GENDER matters

THE INTERSECTION OF VIOLENCE AGAINST WOMEN AND MENTAL HEALTH

An integrated stepped care model of intervention

NOVEMBER, 2017

SNEHA®

Azim Premji Philanthropic Initiatives

GENDER matters

THE INTERSECTION OF VIOLENCE AGAINST WOMEN AND MENTAL HEALTH

An integrated stepped care model of intervention

NOVEMBER, 2017

Published in 2017

For additional copies of this document, please contact:
SNEHA,
The Program on Prevention of Violence against Women and Children,
Room 310, 3rd floor, Urban Health Centre,
60 feet Road,
Dharavi,
Mumbai – 400017.
Tel: +91-22-24042627.
Email: gendermatters@snehamumbai.org
Website: www.snehamumbai.org

Authors:
Dr Nayreen Daruwalla, Program Director, PVWC
Preethi Pinto, Associate Program Director, PVWC
Gauri Ambavkar, Co-ordinator, Counselling and Crisis Intervention, PVWC
Advaita Nigudkar, Consultant Psychologist (Clinical)
Jagruti Wandrekar, Consultant Psychologist (Clinical)
Bhaskar Kakkad, Co-ordinator, Prevention and Community Organisation, PVWC
With contributions from Saee Abhyankar, PhD Scholar, IIT Bombay

Illustrations, design, formatting and layout: Kinni Makwana
Logo design: Krishna Panchal

Printed by:
Girija Screen Printers
Dharavi, Mumbai.

We dedicate this book to those women who found the courage to stand up to the patriarchy that tries its hardest to knock them back down.

We would also like to dedicate this book to those women who are endeavouring to speak out against the violence, the discrimination, the marginalisation, the invisibility, and the trauma of it all. May they realise that all the strength they need lies within.

Finally, we dedicate this book to all those who have struggled with us and for us to help women and girls live lives of dignity, equality, and free from violence.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

We would like to begin by thanking Dr Armida Fernandez, the founder of SNEHA and a visionary, who is committed to improving the health and lives of as many women and children possible through her innovative and ambitious projects. Her compassion, foresight and dedication were what started the Program on Prevention of Violence against Women and Children on its 17-year long journey.

We thank our Executive Director, Dr Shanti Pantvaidya, and our Chief Executive Officer, Ms Vanessa D'Souza, for their guidance, their support and their trust in us. We are grateful to the SNEHA Board of Trustees and Advisors whose unfailing encouragement and direction help us achieve new heights. In particular, we would like to thank Mr Luis Miranda who took upon himself the mammoth task of single-handedly procuring funds for our counselling centres. You have the blessings of the thousands of women who came through SNEHA's doors during those three years.

Our colleagues at SNEHA, we appreciate your steadfast backing and co-operation.

Professor David Osrin, thank you for choosing us to embark on a research project of such magnitude and promise. We are grateful for your contribution in big and small ways over the years that has shaped our Program and brought us to this important juncture.

Our deep gratitude goes out to Mr Azim Premji and the Azim Premji Philanthropic Initiatives. Your astute understanding of development - that working on gender equality and focusing on women facing violence is fundamental to the progress of many of the Sustainable Development Goals – and your determination to empower vulnerable and impoverished women, especially those facing domestic violence and having mental health conditions, deserve special mention as there are few grant makers that are willing to invest in issues as complex and challenging as these.

To the dear staff of our Program: for your conviction and your unwavering courage that no woman or child should have to face violence, your hard-work in challenging situations and conditions, and your tireless belief in a gender-equal world, we cannot thank you enough. Each of you has made the Program what it is through your immense commitment and numerous sacrifices. Thank you.

PREFACE

We have been working to end violence against women and children for two decades. Our model on secondary intervention and primary prevention arose from the needs of women and children survivors of violence. The aim was to provide quality services to those in crisis and work with different communities to prevent violence. We realised that secondary and primary prevention of violence go hand-in-hand. If we want communities to respond to violence, these two interventions cannot be separated.

This document is a humble attempt to inform the reader of the various strategies that our Program on Prevention of Violence against Women and Children has adopted within our counselling and prevention components. There are several organisations that are working on violence against women, and there are many others working on mental health across India, but few have integrated mental health interventions in their work on violence against women. Swayam is one such pioneering organisation in the country. Over the past three years, with the support of Azim Premji Philanthropic Initiatives, we have integrated mental health in our Program on gender-based violence and adapted the 'MANAS model' propounded by the premier mental health organisation in India - Sangath.

The purpose of this document is to give the reader an understanding of the structure, the process of integration, and the tools that we used to develop our model on violence against women and mental health. What we would like to underline is that: any organisation - working either on violence against women or mental health - can consider integrating basic interventions of the other issue. These interventions, once integrated, do not require extra effort to be run.

Sincere regards,
Nayreen Daruwalla and the PVWC Team

CHAPTER I

AN INTRODUCTION TO SNEHA AND THE PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN PROGRAM

ABOUT SNEHA (Society for Nutrition, Education and Health Action)

SNEHA is a secular, Mumbai-based non-profit organisation. SNEHA believes that investing in women's health is essential to building viable urban communities. The organisation targets four large public health areas - maternal and newborn health, child health and nutrition, adolescent health and sexuality, and prevention of violence against women and children.

We work at the community level to empower women and informal urban communities to be catalysts of change in their own right, and collaborate with existing public health systems and health care providers to create sustainable improvements in urban health.

A BRIEF HISTORY OF THE PROGRAM ON PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN

SNEHA's Prevention of Violence against Women and Children (PVWC) Program builds a gender-sensitive society that responds to and prevents violence against women in urban areas. Our theory of change focuses on participatory community engagement with multiple stakeholders to encourage critical thinking about violence against women (VAW) and its consequences, promote equitable gender norms, and reduce tolerance of VAW. The goal is to prevent and respond to violence in urban areas through convergence of a multi-stranded approach, involving relevant stakeholders.

The counselling centre opened in late 2000 in response to the experiences of health workers at Lokmanya Tilak Municipal General Hospital (LTMGH), Mumbai's largest public hospital. Many survivors of domestic violence came to the hospital, but interaction with doctors and nurses tended to stop at treatment for injuries. Engaging with the wider issues—emotional, psychiatric, social, and legal—requires confidence, time, training, protocols, and resources, all of which were in short supply of. The Centre was conceived as a means to address this gap through a partnership between the Municipal Corporation and a non-government organisation (NGO). Founded at a municipal health facility in Dharavi, which at the time was one of the world's largest informal urban settlements in Asia, the Centre is located within the community.

Reviewing our experiences, we think that three issues particularly influenced the Centre's development: the relative invisibility of the problems with which we were trying to deal; women's desire to meet normative expectations and to keep the family together; and a spiralling need to connect with other service providers, families, and communities. The most significant development was a gradual shift in emphasis from institutional support to community action and running programs with other stakeholders like the police, public health doctors and state legal services to respond to violence against women and girls.

WHAT THE PWVC PROGRAM DOES

The Program on Prevention of Violence against Women and Children aims to develop high impact strategies for primary prevention, ensure survivors' access to protection and justice, empower women to claim their rights, mobilise communities around 'zero tolerance for violence', and respond to the needs and rights of excluded and neglected groups. The Program prioritises enhanced co-ordination of the state response to crimes against women through a convergence approach that works with government and public systems to reinforce their roles.

The Program includes eleven counselling centres across Mumbai: five community-based counselling centres and four hospital-based counselling centres linked with community mobilisation, health services, police, and legal support. We take a client-centred, non-directive approach based on the humanistic therapy of Carl Rogers. The Program history follows global developments. The emphasis of a first wave of interventions – driven largely by feminist activism - was support for survivors of violence, reduction in secondary perpetration, strengthening legal recourse, and advocacy.[1] This led to the consolidation of services such as women's shelters, counselling, legal vadvice, and laws such as India's Protection of Women from Domestic Violence Act 2005. A second wave of interventions, led by groups like Stree Mukti Sangathana, Akshara, Forum Against Oppressed Women, and SNEHA, emphasise primary prevention and community activism and takes a public health position: population-based, interdisciplinary, and intersectoral.[2]

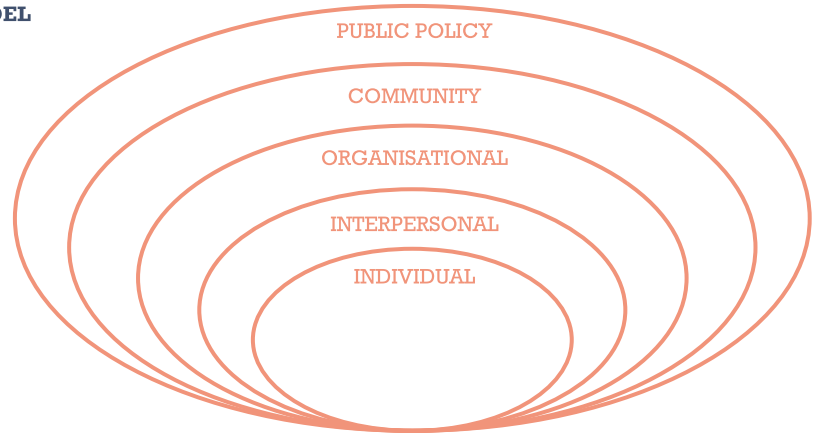
THE UNDERLYING SOCIO-ECOLOGIC MODEL FOR ADDRESSING VIOLENCE AGAINST WOMEN AND GIRLS

The objectives of current efforts are both to respond to the burden of violence and to prevent it from happening.[3,4] The underlying socio-ecological model locates individual personal histories within families, located in turn within communities, and in turn within societies.[5] There is broad agreement that interventions should operate at multiple levels, from individual to societal.[6] Interventional discourse has also moved from a concentration on the needs of survivors to an acknowledgment that intervention should aim to "transform the relations, norms, and systems that sustain gender inequality and violence."[7] Of particular interest are interventions that aim to change norms that privilege controlling and aggressive masculine behaviour.[7,8] Such interventions are usually termed 'gender transformative',[9] involve women, men, and young people,[10] and aim to develop critical mass among community members, leaders, and institutions to change discriminatory social norms, promote gender equality, and reduce violence.[4]

Through various research initiatives, the Program has analysed the inherent and deep-rooted factors that influence violence against women and has given us insights into the complex interplay of factors between individual, relationship, community, institutional, and societal factors that put women at risk for experiencing or perpetrating violence.

THE SOCIO-ECOLOGIC MODEL

Bronfenbrenner 1979
Heise 1998



THE INDIVIDUAL LEVEL

Secondary interventions are provided through counselling and crisis intervention services. The prevention strategies designed are to promote attitudes, beliefs and behaviours with the survivor and the perpetrator to prevent violence.

THE RELATIONSHIP LEVEL:

Our work on counselling focuses on helping the survivor work through her relationships with the perpetrator and significant others, if the survivor chooses to remain in that relationship. The prevention strategies designed with the survivors and perpetrators are family counselling, conflict resolution, and fostering problem solving skills to promote healthy relationships.

THE COMMUNITY LEVEL:

Our work on community organisation activity focuses on schools and neighbourhoods in which social relationships occur. We undertake youth programs, cultural events for women and men in the community fostering a positive community climate that promote gender equal and healthy families, safe schools and neighbourhoods

THE INSTITUTIONAL LEVEL:

Our work with the public systems explores the roles that institutions play in prevention of violence. We work with the police and public health systems. Our prevention strategies focus on creation of guidelines that help to understand their role as a provider and enable them to recognise gender based violence as a public concern.

THE SOCIETAL LEVEL

We work in the communities with a broader framework of challenging societal and cultural norms that support violence as an acceptable way to resolve conflicts. Campaigns, group formation for community organisation are some of the strategies used to transform gender-biased mindsets.

Our proposition is that visible intervention to support survivors makes people aware of the problem and potential solutions. Through primary, secondary and tertiary prevention interventions, we aim to reduce the double burden of domestic violence and mental health.

Our preventive activities involve two kinds of community outreach: group education and enablement, and individual voluntarism. Group education involves women, men, and adolescents and aims

- to develop awareness and understanding of violence, knowledge of rights and recourse, individual and collective local strategies for primary and secondary prevention, and increased confidence and leadership, and
- to reduce community tolerance and increase bystander action. Individual intervention involves women volunteers, sanginis, who identify survivors of violence, provide support, connect them with crisis intervention and counselling services, and facilitate police and health service consultation.

The Sangini response is supported by an innovative mobile electronic platform, Little Sister, which integrates real-time field reports of violence and their interventions with programme services. Our processes increase the social standing and agency of group members and Sanginis, digital literacy, employability, and supportive social networks.

Secondary interventions for survivors include counselling, liaison with the police, medical attention, mental health intervention, family interventions, and legal recourse. Our centres offer support from trained counsellors, consultant psychologists, municipal clinicians, visiting psychiatrists, and lawyers. SNEHA is a service provider under the Protection of Women from Domestic Violence Act and runs women's outpatient departments in three tertiary and one peripheral municipal hospital. We work with the police in five zones, training cadets and officers, and co-developing, piloting, and introducing guidelines for response to violence against women and girls into police practice. Components of our model have been adapted and replicated in collaboration with the organisation Ekjut in Jharkhand.

The Program works with stakeholders such as shelter homes, the legal system, the police and hospitals (especially the Psychiatry departments) within the remit of tertiary prevention. Our convergence model includes the following components which are plotted against the different factors of the socio-ecologic model:

Crisis and Extended response

Community mobilisation

2a. Group education for women, men and adolescents

2b. Sanginis (through the Little Sister mobile application)

Institutional response

3a. Police

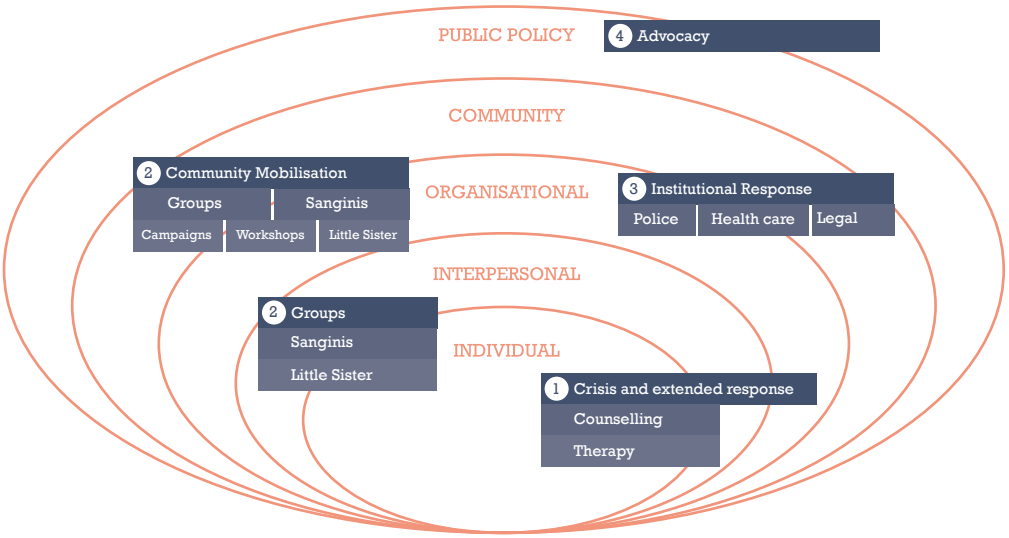
3b. Healthcare

3c. Legal

Advocacy

Replication

SNEHA'S INTERVENTION ON VIOLENCE AGAINST WOMEN AND GIRLS EMBEDDED IN THE SOCIO-ECOLOGIC MODEL



SNEHA is uniquely placed to work at the intersection of domestic violence and mental health because of a long-standing experience of running the violence against women and children program. We have situated the stepped care model of primary, secondary and tertiary prevention interventions for domestic violence and mental health within the socio-ecologic model. At SNEHA, we use a multi-disciplinary, integrated approach to a development issue that is usually seen in isolation by practitioners in the two fields of social work and psychology.

In order for interventions to be long-lasting, empowering women to negotiate spaces of violence becomes very important. This is done through the mental health interventions carried out at SNEHA. While we have already incorporated mental health into the model described above, details on how mental health becomes an important factor in this model can be found in the next chapter.

CHAPTER 2

INTEGRATING MENTAL HEALTH INTO INTERVENTIONS ON VIOLENCE AGAINST WOMEN

Violence against women is common, invisible and ubiquitous, and strongly associated with short- and long-term mental illness. The relationship between violence and mental illness is multi-directional and complex. For almost two decades we have worked to prevent violence against women in Dharavi and other vulnerable informal urban settlements.

Mental health interventions for survivors of violence were always part of our counselling and crisis intervention services. In the past couple of years, we have officially integrated a mental health component in our intervention. We have adapted the 'MANAS' stepped care model on community mental health developed by Sangath, a mental health research organisation. In a stepped care model, identification and psychological first aid begin at the grassroots. The next step is referral to services such as SNEHA's counselling centre, which provides crisis counselling and psychosocial interventions, and screens women for mental health conditions. A successive step is referral to consultant psychologists with a clinical background for diagnosis and therapy. The final step – taken in only a few cases – is referral to a psychiatrist for further intervention that may include medication.

There is modest evidence suggesting that women with mental illness are more likely to be involved in unsafe and abusive relationships, thus increasing their risk of being exposed to violence against women. It has been hard for us to determine the cause and effect relationship between violence and mental health. Women predisposed to mental illness who have undergone violence have a higher likelihood of developing common mental disorders due to abuse and ambiguity in relationships; whereas women who live with mental health conditions suffer violence on account of their inability to perform the role of a care provider in home settings.

SNEHA's counselling centres have registered over 8000 cases of women survivors of violence in the last 15 years. Interventions for survivors of violence are need-based and require immediate responses to women's situation and the environment around them. Helping survivors get support for medical assistance, shelter, police complaints and provisional legal orders often takes precedence over counselling and mental health interventions. In our experience, casework interventions tend to stabilise the situation and a long-term counselling process helps the survivor gain confidence to rebuild her self-esteem. Mental health conditions complicate situations of violence and the complex interplay between individual, relationship, community, institutional and societal factors put women at risk of experiencing violence.

At SNEHA, we adopt a multi-layered psychosocial approach to working with women survivors of violence. Our field workers and community officers are trained in providing psychological first aid, and our counsellors are trained in Rogerian client-centred therapy and other therapeutic interventions like psycho-education, role education and interpersonal therapy. After screening, survivors are

referred to consultant psychologists for further assessment and treatment if necessary. Our psychologists use individual and group psychotherapy, Cognitive Behaviour Therapy, and Rational Emotive Behaviour Therapy. Awareness and destigmatisation campaigns are conducted regularly using participatory methods such as games and street plays in the community, as well as innovative public engagement modes such as the Dharavi Biennale (read more at: http://www.dharavibiennale.com/).

A successful aspect of our approach to violence and mental health interventions has been that it is non-clinical and holistic. Feminist counselling is at the core of our work that aims at change rather than adjustment that focuses on strengthening survivors in areas such as assertiveness, communication, relationships and self-esteem. We acknowledge sex roles, minority status and socialisation in society as possible sources of psychological difficulties and it is important to work on these issues that also lead to violence against women. We believe that the social determinants of violence and mental health need to be understood in order to develop psychosocial interventions that work on the continuum of illness to wellness.

HOW SNEHA HAS INTEGRATED TRADITIONAL PSYCHOTHERAPY AND FEMINIST COUNSELLING

We have found that in addition to using traditional psychotherapeutic techniques such as thought monitoring, thought disputation, guided discovery, behavioural activation, relaxation training and role plays, techniques and concepts unique to feminist counselling have also greatly helped in our work with women clients. Traditional psychotherapy encourages the client to take cognisance of their own moods, thoughts and actions and to focus on and change those aspects of their thoughts and behaviour which are within their control. Feminist therapy, while integrating concepts with other theories and schools of thought, is gender-free, flexible, interactional and life span-oriented. It emphasises the context of women's lives and confronts patriarchal systems. It sensitises counsellors to gendered uses of power in relationships. It adopts a positive and an egalitarian attitude towards men and women. Its concepts emphasise the importance of community building, building a sense of social awareness and social change.

Suggested reading:

Brown, Laura S. Feminist Therapy. American Psychological Association, 2010.

Integrating mental health work with our larger prevention of violence against women program has been easier and positive because of the robust community mobilisation component of our program. We enjoy a high level of credibility and trust in the areas we help in and this has helped us integrate two very complex issues. One of the pillars of our model on intervention and prevention of violence against women is a large volunteer base, often women from informal settlements. We have been able to build a cadre of 'barefoot counsellors', by training these volunteers to provide psychological aid and a crisis response to women undergoing violence and having mental health conditions. The program has managed to create a need with the community to identify this as an important issue affecting them and also to an extent, remove the stigma associated with mental illnesses.

SUGGESTED READING ON BAREFOOT COUNSELLING

World Health Organization, War Trauma Foundation, World Vision International. Psychological first aid: guide for field workers. World Health Organization, Geneva; 2011.

Sanderson, C. Counselling Skills for Working with Trauma: Healing from Child Sexual Abuse, Sexual Violence and Domestic Abuse. Jessica Kingsley Publishers, 2013.

Patel, V. Where There Is No Psychiatrist: A mental health care manual. New Delhi, India: Voluntary Health Association of India, 2002.

Chowdhary, N., Chatterjee, S., & Patel, V. The MANAS Model for Health Counsellors. Goa, India. Sangath Society for Child Development and Guidance, 2011.

There are several challenges when working with women survivors of domestic violence who have mental health conditions and are living in a complex setting of poverty, deprivation and a cultural context that sanctions violence. One is the lack of mental health literacy in communities in informal settlements. Violence is normalised in the day-to-day struggle for stability in a challenging low-resource environment. One of the biggest challenges we face in our intervention is convincing the family about the survivor's mental health condition, especially when the survivor fails to fulfil her expected role and responsibilities. On the other hand, when she deviates from the expected norms of appropriate behaviour, she is often labelled with a mental health condition. Home-based care or community based support is withheld in such situations and women are often abandoned under the pretext of being of no use to families because of their non-functionality.

A second challenge is the fact that rehabilitation services provided by government and non-government organisations are not inclusive of community support and care. Recovery is seen as a linear process without contribution from the environment and absence of positive stimulus. This puts women in isolation and recovery can be slow. It also makes referral difficult. Our response has been to work with shelter homes, the Integrated Child Development Scheme (ICDS), and other NGOs to help them strengthen their capacity for first response and longer-term support.

While integrating interventions on mental health and violence, organisations need to bear in mind the following:

1. Secondary interventions pave the way for primary prevention, especially when adapting a stepped care model. Visible interventions to support survivors make people aware of the problem and potential solutions.

2. An integrated stepped care model on violence against women and mental health requires a robust community-based set-up to link different levels of support and care for identification, response and referral.

3. Consistent engagement with communities, understanding their social, cultural, and economic context and the existing support system to address violence and mental health, will help in building effective rapport on issues of violence and mental health

4. Working with government institutions such as the ICDS, primary health care centres, tertiary hospitals, government shelter homes and non-government institutions such NGOs and community-based organisations help in early identification, referral and providing necessary care.

5. Working simultaneously on two complex issues requires time to bring about a change in community perceptions and attitudes towards these issues.

The following experience shared by Dr Nayreen Daruwalla encapsulates our reason for integrating mental health services in our violence-related work,

> *We had a thriving community mobilisation program. Slowly, legal aid, networks, police interactions, and liaisons with the hospital were being put into place. But there were several cases that came up where we started feeling the need to consolidate mental health interventions with counselling interventions for survivors of violence. Being housed in a public hospital, many destitute women were referred to us who were brought to the hospital with a complaint of an accident, homicide and suicide. The underlying factors for such conditions in women were domestic violence in their homes or sexual violence inside or outside their homes.*
>
> *One case left a very stark impression on me. A -25year-old woman admitted in the ward was referred to the counselling centre. She was deserted by her natal and matrimonial home. She was missing her children and her family and was hoping to go back to her family. With great difficulty, we were able to locate where her natal family lived. The natal family was not ready to take her back. They gave the whereabouts of her husband. The reason for the refusal was that they said she was very "aggressive". One day, she became very aggressive in the ward and attacked other patients. She was unbelievably violent and had to be restrained and then put in a mental institution in Thane. We found the husband and were negotiating with him to take her responsibility. After she got better with the help of medications in the institution, we painstakingly caught hold of the husband and made him go to Thane to take her in. less than 6 months later, we found her again. Sitting at a dargah, she had been abandoned again, possibly due to her continuing mental health condition. That really stayed with me. After doing all we could to help her, to see her in that state. This is why the mental health intervention had to be brought into the picture.*

The subsequent chapters outline SNEHA's process of intervention and its stepped care model to intersect violence against women and mental health.

CHAPTER 3

PHASE 1 -
THE PREPARATORY PHASE

In order to run a robust and integrated stepped care programme on violence against women and mental health, training staff and laying the ground-work in the community are crucial.

The first phase in setting up a community-based program on violence against women and mental health, therefore, is capacity-building and community organisation. In this chapter, we will cover the following strategies:

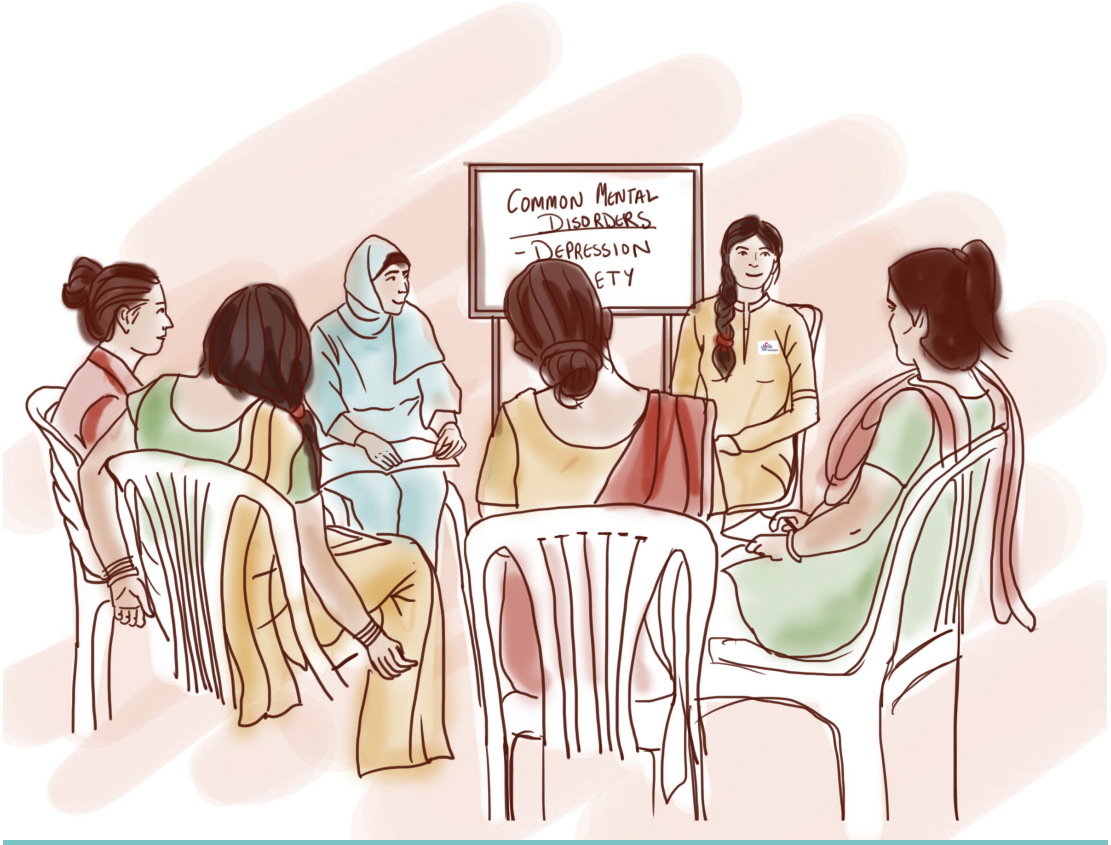
1 CAPACITY-BUILDING

2 MICROPLANNING

3 CAMPAIGNS

4 GROUP FORMATION

5 IDENTIFICATION AND CAPACITY-BUILDING OF VOLUNTEERS



1 CAPACITY-BUILDING OF STAFF –

COMMUNITY ORGANISERS, PROGRAM OFFICERS AND COUNSELLORS/SOCIAL WORKERS

Training has been a major component of our work on violence against women and mental health. We have consistently trained our staff over the past three years on different topics. We divided the content and the complexity of the training sessions depending on our staff members' skill levels.

Year 1

The focus during the first year was to help the staff become more sensitive towards gender issues, to help them understand various aspects of gender-based violence, to create increased understanding and sensitivity to mental health issues, and to help the staff recognise basic symptoms of mental illness. The community team was trained with the intention that they would then implement what they had learned during the women's gat meetings and community awareness campaigns. The counsellors were trained with the objective of helping them understand the process of screening and referral of women facing violence with mental health conditions.

Year 2

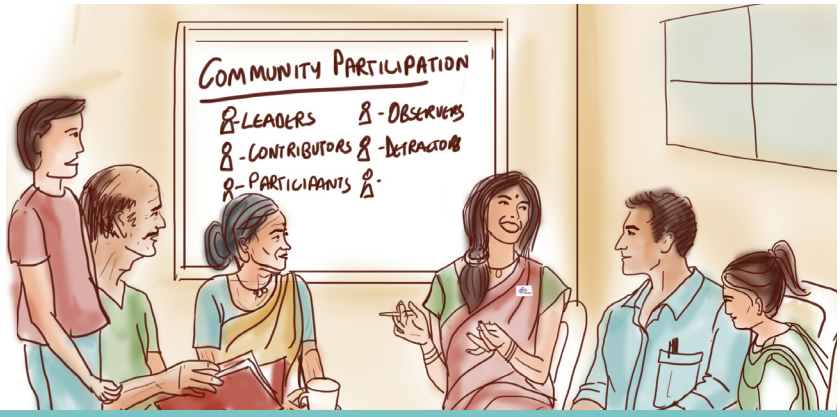
Before planning the staff training program for the second year, we assessed the feedback we had received from the community. Substance abuse, addiction and suicide emerged as the most prevalent concerns present in the community. Therefore, training sessions for year two focussed on substance addiction. We invited psychiatrists from King Edward Memorial Hospital, Parel, (which houses a renowned de-addiction department), and counsellors and community workers from Kripa Foundation, Mumbai, to speak to our staff. During the latter half of year two, training sessions focussed on awareness of suicide and suicide risk prevention.

Year 3

Based on our assessment of the year two interventions, we realised that while our staff had now become adept at identifying, responding to and creating awareness about mental health concerns in the community, they tended to view mental illness and violence against women as being mutually exclusive. Third-year training plans therefore focussed on integrating how violence is likely to increase a survivor's vulnerability to developing mental health concerns. We attempted to build our community organisers' basic skills for intervention by teaching them psychological first aid and skills for intervention in challenging situations. For our counsellors, we worked on enhancing their skills by bringing in a senior counsellor-educator to teach them advanced counselling skills. We also implemented a supervision protocol for our counsellors as part of their continuing counselling education. We recommend organisations hold training and refresher sessions for staff at regular intervals, particularly during the first year, as both concepts are exacting and need some time to be absorbed and understood.

Here is a list of some of the topics covered in our training sessions across three years:

	Community Organisers and Program Officers (field work team)	Counsellors/Social Workers
Year 1		
Violence	How gender affects health What is gender-based violence? Domestic violence Types of domestic violence Understanding the resources- hospital, police, court	Gender-based violence Types of domestic violence The Protection of Women from Domestic Violence Act, 2005 Crisis intervention Protocols
Mental Health	What is mental health? What is mental illness? Difference between distress and disorder Myths related to mental illness Signs and symptoms of Common Mental Disorders- Depression and Anxiety, and Severe Mental Disorders- Schizophrenia Treatment of Common Mental Disorders and Severe Mental Disorders	What is mental health? What is a mental illness? Difference between distress and disorder Myths related to mental illness Signs and symptoms of Common Mental Disorders- Depression and Anxiety, and Severe Mental Disorders- Schizophrenia Treatment of Common Mental Disorders and Severe Mental Disorders Basic principles of counselling and techniques
Year 2		
Violence	Understanding the laws related to gender-based violence First response strategies Bystander intervention	Special and refresher training on laws
Mental Health	Substance abuse- etiology, symptoms, type and treatment Suicide- basic myths, and basic prevention and first aid	Substance abuse- etiology, symptoms, type and treatment Suicide- myths, Suicide Risk Assessment and Intervention
Year 3		
Violence	Understanding sexuality-related issues Intervention in challenging situations	Understanding sexuality related issues Intervention in challenging situations Building skills for working with perpetrators
Mental Health	How violence against women and mental health are connected Basic psychological first aid	How to integrate intervention for violence against women and counselling for mental illness Advanced counselling skills- induction, session planning, termination, goal setting, documentation



2 MICROPLANNING

Once the staff is trained, the next step in setting up the programme is community organisation. The objective is to create a presence in the community and lay the ground-work for the intervention and prevention programme.

The first major step towards community organisation is Microplanning. Microplanning is a rapid assessment process of understanding a community's needs and helping the community prioritise issues that are relevant to them to bring solution oriented actions. The rapid assessment is carried out through the use of Participatory Learning and Action (PLA) techniques and exercises. This is led by community organisers and program officers as a one-time action when entering a new community before one starts work on core issues. The team collects basic information about the potential new geographies of work (community or cluster-level) from various sources: the local MCGM Office, health posts, Census data, and the ICDS Centre. The team creates a demographic profile of the community, including history, issues in the community and geographic details with a map. Team members verify and reconcile the data from the various sources to get consistent numbers of the impact area. As per SNEHA practice, the community team engages in the Microplanning processes, including practical mapping of the cluster with the community members to better understand their community.

MICROPLANNING ACTIVITIES INCLUDE:

Timeline Analysis: Mapping incidents of violence against women that have taken place in that community in the past.

Conflict Areas: Asking community members to gauge the percentage of domestic violence in spaces.

Community Resource Mapping: Mapping accessibility and perceptions about resources for interventions on violence against women.

Mobility Mapping: Mapping (women and girl's) mobility and locating unsafe areas in and around the community.

3 CAMPAIGNS

As step three, campaigns – a specific kind of public awareness activity - are taken up at the nukkad, basti and sarvajanik level by SNEHA with the help of the community, as the second stage of the community organisation process. During the preceding three years, the focus of our campaigns has been to highlight the link between violence against women and mental health concerns. The themes of the campaigns have been centered on the complex intersection between violence against women and mental health: how violence against women is a precipitating factor in the development of mental health concerns and/or conversely, how existing mental health conditions are often exacerbated by the experience of violence. Pamphlets are distributed with information on SNEHA and the contact details of our counselling centres, especially the helpline numbers.

Our experience with community mobilisation has helped us to formulate different types of community campaigns.

NUKKAD CAMPAIGNS

Approximate number of participants
60 to 70

Places where they are held
At the intersection of alleys and lanes in the community

Structure
- On the morning of the campaign, community organisers and Sanginis go door-to-door to talk about mental health.
- Games (such as the Pulley game and Ludo) and story cards are organised to create awareness.

BASTI CAMPAIGNS

Approximate number of participants
80 to 100

Places where they are held
Usually conducted in a small open space in the community, such as outside a temple or a community centre.

Structure
- Community organisers and Sanginis go door-to-door to talk about mental health on the morning of the campaign.
- Games (such as Snakes and Ladders, and Ludo) are organised to explain cause-and-effect with respect to mental health.
- Posters are displayed and explained.
- Street plays, songs are performed.
- Performances and speeches are given by Sanginis.

SARVAJANIK CAMPAIGNS

Approximate number of participants
150+

Places where they are held
In a big maidan (sports or other open ground) or hall or meeting place, and at different venues (pandals) during major festivals.

Structure
- Simple written or verbal invitations handed out a few days in advance to residents of the area where the campaign is to be held.
- Door-to-door mobilisation conducted on the morning of the campaign.
- During the campaign:
  - Movies screened
  - Talks by community team members,
  - Chief guest or resource person.
- Stage presentations interspersed with plays and performance on the subject.

4 GROUP FORMATION

Group formation is the third stage of community organisation process. The community team is responsible for organising *nukkad* (corner) meetings and group meetings. The community corner meetings help the team initiate and facilitate the formation of new community groups, which are conducted separately for women, men, and adolescents.

Group meetings take place once a month, or about eight to ten times a year. The aim of these meetings is to orient the group to SNEHA's work, promote group bonding, and educate the group members on gender, human rights, domestic violence, child sexual abuse, laws relating to violence against women, accessing public services such as hospitals, police engagement, and other subjects. SNEHA's community outreach grows through the formation of women's groups. This is over-and-above the community team's regular visits to the community, micro planning, corner visits, street campaigns, and group events. On an average, it takes about three to six months to form the women's group (which begins informally through gatherings and discussions that the organiser facilitates), and each group comprises of ten to fifteen women. During regular group meetings, the SNEHA community team orients women to SNEHA's work and activities. Groups are managed by community organisers while program officers manage work with the Sanginis.

The three types of community groups (gats) organised by SNEHA are:

- Women's groups
- Men's groups
- Adolescent groups

5 IDENTIFICATION AND CAPACITY-BUILDING OF VOLUNTEERS FROM THE GROUPS

During regular group meetings, the community team orients women to SNEHA's work and activities. For women's groups (gats), the community volunteers are called Sanginis. From the basic women's group meetings, the SNEHA community team observes those who are vocal and participative, show regular attendance, and show leadership and motivation. Based on these attributes, the SNEHA community team short-lists members for the Sangini leadership training.

We have developed the AWARE- ACT- LEAD framework for the training and capacity building of our women volunteers. Within this framework, three different purposive modules are taken up for each year of capacity building of volunteers:

AWARE – Year 1 training involves building awareness on the various aspects of gender-based violence and the various resources that can be used to prevent it.

ACT – Year 2 training covers actions that the volunteers can take when they witness gender-based violence or related issues. The idea is to get them to move away from being bystanders and instead take action while ensuring safety.

LEAD – Year 3 training focuses on building leadership capacity of the volunteers. Training is centred on taking on more responsibility in conducting intervention.

Aware

1. Why Violence, why SNEHA, Why Us?
2. Group bonding and vision
3. Our bodies, our minds: health
4. Gender, health, and Violence
5. Violence against women
6. Know your resources: mental health (providing listening skills here)
7. Know your resources: Nutrition
8. Know your resources: sexual and maternal health
9. Know your resources: hospital and police (basic rights)
10. Violence and consent
11. Intervention, listening/advocacy skills, basic referrals
12. Group communication, conflict, goals

Act

13. Self-care techniques
14. Identity and Sexuality
15. Power and control wheel, empowerment wheel
16. language/spectrum of harm
17. Counselling: Empowerment/motivational interviewing
18. Identification/referral (Depression/suicide, child sexual abuse, VAW) (consent and permission to act)
19. Identification/intervention (Depression/suicide, child sexual abuse, VAW)
20. Bystander Intervention, strategies/techniques
21. Know your resources: Police (filing NC/FIR/more rights/more detail)
22. Know your resources: Hospital (how to accompany)
23. Know your resources: Court (how to navigate)
24. Relation to the community/implement a project

Lead

25. What is a leader? Discuss stories, make lists, identify challenges, warm up activities
26. MY goals, strengths, weaknesses
27. The power of communication
28. Organising skills: think about the hows, wheres, whys, etc.
29. Mobilising: Recognising and relying on others, motivating, delegating, and trusting
30. Entrepreneurship: Running a business, organisation, or initiative
31. Public speaking: conveying your message
32. Temptations in Leadership
33. Leadership relates to counselling/intervention skills -> Build a sense of ownership and responsibility
34. My agenda versus community agenda
35. Community project leadership
36. Passing on leadership, Goals after the program and Graduation

CHAPTER 4

PHASE 2 - THE INTEGRATED STEPPED CARE MODEL

In this chapter, we will delve into the integrated stepped care model on violence against women and children and mental health.

Introduction to the integrated stepped care model

Step 1 - Sanginis

Step 2 - Community organisers and program officers

Step 3 - Counsellors / social workers

Step 4 - Consultant psychologists

Step 5 - Linkages with stakeholders

CASE STORY 1

"Tanya finds inner strength to live her life on her own terms."

It began with a sensitive doctor at the Paediatric OPD at the Urban Health Centre in Dharavi. The doctor noticed that Tanya (name changed), a 27-year old woman frequented the hospital OPD with her 7-year old daughter, Divya (name changed). After talking to them, Tanya told the doctor that she was facing violence from her marital family. The doctor referred them to SNEHA with concerns of family problems and poor parenting.

In her sessions with the counsellor, Tanya revealed that she and her husband (married for ten years) had been living separately for the past seven years. She had also been subjected to extensive domestic violence by her mother-in-law and her sisters-in-law at her marital home. Her husband, though not an active participant in the abuse, did not intervene to stop the violence against his wife nor did he fulfil his responsibilities towards her, happy in maintaining the status quo. For the first four years, he came to Mumbai intermittently to meet her, but had not been in touch with her for the past three years. When Tanya first came to SNEHA, she was not forthcoming with information, reported a high number of somatic complaints, was quite helpless, and was resistant to help. Her daughter also exhibited significant behavioural difficulties.

Her counsellor started regular counselling sessions with her, focused on obtaining more information about Tanya's marital and natal homes, her relationship with her husband, daughter and her family members, exploring her feelings and suggesting possible courses of action to her. She and her daughter were also introduced to the consultant psychologist. While Tanya received therapy from the consultant psychologist, the child psychologist worked with Divya. The focus of these sessions was to help Tanya deal more effectively with her daughter's behaviour (largely through behaviour modification techniques) and to work individually with her daughter for her behavioural concerns. Given her significant

CASE STORY 1

somatic concerns, her counsellor and the consultant psychologist together referred her to the Psychiatric OPD at Lokmanya Tilak Municipal General Hospital for medication. As her sessions progressed, her counsellor felt that Tanya would benefit from attending the weekly group therapy sessions held at Urban Health Centre, and as she met the criteria, she was asked to start attending the sessions.

During her first couple of sessions, Tanya was largely quiet. At the end of one session, she expressed that she found these sessions to be unhelpful, that they "gave her headaches," and that she would no longer be attending them. However, the other group participants refused to let her drop out, noting down her phone number so that they could ensure that she attended the sessions regularly. Since then, Tanya has been a regular group member and has formed a solid social network with the other group participants. As her individual and group counselling sessions have progressed, Tanya's active participation in both has significantly increased. She is more open and expressive with her thoughts and feelings, her decision-making abilities have improved and she has also started considering alternative courses of action for her and her daughter's future.

The way Tanya handles her daughter's behaviour has also improved significantly and her daughter herself is better behaved. Tanya is compliant with her medications and she credits her psychiatric treatment for having helped to reduce many of her symptoms. What is heartening for us is that Tanya's psychiatrist once paid us a visit on a Friday afternoon when Tanya came for her group therapy session. The psychiatrist had noticed a gradual improvement in Tanya and Divya's recovery and learnt from Tanya that she came to SNEHA to meet with a group once a week. He was interested in observing the process as he felt that it was contributing positively to her recovery.

Her counsellor has also held sessions with her father and brother, to help them see things from Tanya's perspective and to ask them to provide her with more freedom to make decisions for herself. She has now asked her counsellor to file a case of domestic violence against her husband and regularly follows up on the case progress with her counsellor. Tanya's recovery has been objectively observed by her counsellor, the consultant psychologist and the other group participants. She herself reports feeling happier and says that her decision-making abilities have improved and that she feels more assertive.

Introduction to the Integrated Stepped Care Model on Violence against Women and Mental Health, and Interventions for Women facing Violence with Mental Health Conditions

A structured model plays a very important role in complex interventions. The Stepped Care model refers to a step-wise system of delivering and monitoring treatments, so that the most effective yet least resource-intensive treatment is delivered to patients (in SNEHA's case, women facing violence with mental health conditions) first; only 'stepping up' to intensive/specialist services as clinically required. The objective of a stepped care model is 'having the right service in the right place, at the right time, delivered by the right person'. A typical stepped care model encompasses five steps-

1. Prevention and Promotion-
Activities dedicated to early identification of mental health conditions by community/ field workers, and activities dedicated towards promoting awareness about mental health and illness, destigmatisation, and teaching community members about access to mental health care services.

2. Recognition by primary health workers-
Activities dedicated to screening of mental health conditions by the community staff, based on which they refer clients/ patients to health care professionals.

3. Assessment / Primary care interventions-
Health care professionals assess the severity of the problem and provide basic interventions.

4. Secondary / specialist services-
Based on the extent of the problem, the client or patient is referred to a mental health professional for therapeutic intervention.

5. Specialist-
If required, for clients with severe concerns, there are referrals and linkages with psychiatrists and in-patient departments of hospitals for treatment.

An example of the Stepped Care Model of Intervention in the Indian context is the organisation Sangath's model 'MANAS- a collaborative stepped care model intervention in primary care'.

Most stepped care models are focused on making mental health care services more accessible. However, we wanted to incorporate elements of intervention for both violence against women and mental health in our approach. Therefore, the Program on Prevention of Violence against Women and Children, in consultation with Dr Neerja Chowdhury, a senior psychiatrist who was instrumental in developing the MANAS module, helped us to adopt the stepped care intervention into our existing primary and secondary prevention work on violence against women and children. In the context of PVWC's work, the stepped care model involves working with layers of actors to ensure that the mental health needs of the survivors of violence receive the right support at the right time. Two key features of our integrated stepped care model are:

It is comprehensive: the woman receives social, legal and rights-based interventions based on her needs, along with the mental health intervention.

It aims to involve members of the community as well as trained professionals.

Key players for each step of our integrated model for violence against women and mental health are:

Step 1- Sanginis

Step 2- Community organisers and officers

Step 3- Counsellors/ social workers

Step 4- Psychologists

Step 5- Linkages with other stakeholders

Step 1
SANGINIS (COMMUNITY VOLUNTEERS)

Sanginis are women from the community who are selected as volunteers from our groups, and undergo training sessions (as described in Chapter 3). They offer the basic level of intervention.

The roles and responsibilities of the Sanginis are as follows:

- Sanginis screen women for violence using a mobile phone application developed in-house called "The Little Sister". The application allows them to screen for mental health issues and suicide risk.
- The Sangini has to get the woman's explicit informed consent before carrying out the screening and entering her information into the Little Sister app. She takes this opportunity to educate the woman on the issue of violence as a violation of human rights, encourages her to seek help and gives her information about the legal provisions.
- In cases where the woman has indicated her desire to approach SNEHA's counselling centre, she is accompanied by either the Sangini or our community organiser.
- If the woman is at high risk of violence and/or suicide, the case is immediately referred to the community organisers and the counsellors.
- Follow-up is carried out regularly by our Sanginis through home visits.

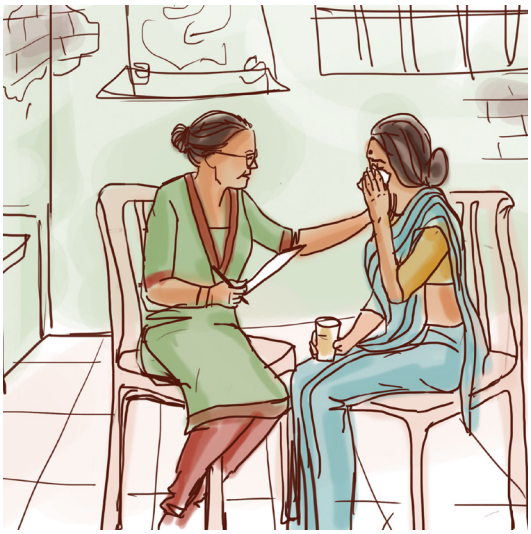
The following table lists a few questions included in the Little Sister application:

Assessment on violence against women	Mental health assessment
Incident of violence (time, date, day, location) Forms of violence (intimate partner, domestic violence, sexual assault, sexual harassment) Type of violence (physical, verbal, sexual, economic, deprivation and neglect) Frequency of violence (everyday, regularly, sometimes, occasional/one-time) Type of support required (medical, police, shelter, family interventions, home-based support)	Competence in self-care and activities of daily living Ability to complete household responsibilities Ability to take care of children Competence in shopping and monetary transactions Ability to fulfil interpersonal responsibilities Suicidal thoughts and ideation

Step 2

COMMUNITY ORGANISERS AND PROGRAM OFFICERS

The community mobilisation team members include community organisers and program officers led by a program coordinator.



COMMUNITY ORGANISERS (COs)

Community organisers (COs) are full-time trained staff of SNEHA. Most of them are hired from the communities they live in as they are involved and engaged in their local community. They must have completed their education up to class XII, and may or may not have field experience. Community organisers work in pre-determined areas of the community, tasked with carrying out community mobilisation such as running group education programmes for women or men, helping in the organisation of campaigns and supporting other community activities. They are also expected to follow up in some cases and help counsellors with home visits

PROGRAM OFFICERS (POs)

Program officers (POs) are usually selected from amongst the community organisers to lead a group of organisers in different areas. They are also tasked with managing the Sangini leadership programme, leading the group education for men, offering psychological aid or following up in complicated community-based cases of violence and/or mental health, and managing monthly data.

Community organisers and program officers have the following key responsibilities:

- When a woman or child approaches a community mobilisation team member while out in the community, it is critical that he or she makes the survivor feel as comfortable and secure as possible.

-Their primary role is referral of the women identified via the Little Sister app to the counselling centre.
In cases where the survivor is facing violence, but is not prepared to approach the counselling centre, our community officers conduct home visits and provide her barefoot counselling, basic education about violence, and the process of violence intervention.
In cases where there is severe violence, high suicide risk and potential threats such as trafficking, house-arrest or child marriage, our counsellors, along with the community organisers or program officers, intervene without waiting for the survivor to come to the counselling centre.

- Providing psychological first aid: Organisers and officers are trained in active listening, empathy, reflection of feelings, paraphrasing, and responding to a woman who is suicidal. They provide psychological first aid to the women survivors of violence who are in high distress.

- For cases of violence against women, the community organisers conduct follow-up activities such as accompanying clients to the police station, conducting home visits to monitor the situation at home. For women with mental health conditions, along with the counsellor or program officer, community organisers engage in follow-ups for medication compliance, and are part of the safety planning process for clients who are suicidal.

CASE STORY 2

“She was the light that helped others see…”

Rani, SNEHA's community organiser, had just finished conducting an intense session for one of SNEHA's 'ghats' (women's groups) on domestic violence and its consequences on health. One of the women who had attended the session was waiting to talk to her. The woman told Rani that she had a daughter who had married a year ago and was living in Uttar Pradesh (UP) with her husband and his family. However, during the course of the year, her daughter told her that her husband was subjecting her to violence. The family in Mumbai was reluctant to intervene as they thought the abuse was because the couple was adjusting to each other and it wouldn't be long before the daughter settled into her life with her in-laws. When the violence escalated, and providentially, SNEHA conducted a session in her area, the mother realised that she could turn to SNEHA for help.

The daughter was not given access to a phone save when her mother called her up each

CASE STORY 2

afternoon. Initially, Rani guided the mother who conveyed Rani's counsel to the daughter during their afternoon conversations. In parallel, Rani came to the counselling centre to discuss the case with a counsellor and get guidance on what to say to the daughter and what options to suggest to her. Rani would intentionally visit the mother's locality in the afternoon in order to have conversations with the daughter, as the in-laws would not suspect that the girl was talking to anyone besides her mother. This continued for a month until a safety and exit plan was put into place for the daughter.

The plan went as follows: the mother called the son-in-law to ask him to send the daughter to Mumbai to attend a function. Permission was granted and tickets were booked. The daughter was prepped by Rani and knew that – as part of the exit plan - she had to pack and bring to Mumbai all her important documents and the jewellery her natal family had given her. Everything went according to plan and the daughter arrived safely in Mumbai. It was with great relief that her mother brought her to the counselling centre, accompanied by Rani. Thus, with the most risky part of the operation behind them, the counselling and extended intervention could begin.

When the daughter did not return to UP after the 10-day period she had initially asked for, the husband and some of his relatives came to Mumbai to take her back. The counsellor was informed and she called the husband to the centre to talk to him. His wife was very clear that she did not want to go back to UP, so, after much negotiation, the wife stayed on in Mumbai, while her in-laws returned to UP. The daughter has now filed a case under the Protection of Women from Domestic Violence Act, 2005, in the Mumbai court with SNEHA's help. She is happy to be living in Mumbai with her family while her case continues in court.

What struck us, as an organisation, was that referrals are not always the solution. As in this case, even though the survivor lived in another state with organisations that could help her, her situation was such that she was not allowed to access any services, especially not on her own. Her only connection to help was through her mother who lived in Mumbai and had sought SNEHA's support. We therefore chose to counsel her over the phone, thus helping her to leave the violent situation and get the resolution she wanted.

Step 3

COUNSELLORS/SOCIAL WORKERS

Counsellors/ social workers are professionals with post-graduate training in social work or counselling. They follow our 'Crisis Intervention and Extended Response Model' to work with survivors of gender-based violence. A 'crisis' is defined as an event or situation perceived as intolerably difficult, that exceeds an individual's available resources and coping mechanisms. A crisis intervention therefore recommends steps to be taken in order to meet the client where she is at, assess her level of risk, mobilise her resources and move strategically towards stabilising the crisis situation.

CRISIS INTERVENTION AND EXTENDED RESPONSE MODEL

First response (crisis intervention)

Crisis Intervention: Safety Assessment through crisis counselling and immediate medical, police, shelter, referral to other services, and home visits within 48 hours.

Extended response for women in crisis

Assessment: In-depth interview carried out with the woman in crisis. Skills that are used by the counsellor: empathy, assurance, validation and probing. A multi-faceted counselling approach and an exploration of viable options for the client are carried out.

Extended response: Psycho-Social intervention

Contact the perpetrator of the violence, with the client's consent and depending on her requirements
Session with the perpetrator (except perpetrators of sexual assault)
Joint counselling session, if necessary, with the client's consent
Family group counselling session, if necessary, with the client's consent
Home visits and follow-ups
Make a plan of action based on the client's decision
Negotiating non-violence in relationship
Follow ups

Extended response: Psycho-therapeutic services

Psychological support is provided by therapeutic services such as cognitive behaviour therapies, relaxation techniques and clinical test. Therapeutic group sessions are also provided.
Women are given the numbers of suicide prevention helplines, referred to day-care centres and other mental health agencies for support.

Extended response: Legal Intervention

Legal support is provided through legal counselling, registering of cases in the police station under relevant sections, filing cases under the Protection of Women from Domestic Violence Act (2005) in the Magistrate Court, and following up civil and criminal cases until the court procedures are complete and the orders are implemented.

Extended services

Home visits and follow-ups

COUNSELLOR'S ROLE IN CRISIS INTERVENTION WITHIN 24 HOURS

When the client first comes to the centre, the counsellor completes the intake sheet of the survivor with her consent. The intake sheet assesses the severity of the crisis, the client's presenting emotional state, the client's level of emotional mobility or immobility; the alternatives, coping mechanism, support systems and other resources available to the client.

If a client arrives at the centre with visible injuries, she is immediately referred to the nearest public hospital for medical treatment and documentation of the injuries.

The counsellor informs the client of her right to file an incident report at the nearest police station.

After the medical intervention is done, if the client wants to register a police complaint, the counsellor supports her in registering a non-cognisable offense (NC) or a first information report (FIR).

In case of a threat of any kind, after the medical and police intervention is complete, the client is immediately referred for shelter services, and counselling services are provided.

If the client lives in the community, the counsellor ensures that she is in constant contact with the community organiser or Sanginis from her area.

THE COUNSELLOR'S ROLE IN COMBINING CRISIS COUNSELLING AND PSYCHO-SOCIAL INTERVENTIONS

The counsellor's interventions for violence against women

A. In-depth interview and screening for trauma

Safety-risk assessment: Within 24 hours of providing crisis intervention, the counsellor undertakes an in-depth interview of the client to gather detailed personal information and assess her physical and psychological status using the intake form.

Choosing interventions: The counsellors provide all viable options (legal and psychosocial) to the woman based on a detailed and systematic analysis of her specific situation and challenges. The process is collaborative, where the focus is on making a plan of action along with the client so that she feels a sense of ownership of the plan.

Goal-setting: The client needs to have a clear goal by the end of the first meeting with the counsellor, with 'definite action steps that the client can own and comprehend'. By the end of the meeting, the counsellor and client should verbally summarise the plan and commit to it.

Mental health screening and related interventions: During the intake session, the counsellors use simple tools for screening women for common mental disorders.

They carry out suicide risk assessment with women, and do basic suicide risk intervention with those women who are at mild to moderate risk. If the woman's suicidal risk is high, the counsellors refer

the woman to the consultant psychologist.

They integrate basic counselling skills, problem-solving and behaviour activation strategies, and supportive counselling techniques in the existing intervention framework.

B. Individual, family and joint counselling

The counsellor then contacts the perpetrator(s) of the violence (husband or family members), if the client wishes to do so and after obtaining her consent, by sending a letter inviting him or her to the centre. If the counsellor does not receive a response, the counsellor conducts a home visit. During the counselling sessions with the perpetrator(s), the counsellor informs the perpetrator of the issues that the client has shared and her expectations.

After preparing both parties individually, a joint counselling session is conducted by the counsellor, preferably at the centre. The primary goal of the joint meeting process is to enable the client to communicate her problem to the perpetrator, enable the perpetrator to respond to the client, and for both to come to a satisfactory solution. During the session with the perpetrator, it is made clear to him/her that violence is a non-negotiable topic and any further instances of violence will not be tolerated by the client.

At the client's request, the counsellor also organises a family counselling session to understand the perspectives of other family members in order to more clearly understand the problem and arrive at a solution. The counsellor also focuses on providing the family with the tools to improve communication so that they understand each other better.

C. Legal interventions

It is imperative that the client be informed of all her legal rights and legal options so that she is able to make an informed decision regarding her situation.

Once the client has decided that she wants to proceed with a legal case, the counsellor refers her to the lawyers who help her with the court procedures and other legal interventions. The counsellor works with her client at every step of the legal intervention.

D. Extended services

Home-visits and follow-ups need to be done to identify any repeat cycle of violence and to provide support for reconciliation and non-violent communication.

HOME VISITS

A home visit may be conducted for the following reasons:

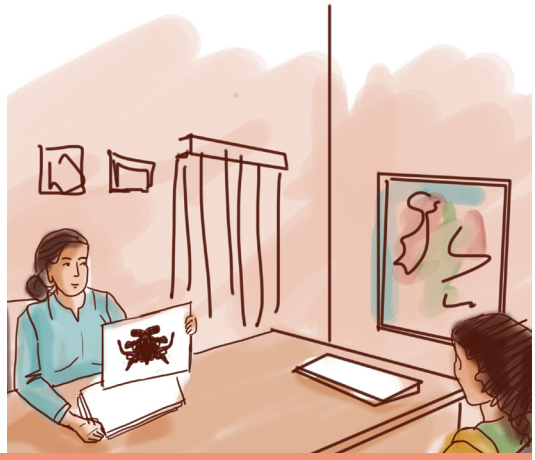
1. The perpetrator has not responded to the letter or phone calls sent by the counsellor requesting them to come to the centre;
2. The client and/or perpetrator are unable or unwilling to come to the centre for a counseling session;
3. The case is unresolved and the client is not responding to phone calls;
4. The client is being referred to another organisation.
5. Two months after the intervention is 'resolved' as per the client's wishes or 'reconciled', an unscheduled follow-up visit is carried out to check on the client's situation.

FOLLOW UP

It is important for the counsellor to keep in close contact with the client through phone calls, home visits, and/or counselling sessions at the centre.

Standard follow-up procedure for resolved or reconciled cases is as follows:

1. Surprise home visit between 45 and 60 days
2. Phone call or home visit at 6 months
3. Phone call or home visits after 1 year



Step 4

THE CONSULTANT PSYCHOLOGIST

The consultant psychologist (trained in clinical work) is responsible for providing intervention for survivors of violence who have mental health issues.

His/her roles and responsibilities are as follows:

Conducting diagnostic evaluation- based on a clinical history, Mental Status Examination, and assessment tools or varied screening instruments- as applicable. Along with assessment of the severity and extent of common mental disorders (CMDs), the psychologists also evaluate clients for severe mental disorders (SMDs).

Providing individual psychotherapy for the women with mental health issues, using a non-directional, client-centred, feminist approach and using Trauma Focused Cognitive Behaviour Therapy and Rational Emotive Behaviour Therapy as the primary therapeutic modalities.

Working with the family to provide psycho-education and caregiver intervention. Co-ordinating with and providing inputs to the counsellor and the community organiser regarding follow-ups.

Liaising with public hospitals to refer those women who require medication to psychiatrists.

Conducting group therapy sessions. (See Annexe 1 for details on the group therapy process.)

CASE STORY 3

"From self-blame to self-belief: one woman's journey through an emotional roller-coaster of a marriage."

The voice on the other end of SNEHA's crisis helpline sounded scared and worried. Yamini (name changed), a 27-year old woman, told the counsellor that she had been separated from her husband for a few months. She reported that she and her husband had married in May 2014, but their relationship deteriorated soon after their marriage. Her husband asked her to leave their marital home in September of the same year and initiated a 'notarised divorce' in December.

Yamini initially consulted SNEHA about the legality of the divorce. She told us that she wished to initiate divorce proceedings through the proper legal channels. She was highly resistant to providing details of her marriage and her relationship with her husband, or even to involve her parents in the intervention process. Her excessive levels of anxiety, her tendency to cry frequently, and to ruminate and brood prompted her counsellor to refer her to the consultant psychologist.

Over the course of her sessions with her counsellor and the consultant psychologist, Yamini reported that she and her husband had dated and had been physically intimate prior to their marriage. When she found out that she had conceived, she and her husband decided to marry so as to avoid social stigma and social alienation they would have to face if they remained unmarried. Yamini reported that she gave birth to a stillborn child a few months after their marriage. She said that both her husband and her mother-in-law used to harass and taunt her verbally and that her husband had been highly unsupportive throughout her hospital stay. His behaviour after their marriage seemed to confirm her suspicions that he married her solely because she had become pregnant while they were dating.

The focus of Yamini's sessions with her counsellor and the consultant psychologist was to help her reduce her sense of guilt related to her self-perceived 'promiscuity' prior to her marriage, her failed marriage and her overall sense of failure and her disappointment with herself. Her thoughts related to her sense of shame and her sense of failure was constantly challenged in her therapy sessions.

In the therapeutic sessions, she was shown that the decision to initiate physical relations had been a mutual one and that she could not hold herself responsible for her husband's comments about her 'character' for having had sex before marriage, and that it would have

CASE STORY 3

been practically impossible for her to have known how he would have behaved in the future prior to marrying him.

Through cognitive behavioural strategies, Yamini learnt to have a better control over her thoughts. Through the use of techniques such as reassurance, validation, reflection of feelings and confrontation, Yamini was provided an outlet for her unresolved emotions and was then gently shown the reality of her situation. She was encouraged to focus on self-care and to think of ways to become financially independent as she frequently worried about being a burden on her parents.

Over the course of four months, Yamini re-enrolled in her Bachelor of Pharmacy course and initiated divorce proceedings against her husband through SNEHA's legal services. She was an active participant in the group therapy sessions held at SNEHA.

To ensure that she received social support, Yamini's parents were involved in her intervention, with her consent, and she showed considerable improvement in her self-confidence, self-belief, and her ability to regulate her thoughts and her emotions, as well as in her decision-making ability.

Step 5

LINKAGES WITH STAKEHOLDERS

We work closely with the Integrated Child Development Services (ICDS), the Department of Women and Child Development (WCD), shelter homes and NGOs working on violence against women or mental health.

Our work has been twofold. One is through building capacity of the stakeholders through workshops that intersect issues of violence and mental health and the other aspect is directly working with them (referral/two-way) in case management and interventions.

The capacity-building workshops are aimed at increasing awareness and knowledge of community health workers and social workers on mental health issues, psychiatric and therapeutic treatments, and the identification of vulnerable women showing signs of mental illness.

We have conducted the following training sessions over the past three years for stakeholders based on their needs and requests:

- Understanding gender-based violence and mental health
- Understanding mental health care, treatment and wellbeing
- First response in crisis intervention and psychological first aid
- Counseling theory and practice (skills and techniques)
- Gender and sexuality
- Understanding burn-out and self-care

CHAPTER 5

PHASE 3- CHALLENGES AND THE WAY FORWARD

Working on violence against women is complex, and integrating interventions on mental health adds more complexities to the work we do, especially in a setting of poverty, deprivation and a cultural context that sanctions violence. We often see the double burden of gender working through the systemic hegemonic patriarchy making women more vulnerable to violence and mental health conditions. It requires arduous and continued efforts to bring about an attitudinal change to issues of violence against women.

CASE STORY 4

> ***Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again . . .***
> ***The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution.***
> *- Patricia Deegan (1988)*

Sheetal (name changed), 48 years old, had visited SNEHA's counselling centre in 2015 with her friend who had come to SNEHA for help in her domestic violence case. When Sheetal understood what interventions the centre carried out, she briefed the counsellor of her situation. She mentioned that she had been in a live-in relationship with a man who lived in her community for the past few years. However, their relationship had progressively worsened because he had become increasingly abusive towards her. Sheetal was reluctant to provide information during her first consult and seemed very unsure about what help she needed from the counsellor, at that point. Our community officer who stayed in her locality was in regular contact with her.

In May, 2016, during a case-sharing meeting in the community, some SNEHA Sanginis informed our counsellor that someone matching Sheetal's description had got into a violent fight with her partner, which resulted in her having to leave their home and seek shelter at a local railway station. With the help of the Sanginis and the community organisers, the counsellor was able to trace Sheetal's residence and conduct a home visit. She held a counselling session with Sheetal at her home and convinced her to come to the centre the next day.

During the session Sheetal shared that her father and brother were chronic alcohol abusers, both succumbing to medical conditions brought on by their addiction. Her mother had had to take care of the family single-handedly, working hard as a sweeper. She had passed away a few years ago from a long-lasting illness; Sheetal nursing her mother throughout the

CASE STORY 4

duration of the illness. Sheetal has an older sister who lives in another village, but they share a poor relationship. Sheetal reported that she felt lonely and that she had no support system.

She revealed that she had met her ex-partner (the accused) a few years ago. He had courted her tirelessly and relentlessly, professing his love for her, convincing her to start a relationship with him. Although he was married, he promised to divorce his first wife and marry Sheetal. Once their relationship began, he became increasingly abusive (physically, verbally, emotionally, sexually) and possessive. Sheetal used to make a living by selling lunch to daily-wage labourers. Her partner forced her to stop this service as he believed that she was soliciting her lunch patrons. He also forced her to stop her daily earnings; she did odd jobs to provide for herself and was self-sufficient. Sheetal reported that this experience made her feel more hopeless and helpless as she felt that the one person she believed in had let her down.

Taking into consideration, that her distress level was very high, the counsellor introduced Sheetal to the consultant psychologist. Her initial assessment showed that she had significant symptoms of depression and high suicidal ideation. The counsellor then accompanied her to the Psychiatric Department of a nearby public hospital. Given her high distress level, Sheetal was put under supervised medication. Her counsellor and the consultant psychologist, with the help of a caring and concerned Sangini, themselves monitored her medication intake to ensure that she took the medicines for a few days at a time so she did not take an overdose. In parallel, the counsellor consistently carried out a series of interventions which included individual counselling, home visits, police interventions, and providing legal guidance through SNEHA's lawyer.

Sheetal was also subjected to abuse by her neighbours and community members. They blamed her for having a relationship with an addict. Our counsellors, community organisers and the Sangini held a series of meetings with the community members to sensitise them to Sheetal's situation, guiding them on how they could intervene when her partner subjected her to violence.

The focus of Sheetal's individual counselling sessions was to reduce her sense of guilt, worthlessness and hopelessness about the future. "The violence is not your fault" is a message that the counsellor reiterated and emphasised in each session. Sheetal attends the group therapy sessions and found that the non-judgemental attitude of the other participants and counsellors has helped her to develop a positive self-belief.

CASE STORY 4

The most significant and acute challenge in Sheetal's case is that there is always the threat of severe crisis looming over her. A few months after her intervention began at SNEHA, Sheetal's partner began physically abusing her again. At that point, the community was not supportive of her, so she was referred to a short-stay shelter home. After a week, Sheetal reported that she had enjoyed her time at the shelter and felt relaxed, but she missed her pet cats and her home. From the conversation, it was obvious that Sheetal still harboured feelings for her partner, which was why she wanted to return to their home. She was asked to reflect on her decision, and at her insistence, she was allowed to move out of the shelter. Ever since, the counselling keeps gently encouraging her to consider moving into a shelter home as it is a much safer option for her.

The counsellor has conducted multiple sessions for her partner, who is an alcohol addict. These sessions have proved to be futile due to his personality traits. The counsellor also attempted to speak to his sister to ask her to intervene and to avoid giving her brother money, but it was to no avail.
Sheetal is irregular in her follow-up visits. Her counsellor communicates with the Sangini or carries out frequent home visits to ensure that she comes to the centre. She typically tends to visit her counsellor whenever she is in severe crisis or is suicidal.

Although Sheetal is doing quite well at the moment (she has started working again and reports feeling much better), it often feels like a waiting game: there is an ever-present danger to her physical and mental well-being, given that her partner continues to visit her.

The counselling centre understands that there is no single, definitive solution to rebuilding one's life as a survivor of gender-based violence, because the personal journey to healing varies for each woman. Another noteworthy point is that recovery is a long process when it comes to violence and mental illness. The violence may reduce, but the mental health recovery encompasses internal processes such as aspirations, personality traits and symptom management, as well as external factors such as interaction with the environment and social support. Independence, rather, inter-dependence, employment and fulfilment of community roles are all part of that recovery process and need to go hand-in-hand.

The past three years have been full of learning opportunities. In this section, we reflect upon some of the challenges that we faced and that continue to offer the opportunity for innovation and improvement.

One concern for an organisation endeavouring to set up a model like this is that it takes a lot of time to start work in the community. Building a rapport with the people, gaining their trust, generating interest in the work that we are doing, creating regular feedback loops, ensuring that the program is implemented at every level, is painstaking, hard work. For SNEHA, the process of incorporating the stepped care model was marginally easier as we already had a community mobilisation program in place.

When integrating two complex issues, one must be cautious of underestimating the time it would take to build counsellors' and field staff members' capacity to address cases of violence and mental health. These were some of the operational challenges we faced: training our field staff on these complicated issues, getting more professionals with a mental health background to be involved in the program (due to the scarcity of professionals in our country), and training our existing counsellors to offer mental health counselling. With counsellors/social workers, we needed to ensure that they fine-tuned their counselling skills in order to correctly administer some of the tools and to be able to pick up on the cues and signals that clients unconsciously provide during a counselling session. These are often points for probing or clues of a mental health condition and need to be flagged.

Our field staff took some time to absorb the technicalities of mental disorders, requiring a few refresher sessions. Once they understood what mental health and illness were, they needed to learn about the intersection of the two and where SNEHA's work lies. It was too ambitious of us to expect them to conduct an initial assessment of women undergoing violence and having a mental health condition using a validated tool (such as GHQ 12). It is worth mentioning that a simpler tool such as the Patient Health Questionnaire 9 might be more effective for community-level interventions.

The stigma attached to psychiatric treatment is a huge barrier to women who need to continue their treatment for a sustained period of time. This has convinced us that we will have to carry out frequent awareness activities in the community to get people to understand the importance of treatment.

There is a dearth of shelter homes for women in crisis. The few that exist do not have the funds to be adequately equipped to provide support and services or are bound by rules that make it difficult for the woman to avail of the shelter at a time when she needs it most. SNEHA has focused its efforts on supporting these shelter homes so that despite limited resources, they will be able to provide quality services to women facing violence and even to those women who have a compounding mental health condition. The Program plans to work closely with shelter homes to co-develop guidelines for psycho-social, quality institutional care within their existing frameworks.

A significant programmatic challenge for our primary prevention activities in the community was the lack of mental health literacy. It has taken years for people in the community to recognise violence against women as an issue. Adding another component of mental health complicated it further. Moreover, gender inequality was no more obvious than in the way men and women responded to information on mental health that SNEHA shared: women were expected to take care of husbands who had mental disorders in fulfilment of her role expectation as the dutiful wife, but husbands were not compelled to stay with a wife who had a mental health condition as she did not perform her role and duties as expected of her. Issues concerning men (such as addiction) were well-received, but communities found it harder to connect violence against women and their mental health. The common perception is that men's mental health suffers on account of having to bear the brunt of making ends meet and taking care of their family in a stressful urban environment. Moreover, health-seeking behaviour is observed to be low in women as compared to men. We have had men walk into the SNEHA office after campaigns, seeking help for mental health disorders all too often. The number of women doing the same is low. We revised our campaign design as hardly any women would come forward to talk about mental health when we conducted sarvajanik campaigns, and if they did, it was more common that they would talk about a male relative's mental health, rather than their own.

In order to sustain work on mental health and violence,

- Through our counseling and extended response centres, we aim to provide more in-depth psycho-social interventions.
  We plan to make our follow up processes in clinical/mental health cases more robust.
  We will focus on developing counsellors' skills sets to work with women with severe behavioural concerns. We will also develop protocols for counsellors to handle the different axes of mental health conditions.

- The current stepped care model that integrates mental health and domestic violence will be enhanced to include more prevention interventions on gender-based violence.

- Lastly, SNEHA will situate its work within the purview of the new Mental Health Care Act, 2017, and The Rights of Persons with Disabilities Act, 2016, as the latter recognises mental illness as a disability.

REFERENCES

References

1. Ellsberg M, Arango DJ, Morton M, Gennari F, Kiplesund S, Contreras M, Watts C. Prevention of violence against women and girls: what does the evidence say? Lancet 2014;385:1555-66.

2. WHO, London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva: World Health Organization, 2010.

3. Ellsberg M, Arango DJ, Morton M, Gennari F, Kiplesund S, Contreras M, Watts C. Prevention of violence against women and girls: what does the evidence say? Lancet 2014;385:1555-66.

4. Michau L, Horn J, Bank A, Dutt M, Zimmerman C. Prevention of violence against women and girls: lessons from practice. Lancet 2015;385:1672-84.

5. Bronfenbrenner U. The ecology of human development: experiments by nature and design. Cambridge MA: Harvard University Press; 1979.

6. Bourey C, Williams W, Bernstein EE, Stephenson R. Systematic review of structural interventions for intimate partner violence in low- and middle-income countries: organizing evidence for prevention. BMC Public Health 2015;15:1165.

7. Jewkes R, Flood M, Lang J. From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. Lancet 2015;385:1580-9.

8. Fulu E, Heise L. What do we know about violence against women and girls and what more do we need to know to prevent it? A summary of the evidence. Pretoria: UKaid, 2014.

9. Alexander-Scott M, Bell E, Holden J. DFID Guidance Note: shifting social norms to tackle violence against women and girls (VAWG). London: UK Department for International Development: VAWG Helpdesk, 2016.

10. Garcia-Moreno C, Zimmerman C, Morris-Gehring A, Heise L, Amin A, Abrahams N, Montoya O, Bhate-Deosthali P, Kilonzo N, Watts C. Addressing violence against women: a call to action. Lancet 2014.

ANNEXE 1

GROUP THERAPY FOR SURVIVORS OF DOMESTIC VIOLENCE

Guidelines and structure of group therapy sessions with women survivors of violence:

RATIONALE:

Women survivors of violence tend to show emotional distress, and a myriad of reactions such as anger, hurt, sadness, resentment, shame, guilt, helplessness, worthlessness, in reaction to their trauma. In addition, women survivors often feel isolated because of lack of family support and societal blame. The main idea is to provide these women with a safe space where they can discuss issues that they face, and build social support networks.

GROUP FORMAT:

Basic structure- Open group (in the Alcoholics Anonymous style)

Group size- Average of 6-8 group members

Inclusion criteria-Women survivors of domestic violence who:

Are between the ages of 20-55 years.

Are in the mid-intervention phase of their intervention process at SNEHA.

Show emotional distress.

Exclusion criteria- Women who are actively suicidal or so extremely distressed that they cannot participate in group activities, or those who show symptoms of a severe mental disorder (for these women, individual psychotherapy and/ or pharmacological intervention is provided first, and they are included in the sessions once the symptoms stabilise).

Facilitators- Sessions facilitated by 2 consultant psychologists.

Frequency of sessions- One session per week.

THERAPEUTIC APPROACH AND THEMES OF SESSIONS:

Cognitive Behaviour Therapy, Rational Emotive Behaviour Therapy, Behaviour Therapy, Psychodrama, and Feminist Therapy are the main therapeutic schools that drive the sessions. Traditional talk therapy sessions are interspersed with sessions based on psychodrama, and on expressive art therapies such as Art Therapy, Music Therapy and Dance Movement Therapy. Some sessions are aimed at recreation or skill building, where skilled volunteers and members of the group itself teach the group members different skills such as mehendi, gardening, etc. as fun/recreational activities. At times, movies, stories and other media are used during the sessions to facilitate discussion.

STRUCTURE OF A TYPICAL GROUP THERAPY SESSION

Introduction of all the members (if there are new attendees) and an introduction to the group session

Updates by each participant about her challenges and emotions over the last week followed by a free-flowing discussion

Facilitator-guided discussion on specific issues that are identified

Psycho-education or teaching specific skills

Summarising and debriefing by facilitator

PSYCHO-EDUCATION- TOPICS COVERED	INTERVENTION-TOPICS AND STRATEGIES
Kinds of abuse- physical, emotional, sexual, economic The cycle of abuse Common reactions (emotional, cognitive, behavioural) in response to domestic violence and abuse Patriarchy and its influence on gender based violence Gender roles and norms Legal rights Consent Connection between thoughts, feelings and behaviours Mental health and illness- myths and reality	Expression and exploration of feelings Relaxation training- deep breathing, visualisation, grounding, progressive muscle relaxation Challenging unhealthy trauma related cognitions and depressogenic cognitions Reducing self- blame, guilt and shame Increasing and strengthening social support networks Self-care Behaviour activation Anger management Assertiveness training and negotiation of personal boundaries Improving self-esteem Problem-solving Decision-making Working on issues related to body image Working on issues related to sex and sexuality Parenting skills Increasing independence and empowerment

OUR EXPERIENCE WITH GROUP THERAPY

We started group therapy at SNEHA in 2015. Over the course of three years, we have had around 50 participants who have attended at least one session, but attendance was erratic in the beginning. It took us around 18 months to set up a group of regular attendees. The counsellors identified clients who would benefit from group therapy and reminded them to attend the sessions. In 2017, we now have around eight to ten regular participants. We found the open group format more effective than a closed group format.

Initially, the facilitators held structured group

sessions focussing on specific issues. Over sessions, however, we realised that allowing the women to set the agenda for the session was more effective.

Evaluation:
We have used different evaluation methods to evaluate the impact of group therapy.

1. Participant feedback (after each session, and after 6 months): This consisted of a short, semi-structured questionnaire, assessing their feedback related to the quality and usefulness of the sessions. The questionnaire also assessed the effectiveness and skills of the facilitators administered by a neutral and objective assessor. It was adapted from the manual 'The Power to Change' written and produced by the organisations participating in the Daphne project "Survivors speak up for their dignity – supporting victims and survivors of domestic violence, 2007-2009". [1]

75 per cent of the participants reported that they found the experience of attending the group very good, while 25 per cent reported that they thought it was a good experience. 50 per cent of the participants reported feeling much better after attending the sessions, while the other 50 per cent reported feeling somewhat better. 75 per cent found the group very helpful while 25 per cent found it helpful. 75 per cent reported that they would definitely recommend the group to other women while 25 per cent said that they would probably recommend it. With respect to the facilitators, 100 percent of the participants reported that the facilitators were knowledgeable, seemed to genuinely understand and care about their concerns, were able to handle the group dynamics well and allowed everyone a chance to express their views, and made them feel at ease when they shared. Our regular participants were also asked to rate the utility of each specific session that they attended, and to also report whether they used the suggestions in each session in their personal life. 100 per cent of the participants reported that they found every session very useful, and that they did successfully try out the strategies discussed.

2. Facilitator assessment and client self-assessment of clients' improvement in various dimensions

We wished to objectively assess whether there was an improvement in the skills and coping abilities of the regular participants through the course of the sessions. This was done using clinician/ facilitator ratings of the participants across various dimensions, as well as the participants' own self-ratings on various skill sets before they started attending the group sessions and after eight sessions. The participants reported an improvement in:

- their ability to express their thoughts and feelings with others,
- their desire to pursue a productive goal in their lives,
- to learn how to stay happy and their relationships with others, and an increase in their self-confidence.

They reported a decrease in:

- their stress levels,

1. Daphne Project. The Power to Change. How to set up and run support groups for victims and survivors of domestic violence. Hungary: *NANE Women›s Rights Association 2008.*

- their tendency to worry,
- their feelings of loneliness and their anger and irritability.

Their ability to empathise with others remained unchanged over the course of eight sessions as it was high from the beginning.

With respect to the clinician ratings, the participants were assessed on attributes such as:
- their level of involvement in group discussions,
- the depth of their emotional disclosure during group activities,
- their interaction with their fellow group participants,
- their self-expression measures in terms of their eye contact, turn taking, sensitivity to others and their ability to regulate emotions.

Additionally, they were also rated on criteria such as:
- their anxiety,
- stress level,
- lack of confidence,
- depression,
- aggression and
- mood.

The participants did not show any changes with respect to their level of involvement, depth of their emotional disclosure and their inter-group interaction across the sessions as they were observed to be high on all these attributes since day one. A couple of the participants showed an increase in their sensitivity to others, their eye contact and their turn taking and also showed an improved ability to regulate their emotions as the sessions progressed.

Finally, all the participants were observed to have shown a decrease in their levels of anxiety, stress, an improvement in their self-confidence, a reduction in their depression and aggression and an improvement in their mood.

3. Qualitative evaluation by an independent researcher using focus group discussions with some of the regular participants

The findings of this qualitative evaluation are as follows:

Group therapy sessions are attended by women who are mostly in their twenties or thirties. Most of them are married and all of them have faced some form of intimate partner violence or family violence. Each of them has been referred to group therapy by their counsellor at SNEHA. The women who were interviewed have all attended more than six sessions of group therapy. Most women shared that although they started attending group therapy at the behest of their counsellors, they started liking it soon after and now attend the sessions out if their own initiative and interest.

The women felt that they could openly share their thoughts, worries and experiences in these sessions. They mentioned that the sessions provided them a platform /safe space to openly talk about the violence they were facing, express the anger and anguish they felt and vent pent up emotions. They felt that the group therapy counsellors encouraged them to talk and share, leading them from being silent attendees to active participants in the group therapy sessions. Most of the women expressed feeling “lightened up” (“mann halka ho jata hai”) after a group therapy session.

The women shared that the group therapy sessions consisted of talking and sharing, role-plays, outings, yoga, music and other such

activities. Some of the women felt that it was a place where they could talk about things which they could not discuss at home with their families. They could ask questions openly without any fear or apprehension. Some even mentioned that group therapy sessions provided them with an opportunity to share a few light moments with their peers and have a hearty laugh.

Most of the women felt that the topics for discussion in a session were mutually decided by the counsellors and them, based on issues emerging from their concerns. But they recognised the role of the counsellors in guiding them to choose the topics and facilitate the sessions. The women were comfortable with the timing as well as the duration of the session plan. They were mostly satisfied with the counsellors, and appreciated their ability to explain things and make them comfortable enough to share personal matters with the group. They appeared to like the therapy counsellors and found them approachable and supportive.

Group therapy sessions appeared to have provided many of the women with an opportunity to make new friends. Some of the women shared that they had even exchanged phone numbers with other women and have forged bonds of friendship beyond the therapy sessions. Most of them mentioned that they look forward to these sessions. One of the participants said,

> ***"When I come here, I leave all the sadness and pain back at home... I don't bring it here. Here I am happy. I like it here."***

The women reflected about the changes that they noticed in themselves. Most of them mentioned that they could express their thoughts and feelings, they could talk, which they could not earlier. A woman shared that she felt confident enough to confront her husband in arguments and could respond to provocative situations without getting emotionally upset. Some of the women revealed that before they started group therapy, they had lost interest in meeting people, dressing well or doing anything. They now felt that their interest in life was returning to them and they had started enjoying small things like dressing up, or going out. A woman who is a widow said,

> ***"As a widow I cannot dress up or wear make-up... If I do that, people will talk... but they (therapy counsellors) said to me that we should dress up and be like what we want to be. So now I dress up, but only when I come here. I don't go anywhere else (when I am wearing good clothes). I come here and go home directly. I like it."***

The women also mentioned that their family members, too, have noticed a change in them, and most of them are encouraged by their family to attend these sessions. They felt that the family has noticed a positive change in them, could see that they are getting better. For some of them the positive change also reflected in their children and their behaviour.

The women appeared to be satisfied with the group therapy sessions, held therapy counsellors in high regard, shared friendship with their therapy peers, and associated positive change in them with the group therapy sessions.

Society for Nutrition, Education and Health Action
A Healthy World Begins with a Healthy Woman

Head Office
310, 3rd floor, Urban Health Centre, 60 Feet Road, Dharavi, Mumbai 400017
Tel No: 91 22 24042627 / 24086011

https://www.facebook.com/SnehaMumbai https://twitter.com/SNEHAmumbai