CHOOSING TO LIVE

Guidelines For Suicide Prevention Counselling in Domestic Violence

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Published in September 2005

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*[A joint initiative of the Public Health Department –
K.B. Bhabha Hospital, Bandra (W) and
Centre for enquiry into health and allied themes (CEHAT)]*

Cover Design by : Lata P M

Drawings by : Lata P M (Pg. No. 1, 11, 13, 17, 21, 23, 35, 41, 45, 50) and
Pramila Naik (Pg. No. 53 & 54)

Design on all pages by : Qudsiya Contractor and Yaquta Contractor

DTP by : Pradeep Kapdekar and Pramila Naik

Printed at :
Satam Udyog
Parel, Mumbai-400 012.

TO

ALL

WOMEN

WHO

CONTRIBUTED

BY

SHARING

THEIR

PAIN

ACKNOWLEDGEMENT

We would like to thank all those who helped us put together these guidelines by reviewing the drafts and giving critical feedback. We thank Ms Jessica Jacob, Ms Ketaki Ranade, Ms Manisha Gupte, Dr Padma Prakash, Ms Radhika Chandiramani, Dr Shekhar Sheshadri and Dr Soumitra Pathare for reviewing the first draft of the document. We also take this opportunity to thank Dr Padma Prakash who has untiringly looked and relooked at several drafts and also edited the document. We thank Ms Prabha Pillai for copy editing of this document. We would also like to thank the women coming to the *Dilaasa* department without whom this book would not have been thought of. We would also like to thank Ms Lata PM for contributing the sketches that aptly convey the message of this document. A special thanks to Ms Qudsiya Contractor for developing designs that have enlivened the document. A special thanks to Dr Seema Malik, the chief medical superintendent and Project Director of *Dilaasa*, without whom *Dilaasa* would not have evolved the way it did. We are grateful to the Ford Foundation for its financial support to the *Dilaasa* project. Last but not the least we would like to thank all our team members.

CONTENT

Note : The names of the women have been changed to protect their identities.

I. WHY THIS DOCUMENT

In the course of our work with the public health system through *Dilaasa* we come across many women who have attempted suicide being treated in the hospital. Women are referred to *Dilaasa* from different departments after they are screened for domestic violence. Often they are self-referred. We observed that there was one distinct referral of women from the Female Medical Ward. That was overwhelmingly frequent. These women had been to this department because they had attempted suicide. Many times domestic violence is a precipitating factor driving them to take this extreme step. Attempted suicide or suicide is also violence directed at self.

After observing the sizeable number, we decided to screen all such women who had attempted suicide and were being treated in the ward. It became very clear that while working on the issue of domestic violence we also have to work with women who have attempted suicide. Before the work began, brainstorming sessions were held with the team. The purpose of analysing suicide cases was to identify high-risk groups, causes and reasons. Planning prevention at the hospital level is important, especially when the frequency of admission is very high (approximately two-three or more every day). Besides, counsellors get very little time with the women, so it was felt that we needed to put together guidelines to increase effectiveness. The women who have attempted suicide are relatively more at risk of suicide in future. It was decided to reach out to each and every woman who has attempted suicide and is recovering in the hospital.

Reaching out to women who faced domestic violence resulting into attempted suicide required sensitivity and information. It was decided to put together information on this issue to create greater sensitivity to heal the women's distressed situation when they are receiving medical treatment and can receive counselling. The woman touches the public health system in particular and society in general at various points. At each point sensitivity and information is needed to help her. With required sensitivity at each point, her situation can be effectively addressed. This document is an effort to initiate the process of reaching out to these women in their hour of crisis.

II. UNDERSTANDING SUICIDE

'Student commits suicide due to failure in examination. He wrote in his suicide note, "I do not like this life. Therefore I am doing it. Nobody should cry over my death. I do not like the school. The marks I am getting are too less.'"

'Debts drive farmers to commit suicide. When the crops fail, they are unable to repay their debts.'

'*Loss of job pushes mill worker to take his life. No alternate employment was available.'*

'Estranged lovers commit suicide……'

'Mother drowns along with her children'.

'*There was argument over money to treat the child in hospital. It was desperation.'*

'Could not bear his extramarital affair.'

'Had no natal family support. The violence in matrimonial family was unbearable.'

'My uncle would take me in the room and touch me all over. I feel horrible after that.'

'My husband has sex several times in a night. It is painful. On protest, he says that it is your duty to satisfy my desire.'

These incidents are commonly reported in the newspapers. Each such event is an awakening call for the planners, doctors, psychologists, sociologists, counsellors, administrators, relatives, colleagues, friends, neighbours, you and me as well. Every suicide is an untold tale of human pain. These many from amongst us have chosen death over life. They have perceived dying as the only solution to their distress. Somewhere their connection with life has snapped. The Alma Ata[1] declaration in 1978 said "health is a state of complete physical, mental and social well-being and not merely the absence of disease".

[1] This landmark declaration was made by representatives of 134 nations in an international conference at Alma Ata (in the former USSR).

For these many lives the sense of well-being on mental, physical and social level failed. In this sense the suicide leaves the trail of clues to find out where correction is urgently needed. It touches all of us whether we are doctors, psychologists, sociologists, counsellors, colleagues, friends, relatives or members of public.

Magnitude of the problem

Nearly a million people take their own lives every year, more than those murdered or killed in war. The World Health Organisation figures show a suicide takes place somewhere in the world every 40 seconds. “Suicide is a major public health problem and accounts for 1.5 per cent of the total cost of disease to world society”, said Jose Bertolote, mental health specialist at the World Health Organisation (WHO).

Suicide is the 13th leading cause of death worldwide. Among those aged 15-44 year self-inflicted injuries are the fourth leading cause of death worldwide and the sixth leading cause of ill health and disability [WHO 1999].

Suicide is a problem that affects people of all ages and economic levels, and is recognised by the WHO as a significant public health problem. Among other causes it is one of the major causes of death. Of the one million cases of suicides reported the world over in the year 2000, over one lakh were in India. This may be low as a proportion of our population. But we have to note that a suicide was attempted every 7.6 minutes in 1989, today it occurs every five minutes. With a suicide being committed every fifth minute and about 15 attempts being made for every suicide committed, India faces a major crisis. All these failed attempts of suicide are admitted in the public hospitals. According to the National Crime Records Bureau (NCRB), the number of cases of suicide has been rising steadily. From 40,245 cases in 1981, the number more than doubled to 84,244 in 1993, and reached 1,08,593 in the year 2000 [NCRB 2000].

The overall male: female ratio of suicide victims for 2000 was 61:39. However, the proportion of suicide victims was almost even, i e, 51:49. Youths (15-29 years) and middle-aged people (30-44 years) were the prime groups attempting suicide. Of the total suicide victims, around 35.6 per cent were youths in the age group of 15-29 years and 33.8 per cent were middle-aged persons in the age group between 30-44 years. Housewives (22,205) accounted for 42.2 per cent of the total female victims committing suicide. They constituted nearly 20 per cent of the total victims. Of these housewives 46 per cent were in their prime youth (15-29 years). 69.0 per cent of the suicide victims were married while 21.9 per cent of these were unmarried. Nearly 26 per cent suicide victims were each illiterate or educated up to primary level, while 23 per cent of them had middle level education and only 2 per cent were graduates or postgraduates. Although more women than men attempt suicide, more men than women actually succumb. All these facts point out those women in 15-44 age group, married, uneducated are the most at risk of suicide. Our experience at *Dilaasa* confirmed these statistics.

For us the statistics did not remain just numbers. We were awakened to the human pain suffered by women through their narrations. It helped us to make connections between domestic violence and the phenomenon of suicide/attempted suicide, as women narrated their individual pain.

Reasons/causes of suicide

Suicide has been defined as the human act of self-inflicted self-intentional cessation of life [Shneidman 1976]. This definition combines the issues of the individual's conscious desire to be dead as well as his/her action to carry out the wish. Defining attempted suicides is difficult. In attempted suicides, the attempt to kill oneself is always inferred retrospectively. It is not clear whether person's intention to die is final or not. Attempted suicide, therefore, describes the behaviour without discussing the apparent intent.

The question is, what price does the society put on the life of its members? The body of knowledge now available points to suicide as a multidimensional phenomenon resulting from a complex array of factors. It is a malaise with emotional, psychological, biological, medical, sociological, economic, cultural, philosophical and environmental roots. Psychologists believe that extreme emotional pain due to pent-up frustrations drives people to suicide.

The NCRB figures show that the proportion of female victims is comparatively more under the head: suspected/illicit relation, non-settlement or cancellation of marriage, not having children, dowry dispute, divorce, illegitimate pregnancy, love affairs, family problems and physical abuse [NCRB 2000]. Terminal illness emerges as the major cause for the age group above 44 years. Among male victims social and economic cause like bankruptcy, sudden change in economic status, poverty, unemployment, property disputes are the major causes. Family problems are the fourth cause of suicide for age groups 15-44 years. For age group up to 14 years failure in examination and love affair gone wrong are the major causes. These indicate the patterns and general trends.

When a person commits suicide, who is responsible for it? The individual or society? Or both?

One argument points out that society cannot be blamed if people who cannot adjust commit suicide. But adjustment problems are not the major cause of suicides. So, the reasons are complex. Each suicide hides the most painful aspect of an individual's response to the societal reality. It is time that we understand its complexity.

Student suicides after the SSC and HSC results highlight the state our schools are in. Our schools are not helping students to develop a sense of achievement or positive attitude. The focus is on marks only. Do we ever pause, and think what must be happening to those declared 'fail'? Of late, there are some

voluntary groups coming forward to counsel those ‘failed’ students. Something needs to be changed at the level of policy. Each individual is caught in this complex matrix. You are more likely to suffer the risk depending on the specific point at which you are located in this matrix. All the students who take this extreme step throw light on their individual psyche as created by the complex social phenomenon.

We have recently seen reports of farmers in Andhra Pradesh and Maharashtra committing suicide. Farmers are unable to cope with the sudden changes in cropping patterns, market fluctuations, and use of pesticides to increase the yield. These are direct results of agricultural policy driven by the market forces. When the crops fail, they are in debt, which they have no means to repay. They are unable to perform the role of provider for the family. All these factors are to be taken into consideration while understanding an individual farmer committing suicide.

Social unrest caused by communal riots in Gujarat from February to May 2002 brought trading to a standstill. Many who were dependent on trading had no means of survival. The events of merchants and businessmen committing suicide surfaced.

For women of 15-29 and 30-44 year, domestic violence or ‘family problems’ is a precipitating factor driving them to take the extreme step. With no power to control, the woman resorts to suicide as a way of correcting injustice or teaching lesson to the perpetrators of violence. There is very little scope to express her deep despair or rage. An attempt at suicide is the only way she can express her distress against the abuse. Most often these attempts fail and the woman survives only to face the contradictions in life all over again. There are few alternatives for her to free herself from the abusive family. She has little education, no earning capacity and the cultural attitude towards divorced women prevents her from contemplating the alternatives.

Whether it is a student who failed in examination, a farmer who could not repay his debts or a woman succumbing to the domestic violence, their act is culmination of complex bio-psycho-social, economic, cultural, political factors; but it is still an individual act. In that sense while it is important to go into external factors, it is equally essential to understand the individual mindset.

The individual act is as much an expression of forces within and outside. Every individual is constantly adjusting to the inner needs with external circumstances. All of us have needs. They are basic like food, shelter, etc. They are emotional needs for satisfying relationships. They concern security. Life would be so good if all types of needs get realised without any hurdles. But we know such is not the case. Many things are denied to many of us depending on the position we occupy in the complex web of social matrix. Therefore the struggle to constantly

adjust between the needs and the possibility or otherwise of their realisation puts a great deal of stress on the individual. The stress of adjustment creates thought of suicide in many of us. But while making choices some of us come to realise that the stress is temporary and death permanent while others perceive their dilemma as inescapable and experience total loss of control.

When individuals experience total loss of control certain patterns are noticed. There are volumes of unexpressed feelings underlying each suicide. A study of causes of suicide is directed at understanding such feelings. The normal balance is upset when an individual takes to extreme step. There is an effort to define normal healthy individual. An individual who is at ease with herself and the world around is considered healthy person. This is too general a definition. Sigmund Freud's definition of the happy, healthy person is an important operative one in understanding suicide. According to him a happy person is one who can love and work. The first ability focuses on an individual's inner needs, perceptions, etc. The other defines the world around the individual. When the individual is sad, lonely, unloved and this is accompanied by a lack of work outlets, suicide becomes a possibility.

There are several elements, that push individuals over the edge. One is the psychological state, i e, depression. Depression is a disturbance of mood. The individual feels low, is inactive and disinterested in the goings-on of life. Depression can result out of life events like death of loved ones, loss of job, sudden loss in business, etc. Depression can also be caused by certain chemical imbalances in the brain, i e, biochemical system of the body. It is observed that women are prone to certain mental illnesses like depression. The causes are multiple. There are few evidence-based studies to establish this conclusively.

Among men it may be difficult to accept their vulnerability due to cultural norms imposed on them. And they might not be reporting this common ailment. Also they have escape routes like gambling, alcohol consumption etc. They also have other resources — economic, social, and cultural — on hand to bounce back to normal functioning. More demands are made on women in terms of fulfilling their roles. Roles imposed on them because of biology, such as childbearing, delivery, lactation along with other social, cultural expectations add to the complexity. Many times women have to face domestic violence, which puts them in a very vulnerable situation adding to the other economic, social, and cultural disadvantages. Their access to find alternatives is thus limited. A study of 100 women in a public hospital in Mumbai psychiatry department indicates that housewives are likely to experience depression. They have no chance to relate to the outside world and find ways to overcome frustrations. (Study by Dr. Dhavale, Nair Municipal Hospital). The deliberate act of suicide is often an act of desperation. The individual holds herself responsible for not being able to meet the expectations of others. The sense of personal failure overpowers them leading to the act of suicide.

Means adopted for suicide by women

Any attempt of suicide by women throws some light on its lethality. This lethality can be assessed by the quantity and type of poison consumed. Women lay their hands on what is easily available at home such as pesticides, phenyl, chalk powder and rat poison. In a majority of cases, women take an overdose of medication like sleeping tablets, ayurvedic tablets and cough syrup. These different means help us to understand the intent of suicide. The means resorted to and quantity of consumption can be classified as 'cry for help', 'teaching a lesson', or a serious intent to end one's life.

Self-immolation whether a means of suicide or more has to be viewed as a separate category. Perhaps women assimilate the myth of - 'sati – as the highest form of sacrifice to prove one's purity' - in their subconscious. Women's movement played a pivotal role in the 1970's where they brought the entire issue of accidental stove bursts of married women in matrimonial homes. Whether these women were killed or had committed suicide was uncertain, but the campaign highlighted domestic violence and lower socio-economic status of women as the basic cause behind these un-natural deaths. In 1980's, feminists protested against the glorification of sati as a Hindu tradition and demanded the state to intervene and punish Roop Kanwar's[2] in-laws and the doctor who drugged her. In today' age, it is important to understand when women douse themselves with kerosene, or self immolate, what is it that they have absorbed of this tradition.

In Maharashtra the single important cause of death among women aged 15-44 years is burns. Almost 11% of suicides are committed by self-immolation and 80% of people who die by self-immolation are women. Keeping these insights in mind would be pertinent to analyze the mindsets of women in order to provide emotional support.

[2] In September 1987, an incident of sati (self immolation) in a village in Rajasthan sparked off a campaign, which questioned the religious sanction, communal identities, role of the state and law. The Rajput community defended the entire pro Sati argument by stating that the Rajput men defend the Hindu tradition on battle field by killing and being killed, while women defended it at home by killing themselves. Thereby Sati also began to exemplify the true Rajput identity. (History of doing, p176, 177, the agitation against sati, by Radha kumar1993).However the sati practice was not restricted to the Rajput community per se. The fundamentalist forces saw anti-Sati campaign as danger to the Hindu (communal) identity. Hence there was also a pro-sati upsurge verging on to demand to legitimize sati. Women were also mobilized for promoting the legitimizing of sati . Sati was being used to keep up the tradition in a modern era. However the state showed ambivalence to the entire issue of sati. Though it did not legitimise sati, it actually introduced a bill under which sati would be defined as suicide and the first person to be punished would be the woman herself for making such an attempt.

III. EFFORTS TO PREVENT SUICIDE

Since the causes are multiple, preventive efforts need to gear on various levels. The individual needs space to make choices. Availability of opportunities and a social system with adequate support structures is ideal. With advances made in understanding the human mind, preventing individual from making this irrational choice is a possibility to be worked out collectively.

Suicide prevention or 'befriending' as it was called began as a movement in 1953. The United Kingdom parish priest Chand Varah felt the need when a 14-year-old girl committed suicide upon attaining puberty – as she had no one to explain to her the natural biological process. The priest organised a small group who would `befriend' those in need. The movement has spread to 41 countries and has 35,000 volunteers and 357 centres.

The International Association for Suicide Prevention (IASP) was founded in Vienna in 1960 as a working fellowship of researchers, clinicians, practitioners, volunteers and organisations of many kinds. September 10, 2003 was observed as the first World Suicide
Prevention Day by the WHO and IASP.

The organised movement began the world over by setting up of 'hotlines' – telephones for those who are driven to the brink. Medico-Pastoral Association in Bangalore began addressing the problem of suicide prevention in the 1970s with the help of National Institute of Mental Health and Neurosciences (NIMHANS). In India in 1986 the first suicide prevention support hotline called 'Sneha' was set up in Tamil Nadu. Sneha's director Dr. Lakshmi Vijayakumar, psychiatrist, is also the vice-president of International Association of Suicide Prevention. Then many more centres were set up in different parts of the country. They offer free support to those who are in need. Providing much needed emotional
support is the first step.

For working in the field of suicide prevention it is important to ensure that one's motivation and commitment are genuine and complete. But noble intentions, if not backed by committed action, can indeed bring greater misery into the life of an already distressed person.

Some principles for suicide prevention efforts

Any effort at suicide prevention has to deal with human emotions at the stage where they are most disturbed and under stress. The approach will change from person to person. But there are certain basic minimum requirements like non-judgemental acceptance, empathy, compassion and understanding of pain. Reaching out on emotional level to restore the disturbed mind is very important.

Simultaneously, awareness of socio-eco-political and cultural influences impacting the individual psychology, on the part of the counsellor/person in helping role will strengthen the process of ‘healing’.

When the cause of tension is domestic violence, ‘victim blaming’ needs to be avoided as a matter of principle. Domestic violence is the result of gender-based power balances maintained in family and marriage as well as in other societal systems.

Helping someone who is threatening suicide

Be direct. Talk openly and matter-of-factly about suicide. This will enable the person to voice her pent -up stress points leading to her preparedness to consider alternatives.

Be willing to listen. Allow expressions of feelings. Accept the feelings. Help her to ease out and ventilate.

Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Create a space where she can pick up her spirits to reflect.

Don't lecture on the value of life. Draw her attention to her strengths to cope in earlier situations. Basically her positives.

Get involved. Become available. Show interest and support. Tell her that she can turn to you whenever needed.

Don't dare him or her to do it. This may lead her to believe that you are not concerned.

Don't act shocked. This will put distance between you and the patient. She may close up. She may conclude that she cannot express her raw feelings.

Don't be sworn to secrecy. Seek support. Respond to the need.

Offer hope that alternatives are available but do not offer glib reassurance. Suggest something, which is within her reach.

Take action. Remove means, such as sharp instruments, insecticides, stockpiled pills, and kerosene, any other poisonous or combustible substance, etc. As far as possible ensure that the person is not alone.

Get help from persons or agencies specialising in crisis intervention and suicide prevention.

Recognising risk factor

A person might be suicidal if she or he

- Talks about committing suicide
- Has trouble eating or sleeping
- Experiences drastic changes in behaviour
- Withdraws from friends and/or social activities
- Loses interest in hobbies, work, school, etc.
- Prepares for death by making out a will and final arrangements
- Gives away prized possessions
- Has attempted suicide before
- Takes unnecessary risks
- Has had recent severe losses
- Is preoccupied with death and dying
- Loses interest in personal appearance

(Adapted from: *Things You Should Know About Suicide,* American Suicidology Association.)

IV. PUBLIC HOSPITAL: A SITE FOR INTERVENTION

Public hospitals offer a unique site for intervention in cases of attempted suicide. As suicide is a criminal offence, most private hospitals refuse admission to such patients and therefore they have to rely on the public hospitals only. All hospitals that have a Casualty Department admit cases of attempted suicide. The number of such cases is considerably high. At Bhabha Hospital, one of the peripheral hospitals of the BMC, there were 105 cases of organo phosphorous poisoning (or attempted suicide) in 1996, 149 cases in 1997 and 115 in 1998. The total number of cases of homicide/suicide is 99 in 1996, 118 in 1997 and 120 in 1998.

Health care providers and social workers working within a health care setting have to handle a variety of functions. These could vary from raising funds for the patients, to donations, to counselling patients. In the counselling aspect too they are expected to look at different issues, such as HIV/AIDS, patients who may be terminally ill, counselling survivors of the bereaved and other patients having health problems. They also have to visit different wards and talk to different patients referred by the hospital staff. In the course of their work, they come across women patients who have attempted suicide. Hence, health care providers and social workers play an important role in providing emotional support to the woman.

But in public hospitals, such patients are often perceived as nuisance and burden as they have failed in their attempt. They are routinely taken from one stage of treatment to another including the psychiatric reference till they are discharged in a matter of two to four days. Very rarely, the required 'human healing concern' touches the woman.

The *Dilaasa* crisis centre, a first attempt to sensitise the public health system to the issue of domestic violence, seeks to provide social and psychological support to all women admitted in the hospital after attempted suicide. *(See Annexure for more details about Dilaasa.)*

Experience at *Dilaasa*

In the initial phase of our work at *Dilaasa*, we studied the medico legal registers for the year 1999. All suspected cases of violence are recorded as medico legal cases (MLC) at the casualty department before they are admitted for treatment. So all cases of burns, accidents, poisoning, assaults, seizures, are MLCs. In our study we found cases of consumption of poison account for 12 per cent of all MLCs amongst women whereas among men these cases were 4 per cent. We found that cases of burns were 14 per cent of all cases amongst women and only 4 per cent amongst men. This helped us to work out our intervention. We began visiting all wards and screening all admitted women who had a MLC recorded for

domestic violence. Amongst these were all women who were admitted for 'consumption of poison'.

These constitute a large proportion of the women that *Dilaasa* caters to. In the first year (2001-2002), out of the 111 women who received services of *Dilaasa*, 22 women had reported consumption of poison because of domestic violence. Of these 22 women, 12 were from the age group 15-25 years, nine from the age group 26-35 years, and one from the age group 36 years and above. In the year 2003, 16 per cent (41 out of 257) of the women who received counselling services had attempted self-harm. Twenty-three out of the 41 women were below 25 years. Most of the women are educated up to the secondary level with incomes less than Rs 1,500 per month. This is true of women who sought services in 2001-2002 too.

We found it difficult to intervene, as counselling in such cases was not a norm at the hospital. Women are admitted for two to three days only. The first two days are spent in receiving medical treatment. During this time they are not in a position to talk. As the hospital is concerned with the physical treatment only, often women are discharged even if screening for domestic violence is not done. We had to follow up with these women every day. The wards too are very crowded making it impossible for the women to share their agony. They are also accompanied by a relative or friend, which makes it difficult for her to share.

We, therefore, requested the hospital authorities to direct the wards to send women to the centre for screening. We felt this was necessary because our concern was not only for women who had attempted suicide because of domestic violence but for all women who had made such an attempt. At the centre we then geared up to provide suicide prevention counselling to all women.

Women have given us a variety of reasons for attempting suicide such as, opposition by parents about choice of partner; being forced to marry someone else; break-up of a relationship; forced sex; incompatibility; not allowed to meet children; control over what to eat and when to eat; witnessing violence against mother; severe physical and emotional violence, and destitution. Reported ways of attempting suicide are: consumption of phenyl, rat poison, Tik 20, kerosene or even dousing themselves with kerosene and setting themselves on fire, consuming pills and taking an overdose of medication.

Being a public hospital, the majority of the patients coming to the hospital for treatment are from the lower socio-economic class. They can be categorised since that determines the disadvantages suffered leading to attempted suicide. The young amongst them suffer from failed love affair or parent's opposition to their choice of partner. The next are young women with one or two young children or no children, or newly married unable to cope with the marriage pressures in matrimonial family. The pressures also include violence of all types. There are married women with husbands having extramarital relations. The other category suffers from economic pressures and is on the verge of destitution.

Unsurmounting economic pressures have snapped their coping mechanism. Since each individual is different, such categories may help to an extent to plan preventive measures.

Consequence of attempted suicide

There are multiple consequences of attempted suicide and there are insurmountable difficulties for women to rebuild their lives. Physically, the woman is weak, exhausted, dizzy and nauseated. The stomach wash and other medicines take their toll. She is in shock. Many conflicting emotions are at play. She is guilty, angry, sad, frustrated, traumatised, depressed, listless, desolate and numb. She blames herself and others, she justifies that this was the only way to teach a lesson to the wrong doer. She denies the attempted suicide and blanks out. She has bouts of crying or sits still and refuses to talk. She is stigmatised within the family and the immediate community as having caused disgrace to the family. Her children and other family matters are neglected, which affects her in turn. Economically, she loses her daily wage if she is working outside home thus adding to her difficulties. These women are from the lowest socio-economic class. There is then the additional burden of hospitalisation that has to be borne by them. They are held responsible for this loss.

Besides, in India, suicide is a crime so the police investigate these cases. This often puts further pressure on women as they are forced to hide the truth. This means that often woman does not get any documentary evidence in her favour. But there have been some cases where the same documents have been used by perpetrators against the women in order to label them as mentally ill and seek divorce. A few cases of perpetrators asking for a letter that says that ‘he’ is not to be held responsible for her death in future have also come to light. All this makes women more vulnerable. In turn this increases the violence in her life.

Psychological impact of domestic violence

Violence against women, a large part of which is domestic violence, is widespread and affects women on multiple levels. “One in three women throughout the world will suffer violence in her lifetime; she will be beaten, raped, assaulted, trafficked, harassed or forced to submit to harmful practices such as female genital mutilation. In the majority of cases, the abuser will be a member of the woman’s own family or someone known to her” (United Nations Development Fund for Women).

Women are socialised not to speak about violence within family. When they are referred to *Dilaasa*, not all of them can break this learnt silence. Domestic violence has already affected them psychologically and socially. Their close relatives who protect them are themselves perpetrators. It is very difficult to come to terms with this duality in their life. Most of the women find themselves at a loss and feel lonely. It impacts them at various levels. It is widespread and yet remains inadequately addressed.

V. WOMEN AND DOMESTIC VIOLENCE

Dynamics of domestic violence

This is how women experience and process domestic violence

> *"My child was admitted to hospital. My husband or in-laws did not visit him. When I wanted to go to the hospital, they have beaten me because I asked for money to take care of my child. I felt like throwing myself under the running train."*

> *"He is going around with a bar girl. When I questioned him about it, I was beaten. Nobody, I mean my in-laws, intervened. I feel lonely. This pain from my broken arm is nothing compared to what I am feeling inside."*

> *"The child began crying. I was about to finish making the last roti. I asked my husband to pacify him. He snatched the rolling pin and began beating me mercilessly. This is my third child. I never wanted it. I wanted an abortion. He locked me inside. I do not want to go back to him. But where can I stay? I have no support."*

The narrations of women point to the need for families and social norms to change urgently. In the family, relationships need to be based on mutual respect and love and not on sacrifice and surrender. Outside the family, in society at large, many things have to change. Women need to increase their access to resources like education, training opportunities, job possibilities, share in property, etc. The societal attitude has to be enlightened. Only then women can make choices. Like police, judiciary, family courts, hospitals that directly come in contact have to show this enlightenment.

> *Take the example of Anandi, who got married into a middle class family after completing her schooling. Her first husband had died of a terminal illness. This was her second marriage. The husband turned out to be an irresponsible partner. He would work on and off and live off his parents. The husband's parents were getting tired of this behaviour and asked the husband and wife to leave the house. Anandi rented a house with some financial support from her natal family. But her husband did not mend his ways. He also had become a womaniser. He used to bring women home. It was difficult for her to put up with it. All her resistance increased the violence. By then she had two children. When she shared her feelings with the close relatives, they advised her to make adjustment. She was driven to do something only when there was threat to her life. She went to police station. With a lot of effort she could register her complaint. The husband filed for divorce. She wanted to salvage this marriage at any cost. She felt that it was her responsibility to make it work, as this was her second*

marriage. She approached Dilaasa centre after having heard about it from some one.

At Dilaasa, Anandi was given the space to talk, share and ventilate her pain which she had never shared for many years. Through provision of emotional support, different strategies were evolved for continuing children's' education, she seeking employment, networking for a sympathetic support system. Along with this, Anandi herself was going through a transitional phase where she gained the courage and confidence to take a decision of giving the divorce on her terms and conditions. Through a long drawn legal battle, she was able to seek maintenance for her children. Today, Anandi has been able to overcome the pain and injustice that has happened to her and also provide support to other women.

Women can make choices provided individuals and society are enlightened at many levels. Basically, we have to acknowledge that domestic violence is not the woman's fault. The Left and democratic women's movement has addressed this issue and studied the complex dynamics of how domestic violence affects women. It exists as an expression of patriarchy where power relations are maintained based on gender discrimination, exploitation and gender-based roles. It exists not just in institutions of family and marriage but in other settings also. In short, it exists in the system that we live in. The change has to happen at all levels, so the work done by the women's movement has helped to create an environment to make some necessary changes at various levels so that women have supports and alternatives. Yet, compared to the severity of the problem these efforts remain seriously limited. In short, the economic, political, cultural and social systems have to change to allow the individual to live without fear and coercion.

What do we do at *Dilaasa*?

The first contact with the woman happens when she is admitted for treatment. Usually some relative or friends accompany her. Sometimes she is on drips. The counsellor can talk to her only when she is in a position to engage in conversation. Some of them come to *Dilaasa* counselling room when referral to psychiatry department takes place. This is before they are discharged as they may or may not follow up at *Dilaasa*.

The typical profile of the woman who has attempted suicide with whom *Dilaasa* counsellors come in touch with is as follows:

If she is in the ward and taking treatment, she is under the spell of medicines. She has probably not eaten in the previous few days since she was full of negative thoughts. She has undergone uncomfortable treatment of stomach wash and is feeling low. She has that needle inserted on backside of her palm.

She is surrounded by some or the other relative. Since it is a ward there is no space to sit and talk to her. She is referred as OP poison case by the health service givers at different layers.

She is routinely referred to the psychiatry department before discharge. Psychological testing is done and anti-depressants given with advice to follow up.

If she is screened and found to have suffered domestic violence she is referred to *Dilaasa*. Her general appearance and mindset are almost the same as in the ward. She has most probably taken turn in psychiatry department, sometimes upset why she has to tell her story at so many places. It is very important for the counsellor to tell her that it is up to her to share. If she is willing, then the counselling proceeds. But if she is not, then a simple message of help in the form of a pamphlet (which is produced in English, Hindi, Marathi and Urdu to make it more relevant depending on the woman) is handed over to the woman and/or is read out to her. She is reassured that if she does not feel like confiding in us now, she can do so whenever she feels lonely or wants to visit us anytime in future. The card with address and phone number is given to her to convey that we are serious. We have come across women following up after sometime. When we show concern, we know it has made a difference by the change in their facial expressions. There is acknowledgement of our concern shown. Women may come to *Dilaasa* only once and therefore the efforts is to ensure that she is able to take something back even from her first visit.

Sometimes we come across women who suffer from mental illnesss; moderate or severe. These disorders may or may not be combined with facing abuse. In such a case, it is best to refer her to the psychologist and psychiatrist. It is important to have access to mental health status diagnosis procedure coupled with counselling. When the symptoms are under control, the counsellor could talk to the patient, which is very crucial.

Another common means of suicide is setting oneself on fire. The women with non-survival percentage of burns are admitted to this hospital, which has no special burns ward. The counsellor visits such women and comes in touch with the relatives. Some of the women are in a position to talk and they do talk when encouraged to do so. Women are encouraged to speak the truth so that some kind of redressal process can begin. The relatives who are supporting the woman are informed how to proceed with the police complaint, etc. This can happen only when some relatives come forward to help the woman. Often, we observe that relatives do not take any initiative. Even then a separate documentation of such details is maintained to measure the psychological and physical/health effects of violence on women. It is important to document such details.

VI. MODEL DIALOGUES AS GUIDELINE TO MAKE COUNSELLING EFFECTIVE

Need for model/representatives dialogue

The experience gathered at *Dilaasa* helped us to formulate these model dialogues for suicide prevention counselling. Although the majority of women attempting suicide fall in the younger age group, women from the middle and older age-groups also attempt suicide. It is important to understand that a small proportion of women attempting suicide may also be suffering from common mental illnesss like depression.

Challenges to counselling

1. They don't seek help voluntarily but are referred for counselling.
2. They may be in physical agony as they may still be receiving intravenous medication.
3. Lack of privacy in the ward.
4. It is difficult for women to reveal history of domestic violence as there is stigma attached to it.
5. They may feel guilty, angry, frustrated, lonely, lost, ….

Hence counselling has to deal with barriers at different levels right from the woman's mindset to the infrastructure of the health setting. The biggest challenge in counselling a woman who has attempted suicide is to be able to provide her adequate emotional support and concern for her safety, as she may not be able to revisit the health setting again.

Counselling skills

Keeping these challenges in mind, there is a need to evolve a protocol or plans that have to be made with the woman in the post suicide attempted phase. The effort is to provide knowledge and develop skills in problem solving and increasing the sense of self-esteem, belonging and worth in the women. Counselling a suicide-attempted woman has to start with placing the woman in the larger context of what has driven her to attempting suicide. The reasons may vary from sheer destitution to domestic violence, to failed love affair, to failure in examination and need for long-term psychological help. Suicide prevention counselling needs to have empathetic understanding of the woman's social reality. The counsellor has to look at suicide as a way of coping with an unbearable situation, or a cry for help. Hence non-judgmental attitude should reflect while counselling such a woman. The counselling has to gear to helping the woman see that she is not alone, that support is available and counselling is

her space to share whatever she feels like. The counsellor needs to place before the woman what are the warning signs and how she should turn to someone for help if a feeling of committing suicide comes again. The skill in counselling lies in being able to communicate these different messages while providing her emotional support and also getting to understand her story without overcrowding the counselling session with too many ideas.

For effectively counselling these women in the first session, following steps are to be kept as guidelines.

i. Emotional state of the woman, whether she is in a frame of mind to talk.

ii. Details of the attempt, i e, type and quantity of poison consumption. What were precipitating factors?

iii. Verbal expression of the woman – how she expresses her guilt, frustrations, anger and her future plan.

iv. Counsellor's impressions and analysis.

v. Plan of action with the woman. Finding her social support and help her reconnect.

Based on our experience we present here four dialogues that are representative of the profile of women accessing hospital services. We hope that these would be a useful framework for counsellors in their attempt to provide support to women attempting suicide. We are sure that these could be developed further.

Model Dialogue I

The situation - Radha is an 18-year old girl. She had an overdose of ayurvedic tablets, which were prescribed to her brother who was suffering from some bowel problem. This was the information that was written on her indoor medical papers.

***Technique 1* - Getting started**

It is usually good to start the dialogue with introducing the centre, ourselves and why a need was felt to talk to the woman attempting self harm. The opening dialogue with the woman/girl need not focus on her attempt to end life.

Counsellor: Hi, Radha, how are you feeling?

Radha: I am ok. (Doesn't look at the counsellor, playing with indoor medical papers.)

***Technique* 2 - Observing verbal and non-verbal communications**.

Such observation may give more clues about her emotional state, comfort/ discomfort.

Counsellor: I am————————. I work at this centre. In this centre, we meet a number of women and girls of your age. They may be facing some kind of problems at home, but may not find any one to confide and share. Could you trust me and tell me if you are facing any problems at home? (Pause). It will remain only between you and me.

Radha: (Smiles awkwardly but says nothing).

***Technique* 3 - Starting the conversation with non-threatening issues.The counsellor has used day mapping as a technique of counselling.**

The counsellor can gauge by the smile that she may want to share something, but not just yet. Hence it may be good idea to shift to some other issues connected to her life. The counsellor can ask the girl to elaborate on her time table at home such as when does she get up, what are the daily chores that she does, when does she get time for herself, etc.

Counsellor: Do you go to school?

Radha: My father……. well I studied
till 5th in Marathi. Now I am at home only.

Counsellor: What do you do at home? Do you have friends?

Radha: I cook, clean. I have two brothers; I have to look after them too. Where is the time for friends?

This helps the Counsellor to get to know the girl better as well as puts the girl at ease by discussing aspects of her routine life. Through this dialogue, the Counsellor also made her own analysis that Radha liked going to school but has been asked to leave it. She is

overburdened with responsibilities of managing the household and taking care of her younger brothers.

***Technique* 4 - Probing in the attempt to suicide sensitively**

The Counsellor has to be aware of the fact that most women have inhibitions to talk about the attempt to end life. They feel awkward, ashamed of themselves. Some women also find it extremely painful to even recall the incident. Most relatives, friends, etc, would have preached to the woman about her 'wrong doings' and also warned her about any such future ideation. Therefore, the Counsellor needs to explore the attempt gently and sensitively. It is pertinent that the Counsellor understands what led the woman to take this step.

Counsellor: Radha, I know that most people would have scolded you about this accident/event. But I have a feeling that your consumption was not an accident. I think that you are in pain, some pain that you are afraid to share with me. Can you trust me?

Radha: (remained silent for a few minutes, tears gushing through her eyes). ———. I am in love with a Muslim boy Rafiq, but my father is against it. He says that he will get me married to some other boy soon. What choice did I have?

***Technique* 6 - Ventilation**

When the girl is crying, it is important that the Counsellor does not jump to ' rescue her', but allows her to ventilate her feelings through crying.

***Technique* 7 - Asking open ended questions**

Counsellor: Radha, How did you feel about your father's behaviour?

Radha: ……. no… no. He is my father and he is doing the right thing.

***Technique* 8 - Dealing with feelings of guilt and anger with empathy**

Counsellor: I understand that you like your father, but you could also feel bad that he does not understand you. Do you think it is wrong to feel bad or angry towards your own father?

Radha: Actually, I get so angry at times, that I feel like crying, I feel horrible inside.

Counsellor: Radha, it is all right to feel angry towards people you love. The reason we may be feeling angry is because we feel controlled by them. At times this control over us gets too hard to tolerate…

Radha: Ya.

***Technique* 9 - Sensitive exploration regarding her future**

By this time, the counselling must try to explore feelings of shame, guilt, regret over having survived the attempt, what is she thinking in terms of her immediate future.

Counsellor: You will be discharged from the hospital today evening. How are you feeling about going home?

Radha: I am wondering what everyone would say about me.

Counsellor: What do you think your neighbours or friends would say?
Radha: Everyone would stare maybe——— My friends would ask me why I did it? I don't know, I am just uneasy about it.

Counsellor: I can understand that it may be difficult or rather awkward for you when you go back. But think about it this way, you have a second chance to live and you have to tell yourself that you have the strength to move forward. I know that it is tough to forget what has happened.

Radha: Yes.

***Technique* 10 - Helping the woman reflect on her relationship**

There is comfort established between the girl and the counsellor, and the girl has still not talked about her relationship with Rafiq. The Counsellor can try to explore this aspect and check for the girl's readiness to discuss the same.

Counsellor: Are you worried about your relationship with Rafiq? What have you thought about it?

Radha: I don't know. Now my father would be stricter than before, I don't know, I haven't thought.

Counsellor: Radha, you have been through a lot in the past two days. You may need time to think about this relationship. Do you think taking some time would help you come to a decision?

Radha: But my father would get me married before that (protests).

Counsellor: Do you think it may be a good idea to talk to your father about this situation?

Radha: (still thinking)

***Technique* 11 - Safety assessment and safety planning**

It is important to assess the safety of the girl and draw a safety plan along with the girl, lest such situation occurs again.

Counsellor: I can see that you are still thinking, Do you want to come back to discuss this aspect later?

Radha: Yes, I need some time. I have still not thought about our relationship. But the thought of marrying anyone else is unbearable. I just cannot imagine—

Counsellor: Radha, I can see that this situation is really very painful to deal. But however painful it may seem, you know that you can overcome it, isn't it?

Radha: I think so.

Counsellor: When a feeling of despair, anxiety or sadness comes to your mind, or you think that there is no good in living, the best thing is to leave that situation for a while. You can come to the centre and share your feelings now that you know me. If you cannot do that, just go out for a walk, meet a friend, listen to music. Remember all that we spoke of today.

Radha: Ya Ya, (seems hopeful) I feel I can come here.

Counsellor: Radha, can you tell me what are the painful situations you foresee?
Radha: Rafiq and I not getting married, my father beating him, I cannot bear to think of all this.

Counsellor: Such recalling is painful, but you know that an attempt to suicide can have health consequences that we may not realise. The consumption of rat poison, cockroach-killing chalk, phenyl, kerosene can be extremely damaging to the body and if the attempt is unsuccessful there may be a life-long impairment like partial loss of vision, problems in joint/body movements, paralysis at times and so on.

Radha: (looks away).

Counsellor: I am not trying to scare you but most of us are not aware of these health implications that is why I am sharing this with you.

Radha: Yes.

Technique **12 - Helping her recall important people whom she can turn to in a difficult situation.**

Counsellor: Please seek help in such situations. We will always talk to you. Do you have friends in the community? Who are the people to whom you can turn to when you are feeling low?

Radha: There is Shama, but she is going to get married soon. The one good thing is that she will come closer to where I stay after her marriage.

Counsellor: Very good, can you talk to her freely?

Radha: Yes, but I wonder if we can after she is married.

Counsellor: We all know that marriage brings a lot of changes in our life and also responsibilities. But do you think that in a situation like this you can turn to her?

Radha: Yes, yes, my father told me she wanted to come to the hospital. My mami (maternal uncle's wife) is also very fond of me. I had confided in her about our love affair.

Counsellor: See, Radha, you have these people's support even in tough situations.

***Technique* 13 - Helping the woman reconnect with life by asking her hobbies.**

The counsellor can help the woman to think of ways to picking up threads of her life. This would help her feel confident. One way of doing this is by mapping her daily timetable.

Counsellor: What is your day like? What time do you get up?

Radha: I have to get up at 6 a.m. no actually 5. 30 a.m. I fill water with the neighbourhood women. I make some chapattis and vegetable for Raju and Sanju. They have to leave for school by 9.00 a.m. Then I am home all day, watching TV. Father does not like it if I go out.

Counsellor: There must be some things that you like doing a lot, can you tell me what they are?

Radha: Nothing much, I draw some silly flowers here and there, on the walls at times. I like to paint. Some of my friends also go for this embroidery classes. I try to pick up from them.

Counsellor: That is wonderful. I would really like it if you could make a greeting card and show it to us at the centre. If you are interested you could make some cards. There are some places where you can sell cards. You can also go and learn more designs from there.

Radha: (Her face brightened somewhat, shyly). I could make one card and show.

Counsellor: I could talk to your father about this occupation.

Radha: (Her face falls). Father may not allow me to come. There is work at home also.

Counsellor: You can chalk your day in a manner that you get two hours on alternate days and meet us. I will talk to your father and tell him that this is a hospital procedure. However, this also means that you are taking the responsibility of coming to *Dilaasa* every alternate day, right?

Radha: I will try my best.

Counsellor: We also have meetings with women once in a while. You could come and attend them. That way you can also make friends with more people if you like.

Radha: Yes, I will try to come.

Model Dialogue II

The situation - Reena is a 35-year old woman, who has been brought by a neighbour as she was found lying on the ground. The history has been reported as accidental consumption of kerosene.

***Technique* 1 - Begin with / opening conversation with an open-ended question**

Counsellor: (Self introduction) Salaam Reena. How are you feeling today?

Reena: I am ok, though my throat hurts a lot.

Counsellor: I see, have you informed this to the ward nurse? They may give you some painkiller for it.

Reena: No, no if I say anything they will keep me here for a longer time. I have to go home. Please ask them to discharge me today. My children are alone at home. I am here for two days. I don't know, how they are. My mother is so old, how will she manage taking care of them? I have to go.

***Technique* 2 - Stressing need for complete medical treatment**

Counsellor: I understand Reena. But you are kept in the hospital, so that you recover as soon as possible. See, once you go, you have to attend to your daily chores. Taking complete medical treatment may help you recover soon. They are discharging you today evening.

Reena: You are right in a way.

***Technique* 3 - Enabling the woman to overcome denial**

Counsellor: Reena, in the indoor papers it has been reported that you have accidentally consumed kerosene. This may be true but in our experience we have also seen women who consume poison because of a very stressful situation.

Reena: No, no I was asleep. You see, and I drank kerosene instead of water.

***Technique* 4 - Be direct and share concern**

Counsellor: I would like to tell you that if there was any such situation, or if you are facing domestic violence, you could share it with me. Whatever you share will remain confidential. I am concerned about you.

Reena: (Breaks down). No one has spoken so warmly to me. Madam I took kerosene on purpose. I know that I am wrong. I should not have done such a thing.

***Technique* 5 - Communicate, don't be judgmental**

Counsellor: I can understand how you must be feeling. Can you trust me and share your story in detail? We do not judge women on the basis of attempt to suicide. Instead we try to find out what was the situation that led them to taking such a step.

Reena: Madam, I have been taking my husband's beatings for the past 15 years but last evening I could not take any more. I asked him for some money, not for myself but for our younger son, so that I could buy some medicine. But he refused outright.

***Technique* 6 - Reducing hierarchy in counselling situation**

Counsellor: Just a minute Reena, why don't you call me by my name? I am not a boss, am I?

Reena: How can I? (Smiles).

Counsellor: Ok, can you call me Behen or Didi?

Reena: Ok.

Counsellor: Oh! But how did this incident happen yesterday?

Reena: Abdul refused to give money. I am tired of making all ends meet. You know he has a good job in the BMC. But he doesn't give us a single rupee. I work as a maid and that's how I am able to put both my sons and my daughters in school. I keep taking advance from my employers and neighbours. But how long can I do that? He spends all his money on the other woman.

Counsellor: Did he marry again?

Reena: No, no but I fear that he will. Why should he remarry? When he has three children. We have suffered so much. I told him that if he remarries and brings that woman in this house, I will end my life. He said that I can go ahead and do it or he will kill me. (Breaks down). That's why I drank kerosene. He just ran away after that.

***Technique* 7 - Validate her feelings**

Counsellor: I can understand how painful it must be. What do you think we can do?

Reena: I want him punished. He should suffer. I don't want him to remarry. What if he removes me and the children from his house?

Counsellor: Reena, you have faced so much violence in the past 15 years. I can see that you are feeling hurt and angry. It is completely justified to feel that he should be punished. But how do you think he should be punished? What help do you want from us?

Reena: I want to file a legal case. I want to teach him a lesson.

Counsellor: Ok, but can you tell me how you want to teach him a lesson? Do you have anything in mind?

Reena: No. I don't know how, but you must help me Didi. I want him to go to jail.

Counsellor: Reena, we are here to help you.

***Technique* 8 - Validate her feelings, however share the effects of 'teaching lesson' without preaching**

Counsellor: It is valid that you want your husband to be punished. However, dragging him to the court may just increase your burden. In our experience, a legal battle is very long and doesn't always succeed. I don't mean to dishearten you, but at the same time, I don't want to give you false hopes. On the brighter side, there are other things that can be done.

Reena: (Seems disappointed). Is there nothing that can be done to him Didi? It is so unfair.

Counsellor: I know Reena, but can I offer a suggestion?

Reena: Yes. Yes.

***Technique* 9 - Share tangible gains so that the woman is not disheartened**

Counsellor: Since he works in the BMC, we can talk to the higher officials. That way, we can get a part of his income for your children, what do you say?

Reena: Is that possible? What if he refuses?

Counsellor: We have to try our best. And we have dealt with such cases in the past.

Reena: If it happens, it will be very good. But I still feel that he should be punished. How can he get another woman in my house? I have suffered for 15 years. What if he throws me out?

***Technique* 10 - Assessing possible consequences in immediate future**

Counsellor: Reena, you feel he may ask you to leave the house?

Reena: Didi, not only me, also my children.

Counsellor: Can you tell me in whose name is the house?

Reena: My husband's. But I had also given him so much money, what about all that? I won't leave the house. Where will I go Didi?

Counsellor: Yes Reena. He cannot throw you out of the house even if it is in his name. We can take the help of the police. After all you are still married to him.

Reena: Yes, yes. Tell me more about this.

***Technique* 11 - Giving information about formal redressal procedure**

Counsellor: Ok, tell me Reena. Did the police record your statement in the hospital?

Reena: Yes, they had come and I told them the truth. I said that I consumed kerosene because of my husband's torture. They were asking me 'why are you giving such a statement?' We will give him two slaps; after all it is a family matter. But I said that I want to say only this.

Counsellor: You are really courageous, Reena, because most women out of fear don't give such a statement. Reena, this statement can act as a proof, in the future.

***Technique* 12 - Shift focus to woman's emotional world**

Counsellor: Reena, we have spoken about different issues, but can you share your feelings regarding this marriage, your husband?

Reena: What is there to say Didi? (starts crying)
It's all over . Why did I tolerate so much violence? Because I thought that some day he would improve. But today, he has gone to another woman. He has ruined my life.

Counsellor: You don't deserve to face violence. No one deserves violence. But most of us tolerate it because of different reasons. So much is at stake in a marriage, isn't it?

Reena: That's so true Didi. Abdul was not such a bad person when we married. But after the birth of my second son, he really became violent. I wonder since when he has been seeing this other woman. It is all because of her.

Counsellor: I know that you must be really angry with this other woman; what's her name?

Reena: Shehenaz, she is a bad woman, that's what everyone says. Someone was saying she is married . Maybe she is after Abdul's money. She is young, you know.

***Technique* 13 - Help the woman place the onus**

Counsellor: Reena, I feel that Shehenaz is in an even worse situation. See everyone in the community is calling her a bad woman. To add to it, she doesn't even have the status of a married woman. Tomorrow Abdul may just leave her too.

Reena: Yes, you may be right, but I don't like her. She destroyed my home.

Counsellor: You don't have to like her. Currently your marriage is going through a rough phase, isn't it?

Reena: Yes Didi, I am scared that he may divorce me. I will end my life if any such thing happens. God save us !

Technique 14 - Communicate concern and ask her to seek help in distress.

Counsellor: Reena, I feel very concerned about you. I know that you are living in a very violent marriage. Do you think such a situation may occur again?

Reena: Definitely, he has run away now. He did not even come to the hospital. But once I go home, Abdul will hit me.

Counsellor: Reena, do you fear that he may try to harm you or even kill you or your children?

Reena: Yes, it is quite possible, but he may not harm the children.

***Technique* 15 - Draw a safety plan along with the woman.**

Counsellor: What have you thought in terms of your own safety then? Have such situations occurred in the past?

Reena: Not such a situation. I usually go to my neighbour. But when he is very violent. I just freeze. I take it.

***Technique* 16 - Communicate intensity of violence and encourage help seeking behaviours**

Counsellor: Yes, but now the situation may be more violent, you know that at times we just freeze. But now you need to protect yourself from it. Can you still try to run out or if not then can you shout loudly for help?

Reena: Yes, I think so.

Counsellor: You can ask your elder son to get the neighbour. Is that a possibility?

Reena: Yes, he has done it in the past.

Counsellor: Reena, such difficult and violent situations may occur once we try to negotiate for getting some amount from your husband's salary. But we have to keep this hope, no matter how difficult it is. Always remember that your life is precious. We are concerned about you.

Reena: Yes Didi. I felt better when I read the Urdu pamphlet given to me by the ward nurse. I felt as though there is someone who is concerned about me.

Counsellor: Yes Reena, now you know that you can visit us at Bhabha Hospital anytime between 9.00 a.m and 4 p.m.

This incident has left an impact on your mind but remember that by threatening to commit suicide, you may harm yourself more. So even if such thoughts come to your mind, we can try to overcome those thoughts.

Reena: Yes, yes I have realised it today that Abdul doesn't love me (breaks down). He did not even come to see whether I am dead or alive.

Counsellor: It is painful, but you have already survived a very difficult situation. This phase will also pass.

Reena: Yes Didi, I have to go now. I will call you on the number you have given. I will also get the necessary details about Abdul's job. Bye.

Model Dialogue III

The situation - Shama is a 32-year old woman, who has been following up at the Psychiatry OPD after an attempted suicide. The clinical psychologist referred her to Dilaasa because she said that she was facing marital problems. Shama had consumed Tik 20 (rat killing poison)

Shama: (Breaks down) I want my children. Didi in OPD 20 said that you would help me to get my children. I haven't met them for three weeks.

***Technique* 1 - Expressing concern and empathising with the fact that recalling past history of violence may be painful**

Counsellor: Yes, Shama, we are here to help you. Can you tell me your story from the beginning? I understand that it may be painful to recall the same events. However, it would help me understand the situation and give us available choices on the next step.

Shama: I was brought to the hospital by my parents when I consumed Tik 20. I am with my parents for the past three weeks, my husband threw me out of the house. He has been wanting to marry another woman for a long time. You know I accepted this as my fate. Now he does not even give the children to me. Is that fair? You tell me (breaks down).

***Technique* 2 - Validation of the woman's feelings**

Counsellor: No Shama, you don't deserve to be separated from your children. How old are your children?

Shama: I have three children, one 4 years old, second one is three years old and the youngest is one year old. I told my husband that I would never come in his way but he should return my children to me. Last week, when I went to meet my children, he and his mother beat me. The children were crying and kept calling me. My husband is telling the children that their mother is mad, she cannot look after them. Tell me, what is my fault? Do I look mad? (Widens her eyes.)

***Technique* 3 - Positive reframing of symptoms experienced by the woman**

Counsellor: No Shama, you don't seem 'mad' to me. Can you tell me what the term 'mad' means to you?

Shama: (Appears somewhat relieved) Everyone says that I keep crying all the time. Since my second marriage, I have been unhappier. Whenever he and my mother in law (m-i-l) scream at me, hit me or starve me, I cry a lot. But they always tell everyone else that I cry without reason; that I am 'mental'. I was not allowed to talk to the neighbours, so everyone believes them (long pause).
Didi, I still wanted to live there because I had to make this marriage work. It must all be my fault. My first husband died of alcoholism; my father says that I must be 'Manhus' (one who brings bad omen).

Counsellor: Shama, You said that your first husband died of alcoholism. Can you tell me more about your first marriage?

Shama: My first husband used to drink a lot and beat me. I have a son from him. He is a little 'mental'. So he stays with my parents. He is 10 years old. He doesn't go to school; he sits in a corner all day and doesn't talk to anyone. He has to be given a bath and fed. Whatever he is, I love this child too.

***Technique* 4 - Reducing self-blame by sharing that domestic violence is related to an oppressive social structure. Helping her understand that facing violence is not her fault.**

Counsellor: You have faced a lot in the past years, Shama. It seems like you always think that something is wrong with you, but that is not true. Your first husband died because of his own habits, how could you blame yourself for it? Now your second husband is being so violent but you still lived with him because you thought that it was only your responsibility to make this marriage work, is it not?

Shama: Yes. (Throws her hands in a state of helplessness) Didi, now everyone will blame me, because this is the second marriage that has failed.

Counsellor: I would like to tell you that most of us women always think that it is our sole responsibility to make a marriage work, but that is not true. A marriage works when both people are interested in holding it together, both love each other and give space to another person's views. Tell me how can it work, when he has made no attempt at all? On the contrary, you said that he wants to marry again.

Shama: (Makes direct eye contact) He and his family are only interested in money, I have heard people say that his first wife left him for another man, but now I think there may be another reason to it.

***Technique* 5 - Expressing solidarity and sharing concerns**

Counsellor: We at Dilaasa talk to women who are facing any type of violence at home. This is your space, Shama, to come and talk freely and unburden yourself. You have suffered a lot and you have a right to be happy. Now you have to stand up for yourself and we will support you in whatever decisions you make.

Shama: I will be happy when I get all my children back. What shall I do? (Seems desperate to get the children back and wants to know a quick way of retrieving her children.)

***Technique* 6 - Sensitive probing about the suicide attempt**

Counsellor: Shama, we are concerned about your children and you. Can you tell me what prompted you to end your life?

Shama: When he and my MIL hit me, they said that they would take me to court and prove that I am mad and never give my children back. (Looks at the floor, seems a bit hesitant to reveal but finally shares her thoughts.) What was I to do? I thought what is

the point of living - no one cares for me, when my children grow up they will hate me. I cannot live in my parental house all my life so I thought it is better to die.

***Technique* 7 - Ask open-ended questions about woman's feelings**

Counsellor: How did you feel then?

Shama: I felt very lonely.

Counsellor: Many of us facing violence feel lonely, angry and/or resentful. Such feelings can push a person towards such an attempt. However, we have to stop these thoughts if we have to move ahead in life, right? Taking such a step can have many health consequences, which do not seem obvious to us. Some of them are loss of eyesight, paralysis and many more. I do not mean to scare you Shama, but most people are not aware of these consequences. You were fortunate to receive immediate medical care. This means that you are given another chance, right?

***Technique* 8 - Linking health consequences to suicide attempt**

Shama: Yes, when I came to the hospital, I was very dizzy. I kept thinking why did I do such a thing, what if I never get to see my children? I know I should have not done such a thing. (Slaps her own face as if punishing herself for the act.)

Counsellor: Shama, please don't blame yourself, when some situations in life are unbearable, we feel that ending our life is the only solution, but we have to learn from this experience, is it not? What statement did you give to the police?

Shama: I told them the truth that I had no hope left as my husband had abandoned me and my children were taken away from me.

***Technique* 9 - Reinforcing positive behaviour**

Counsellor: Shama, that is a very good thing, you know most women fear to give a true statement. Your true statement can be used as evidence if you ever need to approach the court.

Shama: (Her face seems very hopeful about receiving justice from the court) Do we need to go to the court? Can I get my children back? You are my only hope.

***Technique* 10 - Prioritising needs and strategising**

Counsellor: Shama, I can understand how it feels. However, you must know that your son is already with your parents. Now bringing all the three children back from the second husband may put a further strain on your family resources. Your father is quite old.

Shama: (Talks in a determined manner) I will work Didi, I know that I cannot sit at home anymore — I don't want to cause any further burden to my parents.

Counsellor: Shama, we will have to start by making a written police complaint to police station where your husband resides. We should get the youngest child as soon as

possible. If a request is made to the concerned police station, a police constable can accompany you to your marital home and would help you to get your youngest child back.

Shama: Ok, (pauses) but what about the other two children? Can I not bring them back too?

Counsellor: See, it is like this, after you get the youngest child home, you can look for employment. This way you can get more confidence in yourself. By working somewhere, you will also become economically independent and make friends. There is an organisation called 'ABC'. With the help of this organisation, some of our friends have been able to seek work and also make friends. Going there will help you counter feeling of loneliness.

Shama: Yes, but I would like to have all my children back.

Counsellor: I can understand how you feel, but we need to start somewhere. You must not lose heart. After getting the youngest child, you can demand visiting rights to the other two children. Can you come this week with me to the organisation I mentioned? When you leave from here, you need to lodge a written complaint with the police station nearest to your marital home. After that, you can request a police constable to accompany you to get your daughter. You can share with the police that you fear that the marital family may get violent and hence you need a police escort. If the police don't cooperate, call me at *Dilaasa*.

Shama: Yes Didi, can you help me draft the complaint? I will come on Wednesday.

Counsellor: That will be very good.

Follow-up Visit 1
Wednesday

Shama: Namaste, Didi (has come dressed brightly).

Counsellor: Namaste, Shama, you are looking very pretty today.

Shama: (Smiles shyly, hands over the police complaint) My father had come with me to the police station. We showed our hospital papers and got this NC number. However Didi, we were too scared to go and get my daughter. Will you come with us?

Counsellor: Shama, I could come with you. Did you ask for a policeman to escort you?

Shama: We were too scared. We had never been to a police station before this.

Counsellor: I appreciate the fact that you took your father to register an NC immediately. However, it is important to remember that the police system is made for us. Hence a police constable accompanying you may have a far-reaching impact. But if you still want me to come, I could do that.

Shama: I will talk to my father about this?

Counsellor: Have you thought about going to the meeting this week?

Shama: (Seems interested) Yes, we should go.

Visit to 'ABC' (This is an organisation that runs support group meetings. They are conducted by women from the community who are victims themselves. The entire process of participating in such a support group meeting is tremendous for any woman as she is able to connect to other women who have rebuilt their lives in spite of all odds)

Summary of the meeting attended by counsellor and Shama

After reaching the organisation, Shama was feeling too shy to talk, so she sat quietly and observed the entire process of the meeting. The first meeting, Shama shared with the other women her desire to have her children back. She was told that her husband could be called for a joint meeting for discussing the issue of children. If he did not comply, then on Shama's next visit, some of the women would go along with her to get the youngest daughter back. They also spoke to her about the need to be financially independent. Some women shared their own stories; one of them asked Shama, why do you want your children back? I spent all my life for both the sons, but they don't even value it. My husband left me when I was very young, but I never remarried thinking of my children. But see where I am today. Both my sons blame me for having not made an effort to save my marriage. None of them want me as both are married. The woman broke down and actually Shama was trying to console her. From then on, Shama's journey to building her life began.

Shama's current status

She took the initiative of going for the weekly support group meetings, though she was staying far away. She also found employment at a company close to her natal home. She used to visit Dilaasa once in a while. The counsellor called her almost after six months to arrange a meeting with another woman who was facing similar problems and Shama agreed.

Technique **11 - It is important to connect women who are facing similar problems. This reduces their sense of isolation and gives them an opportunity to play a larger role in tackling domestic violence.**

The counsellor met Shama on Sunday. Shama looked very confident and happy. She shared that she had still not got her children back as her husband refused to give them in the joint meeting. But she had decided to wait a little longer as currently her own parents were harassing her. She had moved out of her parent's house and was staying in a rental accommodation with her mentally challenged son.

Model Dialogue IV

The situation - Heena is a 19-year old girl. She has been married for six months. She comes to the psychiatry department for treatment for depression and panic attacks. She was referred to *Dilaasa.*

Heena has been visiting the centre off and on. Each time there is an episode of violence, she contemplates suicide. This dialogue will essentially look at how to help her prevent any such attempt as well as help her to gain confidence in herself.

Counsellor: Heena, how are you feeling today?

Heena: (Sobbing and shivering) Didi, I don't want to live any more. Every time I try to go to my in-law's place, they drive me away calling me mad. They also tell Kabir that I lied to him about my ailment. My parents don't want me, Kabir does not want me, I want to die. Doctor does not give me medicines to sleep either. What is the use of such life?

***Technique* 1 - Positive reframing of symptoms**

Counsellor: You have to believe that you are not 'mad'. When you have worked too much or when you are physically ill, you need to take medicines, you agree right? But when our minds work overtime or they are overloaded with fear, of being hit, ridiculed, and left alone, we become restless and scared. When we are scared we think all the time and our mind does not get any rest. Medication temporarily helps the mind get some rest.

Heena: Yes, I think all the time, I also cry all the time, see, I just cannot stop my tears, I feel as if I have no control on what is happening? (Makes eye contact, tears run down her cheeks)

Counsellor: (Gently holds her hand, offers tea.)

Heena: (Protests weakly but is finally convinced that having some tea will make her feel better.)

Counsellor: Heena, crying is not a sign of weakness. When we feel that everything is out of our control, we feel like crying. But excessive crying cannot finally lead us anywhere. You have a right to cry and share your feelings, but after that you also need to recognise your inner strength. There is a strong woman within you Heena that we need to bring out.
Heena: yes, (irritated) But why the doctor does not give me medicines to sleep? Each time, they say that I should get Kabir. . . but he will never come.

***Technique* 2 - Explaining side effects of over dependency on medication**

Counsellor: I can understand that but how long can you take medication? If you have fever, you have to take the medicines for a specified time, after that you still may feel weak, for which you need enough rest and healthy food. Similarly, these medicines will provide temporary relief. Overuse of the medicines will make you feel sluggish, sleepy, constipated.

Heena: Yes, I feel very sleepy, if I don't sleep then I think all the time, should I end my life? I don't want to live any more, I want to live with Kabir, please help me.

***Technique* 3 - Asking the women to recall facts that may be painful but will help her get clarity about her relationship.**

Counsellor: I know that you love Kabir a lot, but Heena, he needs to take a stand now. What are your feelings regarding the fact that he has not come to see you for the past two months? You have been living in your natal home since then?

Heena: (No eye contact, shifting in her chair) Ya, I tried going once or twice, but he said that I should not meet him at his workplace, as his mother would come to know. Some times, I wonder whether he loves me any more. Didi, I never kept him in dark, the day he proposed marriage to me, I told him that I have to take medication for my illness, and then he had spoken so sweetly to me. I swear I did not lie to him.

Counsellor: Does he know why you are taking medicines?

Heena: I told him that since my sister died I had undergone a shock. To control feelings of depression, I am taking medicines. However, my mother-in-law does not allow me to take medicines (imitates her m-i-l). My hands tremble, I shake and shiver. That is it, then she starts telling Kabir, did I not tell you that she is mad?

***Technique* 4 - Helping the woman reconnect with life**

Counsellor: See, Heena, before talking to anyone, you need to tell yourself that you can live without medication and I am sure that you can. You need to gradually start reducing your dependency on those medicines; did Didi at the psychiatric department tell you the same. Do you think going to work will engage you in another activity and reduce the same thoughts for a while?

Heena: Maybe (seems impatient) but how will that help me to live with Kabir? My parents will not keep me any longer; my-mother-in law does not want me back, what will happen to me?

***Technique* 5 - Helping the woman prioritise her problems**

Counsellor: There are many problems in our life; we have to approach each of them one by one. Your priority is that you do not become shelterless and secondly you want to live with your husband right?

Heena: Yes Didi, very true.

Counsellor: We can try to talk to your father about staying longer in the natal home. What do you think?

Heena: OK, but I am not sure. Maybe calling my father to the centre may help.

Counsellor: You could also talk to your past employer to help you get some job. If you become financially independent, your natal family will feel less burdened.

Heena: That seems like a good idea, but convincing my father would be tough. When can I bring him here?

***Technique* 6 - Preparing the woman for joint meeting**

Counsellor: First we would have to decide what are the points that you would like to discuss. You can tell me when is the earliest that you can call him?

Heena: Yes and what about Kabir?

Counsellor: Heena, we have tried calling Kabir for joint meetings in the past.

Heena: (Interrupts) Yes, but he refused to come here. Could we try one more time?

***Technique* 7 - Preparing the woman for consequences**

Counsellor: We could send him a letter for a joint meeting. But if he does not come, what does it indicate?

Heena: There aren't any options, there are times I think he wants to divorce me, (cries again).

Counsellor: Yes his refusal to participate in the joint meetings does indicate a lack of interest in the relationship. You have the courage to face this reality.

Heena: Yes, I at least have support from the centre, otherwise what would I have done?

***Technique* 8 - Safety assessment**

Counsellor: Thoughts of divorce, separation, etc, may make you think that life is not worth living. You have to overcome these feelings. I am concerned about you.

Heena: Yes, Didi, I don't want to die, those are moments I feel. . . helpless.

Counsellor: Yes, there are such moments in our lives, but we need to counter them right. When you feel depressed call us. If you cannot come to the centre just leave the house and walk for a while or talk to your neighbours. This will help you calm down. Remember that your life is precious.

Heena: I feel better after talking to you. Can we write the points for discussion tomorrow? I have to go home now. My mother would be worried.

Counsellor: Yes, we will talk more tomorrow; remember all that we talked about today.

Heena: Bye.

VII. LOCATING THE SYSTEM'S ROLE IN SUICIDE PREVENTION

Observations

Any public health set-up has to deal with patients who are admitted due to attempted suicide. While treating the patient of attempted suicide the public health system is touching a patient's life on many different levels during the course of treatment. Though it is doing the utmost, given all the constraints within the public health system, there is always scope to expand and improve these services.

On an average two to three women get admitted for attempted suicide. While there is a routine procedure to address the problem, some exceptions need to be taken care of depending on the specific need of the case.

In one case, a woman took poison and fed the same to her two infants. In another, three sisters from the same family were admitted to the hospital at different times with attempted suicide. One woman was admitted with a repeated attempt of suicide.

In one case, a woman approached *Dilaasa* to get her daughter's hospital record when she was treated for complaints arising out of domestic violence. Her daughter came to OPD for gynaecological problems. She revealed domestic violence. She committed suicide in her marital home in Madhya Pradesh five months after she took treatment. The daughter was married for 8 years and was facing violence. Her case papers recorded the history of assault. But MLC was not done. On enquiry at the hospital, it was told that MLC is done only when the patient wants. The police station of MP had asked for proper medical record. Later, an injury certificate was issued by the hospital. However, the MLC would have made difference in this case. Another important link was the much-needed referral to *Dilaasa* for the woman. An opportunity to save the life was lost. All these attempts required a different approach. All the women who report domestic violence can be given the option by the health service givers of seeking support if she desires. If this procedure gets routinised many lives could be saved.

Existing procedures

Patient of attempted suicide- 'Cases of accidental poisoning' comes to the casualty

↓

Medico legal case is registered by the doctor

↓

Police constable on duty is informed

↓

Admitted in Medical ward/ ICU

↓

Medical treatment provided

↓

Psychiatric evaluation done and drugs provided

↓

Follow up for psychological testing and drugs

At casualty and medical ward health service givers can help a lot by being gentle and empathetic. The patients, who are almost on the verge of destitution, need a good meal before anything else to prop up their spirits after the routine stomach wash, etc. Recording of statements and medico legal case should be done with sensitivity. When the women name the perpetrator and come out with causes, they should be helped in terms of getting a copy of the statement that is recorded at the hospital. This will go a long way if the woman wants to take any action against the perpetrators. Suicide must be decriminalised and should be seen as a cry for help and not a crime.

Often women come to the Out Patient Department (OPD) or casualty for treatment of health complaints arising out of domestic violence. The health care giver only treats the patient for the physical complaints without providing any emotional support or referral. Women therefore go back to the violent situation and the violence in their lives remains unquestioned and their vulnerability increases. Sometimes they come back to the hospitals after attempting suicide. At *Dilaasa*, we have documented such cases. All this shows how important it is to take domestic violence seriously to prevent suicide/attempted suicide. An opportunity to save the life should never be lost.

All the cases of suspected violence get registered as MLC when they seek medical intervention. The cases of assaults, falls, attempted suicide, burns, sexual violence and accidents are registered as MLC. The affected women may not have any idea of this procedure. It is essential on the part of the health service givers to explain the procedure of MLC. Often MLC is done as a routine and the patients are not informed/explained about it. When they are approached by the police of the respective area police station, they are supposed to give the statement. At this point, she is forced to hide the truth if it is domestic violence.

All patients of attempted suicide are referred to the psychiatry department. At present, psychiatry department is called 'Manovikruti Vibhag' which needs to be changed to 'Manasopchar Vibhag'. The name itself gives wrong message to the patient. All patients do not have 'deviated/perverted minds' as the name indicates. They are far from it. All patients who have temporarily lost their capacity to cope with the stress are to be treated and restored to their normal coping mechanism. This name needs to be changed on urgent basis to give correct message to the patients who need it most.

The public health structure can devise support systems other than psychiatric drugs and psychotherapy. Setting up a support group could be one such device. This will address the social dimension of individual failures of coping mechanism. They also evolve a referral system where the patients could be referred for further support, which is needed most. Amongst the referral they can include women's groups, youth groups, community groups apart from the other specialised referral that would be required. Basically, the patient needs long-term support and that can be ensured in a variety of ways.

Recommendations

- Based on our observation and experience, the most important step that needs to be taken is sensitisation/training of all involved in caring for any patient reporting accidental/suicidal consumption of poison/tablets. They need to be sensitised to the complex issue of suicide so that they are able to play the role of carer and get out of the victim blaming approach. (Such patients are seen as a burden and nuisance). Unless the attitude towards this entire issue is changed, the changes in procedures would have a limited impact.

- While there exists a procedure for providing care to the patients of attempted suicide, there is a need to review the existing procedure in order to understand ways of strengthening it further and making it more relevant and effective for women. This would essentially mean change in procedures and services provided. For example, there exists a psychiatric referral in the existing procedure, wherein psychiatric evaluation is done and drugs given for a period of seven days. There needs to be coordination with the social worker. At the hospital, there is an opportunity to involve the family members both perpetrators and supporters in caring for the woman. Patients reveal the truth to the psychiatric department and social worker. There should be a method by which this information is used for the benefit of the woman.

Essentially, there is a need for a multidisciplinary approach in providing treatment and care.

- In all cases of attempted suicide our concern is with prevention of another attempt. Preventive level work in the form of support groups for women who have attempted suicide should be undertaken by hospitals.

- The community health workers should be sensitised to this issue so that they can talk to the women in the community about available services and refer them accordingly.
- Often patients do not reveal the actual reason for the attempt at the casualty department. It is almost always reported and recorded as 'accidental'. There are various clues by which the doctor can distinguish between accidental and deliberate attempt. The doctors must record his/her observations. It is important to understand this, as it is crucial in order to provide comprehensive care to patients.

- In all cases, the police record a detailed statement from the patient. A copy of this should be made available to the patients.

- The role of the health care providers must be that of providing referrals, support and treatment. The decision to seek formal redressal should rest with the woman only. At no point any compulsion or pressure should be exerted.

IT IS POSSIBLE – WE CAN DO IT !

The Public Health system gives all of us an opportunity to reach out to those who need help when they are recovering from the consequences of attempted suicide. Suicide prevention is an uphill task. It requires concerted efforts on multiple levels. It has to begin somewhere in the arena of Public Health. *Dilaasa* is committed to reach out to the women by providing the much needed relevant counselling aimed at increasing self worth in them. There is a great potential to share the responsibility to save lives that may be at stake. We can all increase the potential and contribute our bit in the ongoing process to address this issue. Let us together strengthen the process of CHOOSING TO LIVE!

JIG-SAW PUZZLE

Breasts bruised, brains battered,
Skin scarred, soul shattered,
Can't scream – neighbours stare,
Cry for help, no one's there.

In the intervening silences,
I gather up the jagged fragments,
Try to re-arrange them into some semblance of
The jig-saw puzzle I once called 'me'

In the vacant voids, I finally see
I'll be lost forever, chasing isolated
Pieces of fantasy, unless I go out to
Find new pieces of another 'me'

I see you've got some fragments too,
If we put them together, can we start anew
There are lots of pieces everywhere,
But the picture we make is one we'll share.

- By Neena Nehru

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APPENDIX I

The *Dilaasa* Crisis Centre for Women is the first hospital-based crisis centre in India designed to respond to the needs of women facing violence within their homes and families. The Centre is a joint initiative of the Public Health Department of the Brihanmumbai Municipal Corporation (BMC) and the Centre for Enquiry into Health and Allied Themes (CEHAT)[3], a Mumbai-based multidisciplinary non-governmental institution promoting and supporting socially relevant health and related research, action, services, and advocacy.

The BMC provides health care services in the city of Mumbai, which has a population of 119 lakhs. The Public Health Department of the BMC is structured by a three-tier system—the tertiary level consists of three major hospitals and one dental hospital; the secondary level consists of 16 peripheral general hospitals and 5 specialty hospitals; and the primary level encompasses 23 maternity homes, more than 2,000 dispensaries, and 212 health posts.

The partnership between the NGO and the GO is the first attempt in India to sensitise the public health system to domestic violence through the establishment of a public hospital based crisis centre. The goals of this partnership were to (1) institutionalise domestic violence—and more broadly, violence against women—as a legitimate and critical public health concern within the government hospital system, and (2) building the capacity of hospital staff and systems to adequately, sensitively, and appropriately respond to the health needs of domestic violence victims and survivors.

Dilaasa is located in K B Bhabha Hospital, which is a peripheral general hospital of the BMC. The groundwork on the *Dilaasa* project began in August 2000 and the training of trainers programme was inaugurated in October 2000. The counselling centre has been providing counselling, social support, and referral services to women victims and survivors of domestic violence since March 2001. In addition to responding to the urgent needs of women facing domestic violence, the Centre also engages in training and awareness-building activities. *Dilaasa*'s work can be broadly categorised into the following three areas—service provision, training, documentation and research.

[3] CEHAT is a research centre of the Anusandhan Trust.

APPENDIX II

Pamphlet that can be read out to the woman

YOUR LIFE IS VERY PRECIOUS. CHOOSE TO LIVE.

There are moments in your life where you feel unwanted and unloved. The situation seems to have no solutions and circumstances no alternatives. The thought of ending your life may overtake you like these women who shared their pain.

Bright-eyed but exhausted
Lata, 19, said, “The constant fighting
with my parents and brother was
because they were opposed to my friendship with a young man.
One day when the verbal abuse escalated into physical beatings,
I could stand it no longer and
swallowed phenyl.”

Newly married 20-year-old
Kavita also suffered severe physical violence from her in-laws.
‘My husband never stood up
for me. This made me feel
unwanted and useless.
Ending my life seemed the
only way out.”

Young mother Noora, 23, said,
“I was deeply disturbed by my husband’s indifference and
unwillingness to provide
for our ailing 2-year-old daughter.
When he lost his job he turned violent
against me. My patience and endurance
ran out. I was pushed to the brink.”

The consequences of suicide attempt can be worse. It could have a long-term impact on your health, which will make your life more miserable. And it is a crime in the eyes of law.

But all of them were pulled back from the brink of destruction. Now they appreciate their second chance to live and hope to make the most of it. Listen to them.

"Today I see how wrong I was", said Lata. "My life is valuable" she added.

Kavita while attributing the process of recovery to her parents' support said, "Negative emotions had overtaken me. Now I know, I have to struggle to overcome them and support myself."

"Timely medical care has saved me. Now I realise I have to live for my daughter and look after her. You have given me the courage to go on", said Noora.

Whatever the crisis in your life—whether it is a shortage of money, an abusive husband or in-laws, uncaring children, or any other similar problem. The difficult situation that you are in is not entirely your responsibility. There are always some alternatives. Depending on your situation some are possible and some are not.

REMEMBER THIS: No situation is hopeless. Negative emotions can be rechannelised. Coping skills can be restored and strengthened. Your confidence in yourself will return. Like these women, you too can find renewed meaning in life. In fact, you have already been struggling to overcome it courageously and alone.
But now you are not alone. We are here for you.

TALK TO US. CALL US. VISIT US.
YOUR LIFE IS VERY PRECIOUS. CHOOSE TO LIVE.

Dilaasa: Dept. No. 101, K.B. Bhabha Hospital, Bandra (W), Mumbai - 400 050.
Ph.: 26400229 (Direct) l 26422775 l 26422541 Extn. 4376 / 4511

At Dilaasa, we found that reading out this pamphlet to women was quite effective both for helping her open up, build trust and seek support. Considering the diversities in the profile of the women, relevant material for communication could be devised.

APPENDIX III
List of helplines offering suicide prevention counseling

In Mumbai

Aasra
A-4, Tanwar View,
CHS Plot – 43,
Sector – 7, Koparkhairane,
New Mumbai – 400 701.
Helpline: 27546669
Time: 3.00 p.m. to 9.00 p.m. All days

IPH
Apte Hospital, 1st Floor,
Ram Maruti Road,
Cross lane – 1, Navpada,
Thane (W) – 400 602.
Helpline: 25385447
Time: 9.00 a.m. to 9.00 p.m. Mon-Sat
9.00 a.m. to 1.00 p.m. Sun

The Samaritans
C/10, Sevaniketan,
Sir J.J. Road, Byculla,
Mumbai – 400 008.
Helpline: 23073451
Time : 3.00 a.m. to 9.00 p.m. Mon-Fri
10.00 a.m. to 9.00 p.m. Sat-Sun

Outside Mumbai

Health Dialogue
P.B. No. 1512,
Medical College (PO),
Kohikode – 673 008.
Helpline: 0495-2353453
Time: 9.00 a.m. to 5.00 p.m. Mon-Sat

Lifeline Foundation
17/1A Alipore Road
P.O. Box 9455,
KOLKATA **-** 700 016.
Helpline: 33-2474 5255 / 2474 5886 Time : 10.00 a.m. to 6.00 p.m. All days

Maitreyi
255 Thiyagumudiliyar Street
Pondicherry – 605 001.
Helpline: 0413-2339999
Time : 2.00 p.m. to 8.00 p.m. All Days

Maithri
Vimalayam Building,
Ashir Bhavan,
Kacheripady, Kochi – 682 018, Kerala.
Helpline: 0484-2396272
Time: 10.00 a.m. to 8.00 p.m. All days

Roshni
1-8-303/48/21,
Kalavathy Nivas,
Sindhi Colony,
Secunderabad – 500 003.
Helpline: 040-55202000
Time: Mon-Sat 11.00 a.m. to 9.00 p.m.

Sanjivani Society for Mental health
Satsangh Bihar Marg,
A-6, Qutab institutional area,
New Delhi – 67.
Helpline: 011-26864488
Time: 10.00 a.m. to 5.00 p.m. Mon-Fri
10.00 a.m. to 2.00 p.m. Sat
Helpline: 011 – 24311918
Time: 10.00 a.m. to 7.30 p.m. Mon-Sat

Saath (Suicide Prevention Centre)
B-12, Nilamber Complex, 1st Floor,
H L Commerce College Road,
Navrangpura,
Ahmedabad – 380 009.
Helpline: 079 – 26305544 / 26300222
Time : 1.00 p.m. to 7.00 p.m. All days

Sneha
No. 7 Besant Road
Royapettah
CHENNAI **-** 600 014.
Helpline: 044-2835 2345
Time : 8.00 a.m. to 10.00 p.m. All days

Vishwas
203, Surag Plaza,
196/8, 8-F Main, 3rd Block,
Jayanagar, Banglore – 560 011.
Helpline: 080-26632126
Time : 5.30 p.m. to 7.30 p.m. Mon-Wed
10.00 a.m. to 12.30 p.m. Friday

APPENDIX IV
List of organisations offering counselling for domestic violence survivors

Aarohi
Opp. Dental OPD, OPD No. 23,
Chatrapati Shivaji Maharaj Hospital,
Thane – Belapur Rd.,
Kalva – (W).
Phone : 25403813, 25402624

Awaaz-e-niswan
84, Samuel Street, Pala Galli,
1st Floor, Jain High School,
Dongari,
Mumbai – 400 009.
Phone: 23439421, 23466976

Brihanmumbai District, Suburban Legal Service Authorities
Highpick apartment,
Old Bandra court building,
S.V. Road,
Bandra (W),
Mumbai – 400 050.
Phone : 26401240, 26402175

CORO for Literacy
Shell Colony Road,
Opp. Ganesh Mandir,
Chembur,
Mumbai – 400 071.
Phone : 56245240
Time : 11.00 a.m. to 5.30 p.m.
Thursday, Friday & Saturday

Dilaasa
Department No. 101,
K.B. Bhabha Hospital,
Opp. Casualty Dept.,
R.K. Patkar Marg,
Bandra (W), Mumbai – 400 050.
Phone : 26400229, 26422775, 26422541 Extn. 4376, 4511

Stree Mukti Sanghatna
Family Counselling Centre,
Near Matoshri Ramabai Ambedkar Marternity Home,
Ramkrishna Chemburkar Road,
Chembur Naka, Mumbai - 400 071.
Phone : 25297198

Swadhar
Keshav Gore Smaarak Thrust, Arye Rd.,
Goregoan (W), Mumbai – 400 062.
Phone : 28720638

Women Centre
104, Sunrise Apartment,
Nehru Road, Vakola,
Santacruz (E), Mumbai – 400 055.
Phone : 26680403

WRAG
101, Jaitun villa, Vakola Market,
Santacruz (E), Mumbai – 400 055.
Phone : 26672015, 26673799

Dilaasa**,** in hindi means reassurance. *Dilaasa* is a public hospital based crisis centre for women survivors of domestic violence. It provides social and psychological support to women facing domestic violence. Training, research and advocacy are other core activities of the centre.

It is a joint initiative of CEHAT and the Public Health Department - K.B. Bhabha Hospital, Bandra (W).

Cehat

CEHAT, is the research centre of Anusandhan Trust established in the year 1994, stands for research, action, service and advocacy in health and allied themes. Socially relevant and rigorous academic health research and action at CEHAT is for the well being of the disadvantaged masses for strengthening people's health movements and for realizing right to health care.

K. B. BHABHA HOSPITAL

K.B. BHABHA HOSPITAL, Bandra is a 436 bedded, well equipped peripheral hospital with all major clinical departments and is centrally located in the Western Suburb, "H" ward office of Bandra (W), Mumbai.

ABOUT THIS DOCUMENT....

The guidelines on suicide prevention counselling are an attempt to have a concise document that is easy to read. It provides an understanding on suicides as well as practical guidelines on various techniques needed for counselling someone who has attempted suicide. It provides information on causes/reasons of suicide to efforts made to help people attempting suicide. This booklet would be helpful to any person who is socially conscious and wants to reach out to a person who has survived an attempt of suicide.