Original Article

Suffering in Silence: Stories of Indian Women with Chronic Mental Illness and Sexual Coercion

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ABSTRACT

Background: Patriarchy exposes women to various forms of discrimination and oppression. Women are more often blamed for mental illness, which can result in social isolation and stigma. **Method:** Case Study. **Results:** Psycho-social intervention aided in empowering women by giving them voices to speak as well as by utilizing their strengths and available community resources to develop a sense of self-efficacy, coping strategies, and support system. **Conclusion:** Women with chronic mental illness have unique needs and challenges. Mentally ill women face sexual coercion in childhood or adulthood. The factors related to help-seeking in the context of abuse were family reactions, social support, and stigma. Our findings highlight the need to conduct risk assessments and provide community-based and coordinated services during follow-up visits.

Key words: *Abuse, chronic mental illness, psychosocial interventions, survivors*
Key messages: *Trauma-focused intervention should be culturally appropriate and should focus on reducing emotional distress, restoring self-adaptation, and enhancing social support.*

Women face discrimination due to their limited vocabulary, which makes them hold less power and status within the family.[1] They end up paying a terrible price to preserve their identity within the culture, which often justifies violence against women.[2] Davar[3] states that patriarchal institutions such as family, community norms, religion and state institutions influences women's identity. Mental illness is seen as a way of deviating from socially acceptable ways of behavior, so Davar considered it a submissive way of reacting to patriarchy. Women with severe and chronic mental illness are often subjected to sexual and physical abuse, control, coercion, and social neglect, which leads to relapse or exacerbation of symptoms, medical co-morbidities, and poor prognosis.[4] Human Rights Watch published a report in 2018 on women and girls with disabilities who are victims of sexual coercion. The report states that women with disability are reluctant to seek help for abuse because of difficulty in communication and a lack of awareness about their legal rights. Besides, the stigma associated with their

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sexuality and disability makes it difficult for them to access justice.[5] One study had also reported that women with mental illness become victims of domestic violence as they are not able to fulfill their roles and responsibilities in accordance with the expectations of family. They remain silent about abuse because of cultural acceptance of violence and because maintaining a secrecy helps them to cope up with the abuse.[6] Against this background, we aim to review the existing interventions and describe how we provided appropriate interventions to three women with chronic mental illness and various forms of sexual coercion.

Interventions for survivors of sexual coercion and mental illness

During the 1960s and 1970s, the goals of therapy with women survivors was to help them fulfill their domestic roles by being married happily, to have vaginal orgasms and become a mother. Women who turned away from these roles and aspirations were leveled as suffering from 'masculine protest'.[7] The concept of empowerment emphasizes building therapeutic alliance which focuses on developing a collaborative relationship with the client by viewing the client as an expert on herself, and providing a safe, open and non-judgmental atmosphere where the survivors can feel at ease. To decrease self-blame, normalization of their experience and enhancement of their support were done. The focus was also on 'relational empowerment,' which involved training in assertiveness, limit setting, and direct expression of feelings. Ultimately, all these led to engagement with feminist activism.[7] Interventions in the 1990s and 2000s focused on treating post-traumatic stress disorder through cognitive behavior therapy (CBT) and crisis intervention.[8,9] Young developed culturally appropriate programs requiring intervention to be carried out in a place that is familiar and comfortable to the participants and includes artwork or other culturally relevant items.[10] Most of the studies emphasize the importance of having a therapist who is bilingual/bicultural as the survivors feel at ease while narrating their experiences in the language of their origin.[11]

Interventions with families

Couple therapy aims at addressing marital discord by concentrating on men and women as equal participants in the creation of problems in the relationship. However, it has been criticized by feminist theorists raising concerns regarding woman's safety as women will not be able to discuss the abuse in the presence of violent partner and if she discloses in front of her partner there is risk of increased violence. The abusive partner may also blame the victim and minimize the abuse.[12] The therapist can also develop countertransference reactions in the form of feeling angry, frustrated and hopeless on seeing therapy being not that effective in solving the inter-personal problems between the couple.

The therapist may unintentionally and unconsciously dismiss, negate or minimize survivors' experience of abuse.[13] Although most of the studies on couple therapy did directly indicate a reduction in physical violence, some evidence suggests an increase in the partners' alcohol abuse and psychological aggression.[14] Turell and Herrmann state that the family should provide emotional support to the survivors.[15] The therapist needs to address family's concerns, assist the family to work more cohesively and also enhance communication, which helps in reducing conflict within families. Those authors also provide a list of alternatives to help the family enhance their support. Addlaka,[16] in her book titled *Deconstructing Mental Illness*, discusses how building an alliance with the family plays a symbolic and instrumental role in terms of continuity of treatment.

Need for interventions targeting women with chronic mental illness

Mental illness makes women go voiceless and is often cited as reason for getting battered.[3] Psychosocial interventions help in empowering women by giving them voices to speak as well as by utilizing their strength to develop a sense of self-efficacy and coping strategies to deal with the traumatic experience. We attempted through this study to provide insight into the lives of women suffering from mental illness who had experienced violence. We also discuss the role of appropriate psychosocial interventions delivered by mental health professionals.

SETTING, MATERIAL AND METHODS

The current study used qualitative case study method[17-19] to conduct an in-depth analysis of the lives of the participants as this approach, like other methods of qualitative research, helps to discover and understand the participants' perspectives in their natural setting.[20] This study was conducted as a part of clinical and counseling services provided to women with mental illness referred by a psychiatrist for psychosocial interventions in the outpatient department at a government-run tertiary psychiatric care center. Participants recruited did not have active psychiatric symptoms such as delusions or hallucinations. The diagnosis was made as per ICD-10 criteria (International Classification of Disease, Tenth Revision) and symptoms were measured using a validated diagnostic instrument or clinical records. As participants were needed to have a diagnosis long enough to be considered as chronic and had to be able to describe the impact of the illness on their lives, a minimum

illness duration of one year, and those who have been hospitalized more than twice, were considered as having a chronic mental illness. Ethical approval for the study and publication of the case reports was taken from the Institutional Ethics Committee. In order to protect the privacy of the women, their names or other identifying information are not provided.

Case series with interventions

Case 1

Ms. L, a 40-year-old woman from an economically deprived family, presented with an illness of more than 25 years, characterized by delusion of reference, third-person auditory hallucinations, withdrawn behavior, decreased social interactions, amotivation, poor self-care, and impaired occupational functioning. Response to medication has not been good because of the chronic nature of her illness and non-compliance to medication. She was diagnosed with paranoid schizophrenia. A psychosocial assessment revealed that since adolescence she had prodromal symptoms of schizophrenia like unusual behavior and ideas, deterioration in personal functioning, social withdrawal, apathy, and disturbed communication and affect. The family had sought magico- religious treatment under the influence of relatives, which led to worsening of her symptoms and running away from home. A few years after her disappearance, her father passed away due to cardiac arrest and the mother expired due to throat cancer. When her family lost all hopes of seeing Ms. L again, a relative found her wandering on the streets in Mumbai. When Ms. L was reunited with her siblings, they were reluctant to accept her as they were living in extreme poverty. She was pushed around from one sibling's home to another and finally ended up staying with her uncle's family. Slowly, her relationship with her uncle's family was strained by her dependence on them.

Ms. L stated, "I had a bad childhood. My father used to verbally and physically abuse my mother, and on many occasions, under the influence of alcohol, had sexually abused me. I was scared to tell this to my mother, so I quietly left home. I felt safer on the street than at home. I stayed there for eight years and used to roam around happily. Morning, I would beg on the street, and night, sleep under the bridge. There was a dark side of my life on the street, but it was better than living at home and getting abused by my own father… I have a mental problem, and all my life I had it. I have grown along with it, and I'll die along with it. My aunt calls me mad and ridicules me for being mentally unstable. If I take medicines, I feel more stigmatized rather than feeling good."

Psychosocial intervention with Ms. L began with building a therapeutic relationship by having a genuine concern for her problems, listening actively, showing empathy, encouraging her to ventilate her feelings and concerns, validating them, and providing reassurance. We encouraged Ms. L to pursue a hobby, socialize with others/make new friends, and join a recreational club and provided her with a list of places in her community like women's organization/non-government organization and District Mental Health Center to which she and family can turn for support. With the family, we discussed the need to increase their involvement with Ms. L and made them understand what she had gone through and how they can provide support.

Case 2

Mrs. N, a 48-year-old woman, has been living in a rented house in a village of Mewar district of Rajasthan for 20 years. She lived alone and worked as an agricultural laborer. She was barely 18 when her husband died, leaving behind two toddlers who now work as mechanics and stay in Bangalore. She was diagnosed with Bipolar Affective Disorder 28 years ago. She had 5 episodes of mania and 8 episodes of depression. She now presented with a depressive episode, precipitated by sexual abuse and its subsequent events. The psychosocial assessment revealed that six months back, she was raped by her employer's son. She was so much traumatized with the incident that she didn't come out of the house for a few days. With the relatives' and neighbors' help, she went to the police to lodge a complaint. The police were reluctant, began an investigation without filing a First Information Report (FIR) and did not arrest the accused. Neither did she receive any compensation from the government. The family lost all hopes of getting justice as the upper caste landlords threatened them with dire consequences if Mrs. N or her family proceeded further with the case. Her sons brought her to Bangalore, thinking a change of place would help her to recover fast.

Mrs. N recalled," No matter how much I try, I can't forget that day. It keeps coming to my mind. I was like a mother to him. Ignoring my plea, he raped me. He told he is going to use condoms, so that there would be no evidence of rape. Being poor and being Dalit is like a curse. The constant harassment by the upper caste men. The abusive and derogatory words is part and parcel of our life. I don't understand the law but tell me what its use is when the upper caste men are beyond its reach. I am a poor, helpless Dalit women who lost everything – pride, dignity, and reason to live."

Psychosocial interventions began with helping Mrs. N to deal with the feelings of guilt and shame by acknowledging and appreciating her effort for speaking about the abuse. Subsequently, the intervention also focused on restoring her confidence and self-esteem

by encouraging her to see larger meaning in her suffering, which has helped her to build resilience. Her confidence was restored by pointing out all the courage, strengths, and positive ways of coping that she has shown and which defines her today. We encouraged Mrs. N to strengthen her social support by identifying people with whom she can share her feelings and concerns, which will help to decrease her emotional distress.

We also discussed relaxation techniques like deep breathing, yoga, prayers, and meditation to reduce her distress. We helped her to discover her creative self by expressing her anger and hurtful feelings in a healthy way. The sons were provided with information and support to address their distress and concerns about their mother and her illness. We linked Mrs. N to a legal aid clinic to get an orientation about the legal provisions available and about how she can proceed further with her case as she and her sons wanted to seek justice by pursuing the case further.

Case 3

Mrs. R, a 30-year-old woman, hailed from middle socioeconomic status. She was pursuing her undergraduate degree until the second year when she got married and dropped out of college. After being married for 5 years, she got separated from her husband due to physical, sexual, and psychological abuse. Since then, she has been staying with her widowed mother and elder brother. She presented with an illness of 10 years characterized by delusions of persecution and reference and auditory hallucinations (voices asking her to kill family members). Secondary to the abuse, she had developed features of depression such as low mood, anhedonia, suicidal ideation, decreased sleep, and easy fatigability. She was diagnosed with paranoid schizophrenia.

The psychosocial assessment showed that her family got her married without disclosing her illness. Mrs. R was not able to continue her medication after marriage, fearing husband or his family would come to know about her mental illness, which resulted in a relapse of symptoms. Slowly the frequency of relapses increased as there was constant criticism and verbal and physical abuse by the husband. The husband and his family socially isolated her by not allowing her to visit relatives or friends as they feared that others would come to know about her illness. One day, after being severely beaten up by her husband, she left his house and was found by the police wandering on the street in a disinhibited state. She was sent to State Home for Women, from where she was brought to a tertiary hospital for treatment and care.

Mrs. R said, "I was living with a fear of being killed by him someday, which was induced, over time, by his abuse. He raped me continuously over three years. At that time, I didn't think it was rape. I was married and loved him, but my consent was never important for him. That made me feel angry and sad. He would beat me severely if I didn't listen to him and would say, if I cannot take it anymore, I can get out of his house. When I called him now from the hospital, he said I was as good as dead to him. He was glad that I went away; otherwise, he would have beaten me to death. I really feel relieved now as I can tell my family that he doesn't want me anymore, and I should not be forced to go back to him. Now I have a choice to live freely."

Interventions with Mrs. R focused on understanding her subjective experience of being abused, choices she had and her needs. She was helped to reconsider and evaluate the meaning of the trauma with a flexible mind. She was reintegrated with her family. Intervention with the family focused on addressing their immediate concerns and encouraged them to provide emotional support to her. We educated and informed the family to recognize and accept rather than dismiss suicidal thoughts, feelings, and reactions of Mrs. R and keeping all harmful and sharp objects away, which would help to minimize self-harm. Her husband had filed for divorce on the ground of unsoundness of mind. So we linked her to legal aid center for availing free legal aid services under Legal Service Authority Act, 1987 for fighting for justice in the court.

DISCUSSION

Most of the earlier studies have discussed how individuals exposed to adverse childhood experiences such as conflicts between parents, substance abuse, financial difficulties, and impoverished social conditions are more vulnerable to the development of psychiatric illness in adulthood.[21,22] In the case of Ms. L (Case 1), her childhood was quite traumatic. Her father had alcoholism, which resulted in severe conflict between parents, and she was sexually abused by him several times under the influence of alcohol. Fergusson *et al*.[23] suggested that women with a history of child sexual abuse are more predisposed to emotional and anxiety disorders than non-abused women. In the majority of the cases, the perpetrators are family members, like parents or siblings, and victims are legally, financially and emotionally dependent on the perpetrators, which increases the feelings of vulnerability, betrayal, loss of power and control, and hopelessness. If the abuse persists in adulthood, it can precipitate the onset of mental illness in women with poor stress tolerance or trigger relapses in women already diagnosed with mental illness.[24]

Omvedt had called Dalit women as "Dalit among Dalit" as they are at the bottom of the hierarchal structure of the social system, oppressed and marginalized.[25] They face gender- and caste-based discrimination and violence, which is the result of their social, political, and economic status in the society.[26] Mrs. N (Case 2) was reluctant to report the incident because of the fear of being disbelieved or blamed. She decided to remain silent. In India, though the conviction rate for rapes against women is around 25%, it is only 2% for women of caste-affected communities.[27] A study reported that 60% of 146 women with severe mental illness had not disclosed their experience of sexual coercion to anyone and that they had not sought help because of fear of being disbelieved.[4]

Marriage is considered a significant milestone in life, is so much glorified and sanctified, and remains a socially approved way of treating mental illness.[28] Mrs. R's (Case 3) family got her married without disclosing about her illness, fearing rejection of the proposal she stopped taking medicines. As a result, relapse occurred, and frequency of relapses increased due to domestic violence and social isolation. Most of the time, women with mental illness become victims of domestic violence as they are not able to fulfill their roles and responsibilities in accordance with the expectation of the husband's family.[16] Women do not disclose about abuse and seek help, due to deep-rooted patriarchal values that emphasize male dominance over women and because violence is used as a culturally accepted way of disciplining the women if they do not adhere to the patriarchal norms and values. Women maintain secrecy, as they feel responsible for the violence and are afraid of retaliation by the husband, of abandonment, of the children being taken away, or of being not supported financially. All these deter them from seeking help. There are social consequences which act as a barrier for women to seek help, like fear of being blamed by others, of bringing shame to the family, and of social isolation.[4,6] Secondary to the abuse, Mrs. R has developed the features of depression, with suicidal ideation. A study done to assess the consequences of abuse among women with mental illness had found that long-term consequences of physical and sexual abuse can manifest in the form of severe depression, post-traumatic stress disorder, and substance abuse.[29] Simpson[30] reported that women face subtle social pressure to remain with their partner. Family members may encourage the belief that women stay no matter what. This could also be due to financial dependence and lack of community resources to assist women in this transition, which was true in the case of Mrs. R, where her mother wanted her to reconcile with her husband.

The way forward

Trauma-based interventions should focus on the specific needs of women with chronic mental illness, and their need could differ depending upon the frequency and severity of violence and its consequences in their day-to-day life.[13]

At the individual level:

- Dealing with the feeling of shame and guilt and making the women understand that in no situation, violence in any form should be tolerated;
- Assessing the risk of suicide or self-harm;
- Preparing them to minimize the risk for further violence by discussing safety measures;
- Helping them learn to handle crisis situations (e.g., whom they can contact in case of emergency, where they can go for shelter, what they can do if they are psychologically distressed);
- Enhancing coping skills and discussing support system;
- Creating awareness about their rights.

At the family level:

- Perpetrators are known to be manipulative. The therapist should be careful not to believe what is being said or the promises being made about stopping the violence;
- The therapist needs to convince the client and the family to come for a further session as problems cannot be sorted out in just one session. If they are not willing to come, then referrals can be made to community-based organizations;
- Family counseling will be based on their needs and the problem(s) identified (e.g., relationship issues; difficulty in illness management because of poor understanding of the illness which can lead to verbal, physical, or sexual abuse).

At the community level:

- There is a need for community based coordinated response teams which can be located in the community; comprised of police, medical staff, hospital counselors, and various non-profit organizations or agencies; for providing psychological counseling, medical treatment, legal services, and vocational training to the survivors;'[31]
- Referrals can be made to the community-based organizations for different types of services like individual counseling for emotional support and family counseling for relationship problems. A list can be given of organizations which can psychological, social or legal support they require;
- Law enforcement agencies like police or judiciary need to be sensitized. Amendment should be made in the existing laws related to marriage, divorce, rape, and domestic violence. Amendments should

focus on making any form of sexual coercion against women with mental illness a cognizable offence with enhanced punishment.[32]

Challenges while working with the survivors of the sexual coercion

One of the barriers for the survivors could be mental health professionals who are more interested in the victim's role in the abuse, their blaming interpretations or asking the victim to move on which can increase psychological distress. One of the difficulties the therapists face is in being more empathic towards client's experience. Empathy can be developed in the therapist by being more patient and sensitive and by avoiding asking inquisitive questions which may lead to re-victimization. Therapists should also provide the women with a private and safe space for disclosure, which can begin the process of healing. So, mental health professionals should acknowledge their personal belief system and obtain adequate training that would provide them the required knowledge and skills to work more effectively with the survivors.

Professionals can also struggle with maintaining boundaries and countertransference, which often become difficult to manage. It is important to talk about therapist's own emotions related to the client's experience so that the therapists become aware of their own biases, values and principles, and it is ensured that they do not interfere with the counseling process. Regular debriefing sessions with another peer or senior supervisor for guidance and support would also help the therapist to maintain professional objectivity.

The issue of informed consent becomes quite complicated when it comes to women diagnosed with chronic mental illness subjected to domestic violence. In such cases, it is important that the therapist explores the willingness of both the client and the family members in seeking therapy, and their decisions need to be respected and honored. One of the ethical issues is maintaining confidentiality, especially when the women's safety is at stake. In such cases, the client's consent needs to be taken and the therapist should help her to see the pros and cons of disclosure and to take an informed decision.

Strengths and limitations of the study

It was a qualitative case series which emphasized the subjective experience of women with chronic mental illness with abuse leading to psychosocial disability. It also described the interventions provided to survivors and family members, focusing on their strengths and competencies and utilizing available resources which fasten the process of the clients' recovery, growth, and healing. The limitation of this study is that a clinic-based intervention was provided to a small sample in a limited time period.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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