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Research Article

Support needs of survivors of violence against women in urban India: a prospective analysis of client records

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Abstract

Background: Violence against women harms individuals, communities, and society. Supporting survivors requires a combination of skills and resources and involvement of multiple institutions. We aimed to document the range of responses that a counselling service should be able to provide, based on direct experience of working with survivors predominantly from urban informal settlements.

Methods: At non-government counselling centres in Mumbai, we analysed unlinked electronic records collected by counsellors supporting survivors of violence. We examined how women knew of the services, how they described their concerns, what they said they expected, and what was provided. We quantified the proportions of clients who required crisis intervention, police action, legal input, and medical, psychological and psychiatric support.

Results: Counsellors met with 2278 women clients in 2019, almost half of whom had been encouraged to attend through community outreach. Clients described intimate partner violence (37%), domestic violence by a family member other than their partner (22%), or both (27%). Common forms of violence reported were emotional (88%), economic (73%), and physical (71%); 68% of clients reported episodes of neglect, 59% of coercive control, and 36% of sexual violence, while 77% had survived three or more forms of violence. Over a median seven consultations, 32% required crisis intervention, 31% home visits from counsellors, and 17% legal support; 13% saw a clinical psychologist, 7% were assisted in consulting the police, and 5% required medical care.

Discussion: Demand for services was substantial at 200 new clients each month. Key concerns for counsellors were coping with this heavy workload, skills in responding to women's experience of multiple forms of violence and their desire to stay in relationships, skills in emotional support, ability to undertake and act on risk and mental health assessment, and effective engagement with health, police, and legal services.

Future work: Counsellors need to take a systematic approach to interacting with survivors of violence that covers all the considerations and activities needed in order of priority. We have developed a package of guidelines to meet this requirement, including trauma-informed counselling and mental health assessment and support (https://garima.snehamumbai.org/).

Limitations: The record system may have been subject to errors in data entry or systematic differences between counsellor choices, with the possibility of over- or under-identification of need and different counsellors' propensities for and choices of referral. The spectrum of concerns relates to women residents of urban informal settlements, and we should be cautious about their application to other populations.

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Background

Violence against women harms individuals, families, and communities and has consequences for policing, law, and society. It is thought that around 30% of the world's women experience physical or sexual intimate partner violence, or sexual violence by a non-partner, in their lifetime.[1] In India, a systematic review suggested that 22% of women had survived physical domestic violence in the past year; the figure for psychological violence was 22%, for sexual violence 7%, and for multiple forms of domestic violence 30%.[2] India was a signatory to the 1980 Convention on the Elimination of All Forms of Discrimination Against Women.[3] Violence against women is addressed by criminal law (e.g. Section 498-A of the Indian Penal Code addresses domestic violence) and civil law (the Protection of Women from Domestic Violence Act, 2005, addresses a range of perpetrators and forms of domestic violence).

The Council of Europe Istanbul Convention outlines the duty of states to ensure that support for women and girls comes from a range of levels in society: from high-level condemnation of discrimination and efforts to change unacceptable social norms, to individual help. This help is characteristically provided by non-government or civil society organisations and involves service provision and liaison with other organisations: running helplines and websites, assessing risk and providing or organising shelter, organising medical and psychological assessment and treatment, facilitating legal advice and providing support in judicial proceedings, and collecting epidemiological and evaluative data.[4] Evaluative work on support services for survivors of violence against women in low- and low-middle-income countries is limited and reflects the scarcity of services.[5–7]

For survivors of violence against women, seeking professional help is a big step. The fourth India National Family Health Survey (NFHS-4) suggested that only 14% disclosed to anyone, often a family member or friend, while < 1% sought help from a healthcare provider, the police, a lawyer, or a social service organisation.[8] Deciding to seek professional support depends on the balance between competing factors.[9] Across the world, survivors' fear of harm is tempered by fear of loneliness and worry about child care, money, stigma, and poor social support.[10] Survivors often have few sources of validation because perpetrators have restricted their contact with others – their reference group is limited[11] – and their struggle to understand the options is made harder by loss of self-esteem and deconstruction of identity within violent households.[12,13] When women consult, their concerns are often triggered by a critical development and they want a solution to a specific problem.[14,15] This problem is (or more usually, these problems are) not necessarily framed in terms of violence against women. While a counsellor may think of a situation as, for example, domestic violence by an intimate partner, the client may frame it in terms of lack of access to money or problems in arranging education for her children.

Interaction with a professional has, therefore, a naming function. Identifying a set of behaviours as violence validates a woman's suffering, reifies it, and implicates a perpetrator. This may be another big step after months or years of toleration and rationalisation of abuse. Although this appears to be a universal experience, the key literature comes from North America,[16,17] and women in India face some important contextual differences. First, domestic violence is often equated with intimate partner violence. For women in India, it often extends to perpetration within families – and particularly marital families – whose members are implicated in condoning or perpetrating violence.[18] Second, the pressure of patriarchal social norms tends to coerce women into adaptation to ongoing violence. Experience suggests that the tendency is to want the survivor to stay with perpetrators. Rather than asking why women stay in abusive environments,[19] community voices often ask why social service organisations want to 'break the family'.

Support for survivors of domestic violence needs to address a complex system of nested socioecological levels (the individual, her family, her community, and society)[20,21] and a range of needs, in combinations that vary in intensity, duration, and outcome.[22] Survivors need support for disclosure, crisis intervention and counselling; physical and mental health care; shelter; discussion of cycles of violence; safety planning; and referral to local community-based resources and other organisations to address needs such as housing, child care, and livelihoods.[23] Justice systems and other voluntary and statutory agencies may be called upon, along with individual or group intervention to reduce the risk of repeat perpetration.[24] *Tables 1* and *2* illustrate these needs through case stories of two pseudonymous clients. Both underline the need for multidisciplinary intervention. *Table 1* illustrates the importance of gender-based household maltreatment (a combination of emotional and economic abuse, control, and neglect),[25] and *Table 2* the importance of supporting survivors' mental health.

Objectives

We wanted to understand the range of responses that a service for survivors of violence against women should be

able to provide, based directly on the needs of clients. We used record-based information to understand women's concerns and expectations in seeking help. We examined how they reached services, how they described their concerns, and what they said they expected. Of particular interest was the need for multiple strands of support. We aimed to quantify the proportions of clients who required crisis intervention, police action, legal input, and medical, psychological and psychiatric support.

Methods

Setting

Based at the non-government organisation Society for Nutrition, Education and Health Action (SNEHA), the Programme on Prevention of Violence Against Women and Children has provided support to over 13,000 survivors of violence against women since 2001. Services are open to all – particularly residents of informal settlements in

TABLE 1 Supporting survivors of domestic violence requires a range of inputs: gender-based household maltreatment

Background

Tripti was 18 years old when she consulted the counsellor. She was born and raised in a middle-class family and lived with her mother and stepfather. She dropped out of school aged 12 and was married at the age of 16. At the time of consultation, she had been married for 2 years. Her husband worked in a factory.

Access route

At the time of referral, Tripti had moved out of her marital home and back to her natal home. She was referred by a community volunteer who visited her, explained the services that the organisation provided for survivors of domestic violence, advised her to seek help, and connected her with counselling.

Initial consultation

Tripti had moved to the matrimonial home after her marriage. She lived with her husband in a joint family that included her mother-in-law and sister-in-law. When she moved in, the family transferred much of the housework onto her and expected her to do it singlehandedly. She was repeatedly scolded by her husband and in-laws for not cooking and looking after the home properly. After a year of marriage she had a baby boy, and her workload increased. Her mother-in-law died at this time, and the family blamed Tripti and said that she had not taken good enough care of her. Her sister-in-law took Tripti's son away with her to another city, alleging that she was not taking care of him properly. Tripti's husband did not stand up for her and took her back to her natal home and left her there. Tripti was unhappy at being back home. Her mother had remarried, and Tripti felt stressed living with her and her new husband. She said that even in her natal home her position was compromised. She was told that she was unable to take care of her son and she felt guilty and responsible for her situation.

What she wanted

Tripti wanted to get her son back from her sister-in-law. She wanted to give her relationship with her husband one more chance in the hope that things would work out between them. Her natal family had tried and failed to get her son back. She expected the counsellor to intervene with her family to get him back and mediate with her husband so that she and her son could move back in with him.

Risk

The counsellor established that Tripti faced no immediate risk of physical violence or mental health crisis. She explained that medical assistance was available, but Tripti did not feel that she needed it.

Options

The counsellor discussed options with Tripti. Since she was keen to go back to her marital home, the counsellor offered to speak with Tripti's sister-in-law to try to get her child back and counsel her husband to fulfil his responsibilities. She explained the option of legal recourse for child custody and the possibility of filing a case under the Protection of Women from Domestic Violence Act to establish Tripti's right to reside in the matrimonial home. A third option was to seek help from community volunteers who could pressurise the family to allow her to live with them. Tripti chose the option of the counsellor speaking with her husband and sister-in-law.

Police support

The counsellor helped Tripti to consult the police before returning to her matrimonial home, to allow her to call on police help in the event of further abuse.

Family meetings

The counsellor facilitated a preliminary session with Tripti's husband and sister-in-law to understand their perspectives. She explained the husband's role in the relationship and the importance of supporting Tripti in the new home environment. She explained that the sister-in-law had infringed Tripti's right to be with her child and the legalities of the situation. Joint counselling sessions were arranged for all three to discuss their concerns and allow Tripti a platform to negotiate her place in the family. The couple decided to stay together and the sister-in-law gave Tripti her child back. The relationship continues.

TABLE 2 Supporting survivors of domestic violence requires a range of inputs: mental health

Background

Samira was 27 years old when she consulted the counsellor. She had been married as a minor to a man from her community and had a daughter and a son. Samira had dropped out of school young. She lived with her husband and children and earned some money making chapatis at a local temple.

Access route

Samira was referred by a volunteer teacher at a learning centre. The centre provided tuition at nominal fees for women who drop out of school young and want to pursue further education.

Initial consultation and risk

Samira was in visible distress. The counsellor assessed her as at high risk of suicide and provided psychological first aid and crisis counselling. She referred her to the psychiatry outpatient department at a public hospital. Although she had accessed counselling services, Samira did not want the counsellor to involve anyone in her family. Her learning centre teachers were acting as her guardians and agreed to take her to the hospital and follow up on her treatment.

Crisis intervention

Although she presented with suicidal ideation, Samira initially maintained that everything in her life was OK. Over the next few weeks, however, counselling interventions were driven by crises, and her suicidal thoughts increased. Although the counsellor was in almost daily contact, Samira called her at times of extreme vulnerability when she wanted to end her life. The counsellor decided that, despite Samira's reluctance to involve her family, their support was important. She visited Samira's home and met with her husband and her mother-in-law. She did not tell Samira's husband anything specific, but enlisted her own mother's help in watching over and supporting her.

Domestic violence

It took time for Samira to tell the counsellor that she had been sexually assaulted by her husband and three of her brothers-in-law. She had already filed a First Information Report (FIR) of sexual assault and rape against the four men and felt unable to cope with her extreme distress. After counselling had begun, Samira discovered that she was pregnant. She did not want to continue the pregnancy and said that the idea of having another baby with nobody to help her was adding to her distress. She was sure she would not be able to raise another child by herself.

What she wanted

Samira wanted justice for the assault by her husband and brothers-in-law. Her immediate need was to end her pregnancy.

Options

Medical support

The counsellor referred Samira to the Family Planning Association, where she could terminate her pregnancy for a nominal fee.

Police support

The counsellor helped with the police procedures for following up the FIR. She visited the police station and provided statements. She was in touch with the investigating officer and provided him with relevant information after talking with Samira's mother and other family members. The counsellor was required to provide a statement to the police based on Samira's testimony to her. This was a long process during which Samira's husband fled to his family's village of origin.

Mental health support

The counsellor continued to work with Samira to help her with her mental health. She arranged for a series of consultations with an in-house clinical psychologist, who helped her with trauma reduction through relaxation techniques and management of mood, anger, and hostility. Over 2 months, these sessions helped Samira to cope better and prepare her for court hearings. The counsellor accompanied Samira to her appointments with the psychiatrist at the public hospital.

Legal support

Samira withdrew her case against her husband. She said that she wanted to forgive him and start their relationship afresh. After her husband returned to the city, the counsellor spoke with him and arranged for him to sign an undertaking that he would not violate her further. Samira's husband agreed to bring their daughter back from another city where she had been living with her paternal grandparents. Samira continued with the case she had filed against her three brothers-in-law. The counsellor coordinated with the public prosecutor to make sure the case details were correct. The counsellor worked with the in-house lawyer to help prepare Samira to present her statement in court. The lawyer offered Samira a preparatory session before each court hearing.

Joint meetings

Samira requested support from the counsellor to mediate with her husband and work out an amicable solution to living together. The counsellor conducted meetings between the couple, educated the husband on his role, and encouraged Samira to negotiate and work out the day-to-day challenges of living with her husband so that she could stay in her matrimonial home.

Mumbai – and are delivered by postgraduate counsellors at six community and three public hospital counselling centres. Counsellors are trained in domestic violence, counselling techniques, mental health first aid, suicide prevention, ethics in counselling, and facilitating family meetings.

The services are supported by a telephone helpline and e-mail contact if the survivor is unable to physically visit a counselling centre (these were active during the COVID-19 pandemic and protocols for virtual consultation were established). Human resources include community outreach workers, counsellors, legal advisers and visiting lawyers, and clinical psychologists. These are complemented by close liaison with hospital practitioners, the police, District Legal Aid services, shelters, and psychiatrists. The programme also runs women's outpatient departments in public hospitals that help coordinate with medical interventions for survivors of violence. Primary prevention activities are carried out through community campaigns and work with women's and men's groups, leading to individual voluntarism to identify, respond to, and refer survivors of violence.

Support for survivors takes a feminist, intersectional rights-based approach that respects their agency in deciding on the course of action. The response to violence in a woman's life aims to be holistic in addressing her immediate and long-term needs, recognising trauma and challenging the stigma that accompanies gender-based violence. The hope is that the woman herself drives the outcomes of counselling and intervention, based on her right to choose. Mental health conditions complicate violent environments, and counsellors screen to understand survivors' mental states and help them cope with their feelings, emotions, and cognitive processes, which violence often heightens or distorts.

Design and participants

We analysed quantitatively a data set of sequential anonymised electronic records entered by counsellors during client registration and support. Participants were all women clients who registered with counselling services in 2019. We excluded records of consultations with men and children.

Data collection and analysis

Counsellors entered information in an electronic relational database in Commcare (www.dimagi.com) after each consultation, intervention, and referral. Modules summarised the survivor's demographic and crisis profile, including type of abuse, presenting concerns, desires from the consultation, structured risk assessment, screening for symptoms of depression (Patient Health Questionnaire-9; PHQ-9)[26] and anxiety (Generalized Anxiety Disorder-7; GAD-7),[27] followed by crisis intervention, subsequent counselling, and referral for medical, police and legal help. Analysis of unlinked records involved tabulation of frequencies and proportions in Stata® 15 (StataCorp LP, College Station, TX, USA).

Results

We present information on women registered at five counselling centres in 2019. Eleven counsellors saw 2283 adult clients in this year, 2278 of whom were women (2267 cis, 11 trans) and 5 of whom were men. This represented an average 17 new women clients for each counsellor every month.

How did clients reach services and who were they?

Most women consulted after community outreach: 38% (864) were referred by community organisers, 11% (245) by women's group members, 9% (196) by community volunteers, 8% (177) by previous clients, 4% (87) by programme staff, and 3% (68) by the police. Before attending, 39% (883) had learned of services from a community organiser, 17% (382) from a women's group member, 9% (208) from a previous client, 8% (181) from the internet, 3% (76) from the police, and 1% (20) from a community campaign.

Table 3 shows that 75% of women clients were aged between 20 and 39 years and that 65% were married; 16% of these marriages were between faiths and 10% between occupational castes. Three-quarters (1741; 76%) of women had at least one child and 7% (167) were pregnant at the time of first consultation. Over half lived in nuclear and over one-third in joint families. Around 80% lived in either informal settlements (*zopadpatti*) or accommodation originally built for industrial workers (*chawls*). The majority faiths were Islam and Hinduism, and more than half of women had attended at least lower secondary school. A minority were in remunerated employment, largely in the informal sector. Their partners were more likely to have jobs overall: 41% worked in the informal sector, 18% were self-employed, and 14% worked in the formal sector. A small number of clients (40; 2%) reported at least some difficulty in at least one of the six domains of the Washington Group functional classification of disability.[28]

What forms of violence were clients facing?

Clients commonly described intimate partner violence (37%), domestic violence by a family member other than

TABLE 3 Demographic characteristics of 2278 women clients registered in 2019

	n	%
Age (years)		
Under 20	90	4
20–29	994	44
30–39	701	31
40–49	273	12
50+	220	10
Marital status		
Married	1478	65
Separated	133	6
Divorced	22	1
Widowed	151	7
In relationship	36	2
Unmarried	433	19
Unknown	33	1
Family composition		
Nuclear	1268	56
Joint	811	36
Extended	82	4
Living alone	61	3
Other	56	3
Accommodation		
Zopadpatti	939	41
Chawl	886	38
Flat	374	16
Bungalow	8	< 1
Shelter	30	1
On street	8	< 1
Unknown	53	2
Religion		
Muslim	1136	50
Hindu	882	38
Buddhist	205	6
Christian	98	3
Other	169	5
Schooling		
None	455	20
Primary	394	17
Lower secondary	415	18
Higher secondary	440	19
Senior	240	10
Higher education	267	12
Employment		
Not currently	1571	69
Informal sector	343	15
Formal sector	183	8
Self-employed	124	5
Student	12	< 1
All	2278	100

their partner (22%), or both (27%); 2% had faced sexual violence from someone outside the home, 5% were dealing with family conflict, and 1% with neighbourhood conflict. The predominant forms of violence reported were emotional violence (88%), economic abuse (73%), and physical violence (71%). Two-thirds of clients (68%) reported instances of neglect, 59% of coercive control, and 36% of sexual violence. It was usual for women to have experienced more than one of these forms of violence: only 6% had suffered a single form, while 77% had survived three or more.

What were clients' main concerns?

Table 4 summarises the issues identified by > 1% of clients as their major concerns. Physical (45%) and sexual violence (19%), and threats of it, were prominent reasons for consultation. The commonest concern, however, was a woman's distress that she had been denied much-needed money (47%). Although few clients required referral to a shelter, one-third had been compelled to leave their home. Other less common concerns included broken promises of marriage, confinement to the home, pressure to marry, unwanted pregnancy, and non-accidental burns. More than half (59%) of clients consulted with more than one concern, and 25% with four or more.

Notable among the issues that clients thought were at the root of their problems were difficulties in either their adaptation to their expected roles in the marital family or the failure of their partner to live up to theirs; 29% of clients said that their family neglected their needs and 26% that the family exerted too much control over

TABLE 4 Presenting concerns and perceptions of their underlying causes, for 2278 women clients registered in 2019

Presenting concern	*n*	%
Physical or sexual violence		
Physical violence	1068	45
Threatened by partner	438	19
Sexual violence	437	19
Non-partner sexual assault	40	2
Economic abuse		
Denied resources	1064	47
Property taken	373	16
Residential concerns		
Made to leave home	735	32
Requires shelter	47	2
Mental health issues		
Mental health condition	390	17
Relationship issues		
Partner extramarital relationship	308	13
Children taken away	70	3
Harassed widow	60	3
Client perceptions of underlying causes		
Norms		
Roles within the family	657	29
Gender norms	515	23
Cultural norms	389	17
Need for male child	22	1
Family dynamics		
Neglect	657	29
Controlling family	593	26
Personality conflict	335	15
Resources		
Financial problems	310	14
Property issues	187	8
Relationship		
Partner infidelity	300	13
Partner polygamy	62	3
Sexual incompatibility	71	3
Client infidelity	27	1
Health issues		
Addiction	638	28
Partner mental health	335	15
Client mental health	73	3
Client physical health	21	1
Partner physical health	13	< 1
All	2278	100

them. Alcohol or drug use by partners (28%) or their mental health (15%) were concerns in a sizeable minority of cases. Emotional violence often involved in-laws and centred on women's roles as wives and mothers, amplified by financial pressures. That said, client narratives tended to focus on concrete issues such as financial constraint, marital infidelity, neglect of children, and interference by in-laws, rather than on more abstract ideas such as power and control.

What did clients want when they consulted?

Table 5 summarises what clients said when asked their expectations of consultation. Safety for themselves, their children, and their family was a major need. Women wanted counsellors to provide emotional support, take them through their options – including legal action – and help them decide what to do. Reflecting the household nature of violence, 44% wanted counselling for their partner and 32% for their family. Since only 12% of clients expressed a desire to leave their partner or family, and 11% had left the marital home and wanted to go back, the emphasis was on achieving reconciliation and a more tolerable environment. For this to happen, they wanted the counsellor to negotiate with their partner or family to stop the violence. Reflecting the common concern about roles and responsibilities, they wanted to be sure that their children would receive sufficient attention (and money) and that household workloads would be more equitable. This was underlined by their willingness to seek legal help to ensure financial support and protection orders. A common desire was for the police to signal the gravity of the situation to the partner or family by filing a non-cognisable offence (often called an NC: an offence for which a police officer has no authority to arrest without a warrant from a magistrate). It was unusual for women to want to go further by submitting a FIR (a document prepared by the police in response to information about the commission of a cognisable offence for which the police may arrest a person without warrant

TABLE 5 Expectations of 2278 women clients registered in 2019

Expectation	*n*	%
Safety		
For client	1509	66
For children	920	40
For family	418	18
Counselling		
Emotional support	1561	69
Learn options	1489	65
Legal guidance	1216	53
Decision-making	1049	46
Partner counselling	996	44
Family counselling	722	32
Relationship plan	637	28
Safety strategies	483	21
Leaving	282	12
Child counselling	194	8
Reconciliation		
Negotiate to stop violence	1212	53
Financial support for children	506	22
Shared workload	445	20
Child care	426	19
Return to marital home	240	11
Legal help		
Financial support from family	935	41
Protection	817	36
Conjugal rights	344	15
Property rights	245	11
Divorce	264	12
Child custody	43	2
Police		
File NC offence	221	10
Follow up with police	98	4
Make application	79	3
Talk to senior police	43	2
Medical		
Referral	169	7
Entitlements		
Streedhan	183	8
Personal belongings	104	5
Personal documents	98	4
All	2278	100

and are authorised to start investigation or prosecution under Section 498A of the Indian Penal Code).

Risk assessment

Counsellors identified appreciable risk for 79% of clients (*Table 6*). Common scenarios were physical assault and threat of violence against client or family (20% faced threat to kill). In 18% of cases, physical violence had extended beyond the domestic space to public places, and in 13% there had been an escalation in violence in the period preceding consultation. A quarter of clients had been made to move out of their home, 12% forcibly. The majority of clients (1895; 83%) were screened for depressive symptoms (PHQ-9) and anxiety (GAD-7). Screening suggested moderate or severe depressive symptoms in 39% (744) and moderate or severe anxiety symptoms in 35% (667).

Crisis counselling

Around one-third of clients (721; 32%) required crisis intervention after consultation. Most required one crisis counselling visit (88%) and the remainder generally required two (11%). Counsellors provided psychological first aid for 90%, conducted a formal suicide risk assessment for 79%, and worked with 78% to make a safety plan, including assessing the possibility of an increase in violence in response to women's help-seeking. Crisis counselling involved clients' partners in 87% of cases and their families in 37%. Urgent referrals were made to the police in 24% of cases, for medical care in 12%, and for shelter in 1%. Counsellors made home visits to intervene with partners (7%), marital families (14%), and natal families (9%).

Subsequent support

Overall, clients met with a counsellor a median three times [interquartile range (IQR) 2–6, range 1–44]. A single crisis consultation was usually necessary (IQR 1–1, range 1–5), and counsellors made home visits to 31% of clients (*n* = 715) (IQR 1–2, range 1–12); in 88% of cases, this visit involved discussions with the marital family. *Figure 1* summarises the combinations of inputs that clients received: 68% received support from counsellors without referral, while 17% also received legal support (16% from a lawyer as well as a legal counsellor); the bulk

TABLE 6 Risk assessment by counsellors for 2278 women clients registered in 2019

Type of risk	*n*	%
Physical risk		
Assaulted by partner	1433	63
Assaulted outside home	398	17
Escalation in violence	392	17
Another family member assaulted	256	11
Assaulted with weapon	230	10
Non-family member assaulted	83	4
Threat		
To client	541	24
To kill client	446	20
To family	341	15
Of assault to non-family	90	4
To use weapon	142	6
To non-family	85	2
Home		
Client made to move out	568	25
Client thrown out	282	12
Child		
Threat to child	211	9
Child taken away	107	5
Child abused	106	5
Mobility		
Isolated by family	257	11
Isolated location	209	9
Held against will	65	3
Illness risk		
Perpetrator drug or alcohol user	640	28
Perpetrator self-harm	185	8
Client mental health issues	670	29
Client suicidal ideation	336	15
Any safety concern	1798	79
All	2278	100

of this work was prelitigation and litigation consultation. Almost one in eight (13%) saw a clinical psychologist, and 3% saw a psychiatrist; 7% consulted the police; and 5%

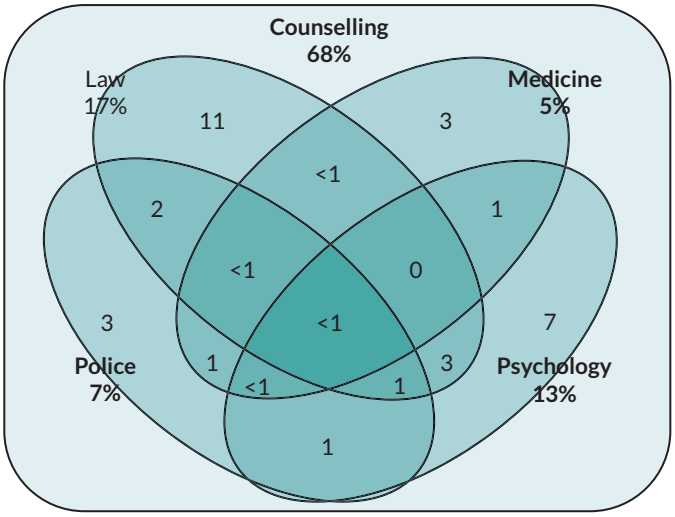

FIGURE 1 Combinations of inputs that clients received.

received medical support. Overall, this meant that clients had a median seven consultations with a counsellor or other professional (IQR 4–12, range 1–72).

Discussion

Our analysis of the routes to consultation, presenting concerns, expectations, and subsequent support of 2278 women clients helps to clarify the skills and networks required of responsive services. What kinds of heuristics should inform service design and what kinds of networks will help meet the needs of survivors of violence? We begin with a series of pragmatic assumptions. Although these will not apply to an appreciable minority of clients, they do indicate the dimensions of a minimum response.

Workload and vicarious trauma

The first assumption is demand. Domestic violence is common, and demand for support is potentially substantial. The initial numbers of consultations will be limited, but our service has reached a level of around 200 new clients every month. Although this is a heavy workload for counsellors, the potential numbers are greater because we know that only a minority of survivors disclose, and fewer consult. Community outreach is invaluable – 58% of consultations were triggered by the work of community organisers, women's group members, and volunteers – but the burden of consultations and the vicarious trauma to counsellors are a source of stress and burnout that we must make efforts to mitigate.

Poverty and economic abuse

In the context of urban India, most clients will be married women with children who live in informal settlements or

low-income housing and are not themselves in paid work. Money worries will be prominent: around half of clients said that they were being denied access to and control of finances. Such concerns are likely to be central to fears that they will not be able to survive if they leave their current home. Dependency on the natal family (and the attendant guilt) may cause problems if they have had to leave the marital home, often as a result of eviction.

Multiple forms of violence from multiple sources

Given the overlap between forms of domestic violence, we should assume that clients will have been exposed to more than one: 94% reported two or more, the commonest of which were emotional, economic, and physical abuse. Simultaneously, around half will have suffered violence from family members other than their intimate partner. Although clients reported physical violence, their concerns often turned more on economic and emotional violence that disrupted their day-to-day lives, affected their children, and harmed their self-respect. They expected counsellors to help stop the violence and negotiate with partners and family members for adequate resource provision for clients and their children.

Desire to stay

An assumption that differs from the largely Northern experience described in the literature is that around 90% of clients will want to stay in the abusive family. What they say they want is for counsellors (with or without the help of the police) to interact with their intimate partners and household to achieve a tolerable environment. This falls considerably short of domestic harmony, and testifies to women's resilience and deep concern for family and children. We are humbled by the idea that women are willing to raise the threat of police, legal, or organisational action to achieve a modicum of self-determination and reduced exposure to physical, sexual, and emotional abuse in an environment in which the satisfaction of basic needs is a daily challenge (see *Table 2* for a stark example).

We turn now to the approaches and actions that a responsive service must offer to clients.

Emotional support

Psycho-educational, supportive counselling may improve self-esteem, affect (anxiety, depression, hostility), assertiveness, social support, internal locus of control, coping abilities and self-efficacy, and may reduce the likelihood of repeat violence and improve quality of life.[29] An important requirement is emotional support, summarised usefully in the WHO LIVES approach: Listen, Inquire, Validate, Enhance safety, and Support.[30] Given the decisional balance around consultation and the big step it represents, clients need to feel that counsellors have heard their voices and validated their concerns. Although our clients articulated a need for emotional support, the articulation was retrospective. It is our impression that, before consultation, women often do not see a need for counselling to manage their emotions, feelings, and thinking; they expect solutions. It is also unrealistic to expect that counselling alone will lead to resolution.[31] Recurrence of violence is common, and the hope that women will remain free from violence is often unrealised.

Risk assessment and crisis response

The need for immediate risk assessment reflects the escalation in violence, concern for children, threats, and financial and mental stress that often tip the decisional balance in favour of seeking professional help. The counsellor has to assess risk adequately and help the survivor navigate the available options for mitigation. Some form of crisis response will be necessary in about one-third of cases. Priorities are psychological first aid, suicide risk assessment, and safety planning. The counsellor will usually need to involve the client's partner and, in around 40% of cases, their family, through home visits in around 30% of cases. This means that counsellors need to have skills in emotional support, psychoeducation, and mediation because these processes will often be called upon. More than one-third of clients will describe symptoms suggestive of depression or anxiety, and 10–15% will be contemplating suicide. The period immediately around first consultation is critical, and counsellors need the training, support, and networks to be able to respond. Along with safety planning, the most important skills are in psychological first aid: only around 15% of clients will need to see a mental health professional. In our context, arranging institutional shelter for clients will only be required in around 2% of situations; a woman's interim relocation from a high-risk environment more often involves her moving back to her natal home or to the home of a friend or community volunteer.

Enumeration of options

Isolation from the global story means that survivors of domestic violence often feel unable to exercise agency. They want to discuss their options with a counsellor who has experience of the challenges involved in deciding and acting and the likely outcomes. Particularly important in this weighing of options is an understanding of the client's rights and the realities of legal processes. Statistically, it is likely that the legal path will be fraught with obstacles and setbacks, although – as our data suggest – approaching the police or a lawyer may itself be sufficient warning to trigger improvements in the home situation. The police will be involved in around a quarter of cases, and familiarity with

the law and procedures is therefore important. It is likely that the counsellor will do more than refer a client to the police, and she needs to be confident in negotiation with them (and, to a lesser extent, with clinicians) to achieve the desired outcomes. Up to one-fifth (15–20%) of clients will need legal support. This sizeable minority need referral to lawyers (e.g. via free legal aid) or development of a paralegal cadre. We find it particularly useful to have paralegal team members who are able to support clients through the sequence of steps, act as the point person between counsellors, lawyers and courts, and adopt a watching brief. This has the secondary benefit of reducing substantially the demands on legal time.

Programmatic challenges

Over 20 years, our programme has steadily expanded to provide comprehensive services that meet the requirements of clients. Central to these is counselling and the protocolisation of risk assessment and crisis response. Our data confirm that these are, in a sense, the bottom line. Relationships and referrals require coordination, and the burden on counsellors to follow clients up and facilitate their progress is substantial. Although our counsellors aim to resolve clients' issues and build their agency to make decisions for themselves, the balance has tended to favour provision of resources over addressing clients' mental health. Long-term follow-up has been challenging and a lot is expected from counsellors with backgrounds in social work. What seems most important is *access* to clinical and legal services and strong relationships with providers, whether in-house or through regular interaction that develops front-line legal and mental health skills in counsellors and ensures that clients receive adequate follow-up.

Limitations

The record system may have been subject to errors in data entry or systematic differences between counsellor choices. Our analysis assumes that the inputs documented by counsellors in client records were necessary. For some (legal advice, interaction with the police, medical consultation), this assumption is reasonable as they would have arisen from agreement between client and counsellor. In some cases, however, there is a possibility of over- or under-identification of need, and differences caused by different counsellors' propensities for and choices of referral; for example, more women than were referred might have benefited from seeing a clinical psychologist, and fewer situations might have been categorised as needing crisis intervention. Although home visits were important for follow-up, the data recorded by counsellors do not unequivocally establish their effectiveness. The spectrum of concerns relates to women residents of urban informal settlements and – although we suspect that they are generalisable to a degree – we should be cautious about their application to other populations.

Conclusion

Our records support the assumption that demand for support services for survivors of domestic violence in India will increase steadily as global and local awareness grows. Our findings suggest that survivors of domestic violence are usually married women with children, have money worries, are surviving multiple forms of violence, but often want to work things out domestically rather than leave. They require emotional support, risk assessment and crisis response, mental health support, enumeration of their options, and referral to and liaison with other agencies. To meet these expectations, counselling interventions – usually provided in the third sector – need to address survivors' relationships with their partner, family, and community. Multiple forms of violence from multiple sources are the rule rather than the exception, and survivors need to meet with trained, well-supported, resilient counsellors who are able to cope with a heavy workload. These counsellors need to show skills in eliciting, validating, and talking about the range of forms of violence that clients will have suffered. They need to be able to make and act on risk assessments, be flexible enough to provide crisis intervention (e.g. through urgent home visits), and ensure safety. At the same time, survivors benefit from meeting with counsellors who can assess their mental health and provide first-line interventions. Finally, survivors need to be helped to navigate the process of engaging with the police, medical practitioners, mental health practitioners, and paralegal and legal professionals. Counsellors need to take a systematic approach to interacting with survivors of violence that covers all the considerations and activities needed, in order of priority. We have developed a package of guidelines to meet this requirement, including trauma-informed counselling and mental health assessment and support (https://garima.snehamumbai.org/).

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Data-sharing statement

Data are available in Open Science Framework: Osrin D and Panchal K (2021, September 6). Prospective analysis of client records. Retrieved from osf.io/6a2rs. Further requests for data should be submitted to the corresponding author for consideration.

Ethics statement

The Multi-Institutional Ethics Committee of the Anusandhan Trust, Mumbai, approved the study (registration 230213). Counsellors took informed signed consent for data recording from clients at first consultation. Clients were aware that their anonymised information could be used in research to evaluate the programme. They were assured of confidentiality, particularly that information would not be shared with the perpetrator's family, community members, or the media, and of their right to access their records as evidence for legal proceedings.

Community engagement and involvement

Our work responds to the urgency of preventing violence and improving services for survivors, primarily through community-based programming in informal settlements. It is driven by survivors' needs. Our programme includes extensive outreach in communities and is in regular dialogue with community leaders, representatives of other non-governmental and civil society organisations, faith groups, the police, and legal advisers.

Equality, diversity and inclusion

Our support services for survivors of violence are, we hope, accessible to all. Most clients come from communities of lower socioeconomic position. We encourage uptake of services by women from different cultural groups, women with disabilities and cis, trans or non-binary individuals.

Information Governance statement

SNEHA and UCL are committed to handling all personal information in line with the UK Data Protection Act (2018) and the General Data Protection Regulation (EU GDPR) 2016/679. SNEHA is the Data Processor and Data Controller. You can find out more about how we handle personal data, including how to exercise your individual rights, by contacting us through https://www.snehamumbai.org/contact-us/

ODA statement

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List of abbreviations

FIR	First Information Report
GAD-7	Generalized Anxiety Disorder-7
IQR	interquartile range
NC	non-cognisable
NIHR	National Institute for Health and Care Research
PHQ-9	Patient Health Questionnaire-9
SNEHA	Society for Nutrition, Education and Health Action

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