings as abnormal or exaggerated
- Pay attention to their needs in the moment
- Avoid using physical restraints
- Check if they are comfortable to share
- Ensure privacy, safety and confidentiality
- Some people may be afraid in the presence of males. This could prevent them from sharing. Check-in with the person about this
- Let the person know they do not have to answer questions that make them uncomfortable
- Explain all processes and seek permission before doing an assessment
- Talk about violence when they are alone and not in front of others
- Respect the decision to go/not go to the police, courts etc.

Some of the most important things service providers do:
(WHO, 2014; Anand et al., 2013)

- Encourage the person to express themselves freely
- Keep an open mind
- Listen actively and validate concerns
- Identify needs and concerns
- Instill hope and confidence
- Help the person feel connected to others
- Empower the person to feel able to help themselves and to ask for help
- Explore the different options to help the person.
- Respect their wishes
- Help them find social, physical and emotional support
- Plan and structure sessions carefully
- Refer them to a professional to provide them with further help
- Enhance safety

Some things to avoid while providing support:
(Satyanarayana & Chandra, 2020; WHO, 2014)

- Telling the person what to do and what not to do
- Making decisions for them
- Judging the person and what they share
- Convincing the person to stay or leave a violent relationship
- Convincing the person to go to any other services, such as police or the courts
- Imposing one's own beliefs on the person and not allowing them to think for themselves
- Having any relationship with them outside of counselling
- Making promises, for instance, promising to solve all their family troubles for them
- Denying their feelings by telling them they shouldn't feel a certain way or that their problem is not serious enough
- Asking them to analyse what happened or why
- Pushing them to give details when they are not ready to share
- Asking detailed questions that force them to relieve painful events
- Forcing them to share their feelings and reactions to events

Things to remember:
(WHO, 2014; Anand et al., 2013)

- The service provider's task is not to tell the person what they should do. They respect the person's right to make a decision in their life.
- The discussion is different from a friendly chat or giving advice.
- The aim is to enable someone to take greater control of their life.
- The provider works with the person to develop a relationship that empowers them, so they can feel responsible for the changes they will have to make.

Things providers have to keep in mind when working with queer persons:
(Ranade et al., 20223)

- Use respectful language for all sexualities and genders
- Use gender-neutral, open-ended language
- Use the terms and pronouns that the person uses, (for instance, in Tamil, thirunambi and thirunangai are respectively used as respectful identity terms for trans man and trans woman)
- Keep the person's gender sexuality in the foreground while interacting with them
- Set up a queer affirmative space
- Explicitly discuss the links between stigma and the person's mental health
- Be aware about resources and services for queer individuals
- Provide resources and connect them to people in the community
- Reflect on one's own sexuality and gender journey
- Recognize one's own privilege with respect to gender, sexuality etc.
- Become aware of and challenge internalised homonegativity/ trans negativity and other prejudices.
- Be willing to change personal beliefs and manner of professional practice
- Recognize that "neutrality" with regard to queer and trans clients can often be harmful
- Be attuned to the person and their life experiences: when a person comes in with previous experiences of discrimination within healthcare systems, building trust with the provider may be challenging for them; there could be other issues such as being closeted, fear of being outed, and so on. Be gentle and respectful

6.3. Provide Information and Take Action Within Your Mandate

When survivors receive timely information about gender-based violence and domestic violence and available support services they will be able to make more informed decisions about their own safety and well-being and have clarity on the various options available to them. All stakeholders including law enforcement, health care providers and social services organizations can and should provide necessary information at the first point of contact to

- Validate feelings
- Listen without judgment
- Enhance safety
- Respond to victims needs with respect
- Ensure privacy and confidentiality are maintained
- Respond to survivor needs within your mandate and provide appropriate referral after assessing the needs of clients.

For example:

If you are a medical practitioner: If someone comes to you with visible injuries, aches and pains, chronic headaches, frequent UTI's etc assess if this is due to domestic abuse. Ask the family members to stay outside and ask direct, non-judgemental questions to ascertain the situation. If there is a history of abuse, apart from providing immediate medical interventions, share information about domestic violence, its impact and available services within the medical system and in other institutions. Explain to the survivor about medico-legal documentation and file a report if they consent to it. You can provide the survivor with information and connect them to a specialist DV organization for support.

If you are a police officer: If a survivor reports physical harm or threat of physical harm, stalking etc, it is important to file an FIR immediately and not engage in negotiation. A lethality assessment should be done and the survivor may be referred to a safe shelter, counseling services, legal aid based on the needs identified. If emotional, verbal or financial abuse is reported, immediate referral to other DV informed support services may be provided.

If you are a NGO or govenment agency: A DV survivor comes to you seeking counselling, legal and shelter support. During the counselling session you identify that the client is living with PTSD and other mental health concerns due to the abuse and trauma she has been living with for many years. Here, as an NGO or government agency, you can provide shelter support, counselling services and other services that you offer within your organisation. You must also connect the client to DV informed mental health practitioners and lawyers for mental health and legal assistance.

6.4. Risk Assessment & Safety planning

6.4.1. Risk Assessment

Domestic violence survivors are prone to various kinds of risks to their physical and mental well-being and safety and that of their families, friends, pets and other loved ones. The violence from the perpetrator can intensify at any given time and therefore it is important for a service provider to ensure risk assessments are done with every client. Risk assessments can help determine the intensity of abuse and the potential impact it can have on the client and children. Usually, the perpetrator's past actions, for example, the objects he has used to threaten or harm or verbal threats to harm himself if she leaves etc are assessed and accordingly a safety plan can be created along with the client. Doing a risk assessment with a client ensures that the potential risks are given due importance and averted rather than being dismissed or minimised, so that the client is prepared to take necessary steps to protect themselves and their loved ones during a crisis situation.

6.4.2. Activity

Think of a recent case you have handled and fill out the risk assessment form that follows:

Practice Tool 2 Common Risk Assessment Tool

Adopted from: Western Australian Family and Domestic Violence COMMON RISK ASSESSMENT AND RISK MANAGEMENT FRAMEWORK

Service providers that have a role in responding to family and domestic violence are required to conduct a risk assessment considering the adult victim's assessment of the risk, evidenced based key risk factors and the service provider's professional judgement[1].

1. Summary

Victim Details:

Name:.....

D.O.B.: .....

Phone:.....

Address:.....

Perpetrator Details:

Name:.....

D.O.B.:.....

Phone:.....

Address:.....

Emergency Contact:.....

Nature of relationship between perpetrator/victim:.....

Names & D.O.B. of Children:.....

Completed by:

Name:.....

Date completed:.....

Agency:.....

Phone:.....

Initial Assessment:

Level of FDV risk: ☐ At **HIGH RISK** of serious harm ☐ At **RISK** of harm

Levels of risk are defined in Section 5: Assessment / Analysis.

Critical or Imminent Safety Concerns: (Please list any immediate concerns) .....

.....

.....

.....

.....

.....

1 This risk assessment tool is based on comprehensive research including multiple examinations of the predictive accuracy of risk factors, victim perception and professional judgement in assessing risk of repeat assault or potential lethality in family and domestic violence cases (Campbell 2003; 2004; 2005). See Fact sheet 5 Key risk factors for further information and reference.

2. Risk Factor Identification

Violence Toward Victim/s				
Risk Factor	**Yes**	**No**	**Un-known**	**Source of information if not adult victim** (e.g. Police)
Was a weapon used by the perpetrator in most recent event*	☐	☐	☐	
Is the violence becoming worse or more frequent*	☐	☐	☐	
Has the perpetrator ever physically harmed or threatened to harm adult victim*	☐	☐	☐	
Has the perpetrator ever raped or sexually assaulted adult victim*	☐	☐	☐	
Has the perpetrator ever choked, strangled or suffocated the adult victim or attempted to do so*	☐	☐	☐	
Has the perpetrator ever tried or threatened to kill the adult victim*	☐	☐	☐	
Is the perpetrator stalking the adult victim (could include harassing and/or monitoring the adult victim using others and/or technology)*	☐	☐	☐	
Is the perpetrator jealous and/or controlling toward the adult victim*	☐	☐	☐	
Has there been a recent separation or planned separation in the near future*	☐	☐	☐	
Has the perpetrator ever harmed or threatened to harm or kill children*	☐	☐	☐	
Has the perpetrator ever harmed or threatened to harm or kill pets or other animals*	☐	☐	☐	
Has the perpetrator ever harmed or threatened to harm or kill other family members	☐	☐	☐	
Has the perpetrator isolated the adult victim from family, friends and/or other social supports	☐	☐	☐	
Has the perpetrator restricted the adult victim's access to money	☐	☐	☐	

Perpetrator				
Risk Factor	**Yes**	**No**	**Un-known**	**Source of information if not adult victim** (e.g. Police)
Does the perpetrator have access to firearms or prohibited weapons*	☐	☐	☐	
Has the perpetrator ever threatened or attempted suicide*	☐	☐	☐	
Does the perpetrator misuse/abuse drugs and/or alcohol*	☐	☐	☐	
Has the perpetrator ever experienced mental ill health#	☐	☐	☐	
Is the perpetrator unemployed	☐	☐	☐	
Is the perpetrator experiencing financial difficulties	☐	☐	☐	
Has the perpetrator breached any court orders (i.e. bail, violence restraining order and/or police order conditions)	☐	☐	☐	
Is the perpetrator currently on bail or parole in relation to violent offences	☐	☐	☐	

Continued on next page

* These risk factors indicate an increased likelihood of a victim being killed.
\# The presence of mental ill health must be carefully considered in relation to the co-occurrence of other risk factors.

Perpetrator				*Continued from previous page*
Risk Factor	**Yes**	**No**	**Un-known**	**Source of information if not adult victim** (e.g. Police)
Has the perpetrator served a time of imprisonment or been released recently from custody in relation to violent offences	☐	☐	☐	
Does the perpetrator have a history of violent behaviour (not family violence)	☐	☐	☐	
Does the perpetrator's family pose a risk to the adult victim	☐	☐	☐	

Children				
Risk Factor	**Yes**	**No**	**Un-known**	**Source of information if not adult victim** (e.g. Police)
Is the adult victim pregnant or is there a new birth*	☐	☐	☐	
Has the child ever been in the adult victim's arms when she/he has been attacked*	☐	☐	☐	
Has the child ever tried to intervene in the violence	☐	☐	☐	
Are there child contact or residency issues and/or are there current Family Court proceedings	☐	☐	☐	
Are there children from a previous relationship present in the household	☐	☐	☐	

* These risk factors indicate an increased likelihood of a victim being killed.
\# The presence of mental ill health must be carefully considered in relation to the co-occurrence of other risk factors.

3. Adult Victim's Assessment of the Risk

Adult victim's assessment of the risk				
How fearful is the adult victim of the perpetrator?	☐ Not afraid	☐ Afraid	☐ Terrified	☐ Unable to answer
What concerns did the adult victim express?				
What did the adult victim think the perpetrator might do and to whom?				
Other important comments:				

Professional Judgement

Are you aware of any other additional factors, circumstances or details which make you believe there is risk or high risk to the safety of the adult victim, children and/or others?
Issues to consider may include: the adult victim's situation in relation to disability, substance misuse, mental health issues, cultural/ language barriers; whether they are willing to engage with a support service; whether the perpetrator's occupation or interests has given them unique access to weapons etc.
Do you believe any children in the household are at risk of harm?

Assessment/Analysis

Level of FDV risk	
Select appropriate level of risk based on professional judgement, evidenced base risk factors and the victim's own perception of their level of risk where available:	
At *HIGH RISK* of serious harm	**At *RISK* of harm**
At high risk of serious harm means there is evidence of a serious risk to the adult victim and children's safety and wellbeing and urgent action is necessary to prevent or lessen the risk. A victim is identified as *at high risk of serious harm* if: · a number of factors with an (*) are checked 'yes' on the risk assessment tool; · there is a history of physical violence by the perpetrator toward the adult and child victims (if there are children); and/or · in your professional judgement, combined with evidence based risk factors, the adult and child victims (if there are children) are likely to be in grave danger if immediate action is not taken.	*At risk of harm* means there is evidence of a risk to the adult victim and children's safety and wellbeing. A victim is identified as *at risk of harm* if: · one or more risk factors are checked 'yes' on the risk assessment tool; · there is a history of violence by the perpetrator toward the adult and child victims, and/or · the violence is escalating.

Next steps	Details of action
Immediate safety addressed	
Safety plans developed	
Agency collaboration & information sharing	
Warm referrals made for: · Adult victim · Children · Perpetrator	
Multi-agency meeting convened	
Police contacted	
VRO application	
Child protection notified	
Other	
Are these next steps working toward making it safer for the adult and child/ren victims?	
Are these next steps holding the perpetrator accountable for their violence?	

NB: The above is a non-exhaustive list of actions to be taken. Every case is unique and appropriate actions will be dependent on the outcome of the family and domestic violence risk assessment.

6.4.3. Safety Planning

Safety planning is an essential strategy for service providers to implement (Campbell, 2002). Periodic interactions with providers and others cannot guarantee that people would never face such experiences again. It is thus important to provide a protective plan that can guide people towards safety when they are facing abuse. (Kress et al., 2008)

People experiencing violence may fear for their safety, although others may not expect the violence to recur. Even for people not facing imminent risk, they could benefit from having a safety plan. If they have a plan, they will be in a better position to deal with a sudden violent situation.

Assessing and planning for safety is not a one-time conversation but an ongoing process. The person's needs and safety concerns may change with situations and time. Providers can explore options and resources as the situation changes. The result is a personalized plan for the unique needs of the person (Murray & Graves, 2012).

The first step for providers is to assess the immediate risk of serious injury. If there seems to be immediate high risk, then providers can say "I'm concerned about your safety. Let's discuss what to do so you won't be harmed." They may consider the following options:

Options to pursue for people at immediate risk of violence:

- Contacting the police and arranging for them to stay that night away from home.
- If the person cannot avoid discussions that may escalate with her partner, advise the person to try to have the discussions in a room or an area that they can exit easily.
- Advise them to stay away from any room where there might be weapons.
- If they have decided that leaving is the best option, advise them to make the plans and leave for a safe place BEFORE letting their partner know. This is to avoid putting themselves and the children at more risk of violence.

Questions to assess immediate risk of violence:

- Has the physical violence happened more often or gotten worse over the past 6 months?
- Have they ever used a weapon or threatened you with a weapon?
- Have they ever tried to strangle you?
- Do you believe they could kill you?
- Have they ever beaten you when you were pregnant?
- Are they violently and constantly jealous of you?

People who answer "yes" to at least 3 of the following questions may be at especially high immediate risk of violence.

Safety Plan for Domestic Violence

Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you? What would you need to do with the children? Do you need to inform or prepare them?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbour you can inform about the violence who can call the police or help you if they hear sounds of violence coming from your home? Is there a family member, friend or colleague you trust to share your experiences with or contact in case of an emergency? When you are not feeling well, who do you like to be with? Who do you turn to for advice? Who do you feel most comfortable sharing your problems with?

Safety planning chart retrieved from "Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook", World Health Organization (2014).

Note: Even if there is no one with whom people wish to share their experiences, they can still connect with family and friends. Spending time with people they enjoy can distract them from their distress. Providers may help them identify past social activities or resources that provide direct or indirect psycho-social support (e.g., family gatherings, visits with neighbours, sports, community and religious activities). They may encourage them to participate.

Safety Planning for Suicide

Warning signs	*feeling hopeless, not wanting to wake up*
Things the person can do to take their mind off the problem	*take a walk, get involved with work*
Places I can go to, to keep safe	*neighbour's house*
People I can contact for support	*sister*
Professional agencies I can call for help	*iCall*
Remembering what I have to live for	*children, future job opportunity*

Emergency Helpline Details		
iCall	022-25521111 +91 91529 87821	Monday-Saturday 10 am–8 pm
Samaritans	+91 84229 84528 +91 84229 84529 +91 8422984530 talk2samaritans@gmail.com	Monday-Sunday 5 pm–8 pm
MANODARPAN	8448440632 manodarpan-mhrd@gov.in	National Toll Free Helpline Number
Fortis National Helpline	8376804102 https://www.fortishealthcare.com/ priya.bendre@fortishealthcare.com	Monday-Sunday 9am–5 pm
NIMHANS	04046110007	Toll Free 24 x 7
Kiran	1800-599-0019	Toll Free 24 x 7
Tamil Nadu Women Helpline	181	Toll Free 24 x 7
Women in Distress (Chennai Police)	8300304207	Toll Free 24 x 7
PCVC	044-43111143/1800-102-7282/9840888882	Toll Free 24 x 7
The Banyan	7338816555	
Nakshatra	9003058479 / 7845629339	

Note on Confidentiality:

People who seek help are often worried about their personal information being passed on to others by the provider they are seeking help from Sahani & Mathur, 2020. Therefore, it is extremely important for providers to reassure the person that the information will be kept confidential unless there is some indication of harm to themselves or others. This must be communicated to them in the very first interaction. Some examples of situations that may lead to a breach of confidentiality are when the person has made a detailed plan to end their life or have harmed themselves physically like cutting their hands. In such a situation, the provider must contact their senior supervisor or the team they work with to discuss the next steps. Decisions about breaching confidentiality and ensuring the safety of the person must be taken in consultation with the supervisor and under their guidance. In such a case, providers may also need to contact someone the person trusts to ensure their safety. The provider must assure the person that the discussions are completely confidential and only the information that is required for keeping them safe will be shared with the trusted person.

- Service providers are not required to maintain confidentiality when a person's life is at risk.
- They may share concerns and explain why they think it is important to contact a referral, get authorities involved, or explore options on how to keep the person safe.
- The person is informed throughout this entire process of the steps that need to be taken and why at every point.
- Providers may say "What you tell me is confidential, that means I won't tell anyone else about what you share with me. The only exception to this is...."
- Providers may ask if there is a trusted person they can include in the discussion and whom they can alert to the risk.

6.4.4. Activity

Instructions: *Pair up with a person. Both of you can practice using 'Domestic Violence' and 'Suicide' safety planning on one another and role-play the situation (take on the role of a person experiencing domestic violence and someone who is feeling suicidal). You can take 15 minutes to think in detail about your situation and then begin. Once completed, you can provide feedback to each other. These are a few questions you can keep in mind when thinking of and providing feedback:*

1. How long did it take to do the safety planning?

2. How did it feel to ask the questions?

3. How did it feel to be questioned?

4. Were there any parts that made you nervous? If yes, could you describe the parts and why you think that is?

5. Did you find any questions difficult to ask or answer? If yes, why do you think so? Is there an alternate way of asking it?

6. What are some things you felt were important to keep in mind while questioning? What were some things that helped you answer the questions? (For instance, keeping an even tone, being slow in your pace etc.)

7. Any other notes and observations?

6.5. Connect to Other Service Providers- Referrals

People's needs are generally beyond what can be offered by any one service provider. It is not possible to deal with all the concerns in the first meeting or by a single person. However, providers can help by discussing the person's needs, other sources of help and assisting the person to get help if they want it. It has been established that people with good support networks are able to overcome violence better and have lower levels of emotional distress (Mahapatro et al., 2021).

What are the different needs?

- Gain awareness about rights, alternatives, information and work with a person to discuss pros and cons
- Empower themselves
- Know they are not alone
- File a complaint against spouse or family
- Seek protection
- Pursue a case in the court
- Receive support if they feel their mental health is worsening
- Receive medication
- Receive practical support

DV affects all domains of a person's life. Hence, actively liaising with other professionals is essential in providing comprehensive care to people experiencing DV that includes: physical/ medical, social, legal and emotional support. Providers can fill in the worksheet below to help them know what support and resources are available in the person's community (WHO, 2014).

Referral Tips:

- Be sure that the referral addresses the person's most important needs or concerns
- If the person expresses problems with going to a referral for any reason, think creatively with them about solutions
- If the person accepts a referral, here are some things providers can do to make it easier for them:
  - Tell them about the service (location, how to get there, who she will see).
  - Offer to make an appointment for them if this would be of help (for example, if the person does not have a phone or a safe place to make a call)
  - If they want it, provide the written information required – time, location, how to get there, name of person to see. Ask them to think how they will make sure that no one else sees the paper
  - If possible, arrange for a trusted person to accompany them on the first appointment
- Always check to see if the person has questions or concerns and be sure that they have understood what has been shared
- It is best to have formal referral agreements with organisations that providers refer people to. If possible, these agreements should specify how providers will find out if the person reaches the referral resource – will the provider contact them or will they contact the provider?

Referral Chart

	Form of Support	Name	Number	Address
1.	Helpline			
2.	Support groups			
3.	Social worker			
4.	Shelter/housing			
5.	Crisis centres			
6.	Legal support			
7.	Financial aid			
8.	Primary healthcare centre/clinic/ hospital			
9.	Mental health practitioner			
10.	Childcare			

6.5.1. Activities

Activity 1

Instructions: *Below are case vignettes of people experiencing violence. Fill in the referral chart for each case. Read the description and answer the questions mentioned below.*

Case Example 1
Maya lives with her partner of 4 years. Her partner has been violent with her and as a result she is now severely unhappy in the relationship. She wants to get out but does not have anywhere to go. She is worried about her finances. She feels anxious and low all the time. She finds it difficult to speak to others about her situation because they have judged her relationship with a woman. She is looking to find people who may be going through similar experiences and can guide her.

1. Among the 10 avenues of support, which 3 will you prioritise to activate, and why?

Case Example 2
Kavi has been married for seven years and has a three-year-old son. Her in-laws are abusive but Kavi has always been silent about the violence. She visited her village one summer and reconnected with a close friend and extended her stay. Her husband and his family did not like this. When Kavi came back to her marital home, her mother-in-law threw her and her son out. They are now abandoned.

1. Among the 10 avenues of support, which 3 will you prioritize to activate, and why?

Activity 2

Instructions: *From the avenues of support you have* ***not*** *selected in the above questions, please talk about in what situations you would access them.*

6.6. Documentation

- Providers must ensure every detail of the domestic violence and suicide assessment and intervention are documented accurately, safely and updated regularly.
- Documents must also include discussions had with professionals including organisation heads or supervisors.
- By maintaining documents, providers can plan for each session and track the progress of people's well-being and safety.
- Documentation may be required for legal purposes and care should be taken to interpret observations carefully and use it to safeguard the person's rights

6.7. Follow-ups

- People experiencing violence may hesitate to reach out and come in frequently to meet providers for various reasons including safety. Providers must respect their decision, however, at the same time discuss how they can follow-up with the person. They may ask, "How often would you prefer to contact me or be contacted by me after the counselling process for follow-up (e.g., weekly, monthly etc.?" and "What modes of contact do you prefer for our follow-up? (e.g., over the phone, in-person etc.)"
- Reassure the person that they can always get in touch again if they need further support and want to restart the discussion.

7

Domestic Violence & Mental Health

7.1. Introduction

Domestic violence has serious mental health consequences. Living with abuse for prolonged periods of time can be very harmful for an individual's well-being and overall health. As discussed in Chapter 2, survivors of violence may be vulnerable to a range of mental health issues including but not limited to depression, anxiety, post-traumatic stress disorder, sleep disorders, eating disorders, low self-esteem, self harm and suicidal feelings etc.

Additionally, it is also to be noted that pre-existence of mental health conditions could also lead to increased incidence of domestic violence. The lack of understanding about mental health, lack of access to treatment options and prevailing stigma around mental health all contribute to viewing persons with mental health issues as a burden and in many cases, treating them abusively because of this.

From a service provider perspective, it is important to examine our own preconceived notions about mental health and also be cognizant of some of the ways in which domestic violence survivors with mental health issues may find the service eco-system and justice mechanisms inaccessible to them. For example, our experience over the years has indicated that survivors with mental health concerns are often unfairly labeled as unfit partners or unfit mothers and may stand to lose custody of their children in many cases. In other cases, mental health concerns might lead to doubting survivor narratives and creating a perception that survivors are not capable of making their own decisions - often resulting in their agency being denied and being forced into choices that are not their own.

In this chapter, we will discuss some of the tools, activities and strategies that can be used to strengthen our own understanding on domestic violence and mental health and support survivors as they navigate the recovery process.

7.2. Assessing Domestic Violence and Mental Health

Why is an assessment important?

- It provides a comprehensive understanding of the problem
- It helps the provider identify risk factors and strengths
- It helps the provider identify an intervention that may be more suited to the person's context
- It helps decide the way forward
- The assessment itself can be helpful and supportive to the person experiencing violence

7.2.1. Understanding Domestic Violence

Adapted from NIMHANS

1. **What is the nature of violence?**
   - Assess who is causing the violence
   - Assess the type of violence the person is exposed to- physical, emotional, sexual or financial

2. **How long has the violence been taking place?**
   - Assess when the violence first began.
   - How old were you at the time?
   - For how long did the violence continue?
   - People may speak about their most recent experiences of violence; however, it is also important to ask about past events and if something similar has happened before
   - Is this the first time this is happening/happened, or have you experienced violence before?

3. **How often does the violence occur?**
   - From the time the violence began, it is important to find out how often violence has occurred
   - How often (how many times) in a week, month etc. does it happen?
   - Has the violence been the same or increased or decreased in frequency?
   - What situations increase or decrease its occurrence?

4. **How harmful is the violence?**
   - Assess how damaging the violence is to the person's physical, sexual and mental health (refer to Section 2, pages 18–19 & 23)
   - Assess the impact on significant relationships
   - Assess risk of self-harm and suicide
   - Assess whether hospitalisation was required

5. **What is the context of violence?**
   - Find out the circumstances around which violence occurs. What factors and situations led to the violence? For example, does it happen when the partner drinks?
   - Remember there can be more than one perpetrator
   - Has the violence increased or decreased over time?
   - What are the situations under which violence increases or decreases?
   - What efforts has the person taken to protect themselves? How have they coped so far?
   - Are there people in the person's environment who can help them? Have they sought their support before and did they intervene? What was the outcome of their intervention?
   - Is there a pattern emerging on how violence typically occurs in a given case?

Things to keep in mind when assessing:

- The assessment is lengthy. It can be emotionally draining. Providers can break down the assessment, focus on certain questions, take breaks and seek only the details necessary to help the person. Most importantly, they must remain patient
- Sometimes they may struggle to recall past events
- They may feel uncomfortable answering certain questions. Providers can let them know that they don't need to answer questions that make them feel uncomfortable.
- Believe their statements. For instance, if they say it is severe, it is
- It is crucial that providers do not try to find a reason for the violence. They must emphasise that there is NO justification for domestic violence

7.2.2. Mental Health Screening

Adapted from Kroenke et at.,] Public Health Questionnaire (2001)

Questions

- Have you been eating too much or too little?
- Have you been sleeping too much, too little or have trouble falling asleep?
- Do you frequently feel tired or have little energy?
- Do you feel hopeless/sad/lonely/scared/stressed?
- Do you have little interest or pleasure in doing things?
- Do you feel bad about yourself?
- Have you noticed changes to your daily routine?
- Do you find it difficult to concentrate?
- Do you feel unable to relax?
- Do you have disturbing thoughts?
- Do you feel body pain?
- Do you feel your heart racing?

7.2.3. Checking for Depression (WHO, 2014)

1. **Core symptoms for at least 2 weeks:**
   - Persistent depressed mood (for children and adolescents: either irritability or depressed mood)
   - Markedly diminished interest in or pleasure from activities, including those that were previously enjoyable

2. **Additional symptoms for at least 2 weeks:**
   - Disturbed sleep or sleeping too much
   - Significant change in appetite or weight (decrease or increase)
   - Beliefs of worthlessness or excessive guilt
   - Fatigue or loss of energy
   - Reduced ability to concentrate and sustain attention on tasks
   - Indecisiveness
   - Observable agitation or physical restlessness
   - Talking or moving more slowly than normal
   - Hopelessness about the future
   - Suicidal thoughts or acts

3. **Considerable difficulty functioning in personal, family, social, occupational, or other important areas of life**

7.2.4. Checking for Post-Traumatic Stress Disorder (PTSD) (WHO, 2014)

If the violence occurred more than 1 month ago, providers may assess the person for post-traumatic stress disorder (PTSD).

1. **Re-experiencing symptoms:**
   - Repeated and unwanted recollections of the violence, as though it is occurring in the here-and-now (for example, frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror)

2. **Avoidance symptoms:**
   - Deliberate avoidance of thoughts, memories, activities or situations that remind the woman of the violence. For example, avoiding talking about issues that are reminders of the event, or avoiding going back to places where the event happened

3. **Symptoms related to a heightened sense of current threat:**
   - Excessive concern and alertness to danger or reacting strongly to unexpected sudden movements (e.g., being "jumpy" or "on edge").

4. **Difficulties in day-to-day functioning:**

If *all* of the above are present approximately 1 month after the violence, then PTSD is likely.

7.2.5. Evaluating Suicide Risk

People may be at risk of suicide owing to the violence they experience. Some providers fear that asking about suicide may provoke the person to act on it. On the contrary, talking about suicide often reduces the person's anxiety around suicidal thoughts and helps them feel understood. Providers must routinely ask about thoughts, urges and actions of suicide in a gentle, direct and non-judgmental manner. The risk may also change with time and situations; therefore, frequent review and follow-ups are required, especially if domestic violence is persistent and symptoms worsen while the provider delivers their intervention.

Identify Risk Factors

- Feeling hopeless
- Has previously hurt herself or attempted suicide
- Has access to weapon or means of dying (e.g., poison)
- Ongoing violence
- Feeling lonely

Identify Protective Factors

- Social support (e.g., family, friends, religion, community, professional services)
- Hope for future
- Someone to care for (e.g., children, pets)
- Access to crisis services
- Positive coping methods

Conduct Assessment

1. **Thoughts**
   - What kinds of thoughts have you been having?
   - I understand you are having some very difficult experiences. In your situation, many people may not want to continue living. Have you ever felt this way in the last few weeks?
   - Have you been feeling hopeless and that nothing can help you?
   - How long have you been having these thoughts?
   - How often have these thoughts come up in the past 2 weeks?
   - Have they increased in frequency?
   - How intense are they?
   - Are you able to distract yourself from these thoughts?

2. **Intent**
   - Do you plan to act on these thoughts?

3. **Plan**
   - Have you planned for how you would hurt yourself?
   - What is it? Where would you carry this out? When would you carry it out?
   - Do you have the means – a method – for carrying out your plan? What steps have you taken to get access to these means?

4. **Previous attempts**
   - Have you ever hurt yourself or tried to end your life in the past?
     High risk if previous attempt is yes

5. **Decide on risk level (low, medium, high) and make a plan (*refer to the table below*)**
6. **Report to higher authorities, make notes and follow-up with the person**

**Adapted from Adapted from Anand et al., 2013 Healthy Activity Program Manual*

Risk Level	Risk/Protective Factors	Suicidality	Action
Low	Few risk factors; adequate protective factors; mental health problems with mild symptoms	Thoughts of death; no plans, intent or behaviour	Normalise these thoughts and provide support; discuss coping skills; provide written resources (e.g., numbers to call)
Medium	Many risk factors; few protective factors; mental health problems with mild to moderate symptoms	Suicidal ideas with plan but no intent or behaviour	Create a safety plan; schedule early/frequent follow ups (e.g., phone-call between sessions)
High	Acute, severe stressful event; few or no protective factors, mental health problems with severe symptoms	Potentially life-threatening suicide attempt; persistent ideas with strong intent	Contact supervisor urgently; supportive referral to specialised services (e.g., psychiatry or inpatient hospitalisation)

7.2.6. Activites

Activity 1

Instructions: *You can pair up with a person. Both of you can practice using the 'Understanding Domestic Violence' and 'Checking for Suicide' assessment on one another and role-play the situation (take on the role of a person experiencing domestic violence and someone who is feeling suicidal). You can take 15 minutes to think in detail about your situation and then begin. Once completed, you can provide feedback to each other. These are a few questions you can keep in mind when thinking of and providing feedback:*

Note: These are questions you can use to initiate conversation with your clients about understanding domestic violence and checking for suicide. These are also questions you could reflect on and respond to which will help you understand yourself better as an individual and as a practitioner.

1. *How long did it take to complete the assessment?* .....

.....

.....

2. *How did it feel to ask the questions?* .....

.....

.....

3. *How did it feel to be questioned?* .....

.....

.....

4. *Were there any parts that made you nervous? If yes, could you describe the parts and why you think that is?* .....

.....

.....

5. *Did you find any questions difficult to ask or answer? If yes, why do you think so? Is there an alternate way of asking it?* .....

.....

.....

6. *What are some things you felt were important to keep in mind while questioning? What were some things that helped you answer the questions? (For instance, keeping an even tone, being slow in your pace etc.)* .....

.....

.....

7. *Any other notes and observations?* .....

.....

.....

Activity 2

Instructions: *Below are case vignettes of people experiencing suicidal tendencies. Read the description and answer the questions mentioned below.*

Note: These are questions you can use to initiate conversation with your clients about suicidal tendencies. These are also questions you could reflect on and respond to which will help you understand yourself better as an individual and as a practitioner.

Case Example 1

Rohini has been finding it difficult to concentrate on work for the last month given the difficult circumstances at home. Her partner displays extreme anger toward her and slowly over time, it has escalated from verbal abuse to physical abuse. Over the last week she has been struggling to get out of bed and been thinking about ending her life. She feels sad constantly and thinks if she is not alive then at least she wouldn't feel this way. Five years ago, Rohini had tried to harm herself and end her life. Right now, she doesn't have a plan but this is something she is strongly considering doing.

1. *What is the level of risk and why do you think so?* .....

.....

.....

2. *What would you do to support the person in this situation?* .....

.....

.....

Case Example 2

Radha is having problems with her family. In a moment of anger, her mother told her she doesn't care if she is dead or alive. Radha was shocked and upset to hear that. She has been feeling like a burden to her family and thinks it'll be better for them if she dies. She thinks she can end her life just be done with all this stress. Recently, she's been speaking to a friend about her situation and feels supported. The thought of ending her life hasn't disappeared but it is occurring less frequently.

1. *What is the level of risk and why do you think so?* .....

.....

.....

2. *What would you do to support the person in this situation?* .....

.....

.....

7.3. Psycho-Social Strategies

This section introduces providers to psycho-social strategies that could support people experiencing domestic violence.

Important Considerations for Service Providers

- Not all strategies need to be applied to every person seeking support.
- Providers can identify each person's unique needs and concerns and select those techniques that would be most suitable to address them.
- Since people experiencing domestic violence may often face difficulties in getting help (e.g., family prevents them from talking to others, unable to leave home alone etc.)., it is likely that they may not be able to meet providers regularly.
- It helps providers to develop a brief and tailored intervention plan for each person keeping in mind their limitations and time commitment.

7.3.1. Awareness about Mental Health

Our thoughts, feelings and behaviour are interlinked. When people are faced with a distressing situation, it affects how they feel, what they think and what they do (Beck, 1967). For instance, people experiencing abuse may think that there is no way out, they may feel sad and overwhelmed and lose interest in things they previously enjoyed doing. This has implications for people's health and well-being in the short and long-term. Recognising and identifying experiences, can help people express these feelings in healthier ways and learn how to manage them (Fenigstein, 1975). It is the first step in working towards improving their mental health. Service providers can help people experiencing domestic violence to identify and make sense of their experiences (Srivastava et al., 2016).

7.3.2. Tracking Mood and Emotions

It is normal for thoughts and feelings to change throughout the day and across situations. This is a basic tendency of the mind to adapt to different experiences. Emotions also provide information, even the most uncomfortable ones. For instance, anger suggests a boundary has been crossed, people are then able to think about how to communicate their boundaries more clearly. Disappointment indicates that an expectation hasn't been met. It encourages them to review and re-assess their expectations. Guilt shows us that there is a mismatch in their behavior and values. It motivates people to align their actions and intentions. Emotions are rich in data and provide context to experiences. When people listen to their emotions, they learn more about themselves and others and how to manage them.

Service providers can help people experiencing DV to recognise their emotions and keep track of it. They can do this using a mood chart (Madhavan et al., 2022).

7.3.3. Mood Chart

Note: *These are questions you can use to initiate conversation with your clients about tracking mood and emotions. These are also questions you could reflect on and respond to which will help you understand yourself better as an individual and as a practitioner.*

Mood	Emotions	Thoughts
How am I feeling?	*What are some of the feelings I'm having?*	*What are some of the thoughts I'm having?*
Very good	*(e.g. "so happy")*	*(e.g. "After a long time, I went and visited my family")*
Good		
Okay		
Bad		
Very bad	*(e.g. "extremely low")*	*(e.g. "I don't think my partner will ever change")*

7.3.4. Thought-Feeling-Behaviour Cycle (Madhavan et al., 2022).

Providers can also work with people to identify the thought-feeling-behaviour cycle. Below are a few questions providers could ask to map the cycle.

Situation	What happened? Can you describe the experience to me?
Feeling	What is the main emotion you were feeling? What do you think you were feeling during the experience? How strong was the feeling (calm, mild, moderate, severe, extreme)? How strong is the feeling now?
Thoughts	What were the thoughts that came up for you during the experience that made you feel this way? What are the thoughts you are having right now?
Response	How did you react?
Outcome	What happened after you reacted that way?
Alternate Response	If we had to think of other responses that could have helped, what do you think they could have been?
Alternate Outcome	How would it be different if you responded this way?

Emotions and thoughts affect how people behave. By being aware of one's emotions, people can choose healthier behaviour to work through them (Madhavan et al., 2022).

Emotion	Usual Response	Healthier Response	Ways to Respond
Fear **Loss of Control**	· Avoid anything that is remotely fearful · Isolate	· Find ways to protect oneself · Make a safety plan (refer to Section 2, page 71-73)	· Emphasise, "You are in a safe place now. We can talk about how to keep you safe." · "This is common, but we can discuss ways to help you feel less anxious." · "You have some choices and options today on how to proceed.
Sadness **Numbness** **Hopelessness** **Helplessness**	· Disconnected from others · Stay in bed · Avoid eating · Smoke/drink	· Make sure to eat in a timely and healthy manner · Rest · Engage in one activity that is pleasurable or calming	· Focus on strengths and how they have been able to handle a past dangerous or difficult situation. · "We are here to help you" · "Many women do manage to improve their situation. Over time you will likely see that there is hope.
Anger	· Fight · Put oneself in danger	· Take a time out · Rehearse the conversation with oneself	· Acknowledge that this is a valid feeling.
Shame **Guilt**	· Blame oneself for all problems	· Express the thoughts and feelings to oneself · Talk to trusted people and share	· "There is no loss of honour in what happened. You are of value." · "You are not to blame for what happened to you. You are not responsible for his behaviour."

Note: Anger

People experience anger. This is a normal reaction to abuse and mistreatment. Anger can be an extremely difficult emotion to control and affects both the mind and the body. Women and queer persons may find it difficult to express their anger or suppress it. Anger may come up during conversations with the service provider, the person may even express it directly towards them. This is a way they cope with their pain. Unregulated anger reactions or outbursts can have even worse consequences for the person experiencing DV, for instance, lead to more violence. Therefore, providers can gently ask the person the following questions to help them deal with their anger and express it safely:

- What do you want to say/do?
- What could be the reaction if you say/do this?
- Will yelling or arguing help improve your situation and convince others about your feelings?
- How do you think you can communicate what you want to say/do to bring out the best possible results in the situation for you?
- What are some safe spaces where you can express your feelings without risk of further violence?

It is important for providers to be aware of these responses and remember that violence results from a partner's need to control and gain power in the relationship, and not because of the person's expression of anger.

7.3.5. Activities

Activity 1

Instructions: *Think of a stressful situation that you have experienced in your life. Complete the thought-feeling-behaviour cycle. Describe the situation, the thoughts that came up, the way you felt, the behaviour you engaged in and the outcome.*

Activity 2

Instructions: *Below are case vignettes of people experiencing violence. Please read the description and answer the questions below.*

Case Example 1

Devi and Priya have been together for 3 years. Priya verbally abuses Devi in front of others. Devi feels humiliated and sad. Whenever this happens, she goes into her room and tries to avoid Priya. She thinks that it is better to not get angry. She thinks that she is overreacting and Priya is just trying to be funny. She also thinks that the situation will get better. However, in the last 2 weeks, Priya has spoken about their personal matters in front of others and made jokes about it. Devi doesn't know what to do. She continues to try to ignore the situation but it is really bothering her.

1. What is the situation the person is experiencing? .....

.....

.....

2. What are the emotions they are feeling? .....

.....

.....

3. What are the thoughts they are experiencing? .....

.....

.....

4. What is the action they are engaging in? .....

.....

.....

5. What is the outcome of this? .....

.....

.....

6. What do you think could be a healthier response? .....

.....

.....

7. How do you think the healthier response would affect the person's emotions and thoughts? .....

.....

.....

.....

Case Example 2

Rajalaxmi's husband takes her salary every month and keeps it with him. When she asks him, he gives her little to nothing. She feels like she can't do anything without asking him for permission. One time, she stole the money from the drawer. Her husband caught her. He then hit her. Rajalaxmi felt ashamed. She thought she deserved his anger; her husband takes care of a lot more financial matters and she shouldn't have stolen from the drawer. So, now she doesn't ask him for much. She has decided to cut down on expenses by not going out, meeting people and engaging in activities she liked.

1. What are the emotions they are feeling? .....

.....

.....

2. What are the thoughts they are experiencing? .....

.....

.....

3. What is the action they are engaging in? .....

.....

.....

4. What is the outcome of this? .....

.....

.....

5. What do you think could be a healthier response? .....

.....

.....

6. How do you think the healthier response would affect the person's emotions and thoughts? .....

.....

.....

.....

Activity 3

Instructions: *Track your mood for 3 days using the mood chart. You can use the following questions to guide your discussion with a person/group:*

1. Did you find it helpful? If yes, why was that so? If no, why do you think that is? .....

.....

.....

2. What did you observe about yourself when doing the activity?
   i. Did you notice a range of emotions? If yes, can you describe them? If not, why do you think that is?

.....

.....

   ii. Did you notice a range of thoughts? If yes, can you describe them? If not, why do you think that is?

.....

.....

3. How did you feel while doing the activity? .....

.....

.....

4. How easy or difficult did you find it? .....

.....

.....

Day 1

Mood	Emotions	Thoughts
How am I feeling?	*What are some of the feelings I'm having?*	*What are some of the thoughts I'm having?*
Very good		
Good		
Okay		
Bad		
Very bad		

Day 2

Mood	Emotions	Thoughts
How am I feeling?	*What are some of the feelings I'm having?*	*What are some of the thoughts I'm having?*
Very good		
Good		
Okay		
Bad		
Very bad		

Day 3

Mood	Emotions	Thoughts
How am I feeling?	*What are some of the feelings I'm having?*	*What are some of the thoughts I'm having?*
Very good		
Good		
Okay		
Bad		
Very bad		

7.4. Self-Soothing Techniques to Support Survivors

The mind and body are deeply connected. Not only do thoughts, emotions and behaviours influence each other, they also affect the body. For instance, people may feel anxious and find it difficult to sleep at night and be exhausted the next day. People experiencing DV often face short and long-term health complications including arthritis, chronic pain and stress, stomach and digestion problems, heart problems, migraine headaches, and substance addiction (Stubbs, 2021; Campbell, 2002). Service providers can help women and queer persons take care of their bodies to support both their physical and mental health. One way they can do this is by increasing the person's body awareness (how they are feeling in their body) and using self-soothing strategies to feel calm and in more control of their body and mind.

Below are simple and useful techniques that providers can teach to help people manage emotions and relax the body.

Focus on Breath

- Breathe slowly and place the hands on the chest. Search for a heartbeat.
- Place the hands on the abdomen and breathe gently (e.g., four counts in through the nose, hold the breath for two and four counts out through the mouth)
- Breathe deeply and feel the air fill your lungs
- Repeat till the breath slows down (3-5 minutes)

Engage the Senses

- Search for 5 things to see
- Search for 4 things to touch
- Search for 3 things to hear
- Search for 2 things to smell
- Search for 1 thing to taste

Use the Body

- Do a body scan. Focus on how the body feels from the head till the toes
- Notice areas that feel tight or concentrated
- See if you can stretch or loosen those areas
- Clench and unclench the fist to release tension
- Move in any way to release the energy, for instance, exercise or dance

Use Water

- Drink water
- Place your hands in water
- Go for a shower
- Wash your face
- Keep changing the temperature of the water and notice the sensations on different parts of the body while doing this
- Hold ice, notice the sensation and observe how it melts

7.4.1. Progressive Muscle Relaxation

Progressive muscle relaxation involves the tightening and relaxing of the muscles, in a specific pattern and one at a time (Jacobson, 1977).

Instructions

- Sit on a chair comfortably. You may also lie down if you prefer
- Keep the body loose, light, and free
- Remain calm and comfortable
- Keep your eyes closed
- Avoid thinking about other things and remain in the moment
- Avoid extra movements of the body
- During the tensing part of the exercise cycle, tense the muscle tightly and hold for a slow count of 5 seconds
- During the release part of the exercise cycle, relax the muscle quickly and completely
- Along with the body, let the mind relax; experience how relaxed the muscle is feeling for 10 seconds
- Try to observe the changes such as tightness as well as light and soothing sensations

1. Lift your toes upward. Tense (5s), then release and relax (10s)
2. Pull your toes downward. Tense (5s), then release and relax (10s)
3. Next, tense your calf muscles. Hold (5s), then release and relax (10s)
4. Move your knees toward each other. Tense (5s), then release and relax (10s)
5. Squeeze your thigh muscles. Hold (5s), then release and relax (10s)
6. Clench your hands. Hold (5s), then release and relax (10s)
7. Tense your arms. Hold (5s), then release and relax (10s)
8. Squeeze your buttocks Hold (5s), then release and relax (10s)
9. Pull in your stomach muscles. Hold (5s), then release and relax (10s)
10. Inhale and tighten your chest. Hold (5s), then breath out and relax (10s)
11. Raise your shoulders to your ears. Tense (5s), then release and relax (10s)
12. Purse your lips together. Hold (5s), then release and relax (10s).
13. Open your mouth wide. Hold (5s), then release and relax (10s)
14. Close your eyes tightly. Hold (5s), then release and relax (10s)
15. Lift your eyebrows. Hold (5s), then release and relax (10s)

7.4.2. Activities

Note: *These are activities you can practice yourself to understand the significance of self-soothing techniques and encourage clients to try to deal with the difficult situation they are dealing with.*

Activity 1

Instructions: *Pair up with someone. Practice progressive muscle relaxation with each other. Make observations about the experience and provide feedback to one another.*

Activity 2

Instructions: *Practice any other self-soothing technique at home for 3 days, specifically during times you are feeling stressed, anxious etc. Make note of how it was to practice the technique. You can use the following questions to guide you:*

1. When did you practice the technique?
   a. What time of the day was it? .....

.....

.....

   b. Why did you decide to practice it then? Was there a situation that encouraged you to practice it?

.....

.....

2. What were you feeling right before doing the technique? .....

.....

.....

3. What did you feel while doing the technique? .....

.....

.....

4. How did you feel after doing the technique? .....

.....

.....

5. What are other situations you think you will find the technique helpful? .....

.....

.....

.....

.....

7.5. Positive Coping Techniques to Support Survivors

7.5.1. Self-kindness

Practicing self-kindness can help in emotional healing and support people experiencing DV to build internal coping skills (also known as resilience). It can also help minimise feelings of self-blame, self-loathing, shame, and guilt. Providers can ask the following questions to help people develop a kinder voice (Madhavan et al., 2022).

Identifying Negative Reactions

- Do you think you are harsh on yourself sometimes, more than you would be on anyone else? Would you like to talk about it? What kinds of things do you say to yourself?
- What would you say to someone who has similar problems, such as a good friend?

Gaining Perspective

- Are there times where you blame yourself for problems? Is it possible that you might be placing too much blame on yourself?
- Is it possible to think about things differently so you can have a more balanced perspective?

Identifying Strengths

- What are some things you like and appreciate about yourself? What are some of your strengths?
- What are some things you are grateful for in your life?
- How could you be kinder to yourself in the process of dealing with these difficulties?
- What is currently going well?
- How have you coped with difficult situations in the past?
- What are some situations you can remember that you overcame and that made you feel proud of yourself?

7.5.2. Activity

Instructions: Reflect and answer the questions mentioned below.

Note: *These are questions you can use to initiate conversation with your clients about positive coping techniques. These are also questions you could reflect on and respond to which will help you understand yourself better as an individual and as a practitioner.*

1. What are some things you like and appreciate about yourself? What are some of your strengths?.....

.....

.....

2. What are some things you are grateful for in your life?.....

.....

.....

3. How could you be kinder to yourself in the process of dealing with these difficulties?

4. What is currently going well?

5. How have you coped with difficult situations in the past?

6. What are some situations you can remember that you overcame and that made you feel proud of yourself?

7.5.3. Problem-Solving

Problem solving refers to the process by which people identify, better understand, and discover solutions to deal with their problems. The problem-solving technique is used to address a wide range of emotional and behavioral difficulties that people experience and enhance their coping skills and resilience (D'Zurilla & Nezu, 2001). This means that they will feel more equipped to manage problems after learning the problem-solving technique (Chinaveh, 2013).

The problem-solving technique focuses on two types of coping. First is problem-focused coping which is altering the situation to make it less threatening to the person. The second is emotion-focused coping, which is changing the emotions or reactions attached to the situation (Baker & Berenbaum, 2007).

If a person is yelling at their partner that is leading to more violence, problem-focused coping may include finding different ways to communicate to their partner. In the same situation, emotion-focused coping may include not getting into a fight and using techniques to help the person feel less sad and angry. Through emotion-focused coping, we change unhelpful or distressing emotions and reactions to cope better.

The main goal of problem-solving is to enhance the person's skills to manage concerns. By adding problem- solving techniques to their coping strategies, it may help them feel more confident in their ability to manage their problems and view the situation differently (Dawson et al., 2015).

Stressful situations may come to be viewed as problems they can overcome rather than overwhelming concerns that they cannot do anything about. This technique may help with problems they sought help for and other concerns they may experience in the future.

People experiencing DV may struggle to identify core problems and resolve them independently. Service providers can enable people to identify problems, explore ways to deal with them and provide support when implementing a solution or technique to manage the problem, and suit it to the person's needs and abilities. They can use the four steps described below.

1. Identify the problem: Identify and define the problem clearly and simply.

- Inquire about the problem
  - What are some of the concerns you have been facing?
  - What are some of the causes of these concerns?
  - How long have you been experiencing them?
  - What is the main issue that needs to be addressed immediately?
- Select the problem the person would like to work on, i.e., target problem
- Define the target problem in clear and simple terms

> ***Problem:*** *Roja's partner has a serious drinking problem and verbal abuse escalates whenever he is drunk.*

2. Generate options: Come up with options to solve the problem.

- Encourage them to think of any kind of strategy, solution or idea that may help them with their problem
  - In what ways can we address these concerns?
  - What are some of the actions that can be taken?
- Encourage them to think of as many options as possible
- No option should be judged as 'good' or 'bad'

> ***Options:***
> - *Roja can have an open conversation when her husband is sober and tell him that she doesn't feel good when he drinks. She can also explain the financial and emotional impact of his alcohol dependence on the family.*
> - *Roja can suggest a visit to a deaddiction centre in the best interests of her husband, herself and their family.*
> - *Roja can reach out to friends and family members that her husband trusts for support to stage an intervention and help him recognize that his alcohol dependence is impacting his health and his family's well-being.*
> - *Roja can reach out to counselling support organizations to address the problem.*
> - *Roja*

3. Choose the '' option:

From the different options, select the one that may be most appropriate.

- Discuss the pros and cons of each option
- Assess how realistic, practical and helpful each option is
  - Can it be applied to the present situation?
  - How practical is the option?
  - How easy is it to implement?
  - Is this going to be helpful or harmful?
- Multiple options may be picked depending on the situation

continued on next page

Choosing the option:.

Roja can suggest a visit to a deaddiction centre in the best interests of her husband, herself and their family.	
Pros:	Cons:
Roja can reach out to friends and family members that her husband trusts for support to stage an intervention and help him recognize that his alcohol dependence is impacting his health and his family's well-being.	
Pros:	Cons:
Roja can reach out to counselling support organizations to address the problem.	
Pros:	Cons:

4. Implement and review the option: Create a plan to implement the option when the person is ready and then review it.

- Visualize carrying out the option
  - How would you carry out the option?
    - Who else will be involved?
    - What will you say?
    - What will you do?
    - Where will you do it?
    - When will you do it?
    - How frequently will you try it out?
  - What would it look like to carry out the option?
  - How does it make you feel to think about carrying it out?
- Make a plan that is practical, simple and easy to implement
- Considerations:
  - What are the barriers you may face?
  - What could you do in these situations?
  - What is the support you require?
  - Is there anyone you can contact for support?
- Identify resources that will help carry out the plan
- Review the plan
  - How was it to carry out the plan?
- Modify and troubleshoot any challenges
  - What happened? Did it work? Was it helpful?
    - If yes, discuss what helped implement the plan
    - If not, what were the reasons behind it? What could have been done differently?
    - If not, what is the alternate option that could be tried?

continued on next page

The plan:

What option does Roja choose? Roja has decided to address the problem in the next 3 days. She will practice the conversation with herself first. What are the things she needs to keep in mind?
1. She will speak about this at night, right after dinner, because that is a time when her partner is not stressed and agitated. 2. She will make 'I' statements instead of 'you' statements and focus on what she is feeling. *What other options will you suggest?* 3.

Barriers Roja May Face	Solutions
1. She may feel nervous and scared before the conversation and worry about her husband's reaction.	She can talk to a trusted family member or friend about her decision to talk to her husband. She can let them know that if the situation escalates she will reach out to them and if they don't hear from her, they should check in to see if everything is okay
2.	
3.	
4.	
5.	

continued on next page

Evaluating the plan:

1. Did her husband listen to what she had to convey?	*If yes, what is the next course of action?* *If not, what is the next course of action?*
2. Has there been a change after that?	*If yes, what is the next course of action?* *If not, what is the next course of action?*
3. Is another solution necessary?	*If yes, what is the next course of action?* *If not, what is the next course of action?*
4. What worked and what did not?	
5.	

7.5.4. Activities

Activity 1

Instructions: *Below are a description of problems of people experience. Please read the descriptions and answer the questions mentioned below.*

Case Example 1

Selvi spoke about how her partner Ravi has gotten more aggressive since the passing of his father. He sometimes pushes her when he's angry and seems to be irritated with Jahnvi on a daily basis. Sometimes she thinks she should talk to Ravi about his behaviour and ask Ravi to seek help. Other times, she thinks he should just leave. Selvi feels lost, confused and sad. She is struggling with basic self-care such as taking a shower or eating.

1. Imagine you were Selvi. What is the main problem you would like to work on? .....

.....

.....

2. What are the options you would come up with to solve the problem? .....

.....

.....

3. What is the 'best' option you would select, and why? .....

.....

.....

4. What is the plan you would implement? .....

.....

.....

Case Example 2

Kavitha's husband insults and puts her down in front of others. He calls her useless and says that she's very dramatic, among other things. It makes Kavitha feel ashamed that he thinks this of her and that he says it in front of others. She also feels guilty and tries to please him constantly. When she does this, he gets angrier.

1. Imagine you were Kavitha. What is the main problem you would like to work on? .....

.....

.....

2. What are the options you would come up with to solve the problem? .....

.....

.....

3. What is the most appropriate option you would select, and why?

4. What is the plan you would implement?

End Note

The strategies mentioned in Chapter 6 and 7 of the handbook, including building awareness about mental health and domestic violence, self-soothing techniques, positive coping techniques, and service flow including safety planning and referrals influence the three internal factors - awareness, perceived support and self-efficacy, affecting a person's readiness to respond and take action when in a situation of violence. For instance, positive coping techniques can help people feel more confident about their actions, i.e., self-efficacy. Similarly providing referrals could help people feel they have a support system, i.e., perceived support. These techniques could also help fight against external factors that reduce a person's capacity to deal with domestic violence.

8

Collective Care & Self-Care

8.1. Introduction

Working on issues of gender-based violence and domestic violence can be challenging. Listening to narratives of violence on a daily basis may cause significant distress, vicarious trauma and burnout. Working in settings and contexts where change takes a long time and care providers have to contend with red tape, institutional obstacles and personal consequences to deliver support might lead to feelings of fear, anxiety, hopelessness and helplessness. The additional pressures that come from dealing with families and communities that cover up or dismiss violence and insist that the service provider do the same means that case workers may often end up facing the risk of threats, intimidation and violent backlash, all leading to high risk and increased stress.

In PCVC's (2022) research study on mapping and effectiveness of support services in Tamil Nadu, service providers across sectors reported being severely impacted by the systemic, familial, individual pressures they encountered in the course of their work.

- Responding to crises 24/7 with inadequate breaks/leaves.
- High caseload and workload.
- Working under threat of physical harm.
- Loss of sleep, appetite, rest and recreation.
- Long term impact on mental and physical health - experience of anxiety, depression, chronic pain etc.
- Impact on relationships with spouse, children, other family members due to the nature of work.
- Lack of collective care and self care mechanisms to access including resources, training & awareness, institutional benefits etc.

Care providers cannot deliver effective support in the face of such widespread impact to their own well-being. In this chapter, we will look at some collective care and self care strategies that will serve as a beginning to taking better care of the individuals who drive first line support services.

Recognising the signs and symptoms of vicarious trauma

"'Vicarious trauma' describes the cumulative effects of exposure to information about traumatic events and experiences, potentially leading to distress, dissatisfaction, hopelessness and serious mental and physical health problems. The effects of vicarious trauma vary from person to person. For some people, there may be a wide range of signs and symptoms, while others may experience problems in one particular area of their lives." (Monash Gender and Family Violence Prevention Center, 2021)

Common signs of vicarious trauma:

- ☐ difficulty leaving work at the end of the day, noticing you can never leave on time
- ☐ taking on too great a sense of responsibility or feeling you need to overstep the boundaries of your role

- ☐ frustration, fear, anxiety, irritability
- ☐ intrusive thoughts of a client's situation or distress
- ☐ disturbed sleep, nightmares, racing thoughts
- ☐ problems managing personal boundaries
- ☐ loss of connection with self and others, loss of a sense of own identity
- ☐ increased time alone, a sense of needing to withdraw from others
- ☐ increased need to control events, outcomes, others
- ☐ loss of pleasure in daily activities.

Adopted from safeandequal.org.au/working-in-family-violence/wellbeing-self-care-sustainability/vicarious-trauma-burnout

What is Burn Out?

'Burnout' describes the prolonged physical and psychological exhaustion that workers can experience from continuous exposure to structural oppression and social injustice at work.

The effects of burnout vary from person to person. For some people, there may be a wide range of signs and symptoms, while others may experience problems in one particular area of their lives.

Common signs of burnout:

- ☐ physical and emotional stress
- ☐ low job satisfaction
- ☐ feeling frustrated by or judgmental of clients
- ☐ feeling under pressure, powerless and overwhelmed
- ☐ not taking breaks, eating on the run
- ☐ unable to properly refuel and regenerate
- ☐ frequent sick days or mental health days
- ☐ irritability and anger

**Adopted from safeandequal.org.au/working-in-family-violence/wellbeing-self-care-sustainability/vicarious-trauma-burnout*

8.2. Collective Care

We might all be familiar with the term self-care, but less so about collective care. We cannot, however, talk about self-care without first understanding collective care.

All organizations and institutions, and especially those working on issues like gender-based violence and domestic violence in high pressure environments, have a duty of care towards the people working within these spaces. The individuals working within these environments cannot just care for themselves as they do the important work of caring for and supporting survivors - we have to cultivate a workplace environment that encourages people to care for one another and look at well-being as a shared responsibility. Stress, burnout and vicarious trauma are collective workplace issues which need a collective workplace solution.

Collective care looks at the well-being, nourishment and growth of all individuals within the organization and how each individual can contribute and shape the direction of these efforts.

This requires:

- Fostering a supportive team environment
- Formal and informal support systems within the organization - sensitive leadership, budgeting for care work, availability and accessibility of resources, trainings, case supervision and mentoring, peer support, space for fun and recreation within the workplace, care circles and support groups, access to mental health support etc
- Preventive and redressal mechanisms to address stress and burnout and nurture well-being.

8.2.1. Activity

https://www.tarshi.net/downloads/A_Guidance_Note%20for_Organisational_Intervention_English.pdf

8.3. Self-Care

It is important for providers to commit to and prioritize caring for themselves while working with people experiencing abuse and violence. They may have strong reactions or emotions when listening to or talking about violence with women and queer persons. This is especially true if they have experienced violence themselves – or are experiencing it now. They must be aware of their emotions, take the opportunity to understand themselves better and seek the support they require.

Ways people can care for themselves:

- Engage in basic self-care.
- Eat healthy, well-balanced meals.
- Move their body regularly.
- Get enough sleep.
- Keep themselves hydrated.
- Avoid excessive use of substances.
- Try to maintain hygiene (take a shower etc.)
- Practice awareness
- Notice triggers.
- Challenge and reframe unhelpful thoughts.
- When in a loop, refocus attention.
- Take perspective.
- Talk to themselves kindly.
- Understand their needs.
- Learn how to soothe themselves.
- Connect with others.
- Reach out and accept help.
- Get in touch with a mental health professional.
- Create a routine that works for them.
- Make time for something pleasurable every day.
- Make pleasure a priority.
- Make time to unwind.
- Establish clear work, play and rest boundaries.
- Set realistic goals.
- Focus on one thing at a time.
- Reward themselves after achieving something.
- Be gentle themselves if they're unable to meet their goals.

Note on working with survivors of gender-based violence

Note on working with survivors of gender-based violence - In talking about burnout and vicarious trauma, it is important to note that there are a variety of individual, environmental, institutional factors that contribute to the experience. Many of the ill-effects of vicarious trauma and burnout may be due to the inability to provide dignified and respectful support to survivors and the lack of access to support to focus on one's own well-being. Working with survivors of violence can be a deeply transformative and empowering experience for service-providers and there is increasing research that also looks at the strength and resilience that service providers may gain in the course of their work.

8.3.1. Activity

https://www.brown.edu/campus-life/health/services/promotion/sites/healthpromo/files/self%20care%20assessment%20and%20planning.pdf

References

Adapted from Saakvitne, Pearlman, & Staff of TSI/CAAP (1996). Transforming the Pain: A Workbook on Vicarious Traumatization. Norton. Adapted by Lisa D. Butler, PhD. https://www.literacymn.org/sites/default/files/self-care_assesment.pdf

American Psychological Association. (2019). Guidelines for Psychological Practice With Transgender and Gender Nonbinary People. American Psychologist, 74(9), 1211–1225. https://doi.org/10.1037/amp0000485

Anand, A., Chowdhary, N., Dimidjian, S., & Patel, V. (2013).

Healthy Activity Program. Sangath. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/

https://sangath.in/wp-content/uploads/2021/05/Healthy-Activity-Program_Manual.pdf

Anderson, D. K., & Saunders, D. G. (2003). Leaving an abusive partner: An empirical review of predictors, the process of leaving, and psychological well-being. Trauma, Violence, and Abuse, 4,163–91.

Ard, K., & Makadon, H.J. (2011). Addressing Intimate Partner Violence in Lesbian, Gay, Bisexual, and Transgender Patients. Journal of General Internal Medicine, 26 (8), 930-933.

Baker, J.P., Berenbaum, H. (2007). Emotional approach and problem-focused coping: a comparison of potentially adaptive strategies. Cognition and Emotion, 21, 95–118. doi: 10.1080/02699930600562276

Barnes R. (2010). Suffering in a silent vacuum: woman-to-woman partner abuse as a challenge to the lesbian feminist vision. Feminism and Psychology, 21, 233–239. Doi: 10.1177/0959353510370183

Beck, A. T. (1967). Depression: Causes and treatment. Philadelphia: University of Pennsylvania Press.

Bornstein, D. R., Fawcett, J., Senturia, K.D., Shiu-Thornton, S., & Sullivan, M., (2006). Understanding the experiences of lesbian, bisexual and trans survivors of domestic violence: a qualitative study. Journal of Homosexuality, 51, 159-181. Doi. 10.1300/J082v51n01_08

Brown, J. (1997). Working toward freedom from violence: The process of change in battered women. Violence Against Women, 3, 5–26.

Brown, T., & Herman, J.L. (2015). Intimate Partner Violence and Sexual Abuse Among LGBTQIA+ People. Discrimination and Violence. UCLA, Williams Institute. https://williamsinstitute.law.ucla.edu/publications/ipv-sex-abuse-LGBTQIA+-people/

Browne, C.H. & Ung, T. (2019). Protective Factors for Survivors of Domestic Violence. QIC-DVCWchrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://dvchildwelfare.org/wp-content/uploads/2019/03/FWV-QIC-Protective-Factors-Brief-Final-09-1.pdf

Buckley, H., Whelan, S., & Holt, S. (2006). Listen to Me! Children's Experience of Domestic Violence. Children's Research Centre. Trinity College: Dublin.

Campbell J. C. (2002). Health consequences of intimate partner violence. Lancet (London, England), 359(9314), 1331–1336. https://doi.org/10.1016/S0140-6736(02)08336-8Foundation for Practice. Families in Society: The Journal of Contemporary Social Health, 5 (1).

Calton, J. M., Cattaneo, L. B., & Gebhard, K. T. (2016). Barriers to Help Seeking for Lesbian, Gay, Bisexual, Transgender, and Queer Survivors of Intimate Partner Violence. Trauma, Violence, & Abuse, 17(5), 585–600. doi:10.1177/1524838015585318

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S. A., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. American Journal of Public Health, 93(7), 1089– 1097.

CDC (2004). Sexual violence prevention: beginning the dialogue. Centers for Disease Control and Prevention.

CEHAT (2016). Guidelines for Counselling Women Facing Violence.https://www.cehat.org/cehat/uploads/files/Guidelines%20for%20counselling%281%29.pdf

Centre, Monash Gender and Family Violence Prevention (2021): Best Practice

Choudhury, A. (2022, May 23). Domestic Violence: When Sanctity of Family Is Prioritized Over Dignity of Survivors. Feminism in India. https://feminisminindia.com/2022/05/23/domestic-violence-when-sanctity-of-family-is-prioritised-over-dignity-of-survivors/

Chinaveh, M. (2013). The Effectiveness of Problem-solving on Coping Skills and Psychological Adjustment. Procedia - Social and Behavioral Sciences. 84. 4-9. 10.1016/j.sbspro.2013.06.499.

Cluss, P. A., Chang, J. C., Hawker, L., Scholle, S. H., Dado, D., Buranosky, R., & Goldstrohm, S. (2006). The process of change for victims of intimate partner violence: support for a psycho-social readiness model. Women's health issues: official publication of the Jacobs Institute of Women's Health, 16(5), 262–274. https://doi.org/10.1016/j.whi.2006.06.006

Cravens, J. D., Whiting, J. B., & Aamar, R. O. (2015). Why I stayed/left: An analysis of voices of intimate partner violence on social media. Contemporary Family Therapy: An International Journal, 37(4), 372–385. https://doi.org/10.1007/s10591-015-9360-8

Cunradi, C.B. (2010). Neighborhoods, alcohol outlets and intimate partner violence: Addressing research gaps in exploratory mechanisms. International Journal of Environmental Research and Public Health, 7, 799–813.

Dahlberg, L., & Krug, E.G., Mercy, J., Zwi, A., & Lozano, R. (2002). World Report on Violence and Health. Geneva, Switzerland: World Health Organization. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf

Dawson, K. S., Bryant, R. A., Harper, M., Kuowei Tay, A., Rahman, A., Schafer, A., & van Ommeren, M. (2015). Problem Management Plus (PM+): a WHO transdiagnostic psychological intervention for common mental health problems. World psychiatry: official journal of the World Psychiatric Association (WPA), 14(3), 354–357. https://doi.org/10.1002/wps.20255

Dempsey, M. M. (2005). [P22] What Counts as Domestic Violence? A Conceptual Analysis. William & Mary Journal of Women and the Law, 12.

Donovon, C., & Hester, M[P23]. (2011). Seeking help from the enemy: help-seeking strategies of those in same-sex relationships who have experienced domestic abuse. Child and Family Law Quarterly, 23(1), 26-40.

D'Zurilla, T.J. & Nezu, A. (2001). Problem-solving therapies. Handbook of cognitive-behavioral therapies. 211-245.

Engel G. (1980). The clinical application of the biopsycho-social model. American Journal of Psychiatry, 137; 535–544.

Emergency and Crisis. Monash University. Online resource. https://doi.org/10.26180/14605005.v1

Fenigstein A., Scheier M. F., Buss A. H. (1975). Public and private self-consciousness: Assessment and theory. Journal of Counselling and Clinical Psychology, 43(4), 522–527. 10.1037/h0076760

Fontanella, L., Maretti, M., & Sarra, A. (2014). Gender fluidity across the world: A multilevel item response theory approach. Quality and Quantity, 48 (5); 2553-2568.

From Transforming the Pain: A Workbook on Vicarious Traumatization by Karen W. Saakvitne and Laurie Anne Pearlman. Copyright 1996 by the Traumatic Stress Institute/Center for Adult and Adolescent Psychotherapy.

Garcia-Moreno. C. (2005). WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization.

Gerino, E., Caldarera, A.M., Curti, L., Brustia, P., & Rolle, L. (2018). Intimate Partner Violence in the Golden Age: Systematic Review of Risk and Protective Factors. Frontier Psychology, 4. https://doi.org/10.3389/fpsyg.2018.01595

Girshick, L. B. (2002). No Sugar No Spice: Reflections on Research on Woman-to-Woman Sexual Violence. Violence Against Women, 8(12), 1500-1520.

Green, K., & Feinstein, B. (2012). Substance Use in Lesbian, Gay, and Bisexual Populations: An Update on Empirical Research and Implications for Treatment. Psychology of Addictive Behaviours, 26 (2), 265-278.

Guidelines: Supporting the Wellbeing of Family Violence Workers During Times of

Guram, B., Salgado, G., Marchbank, J., & Early, S. D. (2020). Making Sense of a Global Pandemic: Relationship Violence & Working Together Towards a Violence Free Society. Kwantlen Polytechnic University: Surrey, BC. https://kpu.pressbooks.pub/nevr/

Harvey, S., Mitchell, M., Keeble, J., Nicholls, C., & Rahim, N. (2014). Barriers faced by Lesbian, Gay, Bisexual and

Transgender People in Accessing Domestic Abuse, Stalking, Harassment and Sexual Violence Services. Social research Retrieved from https://www.gov.wales/sites/default/files/statistics-and-research/2019-07/140604-barriers-faced-LGBTQIA+-accessing-domestic-abuse-services-en.pdf

Hasselle, A. J., Howell, K. H., Bottomley, J., Sheddan, H. C., Capers, J. M., & Miller-Graff, L. E. (2019). Barriers to intervention engagement among women experiencing intimate partner violence proximal to pregnancy. Psychology of Violence. 10(3),

Heise, L., Ellsberg, M., & Gottemoeller, M. (1999) Ending violence against women. Baltimore, Johns Hopkins University School of Public Health, Center for Communications Programs.

Jacobson, E. (1977). The origins and development of progressive relaxation. Journal of Behavior Therapy and Experimental Psychiatry, 8(2), 119–123.

Jennings, A., & Ralph, R. (1997). "In Their Own Words": Trauma survivors and professionals they trust tell what hurts, what helps and what is needed for trauma services. Department of Mental Health, Mental Retardation and Substance Abuse Services: Maine.

Jhonson, J. (2022). How to heal from a trauma bond. Retrieved from https://apn.com/resources/how-to-heal-from-a-trauma-bond-relationship/

Kalokhe, A., Del, R.C., Dunkle, K., Stephenson, R., Metheny, N., Paranjape, A. & Sahay, S. (2017). Domestic violence against women in India: A systematic review of a decade of quantitative studies. Global Public Health, 12 (4); 498-513. doi: 10.1080/17441692.2015.1119293

Kaur, R., & Garg, S. (2008). Addressing Domestic Violence Against Women: An Unfinished Agenda. Indian journal of community medicine: Official publication of Indian Association of Preventive & Social Medicine, 33, 73-6. Doi: 10.4103/0970-0218.40871.

Kelley, M. L., Klostermann, K., Mignone, T., & Milletich, R. J. (2011). Alcoholism and partner aggression among gay and lesbian couples. Aggression and Violent Behaviour, 16, 115–119. Doi: 10.1016/j.avb.2011.01.002

Kirkham, J.G., Choi,N., & Seitz,D.P. (2016). Meta-analysis of problem-solving therapy for the treatment of major depressive disorder in older adults. Int J Geriatr Psychiatry, 31(5):526-535. doi:10.1002/gps.4358

Kress V. E., Protivnak J. J., & Sadlak L. (2008). Counseling clients involved with violent intimate partners: the mental health counselor's role in promoting client safety. Journal of Mental Health Counseling, 30(3), 200–210.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. Journal of general internal medicine, 16(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kusnanto, H., Agustian, D., & Hilmanto, D. (2018). Biopsycho-social model of illnesses in primary care: A hermeneutic literature review. Journal of family medicine and primary care, 7(3), 497–500. https://doi.org/10.4103/jfmpc.jfmpc_145_17

Mahapatro, M., Gupta, R., & Gupta, V. (2012). The risk factor of domestic violence in India. Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine, 37 (3), 153–157. https://doi.org/10.4103/0970-0218.99912

Mahapatro, M., Prasad, M. M., & Singh, S. P. (2021). Role of Social Support in Women facing Domestic Violence during Lockdown of Covid-19 while Cohabiting with the Abusers: Analysis of Cases Registered with the Family Counseling Centre, Alwar, India. Journal of Family Issues, 42(11), 2609–2624. https://doi.org/10.1177/0192513X20984496

Mehra, M. (2019). Why Do Women Stay in Abusive Relationships? Feminism in India. https://feminisminindia.com/2019/10/30/women-stay-abusive-relationships/

Messing J. T., Bagwell-Gray M. E., Ward-Lasher A., Durfee A. (2021). 'Not bullet proof': The complex choice not to seek a civil protection order for intimate partner violence. International Review of Victimology, 27(2), 173–195. https://doi.org/10.1177/0269758021993338

Messinger, A. M. (2011). Invisible victims: same-sex IPV in the national violence against women survey. Journal of Interpersonal Violence, 26, 2228–2243. Doi: 10.1177/0886260510383023

Meyer, D. (2020[P24]). "So Much for Protect and Serve": Queer Male Survivors' Perceptions of Negative Police Experiences. Journal of Contemporary Criminal Justice, 36(2), 228–250. https://doi.org/10.1177/1043986219894430

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: Preparing people for change (2nd ed.). New York: Guilford Press.

Murray C. E., & Graves K. N. (2012). Responding to family violence: A comprehensive, research-based guide for therapists. New York: Routledge.

Murray, C. E., Horton, G. E., Johnson, C. H., Notestine, L., Garr, B., Marsh, A., Flasch, P., & Doom, E. B. (2015). Domestic violence service providers' perceptions of safety planning: A focus group study. Journal of Family Violence, 30, 381-392. DOI: 10.1007/s10896015-9674-1

National Coalition of Anti-Violence Programs. (2016). [P21] National Report on Hate Violence Against Lesbian, Gay, Bisexual, Transgender, Queer and HIV-Affected Communities Released Today. efaidnbmnnnibpcajpcglclefindmkaj/https://avp.org/wp-content/uploads/2017/05/2015_NCAVP_HVReport_MR.pdf

National Crimes Reports Bureau (2021). Crimes in India. Ministry of Home Affairs. https://ncrb.gov.in/sites/default/files/CII-2021/CII_2021Volume%201.pdf

Ministry of Health and family welfare, National Family health survey(NFHS - 5), 2019–21

https://main.mohfw.gov.in/sites/default/files/NFHS-5_Phase-II_0.pdf

Nayak, M. B., Patel, V., Bond, J. C., & Greenfield, T. K. (2010). Partner alcohol use, violence and women's mental health: population-based survey in India. The British journal of psychiatry : the journal of mental science, 196(3), 192–199. https://doi.org/10.1192/bjp.bp.109.068049

NEW Partnership for Children and Families & Behavioral Health Training Partnership ·University of Wisconsin - Green Bay Secondary Traumatic Stress: Building Resilience in Staff Adapted from Saakvitne, K.W. & Pearlman, A. (1996). Transforming the Pain: A Workbook on Vicarious

Traumatization Developed: April 2009 Revised: November 2011 http://muskie.usm.maine.edu/helpkids/TrainingNetwork/Calls/021914/HO%205%20Self-Care%20Assessment.pdf

Nezu, A.M., Nezu, C.M., & D'Zurilla, T.J. (2013). Problem-Solving Therapy: A Treatment Manual. New York. doi:10.1891/9780826109415.0001

Office on Women's Health. (2019). Effects of violence against women. Retrieved from https://www.womenshealth.gov/relationships-and-safety/effects-violence-against-women

Parekh, Aneree & Tagat, Anirudh & Kapoor, Hansika & Nadkarni, Abhijit. (2021). The Effects of Husbands' Alcohol Consumption and Women's Empowerment on Intimate Partner Violence in India. Journal of interpersonal violence. 37. 886260521991304. 10.1177/0886260521991304.

PCVC (2022). Mapping and Effectiveness of Domestic Violence

Pence, E. & Paymer, M. (1993). Education groups for men who batter: The Duluth model. New York: Springer. Domestic Abuse Intervention Programs (DAIP), The Duluth Model, Understanding the Power and Control Wheel. URL https://www.theduluthmodel.org/wheels/understanding-power-control-wheel/ [Date last accessed: 25th November 2021]

Peled, E., Eisikovits, Z., Enosh, G., & Winstok, Z. (2000). Choice and Empowerment for Battered Women Who Stay: Toward a Constructivist Model. Social work, 45, 9-25. Doi: 10.1093/sw/45.1.9.

Porter, S. & Fuller, K. (2022). Cycle of Abuse: What It Is & How to Heal. https://www.choosingtherapy.com/cycle-of-abuse/

Ranade, K., Chakravarty, S., Nair, P., Shringarpure, G. (2022). Queer Affirmative Counselling Practice - A Resource Book for Mental Health. Practitioners in India, Mumbai: Mariwala Health Initiative.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95–103.

Rolle, L., Giardina, G., Caldarera, A., Gerino, E., & Brustia, P. (2018). When Intimate Partner Violence Meets Same Sex Couples: A Review of Same Sex Intimate Partner Violence. Frontier Psychology. https://doi.org/10.3389/fpsyg.2018.01506

Rakovec-Felser Z. (2014). Domestic Violence and Abuse in Intimate Relationship from Public Health Perspective. Health psychology research, 2(3), 1821. https://doi.org/10.4081/hpr.2014.1821

Sabri, B., & Young, A. M. (2022). Contextual factors associated with gender-based violence and related homicides

perpetrated by partners and in-laws: A study of women survivors in India. Health care for women international, 43(7-8), 784–805. https://doi.org/10.1080/07399332.2021.1881963

Sachdev, V. (2022). Explained: Why Marital Rape Is Not a Crime in India (Yet). https://www.thequint.com/news/law/marital-rape-not-recognised-as-crime-in-india-explainer#read-more

Safe+equal-Working in family violence,Wellbeing, self care and professional sustainability,Vicarious trauma and burnout https://safeandequal.org.au/working-in-family-violence/wellbeing-self-care-sustainability/vicarious-trauma-burnout

Self-care assessment worksheet, Brown University https://www.brown.edu/campus-life/health/services/promotion/sites/healthpromo/files/self%20care%20assessment%20and%20planning.pdf

Sahani, B., & Mathur, P. (2020). What should I keep in mind when assessing a client for domestic violence? Retrieved from https://www.whiteswanfoundation.org/mental-health-matters/understanding-mental-health/what-should-i-keep-in-mind-when-assessing-a-client-for-domestic-violence

Satyanarayana, V., & Chandra, P. (2020). First level psychological intervention for women survivors of intimate partner violence. NIMHANS. https://images.assettype.com/whiteswanfoundation/2020-09/3a57161f-6393-4fa4-8d06-e656096c9cdc/Psychological_Intervention_Toolkit.pdf

Seelau E. P., & Seelau S. M. (2005). Gender-role stereotypes and perceptions of heterosexual, gay and lesbian domestic violence. Journal of Family Violence, 20, 363–371. Doi: 10.1007/s10896-005-7798-4

Semahegn, A., Mengistie, B. Domestic violence against women and associated factors in Ethiopia; systematic review. Reprod Health 12, 78 (2015). https://doi.org/10.1186/s12978-015-0072-1

Shrader, E., & Sagot, M. (2000). Domestic Violence: Women's Way Out. Pan American Health Organization. https://www1.paho.org/english/hdp/hdw/womenswayout.htm

Srivastava, K., Chatterjee, K., & Bhat, P. S. (2016). Mental health awareness: The Indian scenario. Industrial psychiatry journal, 25(2), 131–134. https://doi.org/10.4103/ipj.ipj_45_17

Stark, E., & Hester, M. (2019). Coercive control: Update and review. Violence Against Women, 25(1), 81– 104. https://doi.org/10.1177/1077801218816191

Stephens, E., & Eaton, A. (2020). Cultural Factors Influencing Young Adult Indian Women's Beliefs about Disclosing Domestic Violence Victimization. Journal of Social Issues, 0 (0); 1-30.

Stith, S. M., Smith, D. B., Penn, C. E., Ward, D. B., & Tritt, D. (2004). Intimate partner physical abuse perpetration and victimization risk factors: a meta-analytic review. Aggression and Violent Behavior, 10 (1), 65-98.

Stubbs, A., & Szoeke, C. (2022). The Effect of Intimate Partner Violence on the Physical Health and Health-Related Behaviors of Women: A Systematic Review of the Literature.

Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD.

Tarshi and Nazariya (2020). A Guidance Note for Organisational Intervention https://www.tarshi.net/downloads/A_Guidance_Note%20for_Organisational_Intervention_English.pdf

Trauma, violence & abuse, 23(4), 1157–1172. https://doi.org/10.1177/1524838020985541.

Support Services in Tamil Nadu.

Todahl, Jeff & Linville, Deanna & Bustin, Amy & Wheeler, Jenna & Gau, Jeff. (2009). Sexual Assault Support Services and Community Systems Understanding Critical Issues and Needs in the LGBTQIA+ Community. Violence against women. 15. 952-76. 10.1177/1077801209335494.

Turell, C. S. (2000). A descriptive analysis of same-sex relationship violence for a diverse sample. Journal of Family Violence ,15, 281–293. Doi: 10.1023/A:1007505619577

United Nations (2020). What Is Domestic Abuse? United Nations. https://www.un.org/en/coronavirus/what-is-domestic-abuse

United Nations. (1993). Declaration on the elimination of violence against women. New York: UN.

UNW, UNFPA, WHO, UNDP and UNODC (2015). Essential Services Package for Women and Girls Subject to Violence - Core Elements and Quality Guidelines.

https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2015/Essential-Services-Package-Module-1-en.pdf

“UN backs global action to end violence against women and girls amid COVID-19 crisis”, UN News Global perspective Human stories (2020) https://news.un.org/en/story/2020/04/1061132

“UN chief calls for domestic violence ‘ceasefire’ amid ‘horrifying global surge’ UN News Global perspective Human stories (2020)https://news.un.org/en/story/2020/04/1061052

Velleman, R., Chowdhary, N., Dabholkar, H., Dimidjian , S., Fairburn, C., & Patel, V. (2014). The PREMIUM Counselling Relationship Manual. Sangath.

Walker, Lenore E. (1979) The Battered Woman. New York: Harper and Row.

Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework – Second edition, Practice Tool 2 Common risk assessment tool, pg. 88-94.

http://muskie.usm.maine.edu/helpkids/TrainingNetwork/Calls/021914/HO%205%20Self-Care%20Assessment.pdf

Whiting, J. B., Oka, M., & Fife, S. T. (2012). Appraisal distortions and intimate partner violence: Gender, power, and interaction. Journal of Marital and Family Therapy. Doi: 10.1111/j.1752-0606.2011. 00285.x

Women's Domestic Violence Court Advocacy Program. (2020). Charmed and Dangerous. Legal Aid, New South Wales. https://www.dvwest.org.au/wp-content/uploads/2020/11/Charmed-and-dangerous.pdf

Wood, Julia. (2001). The Normalization of Violence in Heterosexual Romantic Relationships: Women's Narratives of Love and Violence. Journal of Social and Personal Relationships. 18. 239-261. 10.1177/0265407501182005.

World Health Organization (2002). Understanding and addressing violence against women. World Health Organization. https://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf

World Health Organization. (2013). Global and regional estimates of violence against women: prevalence and health impacts of intimate partner violence and non-partner sexual violence. World Health Organization. https://www.who.int/publications/i/item/9789241564625

World Health Organization. (2014). Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. World Health Organization. https://apps.who.int/iris/handle/10665/136101

World Health Organization. (2020). The ecological framework. Retrieved from https://www.who.int/violenceprevention/approach/ecology/en/

Yadav, P. (2018). Why Sexual Assault Is Among the Most Traumatic Experiences Women Can Face. https://thewire.in/health/metoo-timesup-sexual-assault-trauma-anxiety-ptsd-recovery

Zeoli, A. M., Rivera, E. A., Sullivan, C. M., & Kubiak, S. (2013). Post-separation abuse of women and their children: Boundary-setting and family court utilization among victimized mothers. Journal of Family Violence, 28(6), 547–560. https://doi.org/10.1007/s10896-013-9528-7

Zoppi, L. (2020). What Is Trauma Bonding? Medi Lexicon International. https://www.medicalnewstoday.com/articles/trauma-bonding

PCVC
INTERNATIONAL FOUNDATION
FOR CRIME PREVENTION
& VICTIM CARE

UN WOMEN

여성가족부
Ministry of Gender Equality and Family