FREQUENTLY ASKED QUESTIONS ON

VIOLENCE AGAINST WOMEN & MENTAL HEALTH

by iCALL,
Tata Institute of Social Sciences (TISS)
Jan 2022

iCALL TISS UNFPA

DEVELOPED BY
iCALL,
Tata Institute of Social Sciences
In Partnership with the
United Nations Population Fund
(UNFPA)

AUTHORS
Dr. Aparna Joshi,
Assistant Professor,
Project Director iCALL, TISS

Ms. Arjita Mittal,
Project Officer, iCALL

Ms. Drishti Mehta,
Research Assistant iCALL

Ms. Vaishnavi,
Programme Assistant iCALL

GUIDANCE BY
Ms. Anuja Gulati
Program Management Specialist,
United Nations Population Fund

DESIGN AND LAYOUT
Mr. Prathamesh Ghate

ACKNOWLEDGEMENTS

iCALL team wishes to thank all those who have contributed to developing this 'Frequently asked Questions on Violence against women and Mental health document.'

To begin with, we wish to thank Dr. Vindhya Unudhruti (Former Professor, Tata Institute of Social Sciences, Hyderabad) and Dr. Amrita Joshi (Psychotherapist and Co-Director, Sukoon field action project, Tata Institute of Social Sciences) for their thorough review of the document and valuable suggestions. Their feedback has tremendously helped improve the readability and applicability of the document.

We also wish to thank Dr. Shruti Chakarvarti (Mental health practitioner, QACP Faculty and Chief Advisor, Mariwala Health Initiative) and Ms. Pooja Nair (Independent Counsellor and QACP Faculty, Mariwala Health Initiative) for their contributions to the section on Violence against LGBTQIA+ individuals and mental health. This section addresses concerns of an important vulnerable group that is often left out from documents and manuals on violence and mental health.

Last but most importantly, we wish to thank all the counselors and service providers from different parts of India, and trainers involved in our capacity enhancement sessions whose sharings and views made this document possible.

INDEX

BACKGROUND

Violence against women and girls (VAWG) is one of the most widespread, persistent and devastating human rights violations in our world today.

Emerging data from the field also show interconnections between domestic violence against women and girls, and mental health. Ongoing experiences of violence have been known to make women vulnerable to depression, anxiety, post-traumatic stress disorder and sometimes even suicide and self-harm. Conversely, women who show pre-existing mental health issues are more likely to be targets for abuse and violence. Despite these facts, violence against women and girls and its connections with mental health remain neglected.

Since the outbreak of COVID-19, data from the field has shown that all types of violence against women and girls, particularly domestic violence, have intensified, resulting in a shadow pandemic. Apart from the physical threat posed by the virus, socio-economic stressors such as food insecurity, unemployment, slowing down of economy and strained family relations have had a significant impact not only on experiences of violence but also on women's overall well-being.

There is a pressing need therefore, for tailored strategies and programs designed to safeguard violence survivors' health and well-being, including mental health. All interventions with women and girl survivors of violence need to integrate a focus on their psychosocial and mental wellbeing.

About the Partners and the Partnership

Against the backdrop of the COVID-19 outbreak and the resultant shadow pandemic of violence against women, United Nations Population Fund (UNFPA) partnered with iCALL Psychosocial Helpline, a field action project of the Tata Institute of the Social Sciences in the year 2020.

iCALL, a pioneering and empowering technology-assisted mental health initiative, was started in 2012 as a project at the School of Human Ecology, Tata Institute of Social Sciences (TISS), Mumbai. iCALL Psychosocial Helpline was introduced to bridge the vast mental health treatment gap in India; and make affordable, anonymous, multilingual and professional counselling services available to those experiencing psychosocial distress. At present, iCALL is a leading National level telephonic and email-based counselling service for individuals across all age groups (with a special emphasis on vulnerable groups). The helpline provides information, emotional support and referral linkages. Apart from service provision, iCALL also conducts research, capacity enhancement, content development and awareness generation activities in the area of mental health in collaboration with state governments, civil society organizations and international organizations.

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA calls for the realization of reproductive rights for all and supports access to a wide range of sexual and reproductive health services – including voluntary family planning, maternal health care and comprehensive sexuality education. UNFPA's work is guided by the principles of a human-rights based approach set in place by the 1994 International Conference on Population and Development (ICPD), gender empowerment and equality, and the imperative that no one is left behind. UNFPA works towards achieving three transformative results that promise to change the world for every woman, man and young person by 2030:

- **Zero Unmet Need for Family Planning**
- **Zero Preventable Maternal Deaths**
- **Zero Gender-Based Violence and Harmful Practices**

UNFPA and iCALL partnered in 2020 to deliver support and enhance capacities of counselors working at One Stop Centers, family counseling centers and special cells in five states (Maharashtra, Madhya Pradesh, Rajasthan, Bihar and Odisha) of India. Informed by a participatory, survivor-centric and empowerment-oriented approach, this 16 session workshop series, spanning over seven months, focused on strengthening counselors' understanding and skills related to social, legal, health, and mental health aspects of violence against women and girls and counseling interventions for the same. The workshop sessions were delivered online, by subject matter experts from fields of Law, mental health, health, social work, policy etc. After receiving excellent feedback from the participants, the project was extended to two more states (Punjab and Chhattisgarh) in 2021. Through these workshops, a need for a separate series emphasizing mental health and psychosocial support (MHPSS) for violence survivors, was perceived. Subsequently, a six-session series with counselors from three states was conducted to address mental health and psychosocial support (MHPSS) for the survivors of violence.

The project also highlighted the need for simple and easily applicable knowledge products on violence against women and girls, mental health and counselling. The 'Frequently asked questions on violence against women and mental health' document is one such attempt. This document will be helpful for service providers and responders addressing issues of violence against women and mental health, especially in view of the following:

Mental health issues and mental illnesses are primarily neglected on account of the stigma and lack of awareness

VAW service providers may fear that a mental health diagnosis may lead to further pathologizing of women and girl survivors of violence.

VAW service providers and responders may lack systematic training and support on mental health issues

VAW service providers may hold a perception that dealing with mental health issues may require additional time and resources

VAW service providers may not possess the knowledge about whom to refer for mental health concerns or may experience a lack of availability of mental health services for referral

About the ‘Frequently Asked Questions’ Document:

The ‘Frequently Asked Questions (FAQs) document’ has been developed through our interactions with VAWG counselors and service providers over two years. The FAQs are informed by the questions and case studies shared by the participants and the resource persons involved in these capacity enhancement sessions. Additionally, literature on themes related to violence against women and mental health, counseling interventions for the same and the role of service providers has been reviewed to develop this document.

The frequently asked questions are broadly divided into the following five sections:

1. Importance of the interconnections between violence against women and mental health
2. Mental health concepts and facts
3. Mental Health Services, Laws and Policies in India
4. Violence against LGBTQ individuals and mental health
5. Self-care and mental health of service providers and responders

Section I: Importance of the Interconnections between Violence Against Women and Mental Health

What is the relationship between violence against women and mental health? Why is it important to talk about mental health issues in the context of violence against women?

Mental health and violence against women share a complex and reciprocal relationship. The following four kinds of interconnections can be found between mental health and violence against women:

1. i. Violence as a predisposing factor to mental illness: Violence may serve as a factor that increases women's vulnerability to mental health concerns
2. ii. Violence as a precipitating factor for mental illness: Violence can serve as a trigger for the onset of a mental health concern
3. iii. Violence as a maintaining factor in mental illness: Violence may contribute towards the persistence of already existing symptoms of mental health concerns or worsening of the same
4. iv. Violence as a consequence of mental illness: Exposure to Violence may lead to mental health concerns ranging from depression, anxiety, post-traumatic stress disorder (PTSD), substance misuse and abuse, and thoughts and attempts of self-harm/suicide.

Additionally,

- Exposure to ongoing violence can exacerbate mental health concerns and make it more difficult for women survivors to access violence and mental health-related resources and services. This, in turn, can increase perpetrators' control over their partners' lives
- It is not uncommon for people to dismiss and disbelieve women's reports of abuse and violence in cases where they are already diagnosed with a mental illness
- Stigma associated with mental illness and service providers' lack of knowledge about violence reinforce perpetrators' abilities to manipulate mental health issues to control their partners, undermine them in legal battles and discredit them with friends, family and the courts
- Women who are subjected to more than one form of violence, e.g., physical combined with psychological and/or sexual, are at increased risk of mental illness.

What is the relationship between violence against women and mental health? Why is it important to talk about mental health issues in the context of violence against women?

There is a lot that can be done as a VAWG service provider to address mental health issues. Many mental health concerns are preventable. Studies show that people with mental health problems get better and recover completely. Here are a few ways in which VAWG service providers can integrate mental health into their work:

- Building our own capacities for understanding and addressing mental health issues
- Routinely checking for mental health concerns in your intake and ongoing sessions
- Identifying signs of distress for mental health concerns (for example, depression, anxiety, substance abuse, suicide and self-harm, psychosis)
- Providing ongoing emotional and psychological support, and integrating basic mental health interventions in one's ongoing work
- Familiarizing ourselves with information about mental health symptoms, medicines, side effects, types of mental health professionals and services etc. and then providing the same to women survivors with mental health concerns as well to their families
- Initiating effective referrals to mental health service providers and closely following up with the referrals
- Gain knowledge about the connections between mental health diagnosis and existing laws that at times may put women in a disadvantageous position and infringe upon their civil, political and economic rights (related to marriage, custody, divorce, property, contracts etc.) based on the diagnosis of 'unsoundness of mind'
- Advocating for the rights of women clients with mental health concerns to other helping professionals, service providers, police, law enforcing agencies etc.
- Informing women with mental health concerns and psychosocial disabilities about legal provisions that can help them assert their rights (for example, right to mental health care, right to reservations in educational institutes, employment opportunities, etc).

Section II: Mental Health Concepts and Facts

What is Mental Health?

The World Health Organization (WHO) conceptualizes mental health as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Although there are several understandings of mental health, some common characteristics that may be found in an individual with optimal mental health include the ability to:

- Cope with the everyday stresses of life
- Realize one's capacities and potential
- Think clearly and work productively
- Solve problems in life
- Enjoy good relationships with other people
- Have a positive attitude towards self
- Make a contribution to the community

What are some of the common factors that affect mental health?

- Biological factors: For example, chronic illness, genetics, brain injury
- Psychological factors: For example, negative thinking, low self-esteem
- Adverse childhood experiences: For example, emotional neglect, death of a parent, experience of abuse
- Relational and interpersonal factors: For example, conflictual family dynamics, hostile relationships, domestic violence/abuse, absence of trusted interpersonal connections, interpersonal isolation, being overburdened with domestic responsibilities
- Socio-economic factors: Poverty, unemployment, poor access to basic needs (for example, food, water, etc.), inadequate healthcare, stigma and discrimination, belonging to marginalized social groups

What is Mental illness?

The Mental Health Care Act (2017) defines 'mental illness' as a substantial disorder of thinking, mood, perception, orientation, or memory that grossly impairs judgment or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs. Mental illnesses are usually associated with significant distress in social, occupational, or other important activities.

What are some of the examples of mental disorders/ illnesses?

Mental disorders can be categorized into two large groups: Common mental disorders and Severe mental disorders.

Common mental disorders are mental disorders with symptoms that are experienced most commonly by a majority of the population. These include depression, anxiety disorders (generalized anxiety disorder, phobias, panic disorder), post-traumatic stress disorder and substance abuse.

Severe mental disorders refer to those disorders whose symptoms cause high levels of psychosocial disability to the individual experiencing them. These may include withdrawal or disorientation from reality such as hallucinations and delusions (e.g., hearing voices, belief that one is in danger despite no such evidence), unusual, odd, uncharacteristic, and peculiar behavior, dramatic sleep and appetite changes or decline in personal care; an unusual drop in functioning at school, work or social activities, rapid or dramatic shifts in emotions or depressed feelings, problems with concentration, memory or logical thought and speech etc. Schizophrenia and bipolar affective disorder are examples of severe mental disorders. The frequency of severe mental disorders in the general population is lesser than that of common mental disorders.
It is essential for the VAWG counselors and service providers to know about the distinction between these major categories of mental disorders and to make a basic identification of the symptoms so that appropriate referrals can be made.

How prevalent are mental health problems in India?

Mental health problems are widely prevalent in the world and also in India. National Mental Health Survey, reports that an estimated 150 million persons in India need mental health interventions and care (both short term and long term) (NIMHANS, 2016).

- According to a more updated source, there are 197.3 million people with mental disorders in India, comprising 14.3% of the total population of the country (Sagar et al., 2020)
- One among every seven people in India has a mental disorder, ranging from mild to severe (Sagar et al., 2020)
- Depression and anxiety disorders are the most common mental disorders in India, with 45-46 million people suffering from each (Sagar et al., 2020)
- According to the WHO (2021), suicide is an emerging and serious public health issue in India. In 2019, the National Crime Records Bureau (NCRB) reported a total of 1,39,123 suicides in the country (NCRB, 2019)
- The National Mental Health Survey (NIMHANS, 2016) found that nearly 80% of those suffering from mental disorders do not receive treatment for over a year

What are the common mental health concerns among survivors of violence?

Some of the common mental health concerns seen among survivors of violence include:

Depression: Survivors of Violence may often present with persistent feelings of sadness, helplessness and hopelessness. They may also report a loss or gain in their sleep and appetite, fluctuations in their weight, an inability to feel pleasure, frequent bouts of crying, feeling low and irritable, and social isolation. These can all be manifestations of depression.

Anxiety: Anxiety is characterized by feelings of tension, worried thoughts, and physical changes. Survivors of Violence may often report feeling excessively worried, and feeling like they are losing control and cannot cope with their day to day lives. They may also complain about physical symptoms of anxiety such as palpitations, dizziness, gastro-intestinal problems, trembling, shivering, sweating, heavy breathing or breathlessness. These can all be symptoms of anxiety

Post-traumatic stress disorder (PTSD): Experiencing abuse/violence may result in trauma. Psychological trauma occurs when an individual experiences a threat to life, bodily integrity, or sanity. It can trigger extreme emotional and bodily responses in some survivors. This is known as PTSD and is characterized by negative thinking and mood, unwanted and interrupting thoughts usually of the abuse/violence, constant reminders of violence and its experience, avoidance of associations/reminders of violence/abuse, and alterations in bodily functions like sleep, appetite, breathing, muscle fatigue, etc. On account of these symptoms, survivors are often unable to function effectively in their daily lives

Substance abuse: Experiencing violence might hamper the survivors' abilities to utilize their ordinary coping mechanisms. In such instances, some survivors may turn to substances such as alcohol, pain or sleep medication, illegal drugs, etc., to cope with their trauma. The abuse of these substances involves a pattern of usage that hampers an individual's everyday functioning. It may interfere with their relationships and cause dependence on these substances

Suicidality: Survivors of Violence may have thoughts about hurting or harming themselves and sometimes, even thoughts of ending their lives. These are usually triggered in response to ongoing or intense abuse coupled with diminished sense of self-worth, hopelessness, helplessness, feelings of isolation and lack of support, bleakness about the future, feeling of being stuck etc. Some survivors might only 'think' about ending their lives, but may not act on it. This is known as suicidal ideation. A suicide attempt on the other hand, refers to any non-fatal, self-directed, and potentially injurious behavior, carried out with an intent to die.

Non-suicidal self-injury (NSSI) and Self-harm refer to those self-directed actions or behaviours of survivors that cause any kind of major or minor injury or harm to themselves without the intent to die. Self-harm is often used to escape distressing thoughts and feelings, express pain, and/or cope with life stressors. Common self-harm behaviours include cutting, hitting or burning oneself.

What is the link between VAWG and Suicide?

Gender based violence is an important social determinant of suicide in India (Patel et al., 2021). For example, data from India shows that married women account for the highest proportion of suicide deaths among women in India, and that factors such as arranged and early marriage, young motherhood, low social status, domestic violence, and economic dependence are associated with the same. Recently, high suicide deaths in adolescent girls have gained attention (Dandona et al., 2018; Petroni et al., 2015). This again is shown to be related to gender role differentiation and gender-based discrimination.

India accounts for 36.6% of suicide-related deaths among women worldwide (Dandona et al., 2018)

The National Crime Record Bureau (NCRB) reported that in 2018, an average of 63 homemakers died by suicide every day (NCRB, 2018). The 2019 NCRB report also noted that the larger proportion of females who died by suicide did so because of "marriage-related issues" (NCRB, 2019).

In countries like India, cultural and psychosocial factors like family problems and intimate relationship concerns are found to play a significant role in suicidality (Rane & Nadkarni, 2014).

What is psychosocial disability and how is it different from mental health diagnosis?

There are many terms used to refer to persons who have the impairment of a 'mental disorder' – mentally ill, patients, users and survivors of psychiatry, persons with mental illness and persons with psychosocial disability. Psychosocial disability is a term used to describe a disability that may arise from a mental health issue. Psychosocial disability is not about a diagnosis; it is about the functional impact (impairment) and barriers which may be faced by someone living with a mental health condition. A psychosocial disability arises when someone with a mental health diagnosis interacts with a social environment that presents barriers to their equality (equal participation) with others (Mental Health Branch, NSW Health, 2020).

What is the role of medicines in the treatment of mental illness?

Many of us have existing resources and mechanisms for coping with distress. We may use our social support networks and family resources that help us reduce the distress we feel. These resources do so much for our mental health and may be adequate to reduce mild symptoms of depression or anxiety and stress in response to difficult situations. But sometimes, more is needed to relieve symptoms of mental health problems, including those of severe mental illnesses.
Some mental illnesses may occur because of certain chemical imbalances or changes in the brain. Symptoms of poor mental health and emotional distress may also be correlated with changes in these chemicals. Psychiatrists may prescribe psychiatric medications for various mental illnesses/symptoms, from depression and anxiety to post-traumatic stress disorder and schizophrenia. The medications may either reduce distress or provide complete relief from

symptoms of mental illness. Although counseling and therapy are extremely useful in the treatment of mental illness, in some cases (For example, more severe and/or long-standing mental illness), medications can be helpful to alleviate symptoms. Medications may also help in decreasing the need for long-term, inpatient treatment in some cases.
It is important to note that these medicines have side effects. It is necessary that these medicines must only be prescribed by a licensed psychiatrist and consumed only as instructed by the doctor.

What are the commonly prescribed psychiatric medications

A wide range of safe and effective medicines are available to treat different mental illnesses. Some broad classes of psychiatric medications include antidepressants, anti-anxiety medications, mood stabilizers, and antipsychotics.

- Antidepressants: These are primarily used to treat symptoms of depression like persistent feelings of sadness, significant loss of interest in daily activities, appetite and sleep disturbances, and suicidality. They are also used to treat other conditions like anxiety and eating disorders.
- Anti-Anxiety medications: These are used to treat symptoms of anxiety and insomnia. They may also be used in the treatment of seizures (fits).
- Medication for stabilizing mood: They are used to reduce the severity of mood swings in bipolar disorders, depression and other mood disorders. Some may be prescribed to control some types of seizures (fits) in treating epilepsy.
- Anti-psychotics: These are used to treat and prevent symptoms of psychosis in schizophrenia such as hallucinations (hearing or seeing things which are not present in reality), disorganized or unreal thoughts, suspiciousness, uncontrollable anger or social isolation.

Section III: Mental Health Services, Laws and Policies in India

Who are the mental healthcare professionals in India, and what help can they provide?

Given below is a list of key metal health care professionals in India and the work they do:

Psychiatrist: A medical doctor specializing in the diagnosis and treatment of mental disorders. They are licensed medical practitioners who evaluate symptoms to determine the kind of mental illness affecting the patient and prescribe psychiatric medication accordingly. They may work in government and/or private consultation clinics/hospitals. They may also consult at rehabilitation facilities and mental health care institutions.

Counseling Psychologist: A trained mental health professional whose skill set comprises listening to and understanding emotional distress experienced by individuals and thus helping them address it. They usually use talk therapy, and some may also be trained in other modes of therapy like art, dance and movement therapy to help individuals work through their emotional and interpersonal troubles. They may work in government and/or private consultation clinics. They may also be affiliated with various government, non-profit, and other private mental health organizations and services like schools and family courts.

Clinical Psychologist: A mental health professional specialized in the diagnosis and treatment of mental, behavioral and emotional disorders. They may use the aid of certain psychological tests to determine the specific concern of the client and provide correspondingly appropriate counseling and therapy. They do not prescribe medications for the treatment of mental illness. They may work in government and/or private consultation clinics or be affiliated with non-profit, and other private mental health organizations and services.

Psychiatric Social Worker: A psychiatric/mental health social worker is a social worker trained to support individuals with mental illness and their families. When working with clients, psychiatric social workers utilize tools like psychosocial and risk assessments, individualized and group therapy, crisis intervention and support, and care coordination. They are employed in a variety of settings, ranging from inpatient departments of hospitals to non-governmental organizations.

How can counselors decide which mental healthcare professional to refer a violence survivor to?

There is often an overlap among the professional roles and services offered by the aforementioned mental healthcare providers; thus, deciding when and whom to refer a survivor of violence to, may become slightly confusing and challenging. However, here are a few considerations that may be useful in taking a decision:

- For any sort of medical intervention (for example, if the survivor is experiencing extreme levels of emotional distress, thoughts about suicide, psychotic symptoms (e.g. hallucination or delusions), or any other symptoms that may pose a severe challenge to her functioning and well-being in her daily life), it might be helpful to refer the survivor to a licensed psychiatrist for a medical intervention.

- For any sort of long-term counseling and therapeutic care for dealing with impacts of abuse and trauma (poor self-perception, negative thinking, lack of trust in relationships, difficulty in decision making or re-building life etc.), the survivor may be referred to a trained counseling or clinical psychologist or even a psychiatric social worker.

- If determining the level and kind of mental health concern of the survivor becomes confusing and challenging, referral to a trained clinical psychologist may help ensure an accurate diagnosis and formulate a future course of intervention

- For survivors who present with mental health concerns, psychiatric social workers can be an effective referral for ongoing follow up, home-based and family interventions, and connecting the survivor to resources for asserting her rights (disability-related certification and benefits, legal aid, skill building and employment opportunities etc.).

How can VAWG service providers ensure effective referrals to mental health care professionals?

- For a referral to be effective and helpful for the survivor, VAWG service providers must first and foremost maintain a ready and updated contact list of trained and qualified mental health care professionals from their area who engage in survivor-centric work.
- In addition, they can also maintain a list of credible helplines and other technology-assisted mental health care resources. This list has to be frequently checked and updated.
- The service providers must establish contact with mental health care professionals in their vicinity, introduce their own work and maintain ongoing coordination.
- During referral, VAWG service providers must offer details to the survivor of the services (contact details, address, timings, nature of services, names, etc.) and also information about the role of the mental health care professional and the help they will offer
- Multiple referrals may be provided to a survivor depending on the unique needs of the survivor. For example, a referral of a psychiatrist along with that of a psychologist may be provided to address both the medical and therapeutic needs of the survivor.
- VAWG service providers can, if possible, facilitate an appointment with the mental health care professional.

- The survivor must be followed up for feedback about their interaction with the mental health care professionals to gauge if adequate help has been provided and to check the progress made by the survivor.

- The VAWG service provider can also act as a liaison between the mental health care provider and the survivor to facilitate easy communication, translate information in a non-jargonized manner and assert survivor's rights. They can also work closely with the survivor's family to educate and negotiate on the survivor's behalf.

- Considering the 'unsoundness of mind' clause included in many Indian laws that can deprive a person of their civil, political and economic rights, service providers have to be extremely cautious in handling reports, prescriptions or any records related to women's mental health, histories as well as treatment. Service providers must ensure that only women survivors or other trusted adults have access to these documents and that they are not shared with anyone capable of misusing them. In case of misuse, counselors must support and advocate for women survivors' rights.

How can VAWG service providers support a survivor living in a mental health facility whose family refuses to accept her upon her recovery?

It is often noted that the families of women who are admitted to mental health facilities and Institutions are reluctant to receive them back. In such a situation, the survivor is likely to feel extremely abandoned and isolated. The service providers must begin by expressing genuine empathy and constant validation of her feelings. Here are a few things that the service providers can do:

- - Service providers may clearly convey to the survivor that she need not feel any guilt or shame for her situation. The service provider can reframe the problem as a function of the family and social systems that have stigmatized mental illness and not as something that is her fault and responsibility.

- If possible, service providers must try to work with the family members and provide psychoeducation about mental illness in the context of what the survivor is going through and how she can feel supported. The service providers must also empathize with challenges faced by the family; however, they assertively communicate the need to facilitate the survivor's re-entry into the family environment.

- It is vital for service providers to focus on and build upon the inherent resilience and strengths of the survivor. This can be done by identifying social support networks that can aid her in her social reintegration (friends, particular family members) and identifying community networks, women's groups, etc. to ensure ongoing acceptance and support.

- The service providers must regularly schedule follow-ups to ensure that the survivor feels supported during her journey of reintegration and re-building life. This may include support in social skills training, education, employment etc.

What are some of the mental health programmes initiated by the Government of India?

There is a stark treatment gap that exists in India to address mental health concerns (NIMHANS, 2016). In order to address this treatment gap, the Government of India has been implementing the National Mental Health Program (NMHP) since 1982 by integrating mental health into primary health care and community work. The District Mental Health Program (DMHP) was introduced in 1996. According to the latest reports, DMHP is operational in almost 692 districts across the country (Press Information Bureau, 2021).

- The DMHP works towards providing care and basic facilities to address poor mental health and illness at the community level; mandating its provision at the primary health care level.
- The DMHP comprises mental health care services at the Community Health Centers/Primary Health Centers by a trained medical doctor. At the district level, the DMHP team includes qualified mental health care professionals consisting of a psychiatrist, clinical psychologist, psychiatric social worker and a psychiatric nurse who provides medical, counseling and family-based interventions (Ministry of Health and Family Welfare, 2015).

What are some of the laws concerning mental health in India?

The recent laws concerning mental health in India are crucial to VAWG intervention as they have replaced the paternalistic older acts with the newer patient-centric and rights-based laws. They recognize people suffering with mental health concerns, mental disorders or illnesses as individuals with the agency to make their own decisions. These recent laws play a crucial role in protecting survivors of violence suffering from mental health concerns and making their voices heard in the VAWG intervention. By being aware of these laws, the service providers can advocate for the survivor and intervene in the survivor's best interests. Following is the description of the two critical laws in the mental health and disability sector in India that the service providers need to be aware of:

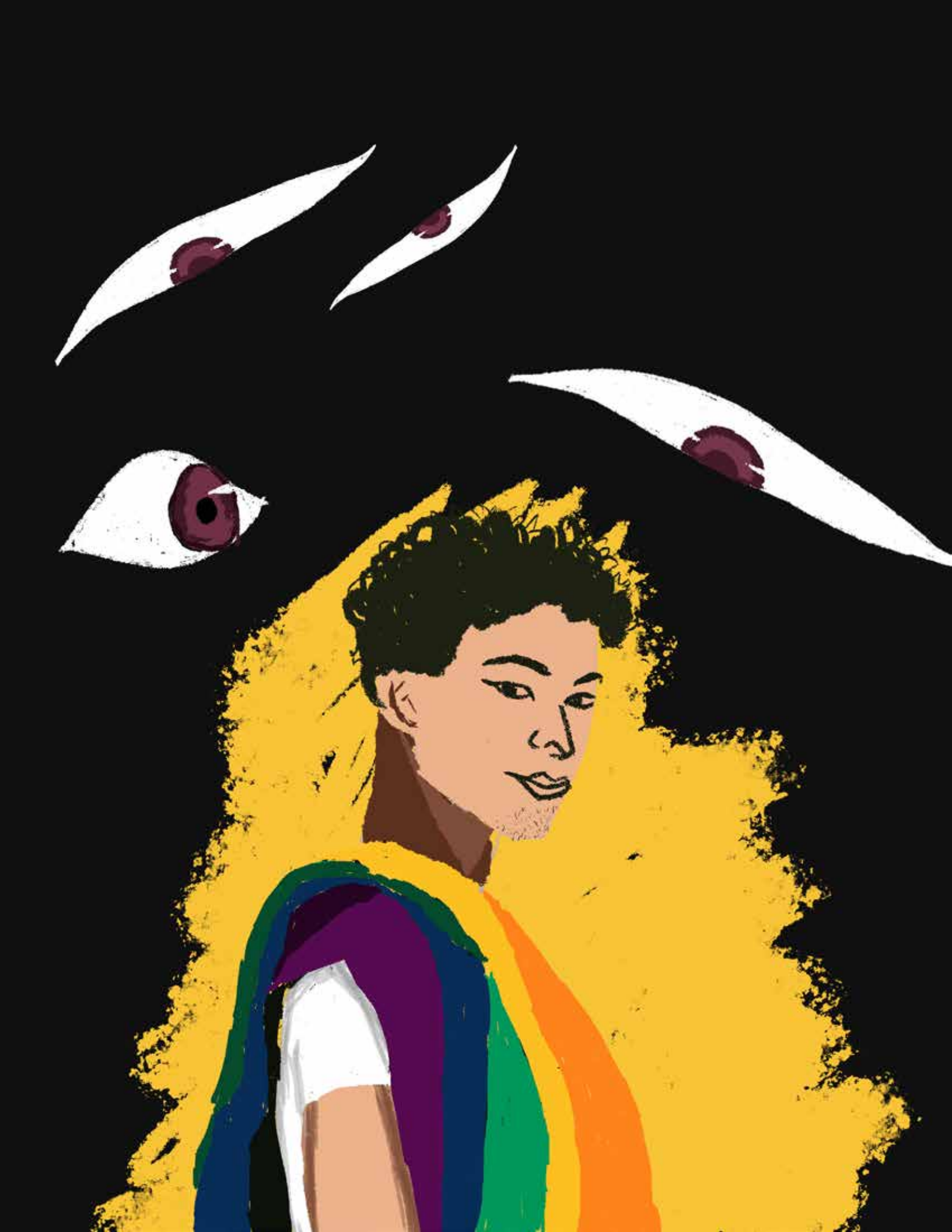
1. The Mental Healthcare Act, (2017):

The Act aims to provide mental healthcare and services for those suffering from mental illness. It also aims to promote and fulfill the rights of these individuals during the delivery of mental healthcare and services. The Act is progressive, patient-centric, and rights-based. Here are some key features of the Law:

- The Law presumes that everyone with mental illness is capacitous of mental healthcare (until proved otherwise) and enshrines the right to protection from cruel, inhuman and degrading medical treatment.
- The Law believes that discrimination because of mental illness in any sphere of life is illegal
- The Law demands equality of mental healthcare and physical healthcare
- The Law sees access to mental healthcare in the community as a governmental responsibility to people with mental illness.
- The Law assumes that free legal aid, access to medical information, access to community living, the confidentiality of medical information, and access to personal contacts and communication are all rights of patients receiving inpatient mental healthcare enshrined under this Statute.
- The individual suffering from mental illness has a right to make an advance directive; i.e., the individual can choose how to be treated.
- The individual suffering from mental illness has a right to appoint a nominated representative to take mental health care decisions on their behalf. The Law instructs Nominated Representatives to make decisions only after giving due credence to patient choice, best interests, will and preferences. Supported admission is a concept introduced in the new Law to replace involuntary admission as enlisted in the previous Act (Mental Health Act, 1987). Support lies on a continuum ranging from minimal to near complete. People requiring high levels of support for decision-making are likely to require supported admission and treatment.
- The new Law decriminalizes suicide.

2. The Rights of Persons with Disabilities Act, (RPwD, 2016):

This Act aims to protect the rights, interests and dignities of persons with disabilities in various aspects of life – educational, social, legal, economic, cultural and political. The RPwD Act has important implications for the rights of persons with mental illness, as 7 out of the 21 categories of disabilities are related to mental health. In congruence with the United Nations Convention on Rights of Persons with Disabilities (UNCRPD) (Convention on the Rights of Persons with Disabilities, 2006), the RPwD Act has introduced the right to legal capacity, that is, the right to equal recognition of PwDs before the Law. The Law facilitates full acceptance of people with disability and ensures full participation and inclusion of such persons in society. It provides for both the preventive and promotional aspects of rehabilitation like education, employment and vocational training, reservation, research and human power development, creation of barrier-free environment, etc. It also provides protection from abuse, Violence, and exploitation and means/ways to report any such act.



Section IV: LGBTQ Community, Violence and Mental health

What are the important terms we need to know of, when working with the LGBTQ community?

It is important to familiarize oneself with the appropriate language and terms to uphold the respect and dignity of LGBTQ individuals and avoid stigmatization. Unfortunately, many terms are used for queer and trans people that are stigmatizing and shaming. Thus, an effort needs to be made to learn about respectful terms and labels.

Gender labels– Counsellors should know that cis refers to a person who identifies with the gender that was assigned to them at birth. Trans is an adjective that refers to a person who does not identify with the gender that was assigned to them at birth. Eg: a Trans man is someone who was assigned gender female when he was born but does not identify as a woman, but instead as a man.
Non-binary is a gender identity used by persons who wish to identify as neither man nor woman and hence place themselves outside of the two genders that society provides. Labels like gender-queer, gender-fluid etc. refer to persons who do not see themselves fitting the two boxes of man or woman. There are also labels and identities that are native to different regions in India. Counsellors must find out non-stigmatizing words for these labels and idenitities in these regional languages (For example, terms like Hijra, Aravani (Tamil Nadu), Jogappa (Karnataka) etc).

Sexuality labels– The term Heterosexual refers to those who are attracted to what we understand as the opposite sex. Gay is an identity used by men who are attracted to other men, and lesbian is a word for women who are attracted to other women. Bisexual is a person attracted to two genders. Pansexual is a person attracted to all genders. The word 'Queer' is also used as a sexuality label to indicate that one is not heterosexual.

Counsellors must attempt to update themselves with the correct terminology and pronouns that the LGBTQ community uses for themselves.

What is the kind of Violence that LGBTQ individuals are likely to face, and how to understand the same?

Violence against the LGBTQ community needs to be understood through phenomena such as homophobia, transphobia and queerphobia, which are forms of hate and revulsion towards identities that do not fit the social ideal of man-woman-marriage-child. Another essential thing to keep in mind is that violence against LGBTQ individuals may be perpetrated in the most intimate relations like family, parents, friends etc. Additionally, social institutions often can participate in the perpetration of violence. Counselors and Mental health professionals, too, can add to the stigma and violations experienced by LGBTQ individuals by believing that these identities are 'abnormal' and, therefore, in need of 'cure'.
Given below are a few examples of the possible violence presentations by LGBTQ individuals at one-stop centers:

1. Risk of being thrown out of homes, schools, colleges, or workplace
2. Withholding of property and resources by families;
3. Physical, emotional and sexual violence
4. Conversion 'treatments' (Highly controversial practices or attempts to change an individual's sexual orientation and gender identity or expression to fit into heterosexual or cisgender norms
5. Forced into heterosexual marriages
6. Forcefully separated from queer partners
7. Threats of revealing their identity and being blackmailed over it
8. Continuous and everyday hostility from near and dear ones and peers
9. Violence or discrimination by medical professionals, including mental health practitioners
10. Violence from police personnel, religious leaders etc

What is the connection between violence faced by LGBQ individuals and mental health?

Living in an unequal society where lives and identities are stigmatized, often has negative mental health consequences. There is nothing inherently wrong with any gender or sexuality. What is important is to note that the distress is introduced by the environment that does not see all genders and sexualities as valid and normal. LGBTQ individuals often face unique life stressors such as lack of self-acceptance, stress of coming out and facing the consequences of it, lack of acceptance by others, discrimination and harassment, invisibility and erasure of self and intimacies, being forced to live double lives, violence faced in private as well as public spaces, internalization of shame and stigma leading to feelings of worthlessness, self-harm, suicide risk etc

What is the kind of Violence that LGBTQ individuals are likely to face, and how to understand the same?

Violence against the LGBTQ community needs to be understood through phenomena such as Counsellors need to intervene in cases where LGBTQ individuals and couples are facing violence. Some steps they can take are-

1. Design counseling centers that are LGBTQ-friendly
2. Carry out risk assessment and safety planning when LGBTQ individuals present concerns of violence
3. Consider removing individuals from violent locations to safer locations if the violence continues
4. Maintain list of LGBTQ crisis helplines
5. Prepare a list of LGBTQ friendly shelter homes for victims of violence
6. Refer the LGBTQ individuals to local LGBTQ organizations and support groups
7. Legal provisions such as Mental Health Care Act and anti-discrimination clause within the same can be used against conversion treatments used with LGBTQ individuals
8. Create a database of LGBTQ friendly lawyers and activists who can help in providing redressal

Additionally, counsellors must be aware of how their own prejudices that may interfere with their work of supporting the clients. Counsellors must recognize that their current knowledge may be inadequate as most mainstream teaching and training curricula do not address LGBTQ issues. Counsellors, therefore, need to equip themselves by engaging in continuing education. They must acquaint themselves with positive and strengthening language the LGBTQ community uses.

Section V: Self-care and mental health of service providers and responders

As a service provider and responder to violence against women and girls' issues, I too feel stressed. How can service providers take care of their own mental health whilst working with survivors of violence

Service providers working with violence issues invest significant time listening to their clients' traumatic and emotionally overwhelming stories, which can lead to stress and trauma. Working with issues of violence/trauma can adversely impact service providers' well-being.

- It can result in "burnout" which can manifest through physical, emotional or mental fatigue. Burnout can also show up as feeling overwhelmed/overburdened, angry/frustrated, hopeless, and emotionally numb

- Continued engagement with issues of trauma can result in compassion fatigue. Compassion fatigue can show up as feeling alienated from work and/or the survivor, a loss of pleasure, sleep and/or appetite, and an inability to socialize.

- Listening to the survivors' experiences of violence and abuse can also lead to a personal preoccupation with those experiences of the survivor. This is called "vicarious trauma" which may manifest as nightmares and intrusive, recurrent thoughts about these experiences.

- Self-care strategies are useful for counselors to prevent and resist these negative impacts of their work. Although self-care may work differently for different people, some common domains of self-care are useful to remember. They are as follows:

  i. Physical self-care can include eating and hydrating well, physical movement, exercise, routines and work breaks.

  ii. Emotional self-care ensures being aware of and managing one's emotions. Emotional self-care can include expressing feelings through writing down your thoughts, maintaining a diary, talking to a friend or a therapist, listening to music, painting etc. Peer supervision, speaking with colleagues about burnout, and sharing positive stories of survivors' resilience can contribute to emotional self-care at the workplace.

iii. Spiritual self-care involves engagement in spiritual/religious rituals and practices that help restore meaning and purpose in life

iv. Social self-care can help feel connected with one's surrounding world and involves spending quality time connecting with loved ones or supportive communities.

In these ways, counselors can make self-care a part of their daily routine as a preventive strategy rather than turning to it only during a crisis.

References

Convention on the Rights of Persons with Disabilities (CRPD). (2006). https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

Dandona, R., Kumar, G. A., Dhaliwal, R. S., Naghavi, M., Vos, T., Shukla, D. K., Vijayakumar, L., Gururaj, G., Thakur, J. S., Ambekar, A., Sagar, R., Arora, M., Bhardwaj, D., Chakma, J. K., Dutta, E., Furtado, M., Glenn, S., Hawley, C., Johnson, S. C., & Khanna, T. (2018). Gender differentials and state variations in suicide deaths in India: the Global Burden of Disease Study 1990–2016. The Lancet Public Health, 3(10), e478–e489. https://doi.org/10.1016/s2468-2667(18)30138-5

Gururaj, G., Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, Mehta RY, Ram D, Shibukumar TM, Kokane A, Lenin Singh RK, Chavan BS, Sharma P, Ramasubramanian C, Dalal PK, Saha PK, Deuri SP, Giri AK, Kavishvar AB, ... NMHS collaborators group. (2016). National Mental Health Survey of India, 2015-16: Prevalence, patterns and outcomes. http://indianmhs.nimhans.ac.in/Docs/Report2.pdf

Guidelines for implementing of district level activities under the National Mental Health Programme (NMHP) during the 12th plan period, (2015). Ministry of Health and Family Welfare. https://main.mohfw.gov.in/sites/default/files/56464578341436263710_0_0.pdf

Mental health crisis in the country, (2021). Press Information Bureau. https://pib.gov.in/PressReleasePage.aspx?PRID=1694440

National Crime Records Bureau. (2019). Suicides in India. https://ncrb.gov.in/sites/default/files/Chapter-2-Suicides_2019.pdf

National Crime Records Bureau. (2018). Suicides in India. https://ncrb.gov.in/sites/default/files/chapter-2-suicides-2018.pdf

NSW Health. (2020, January 20) What is psychosocial disability?. Retrieved August 17, 2022, from https://www.health.nsw.gov.au/mentalhealth/psychosocial/foundations/Pages/psychosocial-whatis.aspx

Sagar, R., Dandona, R., Gururaj, G., Dhaliwal, R. S., Singh, A., Ferrari, A., Dua, T., Ganguli, A., Varghese, M., Chakma, J. K., Kumar, G. A., Shaji, K. S., Ambekar, A., Rangaswamy, T.,Vijayakumar, L., Agarwal, V., Krishnankutty, R. P., Bhatia, R., Charlson, F., ... Dandona, L. (2020). The burden of mental disorders across the States of India: The global burden of disease study 1990–2017. The Lancet Psychiatry, 7(2), 148–161. https://doi.org/10.1016/s2215-0366(19)30475-4

The Mental Healthcare Act. (2017). https://main.mohfw.gov.in/sites/default/files/Final%20Draft%20Rules%20MHC%20Act%2C%202017%20%281%29.pdf

The Rights of Persons with Disabilities Act. (2016). https://disabilityaffairs.gov.in/content/page/acts.php

Patel, A. R., Prabhu, S., Sciarrino, N. A., Presseau, C., Smith, N. B., & Rozek, D. C. (2021). Gender-based violence and suicidal ideation among Indian women from slums: An examination of direct and indirect effects of depression, anxiety, and PTSD symptoms. Psychological Trauma: Theory, Research, Practice, and Policy, 13(6), 694–702. https://doi.org/10.1037/tra0000998

Petroni, S., Patel, V., & Patton, G. (2015). Why is suicide the leading killer of older adolescent girls?. Lancet (London, England), 386(10008), 2031–2032. https://doi.org/10.1016/S0140-6736(15)01019-3

Rane, A., & Nadkarni, A. (2014). Suicide in India: a systematic review. Shanghai archives of psychiatry, 26(2), 69–80. https://doi.org/10.3969/j.issn.1002-0829.2014.02.003

World Health Organization. (2021). Suicide - india. World Health Organization. Retrieved August 17, 2022, downloaded from

https://www.who.int/india/health-topics/suicide#:~:text=Suicide%20is%20an%20emerging%20and,was%2010.5%20per%20100%20000.