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GENDER-BASED VIOLENCE AND MENTAL HEALTH:

INTERVENTION WITH WOMEN IN CRISIS

a brief guide for field workers

Acknowledgements

First and foremost, we would like to acknowledge and show gratitude to survivors of violence for approaching our service and showing faith in out work. We would like to appreciate and acknowledge the SNEHA team of Prevention of Violence against Women and Children (PVWC) for their tireless efforts in providing counselling, crisis intervention and rehabilitation services for survivors of violence. We thank our CEO Ms. Vanessa D'souza and Our Executive Director, Dr.Shanti Pantviadya for providing support and encouragement in all our endeavours.

We would like to thank Department of Women and Child Development for collaborating with us wholeheartedly in providing access to survivors in the government shelters.

We extend our special regards to the following organizations whose participation in the workshop on 'Understanding the mental health needs of clients in shelter homes' has been of enormous help in considering the practical challenges and formulation of strategies in the manual.

New Generation Trust
Garden Reach Slum Development
Shantighar
One Stop Centre- KEM
Kasturba Mahila Vastigruha
Urja Trust
Government Beggars' Home, Chembur
Bapnughar
Paripurnata Halfway home
Abhyashram
Snehalaya
Kshamata
Nari Niketan
Sangath

The National Institute for Health Research (NIHR) has been encouraging of us to extend our services and experiences in the form of a document that could have a wider outreach and we are grateful for their support.

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VIOLENCE against women and girls 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. In SNEHA's two decades of work in preventing violence against women in Asia's largest informal settlement in Dharavi, we 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', and respond to the needs and rights of excluded and neglected groups by providing counselling and mental health interventions.

In addition to the millions of women suffering from defined mental disorders, there are millions of others who, because of extremely difficult conditions or circumstances of life, are at special risk of being affected by mental health problems. This is the double burden of mental health on gender. Three dimensions define the double burden of violence and mental health of women: gendered difference in roles and the stressors they go through, gendered difference in responsibilities on account of mental health conditions and the gendered nature and response to conflict i.e. intimate-partner and domestic violence.

SNEHA's experience with women survivors of violence suggests that women with mental illness are more likely to be involved in unsafe and abusive relationships, thus increasing their risk of being exposed to gender-based violence. 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. Their dysfunctionality of day-to-day living and

difficulty in dispensing with their roles is most often the reason to deprive them of a family life, both natal and marital. These women so called as destitute or deserted or disowned land up in shelters as there seems to be no other alternatives for them. They often come in on a backdrop of trauma, violence and varying degrees of mental health conditions.

Management of such women with different mental health conditions poses to be a big challenge for shelter services for both government and private shelters. Paucity of trained resources, lack of knowledge on mental health, workload pressures and unconscious personal biases contribute to quite an extent in management of mental health conditions of women and girls in shelters. This manual has been developed for staff working in these shelters to understand the basic management of women and girls' survivors of violence with underlying issues of mental health. This manual is a tribute to the shelter staff of various shelters that SNEHA works with, who sacrifice their personal lives and preferences to serve women and girl survivors of violence being admitted to these shelters. The manual describes different types of mental health conditions and guidelines for its medical and psychological management, protocols to follow while dealing with women and girls' survivors of violence with mental health conditions and treatment plans for survivors of violence with mental health conditions

A) TRAUMA INFORMED CARE

Women in shelter homes experience homelessness and have a history of experiencing different traumatic experiences. Certain guidelines are recommended for trauma-informed care.

- ✔ Staff trainings about Trauma Informed Care
- ✔ Establishing a Safe Physical Environment
- ✔ Building trust
- ✔ Establishing Informed Consent
- ✔ Cultural Humility and Anti-Oppression
- ✔ Confidentiality
- ✔ Safety and Crisis Prevention Planning
- ✔ Offering Trauma-Specific Interventions
- ✔ Providing Residents with Agency

B) WORKING WITH WOMEN WITH MENTAL HEALTH CONDITIONS

How can the shelter home staff help?-

1) Treatment –

- Help them manage symptoms
- Provide access to professional support

2) Rehabilitation – help people return to life as it was before the illness.

How can you help?

1. **Treat a woman with respect**
2. **Establish good relationship**
3. **Keep a non judgemental attitude**
4. **Be a patient listener**
5. **Do not comment, control, criticize, laugh at her.**
6. **Use person first and descriptive language rather than characterizing terms**

7. **Ensuring that the illness is being treated properly:**

A) Referring to mental health professionals and services when required.

B) Regular follow up and giving meds medicine and injections close up

C) Provide psychoeducation about the mental health services and its nature.

8. **Develop a structure & schedule of activities with the woman.**
9. **Women with longstanding (chronic) illnesses may not be completely cured. They may benefit from:**
   - Involving them in recreational activities,
   - Teaching them simple, repetitive type of jobs,
   - Include them in the daily routine work of shelter homes.

Remember !

– To include significant family members

– To keep in mind her actual abilities before she fell ill.

a) Women with SUICIDE RISK

Suicide is the act of killing oneself, or death caused by self-injurious behaviour with any intent to die as a result of the behaviour.

Suicidal ideation could be >>

UNDERSTANDING THE CONDITION

- Passive,
- Intermittent,
- Persistant or
- Impulsively triggered by situational stressor

GUIDELINES FOR CARE

Questions to ask for Suicidal Risk.

– Have you ever thought of harming yourself or ending your life?
– How often do you get such thoughts?
– Have you previously attempted ending your life?
– Do you have any plans of harming yourself or others?
(If yes, gather more information)

Check for :	✔ RISK FACTORS	✔ PROTECTIVE FACTORS
	Depression	Social support
	Hopelessness	Access to services
	Trauma	Insight & a sense of hope.
	Impulsivity	
	Lack of social support	

Risk Assessment >> Intervention

High risk

Persistent thoughts of committing suicide with definite plan, multiple severe risk factors, very few protective factors

- *Referral to psychiatrist, who may consider in patient admission and close monitoring.*
- *After discharge, continual follow up and psychiatric consultation.*
- *Keep away the possible means the client might use for self harm.*
- *Psychoeducation to family members (if present) about monitoring the person*

Moderate risk

Persistent suicidal ideation with no definite plans, moderate to severe risk factors, limited but present protective factors

- *Break confidentiality to authority figures/ family members/trusted sources.*
- *Refer to mental health professionals to treat underlying illnesses*
- *Increasing protective factors*
- *Inform family members (if present) and provide psychoeducation*

Low risk-

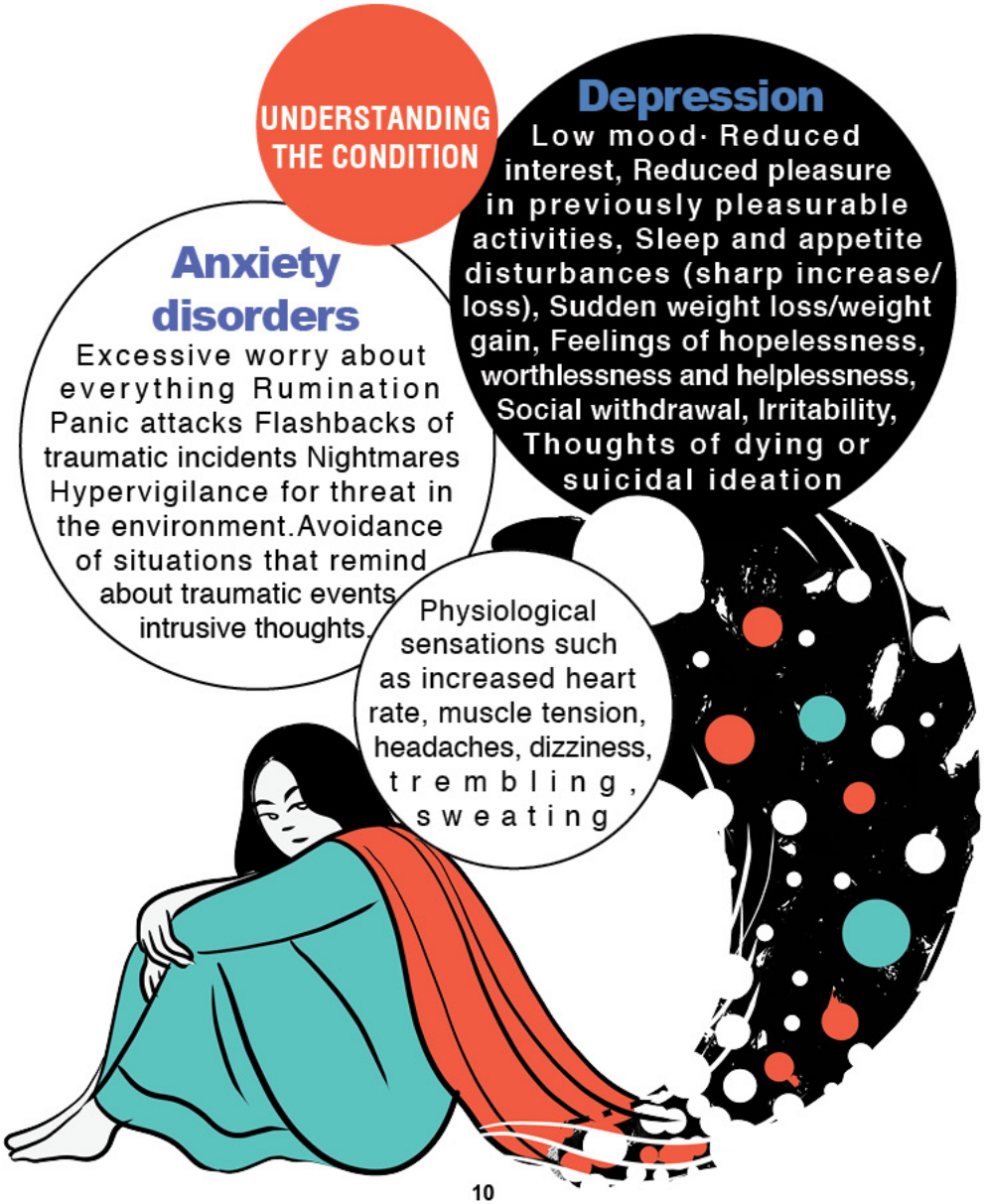
Occasional thoughts of suicide or dying, no immediate risk factors, presence of adequate protective factors

- *Provide psychological first aid without judgement for having suicidal thoughts*
- *Ensure safety and connectedness*
- *Listen to the client*
- *Provide a safe space to talk.*
- *Monitoring the client*

Remember !

Don't take suicidal gestures, ideation expressed lightly or dismiss it as 'attention seeking gimmick'.

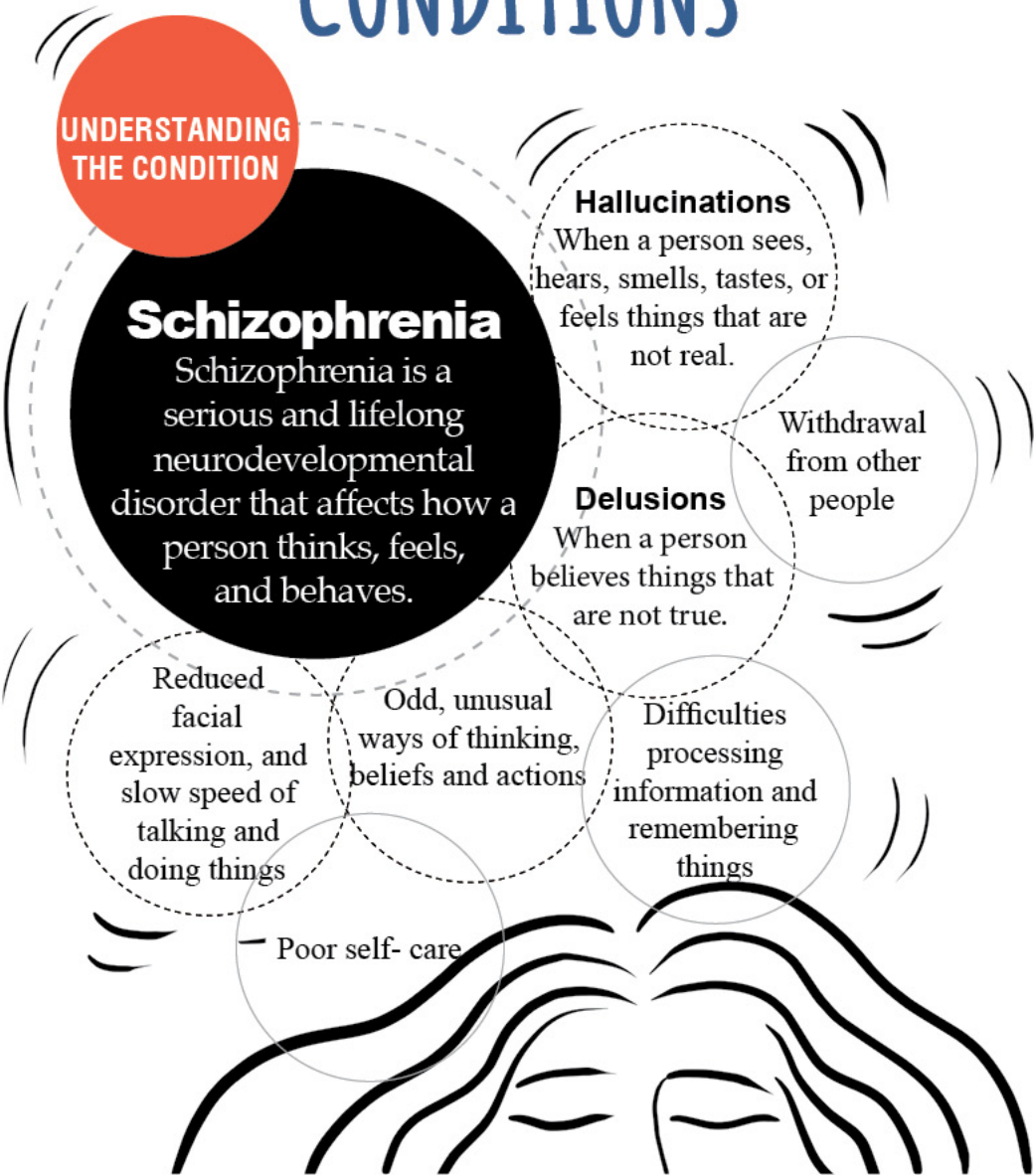
b) Women with DEPRESSION AND ANXIETY

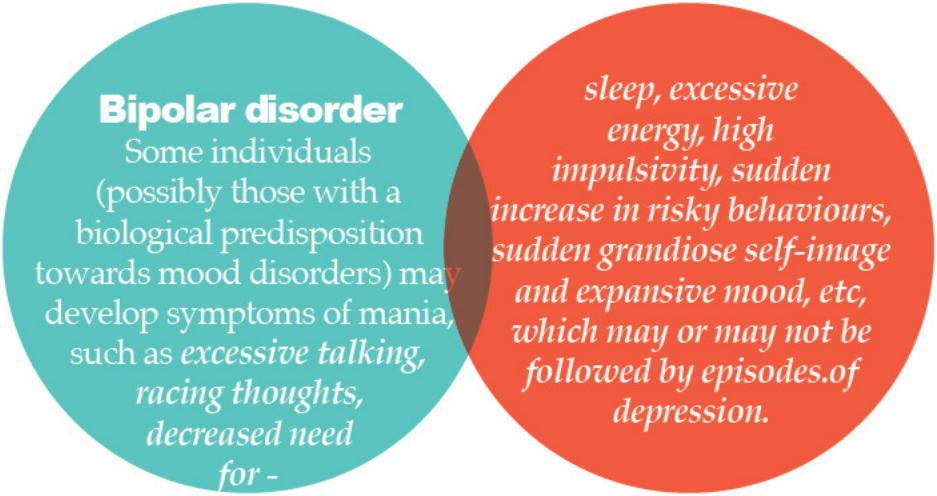


GUIDELINES FOR CARE

DO'S	DON'T'S
Understand that these are illnesses	Dismiss the women's concerns.
Be mindful of the triggers in the environment that might create anxiety response.	Label the women as weak
Listening without judgement.	Ask them to "think positively", "stop worrying", "stay strong".
Emotional support	
Conduct Suicide Risk Assessment (Imp*)	
Behavioural activation- Create structured activities from easy to manageable difficulty level. Encourage a woman to participate in the same.	

c) Women with SEVERE MENTAL HEALTH CONDITIONS





GUIDELINES FOR CARE

DO'S

Regular follow up with the doctor –Imp*
Medication management- Making sure the patient is taking her medicine.- Imp*
Keep in touch with healthcare professionals
Helping maintain a daily routine at the shelter home
Helping with daily activities if the client needs it.
Watch out for worsening of symptoms
Talk to the psychiatrist/ social worker/psychologist about how you can support the treatment plan
Helping with a healthy diet
Enough sleep
Regular doctor or dentist visits to maintain good health.

d) Women with POST-PARTUM DEPRESSION AND PSYCHOSIS

Postpartum depression and psychosis are disorders that can affect women after childbirth. Some symptoms may be:

UNDERSTANDING THE CONDITION

- Feeling sad, hopeless, empty, or overwhelmed
- Crying more often than usual or for no apparent reason
- Worrying or feeling overly anxious
- Oversleeping, or being unable to sleep even when her baby is asleep
- Experiencing anger or rage
- Losing interest in activities that are usually enjoyable
- Hallucinations or delusions
- Withdrawing from or avoiding friends and family
- Having trouble bonding or forming an emotional attachment with her baby
- Persistently doubting her ability to care for her baby
- Thinking about harming herself or her baby.

GUIDELINES FOR CARE

DO'S

It is important to consult and follow-up with mental health professionals

Help in balancing self-care and care of the baby:-

1. Timeout from baby care
2. Turn taking for babysitting
3. Avoiding allotting excessive tasks
4. Allotting times for rest and relaxation

DON'T'S

Judging the woman or calling her a 'bad mother'

e) Women with INTELLECTUAL DISABILITY

Intellectual disability is diagnosed with an intelligence test by a psychologist. Some ranges of Intellectual Quotient are:

50-69	Mild Intellectual Disability
35-49	Moderate Intellectual Disability
20-34	Severe Intellectual Disability
< 20	Profound Intellectual Disability

Women with intellectual disability are not able to perform activities of daily living like:

- Self-care tasks,
- Basic chores,
- May struggle with comprehension, attention, memory, decision making, problem solving.
- Some may have speech and motor difficulties.
- Their ability to function is not age appropriate.

They may demonstrate challenging behaviours, such as:-

- Poor emotion regulation skills
- Mood swings
- Aggression
- Impulsivity
- Antisocial tendencies
- Less ability to tolerate frustration
- Poor social and personal judgment

UNDERSTANDING THE CONDITION

They are most vulnerable to abuse

Intellectual disability cannot be cured and is a lifelong condition. Hence, focus on rehabilitation is important, rather than on treatment. Rehabilitation, depending upon the severity of symptoms could entail training in some of the following areas:

1. Basic ADL training
2. Work on speech-motor deficits
3. Teaching social skills
4. Understanding safe-unsafe touch.
5. Basic literacy

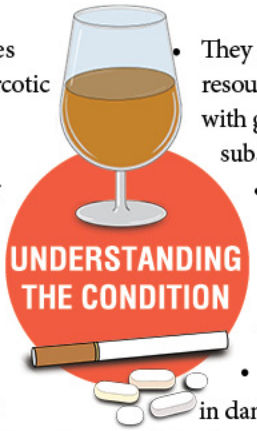
Professionals who can help

1. Occupational Therapists
2. Physiotherapists
3. Psychologists
4. Psychiatrists

GUIDELINES FOR CARE

DO'S	DON'T'S
Understand IQ range and document it, and decide who can then take decisions for this person	Be punitive towards these individuals or use harsh punishments.
Make more concrete, explicit rules and modify them if needed.	
Simplify tasks, instructions and supervise if necessary.	
Emotional support	
Can use principles of behaviour modification, example, grade the task and use rewards / reinforcements for desirable behaviour	
Seek psychiatric opinion for aggression, impulsive or self harm behaviours.	

f) Women with SUBSTANCE USE DISORDERS



- Consumption of substances like alcohol, cigarettes, narcotic substances, etc.
- Increased tolerance- they require higher amounts of the substance to achieve the same 'high'
- They may experience cravings and urges to consume the substance and may show withdrawal symptoms whenever they do not consume the substance
- They may spend a lot of time and resources and may be preoccupied with getting and using these substances
- Substance use may cause problems in relationships and their jobs and they may not be able to fulfil their responsibilities because of the same
- Substance use may put them in danger and encourage risky behaviours, but they may still continue to consume substances.

GUIDELINES FOR CARE

DO'S	DON'T'S
Understand that this is an illness and it can be difficult to 'just stop taking drugs'	Do not judge her for her substance use
Provide information about the impact of the substances	
Direct the woman to a psychiatrist for medication	
In-patient treatment or hospitalisation, followed by a controlled de-addiction and rehabilitation programme initially.	
Provide supportive environments at the shelter home.	
Monitor for symptoms and relapse.	

A) WORKING ON SEXUALITY RELATED ISSUES

POINTS TO REMEMBER

Women's sexual health is important to emotional and physical well-being. It is important to understand her sexuality from her point of view.

- Women of all ages including teenage girls and elderly women may show sexual desires and behaviour.
- Respect a woman's right to decide whether she wants to keep her baby or undergo an abortion.
- Do not shame a woman for her choices.
- Any sexual activity under the age of 18 is considered child sexual abuse, and there is 'mandatory reporting' regarding the same.
- Sexual orientation refers to who individuals feel attracted to. Women may be attracted to other women. Homosexuality is a natural variant of sexuality.
- It is not a- criminal offence / unnatural/ a mental illness.
- Women cannot be cured of their homosexuality.
- Allow women to express their sexual and romantic desires without judgment.
- Some women may be 'bisexual' or attracted to men and women; others may be 'asexual'or may not experience any sexual attraction. These are some of the many possible expressions of sexuality in women and are normal.
- Women with physical or intellectual disabilities may also experience sexual attraction, desire sexual relationships and may be capable of sexual activity.

Challenges in woman's sexual & reproductive health

- Abortions
- Miscarriages
- Pregnancy and delivery
- Menarche & menopause.
- These might have associated mental health impacts that may be different for different women
- Sexual assault, child sexual abuse, rape, gender based violence, etc are examples of severe trauma and women coming to shelter homes may be highly vulnerable to the same.

GUIDELINES FOR CARE

DO'S	DON'T'S
Treat all women regardless of their sexual orientation the same without discrimination.	Judge or shame women for their decisions about their sexual actions, reproductive health, or expressions of sexuality.
Provide adequate health and sanitation resources for their sexual and reproductive health.	
Sex education whenever required (which is based on safe sexual practices such as the use of condoms, rather than preaching abstinence).	Gossip about an individual's sexual orientation, behaviour or choices.
Provide some privacy and maintain confidentiality with respect to individual's sexual orientation or their sexual behaviour.	
Provide psychological support to women having undergone sexual trauma	
Communicate and enforce rules about sexual behaviour in the shelter home in a sensitive and non-punitive manner.	

B) MEDICATION MANAGEMENT

- Medications may be required for treatment of some mental health conditions. These are prescribed by psychiatrists.
- The treatment of common mental disorders with medications can be conveniently divided into 3 phases.

	1. THE INITIAL/ ACUTE PHASE	2. THE SECOND/ CONTINUATION PHASE	3. THE PLANNED DISCONTINUATION PHASE
Duration of treatment	About 4-6 weeks	Up to 6 months or longer	Variable, some conditions might require long term medications or continuation of a maintenance dose for months or years.
Aim	To reduce the symptoms. Enable the patient to resume his/her life before the onset of the illness. Note: There may be some initial trial and error before suitable medications are found.	Continue the medicine even when the client is better. Prevent relapse.	Gradual tapering of the dosages. Relapse prevention for women suffering from severe and chronic mental health conditions like bipolar disorder or schizophrenia through maintenance dose and a regular follow up. Psychoeducation about necessity of medications and the need to continue taking them, monitoring that women take these medications, checking for signs of relapse and following up with the doctor, are crucial.

Remember !

One must never stop any psychiatric medication without the doctor's permission.

C) Features of the Mental Healthcare Act of 2017

- Every person with mental illnesses has a right to access mental healthcare and treatment at an affordable cost, of good quality, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis.
- Every person with mental illness also has a right to community living and to access of their medical records.
- Every person with mental illness has the right to make decisions about their own treatment.
- Every citizen of India can write an Advanced Directive- a written document where they declare the form of treatment they would prefer, how they would not wish to be treated, and they can nominate a representative to take decisions on their behalf if there is an emergency and they cannot take this decision.
- Forcible hospitalisations and treatments are not allowed.
- The Act also lists different professionals and guidelines for the setting up for central and State bodies dedicated to mental health services.

SELF-CARE FOR SHELTER HOME STAFF

WATCH OUT FOR!

Compassion fatigue

"The overall experience of emotional and physical fatigue that social service professionals experience due to chronic use of empathy when treating patients who are suffering in some way"
(Newell & MacNeil, 2010).

Vicarious trauma

Due to social worker's direct exposure to victims of trauma, they may experience symptoms similar to those of their clients who have undergone trauma, for example flashbacks, nightmares, anxiety, triggers, avoidance, etc

Burnout

Freudenberger (1975) to describe what happens when a case worker becomes increasingly "inoperative." This may take many different forms, from simple rigidity, in which "the person becomes 'closed' to any input," to resignation, irritability, anger, fatigue and even symptoms of depression and anxiety.

GUIDELINES FOR SELF CARE

- Understand professional and personal boundaries and the extent and limits of one's responsibilities

- **Reflective practice**- maintaining a journal of thoughts, feelings, reactions after challenging cases, self work to understand what about those cases troubled them

- Seek supervision and therapy for self when required

- Work on building a healthy work-life balance, and cultivate hobbies and relationships outside of professional ones, with adequate time for rest.

- Learn about vicarious trauma, burnout and compassion fatigue, and keep track of when they feel the same, and be mindful of personal triggers.

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