Provided for non-commercial research and education use.
Not for reproduction, distribution or commercial use.

This article appeared in a journal published by Elsevier. The attached copy is furnished to the author for internal non-commercial research and education use, including for instruction at the authors institution and sharing with colleagues.

Other uses, including reproduction and distribution, or selling or licensing copies, or posting to personal, institutional or third party websites are prohibited.

In most cases authors are permitted to post their version of the article (e.g. in Word or Tex form) to their personal website or institutional repository. Authors requiring further information regarding Elsevier's archiving and manuscript policies are encouraged to visit:

http://www.elsevier.com/authorsrights

Author's personal copy

Mental Health & Prevention (2013) 1, 4–10

Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/mhp

REVIEW

Violence against women and mental health

Anant Kumar[a,*], S. Haque Nizamie[b], Naveen Kumar Srivastava[b]

[a]*Department of Rural Management, Xavier Institute of Social Service, Dr. Camil Bulcke Path, Ranchi, Jharkhand 834001, India*
[b]*Central Institute of Psychiatry, Ranchi, India*

Received 4 June 2013; accepted 18 June 2013
Available online 13 August 2013

KEYWORDS
Mental health;
Violence against women;
Women;
Policy;
Human rights;
Abuse

Abstract
Violence against women is a serious social and mental health problem and human rights abuse worldwide. It is an extremely complex phenomenon, deeply rooted in gender based power relations, sexuality, self-identity, and social institutions that pose a serious threat to women's mental health. This paper discusses the various factors behind violence against women with some cases and its consequences on women's mental health and wellbeing. The paper suggests that recognizing violence against women as a mental health issue is an essential first step which requires concerted and multi-sector responses backed by strong political commitment aimed at ending discrimination and violence against women.
© 2013 Elsevier GmbH. All rights reserved.

Contents

Introduction . . . 4
Causes . . . 5
Objective and methods . . . 5
Mental health consequences of violence against women . . . 5
Intervention and strategies to reduce mental health consequences of VAW . . . 7
Policy recommendations . . . 7
Conclusion . . . 8
References . . . 8

Introduction

Violence against women is a serious social, mental health problem (World Health Organization, 2013a, 2013b, 2013c; Vachher & Sharma, 2010; Babu & Kar, 2009; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Bonomi et al., 2006; Kumar, Jeyaseelan, Suresh & Ahuja, 2005; Campbell & Boyd, 2003) and human rights abuse against women (World Health

*Corresponding author. Tel.: +91 651 2200873x401 (office), +91 651 6452110 (residence), mobile: +91 9934160637; fax: +91 651 2213381.
E-mail addresses: pandeyanant@hotmail.com, pandeyanant@gmail.com (A. Kumar).
URL: http://www.xiss.ac.in (A. Kumar).

2212-6570/$ - see front matter © 2013 Elsevier GmbH. All rights reserved.
http://dx.doi.org/10.1016/j.mhp.2013.06.002

Author's personal copy

Organization, 2013c; Kulkarni, 2012; Tokuç, Ekuklu, & Avcioglu, 2010; Dalal, Rahman, & Jansson, 2009; Koenig, Stephenson, Ahmed, Jejeebhoy, & Campbell, 2006; Kishor & Johnson, 2004; United Nations, 1997). Research studies show that the consequences of such violence on women's mental health, her dignity, self-identity, self-esteem and wellbeing include an increasing health burden, intergenerational effects and demographic consequences (Babu & Kar, 2009; Ellsberg et al., 2008; Bonomi et al., 2006; Kumar et al., 2005; Jewkes, 2002; Campbell, 2002; Campbell et al., 2002; Heise, Mary, & Megan, 1999).

United Nations General Assembly, Declaration on the Elimination of Violence against Women, 1993 defines violence against women (VAW) as, "*Any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life*". The definition includes various forms of violence including the mental and psychological harm. In most cases, the perpetrators of VAW are intimate partners (World Health Organization, 2013c; Campbell, 2002; Martin et al., 1999; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005) which compels women not only to bear their sufferings silently, but are even socialized to accept, tolerate and rationalize it (Prasad, 1999; Rao, 1997; Jaisingh, 1995; Hegde, 1996). Violence against women is widespread (Kulkarni, 2012) (beyond the class, caste, age, gender and geographical boundaries) and thus they experience psychological and mental abuse throughout their lifecycle, during infancy, childhood and/or adolescence, or during adulthood or older age (Heise, Lori, Pitanguy, & Germain, 1994). The World Health Organization's recent report on 'Global and regional estimates of violence against women' shows that both intimate partner violence and non-partner sexual violence are widespread and that they have important effects on women's physical, sexual and reproductive, and mental health (World Health Organization, 2013c). The World Health Organization (WHO) multi-country study on women's health found that 15–71% of women (aged 15–49 years) have experienced violence physically or sexually by their intimate partners at some point in their lives (World Health Organization, 2005, 2013b). The few studies available also indicate that physical abuse on Indian women is quite high, ranging from 22% to 60% (World Health Organization, 2005; Mahajan, 1990).

Causes

The most common causes for women stalking and battering include demand and dissatisfaction with the dowry, arguing with the partner, refusing to have sex with him, neglecting children, going out of home without telling the partner, not cooking properly or on time, indulging in extramarital affairs, and not looking after the in-laws, etc. In some cases, infertility in females also leads to violence and assault by the family members. The greed for dowry, desire for a male child and the alcoholism of the spouse are major factors of domestic violence against women in rural areas. The combination of all three factors can be seen in the Case 1 discussed below of a poor woman who visited Central Institute of Psychiatry (CIP) at Ranchi.

Case 1:

This twenty two year old poor female patient came with her father with two years history of remaining sad, apathetic, having poor interaction with others and not taking care of her two year old female child after serious head injury with a rod by her husband. The patient reported that she faced frequent criticism and assault by her alcoholic husband and in-laws for bringing less dowry soon after the marriage. After one year of marriage, when she delivered a female baby, this abuse got further worsened. One day on a trivial issue, her husband hit on her head with a rod and tried throttling her. Somehow, she survived and with the help of some neighbours, she got admitted in a hospital. After that head injury, she started behaving differently and was brought to Central Institute of Psychiatry (CIP) for her treatment.

Objective and methods

The paper focuses on violence against women and its mental health consequences. The paper is based on the desk review of research studies, reports, documents available online and select case studies of women victims of violence. The paper focuses on mental health consequences of violence against women, barriers, challenges, opportunities, and highlights the role of mental health professionals and practitioners in reducing the mental health consequences of VAW.

Mental health consequences of violence against women

The mental health consequences of violence are far reaching. A growing body of research has emerged in recent years indicating the mental health (MH) consequences of violence against women on individuals (World Health Organization, 2013a, 2013c; Babu & Kar, 2009; Ellsberg et al., 2008; Bonomi et al., 2006; Kumar et al., 2005; Canadian Women's Foundation, 2011), as well as the burden it places on the social and health care system (World Health Organization, 2013c; Ellsberg et al., 2008; Cook & Bewley, 2008). Women exposed to intimate partner violence are twice as likely to experience depression and almost twice as likely to have alcohol use disorders (World Health Organization, 2013a). In addition, it affects all aspects of women's life, her health, productivity, and ability to care for herself and her family. Within the field of mental health, there is growing recognition of the possible linkages between violence and a range of adverse mental health outcomes (World Health Organization, 2013a, 2013c; Babu & Kar, 2012; Kaur & Garg, 2008; Mayhew & Watts, 2002) (see Fig. 1).

The mental health consequences of violence are far reaching. Besides the negative mental health consequences, violence against women also has indirect effects on the society. It undermines women's sense of self-worth, sense of autonomy, and their ability to think and act independently. It also increases their risk for a wide range of negative mental health outcomes and premature death. Physical, psychological, and sexual abuse and violence have negative

Author's personal copy

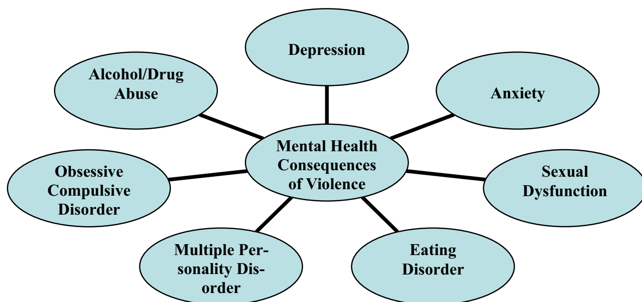

Fig. 1 Mental health consequences of violence against women.

health consequences for women's mental health, such as post-traumatic stress syndrome (World Health Organization, 2013c; Dutton, Kaltman, Goodman, Weinfurt, & Vankos, 2005), depression (World Health Organization, 2013c; Golding, 1999; Cascardi, O'Leary, & Schlee, 1999; Campbell, Sullivan, & Davidson, 1995; Campbell, Kub, Belknap, & Templin, 1997; Campbell & Soeken, 1999; McCauley et al., 1995; Ratner, 1993; Silva, McFarlane, Soeken, Parker, & Reel, 1997), anxiety (World Health Organization, 2013c), and low self-esteem (World Health Organization, 2002). Violence such as rape, sexual abuse, and battering leads to a range of mental health problems such as depression, obsessive-compulsive disorder, and multiple personality disorder, etc. Behavioural outcomes, such as alcohol, drug and substance abuse (Golding, 1999), sexual risk-taking, and a higher risk of subsequent victimization are also likely to arise as a result of violence. This is clear from Case 2 discussed below.

Case 2:

This is a case of twenty two year old female. She came with history of Corex syrup intake and smoking since last three years along with her mother. Her father and eldest brother died due to complications of alcohol dependence. She has two other siblings, one brother and one sister. She was the youngest child of her three siblings. The mother and sister of the patient are also having a similar habit of Corex intake and smoking. As there is no earning member in the family, mother has to work and she spends most of her money in procuring substances. They used to fight with each other due to money problem, as everybody requires it for procuring Corex. She was frequently scolded and at times she faced assault by the family members. At times, the patient was not even provided her daily needs, e.g., meals and clothes. She was not given money even for her essential needs, thinking that she would spend it all in acquiring substance. To fulfil her demands, she used to abuse and threaten the family members of committing suicide. Over the time, she developed sexual relationships with some of her male friends and got cheated. Gradually, she started feeling low and started taking substance like her mother and sister, which increased over time.

This case shows that disturbed family history and substance abuse in the family negatively affects the mental health and often leads to substance use and mental illness. In such circumstances and situations, violence is often used and arise out of a need for power and control of one over the other. An abuser often uses various tactics of abuse (e.g., physical, verbal, emotional, sexual or financial) in order to establish and maintain control over the other family members or partner. The case shows that abusive personalities often result from a combination of several factors, to varying degrees and leads to feelings of low self-esteem or feelings of inadequacy.

Women experiencing domestic violence are more likely to suffer from depression, anxiety, psychosomatic symptoms, and eating problems (World Health Organization, 2013c). For many women, the psychological effects of domestic violence are far more debilitating than the physical effects. Fear, anxiety, fatigue, post-traumatic stress disorders are common outcomes of physical abuse. The abused woman is always at a greater risk for developing a serious mental illness in her life. Study by Kumar et al. (2005) show that 40% of Indian women have experienced some sort of spousal violence during their marital life and that has led to their poor mental health. For some women, the burden of violence is so intense that they take their own lives or try to do so. Studies from a number of countries have shown that domestic violence is closely associated with depression and subsequent suicide. Women who experience sexual assault either in childhood or as adults are more likely to suffer from depression and attempt suicide than the non-victims. The probable consequence of sexual assault can be seen in Case 3 discussed below.

Case 3:

The twenty two years old female patient came with around five month history of talkativeness, irritability and sleeplessness. About one and half years back, in her village, she was sexually assaulted by two persons while she was returning to her home. After reaching her home, she faced frequent criticism by her family members and at times she was beaten by them too. No police case was registered in this matter, due to shame and considering the future problems in marriage. Due to this, she started feeling low, withdrawing herself from doing any work. Later, she was sent to Delhi to one of her relative for work, where she was working as a full-time household helper. Here again, she was sexually assaulted and had to face repeated scolding. Gradually, there was a change in her behaviour and her father brought her to our hospital (CIP) with the aforementioned complaints.

In countries like, India and Bangladesh etc., where virginity is closely associated with the status of the woman and the family, the rape victims are forced to commit suicide. They feel that after the rape, they are a burden to their family as no will marry them (due to loss of virginity) and their family has lost the reputation in the society because of them. Besides these negative mental health consequences, violence against women also indirectly affects the society. For example, violence against women represents a drain on an economically productive workforce and generates a climate of fear and insecurity.

A common feature of most of the cases related to VAW is experience of harassment, torture and violence (both within the household and outside) where women find themselves more vulnerable which has negative mental health consequences such as depression, stress, fear, insecurity and alienation (World Health Organization, 2013c). Some of

Author's personal copy

the factors which make women more vulnerable which have negative mental health consequences are individual fear and apprehensions relating to consequences of leaving home, lack of support from parents, inadequacy of social support, cultural forces, and non-availability of alternatives in terms of physical, economic and social rehabilitation, care and custody of children, which provokes women to take a drastic step such as suicide.

The common mentality of many Indians is to have at least one male child after marriage; the girls in most of the occasions are cursed and assaulted for having taken birth in that particular house. This kind of abuse is prevalent both in cities and villages but is more common in the latter case. This type of behaviour of a father and other family members can be seen in Case 4 discussed below.

Case 4:

This case was narrated by the nineteen years old female patient and her mother during a visit to CIP for treatment. The patient came with complains of repetitive thoughts since last five years and low mood along with loss of interest for around a year. She has three other siblings, two sisters and a brother. Her brother is mentally retarded. Her father, who has a small shop, always wanted to have a male child. But his only son is mentally retarded. Since the time of her (the patient) birth, her father hates his female children. He does not like to spend money on any of them, either for their health or education. He used to abuse them and makes critical comments. The mother is the only support for these poor children. When this patient developed psychiatric problem, father started to hate her even more. He used to comment on her for poor fate and problems related to her marriage due to illness. He never tried to get her treated. In this case, the patient developed obsessive compulsive disorder, which may be a consequence of such emotional abuse, as already reported in literature.

This case shows that son preference is very common in our society, particularly in India. Many people believe that female child is a burden to them whereas a male child is a blessing. The main reason behind this discrimination between male and female child is associated with the belief that a male child will run the family name and essential for last rituals of life (death). This belief is further strengthened by increasing dowry demands in the marriage of females. The problem gets further exaggerated, if a female child is suffering from any illness. The case shows that due to her father's false belief and callous behaviour, this young girl is suffering; not getting the proper care and attention, which is her right.

Intervention and strategies to reduce mental health consequences of VAW

To reduce the mental health consequences of violence against women, it is important to take pro-active actions by the MH professional, practitioners and other stakeholders (World Health Organization, 2013d). VAW is an extremely complex phenomenon, thus any strategy to reduce MH consequences of VAW must aim to address the underlying cultural beliefs and social structures that perpetuate it. To be effective, the strategy should draw on a wide range of expertise and resources, both at governmental and non-governmental levels with maximum possible community participation. There could be curative and preventive strategies for combating VAW.

Curative intervention may deal with extending support services to the victimized woman such as counselling services to help her regain her lost self-esteem, medical, legal, shelter home, rehabilitative services and mainstreaming efforts.

Preventive intervention may deal with creating an environment for violence free society. This calls for an interdisciplinary approach with a large amount of resources invested in preventing the increasing cases of crime. Preventive measures may include training of mental health personnel, professionals, practitioners and social workers to identify children and women living in violent homes and take the necessary measures to help and assist them. The creation of crisis centres, hotline services, counselling centres for intake of VAW cases and provision of referral services will further help in curbing VAW. Other preventive measures can be provision of medical services for women-in-need, availability of legal consultation before taking a legal action against the offenders; creation of short stay home for women who are unable to stay in the violence affected home. These resources and interventions will help to address the gap experienced by women where they remain silent because they are not aware of resources available to help them with VAW. In most of the male dominated society, women who are denied of resources find it difficult to live on their own, without the support of the partner and they are left with no choice but to bear the sufferings. Finally, no effort to cure a victimized woman would be complete until she is able to earn for herself and her children. For example, vocational training, job reservations for victimized women, and availability of loans for starting entrepreneurship programme are some of the ways for rehabilitation of the victims and should be encouraged as part of any VAW focused intervention strategy.

Establishing women's helpline may be one such initiative to provide immediate relief and services to women in distress and in need of care and protection. This will not only help women and create women friendly environment, do advocacy for women's rights, but also act as a centre,

1. to act as a crisis intervention centre for women victims of violence;
2. to provide counselling services to women victims of violence in distress to overcome the sense of hopelessness and depression;
3. to provide short and long term services;
4. rescue and rehabilitation of the victim; and
5. to advocate the issue of gender based violence.

Policy recommendations

Ignoring violence as a factor in women's mental health and well-being not only leads to misdiagnosis and inadequate treatment, it also disregards the full extent of the personal and social consequences of violence. In recent years,

Author's personal copy

particularly after the rape and murder of 23 year old female student in Delhi last year on 16 December; VAW has emerged as a serious public concern which led to mass mobilization and public outrage and anguish across India. This led to immense pressure on the government to take effective measures and legislation. The Prime Mister of India, Dr. Manmohan Singh promised to take a constructive course of action to stop VAW and constituted a commission on an amendment to the Criminal Law, chaired by Justice J.S. Verma, with Justice Leila Seth and Gopal Subramaniam as members. The committee submitted its report on 23rd January, 2013. It is good news in that direction that the Sexual Harassment at the Workplace (Prevention, Prohibition and Redressal) Act, 2013, is passed by the Government on 22nd April, 2013. However, despite these promises, the constitutions of commissions and their reports, and enactment of new law, VAW is rampant. In such a situation, it is important to look at other stakeholders such as civil society, academia, researchers, opinion makers, etc., and service providers such as doctors, mental health professionals and counsellors, etc., who can make difference. Based on a review of studies and discussion, the authors recommend the following policy suggestion and intervention which may help in stopping mental health consequences of violence against women (World Health Organization, 2013a, 2013b, 2013c, 2013d).

- Recognizing domestic violence as a serious public mental health issue.
- Training of mental health care providers.
- Integrating violence against women and gender studies into medical and nursing education curricula and training for current practitioners.
- Implementing domestic violence protocols such as intimate partner violence assessment and interventions in treatment for depression and substance abuse.
- Ensuring medical exams of sexual assault victims by female physicians.
- Developing coalitions for public mental health research and advocacy.
- Conducting research, building research capacity, and disseminating research findings.
- Using research to advocate for policy reforms and an appropriate allocation of resources.

World Health Organization's new clinical and policy guidelines on the health sector response to partner and sexual violence against women emphasize the urgent need to integrate these issues into clinical training for health care providers (World Health Organization, 2013a, 2013b, 2013d). WHO has identified the key elements of a health sector response to violence against women such as women-centred care; identify and care for survivors of intimate partner violence; clinical care for survivors of sexual violence; training of healthcare providers on intimate partner violence and sexual violence; healthcare policy and provision; and mandatory reporting of intimate partner violence.

Mental health professional, practitioners and social workers can play an important role in identifying and caring for battered women because they may be the safest, or even only contact for women victims suffering from mental illness as a consequence of VAW. With training, mental health social workers can recognize, discuss, and provide support for women experiencing violence. Mental health care providers can help in reducing the problem of VAW if they learn how to ask clients about violence, become better aware of signs that can identify victims of domestic violence or sexual abuse, and help women protect themselves by developing a personal safety plan.

It is clear from the literature and various research studies that there is a need to develop coalitions for public mental health research and advocacy which will conduct research, build research capacity, disseminate research findings and use research to advocate for mental health policy reforms. For example, the South African Violence against Women and Health Initiative convinced two medical schools to include the issue of VAW in their curriculum. The initiative helped to develop a 1-week module on rape for medical students, and contributed to new national policies on the issue. Relevant questions on VAW should also be integrated into national mental health surveys.

Although, reform in the mental health sector alone cannot resolve the problem, it would go a long way towards bringing change relating to attitudes, beliefs and social responses to a considerable degree. Since very little or in fact no effort is being done by health care staff in dealing with abused woman, apart from some exceptions which are mostly done at the philanthropic level.

Conclusion

Violence against women is a widespread social, human rights and public mental health problem. Therefore, while the causes of VAW are complex, the issue must be addressed at all levels – within mental health policy, programmes, sector reform and changes to social norms and cultural beliefs. It is hoped and believed that with appropriate routine screening as well as a thorough assessment of physical, emotional, and sexual violence, mental health care professionals can identify the problem and provide solutions. With the recognition that VAW is a mental health and human rights concern, it is required that violence against women should be added in mental health policy and programmes. Apart from these, concerted and multi sector responses backed by strong political commitment towards ending violence against women are also required.

References

Babu, B. V., & Kar, S. K. (2009). Domestic violence against women in eastern India: A population-based study on prevalence and related issues. *BMC Public Health*, *9*, 129. http://dx.doi.org/10.1186/1471-2458-9-129.

Babu, B. V., & Kar, S. K. (2012). Abuse against women in pregnancy: A population-based study from Eastern India. *WHO South East Asia Journal of Public Health*, *1*(2), 133–143. (Accessed 07.01.13).

Bonomi, A. E., Thompson, R. S., Anderson, M., Reid, R. J., Carrell, D., & Dimer, J. A., et al. (2006).Intimate partner violence and women's physical, mental and social functioning. *American Journal of Preventive Medicine*, *30*, 458–466. (PMid:16704938).

Author's personal copy

Campbell, J., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., & O'Campo, P., et al. (2002).Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, *162*, 1157–1163. (PMid:12020187).

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*(9314), 1331–1336. http://dx.doi.org/10.1016/S0140-6736(02)08336-8.

Campbell, J. C., Boyd, D. (2003). *Violence against women: Synthesis of research for health care professionals*. Document no.: 199761. United States Department of Justice. 〈https://www.ncjrs.gov/pdffiles1/nij/grants/201567.pdf〉 Accessed 15.01.13.

Campbell, J. C., Kub, J., Belknap, R. A., & Templin, T. (1997). Predictors of depression in battered women. *Violence Against Women*, *3*, 271–293. http://dx.doi.org/10.1177/1077801297003003004.

Campbell, J. C., & Soeken, K. (1999). Women's responses to battering over time: An analysis of change. *Journal of Interpersonal Violence*, *14*, 21–40. http://dx.doi.org/10.1177/088626099014001002.

Campbell, R., Sullivan, C. M., & Davidson, W. S. (1995). Women who use domestic violence shelters: Changes in depression over time. *Psychology of Women Quarterly*, *19*, 237–255. http://dx.doi.org/10.1111/j.1471-6402.1995.tb00290.x.

Canadian Women's Foundation. (2011). *Report on violence against women, mental health and substance use*. Available from: 〈http://www.bcsth.ca/sites/default/files/BCSTH%20CWF%20Report_Final_2011.pdf〉 Accessed 15.01.13.

Cascardi, M., O'Leary, K. D., & Schlee, K. A. (1999). Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *Journal of Family Violence*, *14*, 227–250. http://dx.doi.org/10.1023/A:1022827915757.

Cook, J., & Bewley, S. (2008). Acknowledging a persistent truth: Domestic violence in pregnancy. *Journal of the Royal Society of Medicine*, *101*(7), 358–363. http://dx.doi.org/10.1258/jrsm.2008.080002. (PMid:18591689; PMCid:2442136).

Dalal, K., Rahman, F., & Jansson, B. (2009). Wife abuse in rural Bangladesh. *Journal of Biosocial Science*, *41*(5), 561–573. http://dx.doi.org/10.1017/S0021932009990046. (PMid:19534836).

Dutton, M., Kaltman, S., Goodman, L., Weinfurt, K., & Vankos, N. (2005). Patterns of Intimate partner violence: Correlates and outcomes. *Violence and Victims*, *20*(5), 483–497. http://dx.doi.org/10.1891/vivi.2005.20.5.483. (http://dx.doi.org/10.1891/0886-6708.2005.20.5.483).

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet*, *371*(9619), 1165–1172. http://dx.doi.org/10.1016/S0140-6736(08)60522-X.

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. H. (2005). *WHO multi-country study on women's health and domestic violence against women. Initial results on prevalence, health outcomes and women's responses*. Geneva: World Health Organization.

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, *14*, 99–132. http://dx.doi.org/10.1023/A:1022079418229.

Hegde, R. S. (1996). Narratives of silence: Rethinking gender, agency and power from the communication experiences of battered women in south India. *Communication Studies*, *47*(4), 303–317. http://dx.doi.org/10.1080/10510979609368485.

Heise, L., Lori, L., Pitanguy, J., & Germain, A. (1994). *Violence against women: the hidden health burden. World Bank discussion papers no. 255*. Washington, DC: The World Bank. (PMCid:1195305).

Heise, L., Mary, E., & Megan, G. (1999). *Ending violence against women, Population Reports*. Series L, Number 11, Volume XXVII, Number 4. Available from: 〈http://www.infoforhealth.org/pr/l11/violence.pdf〉.

Jaisingh, I. (1995). Violence against women: The Indian perspective. In: J. Peters, & A. Wolper (Eds.), *Women's rights, human rights*. New York: Routledge.

Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *The Lancet*, *359*(9315), 1423–1429. http://dx.doi.org/10.1016/S0140-6736(02)08357-5.

Kaur, R., & Garg, S. (2008). Addressing domestic violence against women: An unfinished agenda. Indian. *Journal of Community Medicine*, *2008*(33), 73–76. http://dx.doi.org/10.4103/0970-0218.40871. (PMid:19967027; PMCid:2784629).

Kishor, S., & Johnson, K. (2004). *Profiling domestic violence—A multi-country study*. Calverton, Maryland: ORC Macro. (PMid:15002665; PMCid:3329012).

Koenig, M. A., Stephenson, R., Ahmed, S., Jejeebhoy, S. J., & Campbell, J. (2006). Individual and contextual determinants of domestic violence in North India. *American Journal of Public Health*, *96*(1), 132–138. http://dx.doi.org/10.2105/AJPH.2004.050872. (PMid:16317213; PMCid:1470450).

Kumar, S., Jeyaseelan, L., Suresh, S., & Ahuja, R. C. (2005). Domestic violence and its mental health correlates in Indian women. *The British Journal of Psychiatry*, *187*, 62–67. http://dx.doi.org/10.1192/bjp.187.1.62.

Kulkarni, J. (2012). *Women and mental health*. Australian Women's Health Network. Available from: 〈www.awhn.org.au〉. ISBN:978-0-9578645-6-6.

Mahajan, A. (1990). Instigators of wife battering. In: S. Sood (Ed.), *Violence against women*. Jaipur: Arihant Publishers.

Martin, S. L., Kilgallen, B., Tsui, A. O., Maitra, K., Singh, K. K., & Kupper, L. L. (1999). Sexual behaviours and reproductive health outcomes. Associations with wife abuse in India. *JAMA*, *282*(20), 1967–1972. http://dx.doi.org/10.1001/jama.282.20.1967. (PMid:10580466).

Mayhew, S., & Watts, C. (2002). Global rhetoric and individual realities: Linking violence against women and reproductive health. In: K Lee, K Buse, & S. Fustukian (Eds.), *In health policy in a globalising world*, 2002 (pp. 159–180). Cambridge: Cambridge University Press.

McCauley, J., Kern, D. E., Kolodner, K., Dill, L., Schroeder, A. F., DeChant, H. K., Ryden, J., Base, E. B., & Derogatis, L. R. (1995). The "battering syndrome": Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Annals of Internal Medicine*, *123*, 737–746. (PMid:7574191).

Prasad, S. (1999). Medicolegal response to violence against women in India. *Violence against Women*, *5*(5), 478–506. http://dx.doi.org/10.1177/10778019922181338.

Rao, V. (1997). Wife beating in rural south India: A qualitative and econometric analysis. *Social Science and Medicine*, *44*(8), 1169–1180. http://dx.doi.org/10.1016/S0277-9536(96)00252-3.

Ratner, P. A. (1993). The incidence of wife abuse and mental health status in abused wives in Edmonton, Alberta. *Canadian Journal of Public Health*, *84*, 246–249. (PMid:8221497).

Silva, C., McFarlane, J., Soeken, K., Parker, B., & Reel, S. (1997). Symptoms of posttraumatic stress disorder in abused women in a primary care setting. *Journal of Women's Health*, *6*, 543–552. http://dx.doi.org/10.1089/jwh.1997.6.543. (PMid:9356977).

Tokuç, B., Ekuklu, G., & Avcioglu, S. (2010). Domestic violence against married women in Edirne. *Journal of Interpersonal Violence*, *25*(5), 832–847. http://dx.doi.org/10.1177/0886260509336960. (PMid:19587297).

United Nations, (1997). *Report of the fourth world conference on women*. Beijing, China: United Nations.

Vachher, A. S., & Sharma, A. K. (2010). Domestic violence against women and their mental health status in a colony in Delhi. *Indian Journal of Community Medicine*, *35*, 403–405, http://dx.doi.org/10.4103/0970-0218.69266. (PMid:21031106; PMCid:2963879).

Author's personal copy

World Health Organization, (2002). Violence and injury prevention: Violence and health: Violence against Women: A priority health issue. *WHO information kit on violence and health*. Adapted from Heise and Garcia Moreno, 2002; and Heise, Ellsberg and Gottemoeller, 1999.

World Health Organization (2005). *WHO multi-country study on women's health and domestic violence against women: Summary report of initial results on prevalence, health outcomes and women's responses*. WHO.

World Health Organization (2013a). *Violence against women: Global picture health response*. Geneva, Switzerland: Department of Reproductive Health and Research, World Health Organization. 〈http://www.who.int/reproductivehealth/publications/violence/VAW_infographic.pdf〉. (Accessed 24.06.13).

World Health Organization (2013b). *Violence against women: The health sector responds*. Geneva, Switzerland: Department of Reproductive Health and Research, World Health Organization. 〈http://apps.who.int/iris/bitstream/10665/82753/1/WHO_NMH_VIP_PVL_13.1_eng.pdf〉. (Accessed 24.06.13).

World Health Organization (2013c). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva, Switzerland: Department of Reproductive Health and Research, World Health Organization. (ISBN:978-92-4-156462-5. Accessed 24.06.13).

World Health Organization (2013d). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, Switzerland: Department of Reproductive Health and Research, World Health Organization. (ISBN:978-92-4-154859-5. Accessed 24.06.13).