INTIMATE PARTNER VIOLENCE AGAINST WOMEN: PERCEPTIONS ACROSS GENDER IN AIZAWL CITY

CATHERINE LIANHMINGTHANGI

DEPARTMENT OF SOCIAL WORK

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INTIMATE PARTNER VIOLENCE AGAINST WOMEN: PERCEPTIONS ACROSS GENDER IN AIZAWL CITY

Catherine Lianhmingthangi

Department of Social Work

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DECLARATION

MIZORAM UNIVERSITY

JUNE, 2014

I, Catherine Lianhmingthangi, hereby declare that the subject matter of this dissertation is the record of the work done by me, that the contents of this dissertation did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institution.

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Place: Aizawl, Mizoram

(CATHERINE LIANHMINGTHANGI)

Department of Social Work

Mizoram University, Aizawl- 796004

CERTIFICATE

MIZORAM UNIVERSITY

JUNE, 2014

This is to certify that the dissertation "Intimate Partner Violence Against Women: Perceptions Across Gender in Aizawl City", submitted by Ms Catherine Lianhmingthangi for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporates the student's bonafide research and this has not been submitted for award of any degree in this or any other university or institute of learning.

Date: 30th June 2014

Place: Aizawl, Mizoram

(KANAGARAJ EASWARAN)
Head
Department of Social Work
Mizoram University, Aizawl

(KALPANA SARATHY)
Research Supervisor
Associate Professor
Department of Social Work
Mizoram University, Aizawl

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LIST OF ABBREVIATIONS

APL	**Above Poverty Line**
ATM	**Automatic Teller Machine**
BPL	**Below Poverty Line**
CCV	**Common couple violence**
CDC	**Centers for Disease Control and Prevention**
DV	**Domestic Violence**
ED	**Emergency Departments**
GYN	**Gynaecological**
IPV	**Intimate Partner Violence**
IT	**Intimate terrorism**
NCRB	**National Crime Records Bureau**
NCVS	**National Crime Victimization Survey**
NFHS	**National Family Health Survey**
NGO	**Non Governmental Organization**
NVAWS	**National Violence Against Women Survey**
PTSD	**Post Traumatic Stress Disorder**
PWDVA	**Protection of Women from Domestic Violence Act**
RO	**Restraining Order**

UN	**United Nations**
VR:	**Violent resistance**

CHAPTER I

INTRODUCTION

This study attempts to explore the perceptions of Intimate Partner Violence across gender in Aizawl and to understand the social support available for the victims of Intimate Partner Violence.

1.1 Concept of Violence

According to Platform of Action 1995, World Women's Conference, Beijing 1995 *Violence against women is a manifestation of the historically unequal power relations between men and women,* which have led to domination over and discrimination against women by men and to the prevention of women's full advancement. (North East Network 2004).

The United Nations Declaration on the Elimination of Violence against Women (1994) defines violence against women as ‘‘*any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life’’.* (Nussbaum, M.C. 2005).

Domestic violence is serious and pernicious. It ruins lives, breaks up families and has a lasting impact. It is criminal. It has been with us for a very long time. Yet it is only in the last ten years that it has been taken seriously as a criminal justice issue. Before that, the vast majority of cases were brushed under the carpet with the refrain ‘it's just a domestic'. In the year 2002, there were an estimated 1.6 million deaths due to violence throughout the world. This was around half the number of deaths due to HIV/AIDS. (Mercy,J. A., Butchart, A., Rosenberg ,L. R., Dahlberg, L. & Harvey, H, 2008).

Domestic violence as defined by Comnet is *'physical abuse or threats of physical abuse by an adult family or household member against another adult family or household member'*. This definition can be expanded to include violence in intimate relationships where the partners never lived together. It includes physical, emotional and sexual battering as well as destruction of property and pets. Domestic violence can also take the form of 'controlling behavior to maintain an imbalance of power between an abuser and a battered woman, including any act that causes the victim to do something she does not want to do, prevents her from doing something she wants to do, or causes her to be afraid. The United States Department Of Justice statistics show that 'a woman is beaten every 15 seconds' and 'domestic violence is the leading cause of injury to women between ages 15 and 44 in the United States—more than car accidents, muggings, and rapes combined'. (Miller, C. E., & Mullins, B. K., 2002).

Intimate Partner Violence (IPV) is a common, serious, and preventable public health problem. *IPV includes psychological, physical or sexual harm by a current or former partner or spouse. It occurs between married and unmarried couples.* In defining IPV, the centers for Disease Control and Prevention (CDC) includes the following forms of violence:

1.1.1 *Psychological/Emotional Violence*: This involves trauma to a victim caused by acts, threats of acts, or coercive tactics.

1.1.2 *Psychological/Emotional abuse:* This can include, but is not limited to, humiliating a victim, controlling what a victim can and cannot do, withholding information from a victim, deliberately doing something to make a victim feel diminished

or embarrasses, isolating a victim from friends and family, and denying a victim accessed to money or other basic resources.

1.1.3 *Physical Violence*: This is the intentional use of physical force with the potential for causing disability, injury, harm, or death. Physical violence includes, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, strangulating, shaking, Slapping, punching, burning, using a weapon, and using restrains or one's body, size or strengths against another person.

1.1.4 *Sexual Violence:* This is divided into three categories: (i) Use of physical force to compel a person to engage in sexual acts against his or her will whether or not the act is completed: (ii) attempted or completed sex act involving a person unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in sexual; act (eg because of illness, disability, or the influence of alcohol or other drugs or because of intimidation or pressure): and (iii) abusive sexual contact.

Intimate Partner Violence (IPV), is a pattern of behavior which involves the abuse by one partner against another in an intimate relationship such as marriage, cohabitation, dating or within the family. "Pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner". Intimate Partner Violence 'can happen to anyone regardless of race, age, sexual orientation, religion or gender'', and it can take many forms including physical abuse, sexual abuse, emotional, economic, and psychological abuse. (en.wikipedia.org/../Domestic_Violence)

CHAPTER II

REVIEW OF LITERATURE

It is important to review literature in the area of research as it indicates the relevant and significant dimensions to a problem and guides the study. In this chapter the review is related to Concepts of Violence, nature, causes, types, consequences of intimate partner violence. Attempt has been made to document empirical studies that have been conducted across the world in relation to intimate partner violence.

2.1 Intimate Partner Violence

One of the most common forms of violence against women is that performed by a husband or an intimate male partner. The fact that women are often emotionally involved with and economically dependent on those who victimize them has major implications for both the dynamics of abuse and the approaches to dealing with it. Women's organizations around the world have long drawn attention to violence against women, and to intimate partner violence in particular. Through their efforts, violence against women has now become an issue of international concern. Initially viewed largely as a human rights issue, *partner violence* is increasingly seen as an important public health problem. (L Heise,nd).

Intimate partner violence (IPV) is a common, serious, and preventable public health problem. IPV includes psychological, physical, or sexual harm by a current or former partner or spouse. It occurs between married and unmarried couples and between heterosexual and same-sex couples. In defining IPV, the Centers for Disease Control and Prevention (CDC) includes the following forms of violence in its definition of IPV:

2.1.1 Psychological/emotional violence: This involves trauma to a victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse includes, but is not limited to, humiliating a victim, controlling what a victim can and cannot do,

withholding information from a victim, deliberately doing something to make a victim feel diminished or embarrassed, isolating a victim from friends and family, and denying a victim access to money or other basic resources.

2.1.2 Physical violence: This is the intentional use of physical force with the potential for causing disability, injury, harm, or death. Physical violence includes, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, strangulating, shaking, slapping, punching, burning, using a weapon, and using restraints or one's body, size, or strength against another person.

2.1.3 Sexual violence: This is divided into three categories: (1) use of physical force to compel a person to engage in a sexual act against his or her will whether or not the act is completed; (2) attempted or completed sex act involving a person unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (eg, because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure); and (3) abusive sexual contact. (Zolotor J A, Amy C. Denham, Amy Weil nd).

Domestic violence occurs between and among all population groups, including children, adults and elders. According to Gelles, it may encompass actions which range from a meaningful facial expression used to control a person to physical or sexual contact and, at the most extreme, incorporates injury and murder. Quoting Barnett and La Violette rarely does one form of domestic violence occur in isolation. Walker says that Emotional abuse typically occurs more frequently than physical abuse. However, Crowell and Burgess &Tjaden and Thoennes added that researchers usually limit their operational

definitions of violence and their population to either child, adult, or elder groups. Quoting Barnett and LaViolette, within a selected population group, researchers more specifically define actions to include those that are threatening – such as verbal threats, the destroying of prized possessions or objects, the injuring of family pets, or the monitoring or limiting of victim activity – and those that cause physical injury (such as injuring with an object or direct physical assault). Gelles refined typologies of violence to include those that are within the 'normal' range used within families as a part of child-rearing or spouse interactions and those that could be considered 'abusive'.(In Scott & Kunselman,2007).

Violence against women is now widely recognized as a serious human rights abuse, and increasingly as an important public health problem with substantial consequences for women's physical, mental, sexual, and reproductive health. This recognition was strengthened by agreements at key international conferences during the 1990s, including the Fourth World Conference on Women. Its Platform for Action identified the scarcity of adequate information on the prevalence, nature, causes, and consequences of violence worldwide, as a serious obstacle to the wider recognition of the magnitude and seriousness of the issue, and the development of effective intervention strategies. (Moreno C G, Jansen H, Ellsberg M, Heise L, Watts C 2006).

Intimate partner violence, which describes physical or sexual assault, or both, of a spouse or sexual intimate, is a common health care issue. In review of US and Canadian population-based surveys during 1985-98, between 8 and 15% of women of all ages reported physical assault in the previous year by a husband, boyfriend, or ex partner, the lifetime prevalence was 25 and 30%. (Schafer J,Caetano, L Catherine,1998).

Studies conducted reveal that between 10% and 26% of women experience rape in marriage. Rape also occurs in non-marital intimate relationships. Goetz and Shackelford secured prevalence estimates of rape in intimate relationships from a sample of young men and from an independent sample of young women in a committed relationship. They documented that 7.3% of men admitted to raping their current partner at least once, and 9.1% of women admitted that they had experienced at least one rape by their current partner. (In Goetz, A.T., Shackelford, T.K., Starratt,V. and Mckibbin, W.F., 2008).

Population-based estimates demonstrate that 32 million Americans have been affected by IPV. The prevalence and incidence of IPV can be measured on a continuum from rare events, such as death, to more common events, such as self- reported pushing, slapping, and intimidation. It also is useful to consider how this pervasive phenomenon affects clinical practice. The ecologic model of IPV considers IPV a result of a complex set of circumstances from risk factors that occur at the level of the victim, the perpetrator, their relationship, the family, the community, and society. Risk factors at the level of individual victims include women gender, young age, history of IPV, history of sexual assault, history of child abuse victimization, heavy alcohol or drug use, unemployment, depression, and racial or ethnic minority status. Relationship level risk factors include income or educational disparity and male control of relationship (eg, psychologic or economic). Community level risk factors include poverty, poor social cohesion, and weak sanctions, including minimal legal penalties or rare successful prosecutions. Societal level risk factors include traditional gender norms and general acceptance of violence for conflict resolution. (Zolotor J A, Amy C. Denham, Amy Weil nd).

Violence against women is a significant health problem that has both short and long term physical and mental health consequences for women and their families. Women experiencing Intimate Partner Violence use a disproportionate share of health care services, making more visits to emergency departments, primary care facilities and mental health agencies than non abused women. Substance abuse and violence in the woman's family of origin were the strongest correlates of intimate partner violence, including psychological battering or emotional abuse without physical or sexual violence. This suggest that current psychological battering or past perceived emotional violence not accompanied (as yet) by physical violence and may result in the same mental and, perhaps, physical health consequences experienced by victim of physical violence. Interventions are needed for this group, as well as for those being physically and/or sexually assaulted, to prevent a range of physical and mental chronic and acute health consequences. Future research is necessary to assess short and long term mental and physical health consequences of intimate partner violence by type and timing, as well as the health care costs of such values. (Coker A, Smith,P.H., McKeown , King, M.J., 2000).

It is well recognized that the battering of women partners is a significant health problem affecting millions of women each year. That survey, however, does not include women battered but not actually living with the abusive intimate partner, those either in a "dating" relationship or having separated from him (or her) and still being abused. Both of those categories also involve significant numbers of battered women. Battering is defined here as repeated physical or sexual assault by an intimate partner within a context of coercive control. The emotional abuse that is almost always part of the coercive

control also has serious psychological consequences according to women themselves, but the actual effects on women's health seldom have been measured separately. (Campbell J, Lewandowski L 2002).

The National Family Violence Surveys of 1975, 1985, and 1992 conducted in the US estimated that nearly *1 in 6 couples had experienced 1 or more episodes of intimate partner violence in the previous year*. Intimate partner violence is especially problematic for women, because 1 in 3 will be assaulted by an intimate male partner during her lifetime. Male-to-women partner violence is more often repeated and is more likely to result in injury and death than women-to-male partner violence. For instance, women are victims of intimate partner homicide at a rate *approximately 8 times that of men*, and women are assaulted by armed intimates at a rate approximately 7 times higher than that of men. Therefore, it is important both to distinguish between male-to-women and women-to-male partner violence and to understand that male-to women violence represents the more serious public health concern. The reason for this sex difference is not known, but men and women may vary in their habituation to, memory of, and willingness to disclose violent episodes, either as perpetrator or victim. Certainly, given that women are more likely to be repeatedly abused, to be injured, and to die as a result of intimate partner violence, it seems adaptive for women to be especially concerned about this potential health risk. (Schafer J, Caetano, and L Catherine 1998).

Domestic violence, or intimate partner violence is not limited to any one class or culture. IPV is considered a silent disease, often hidden from public awareness by cultural norms about privacy, family relations and dignity. Nowadays, intimate partner violence (IPV) against women is recognized as a priority health problem. It is recognized

as a health problem in developed more than developing countries. (Hassan, F et al, 2004).

The study analyzed data from the National Violence Against Women Survey (NVAWS) of women and men ages 18-65. This random-digit-dial telephone survey included questions about violent victimization and health status indicators. Women were significantly more likely than men to experience physical or sexual IPV (relative risk [RR] =2.2, 95% confidence interval [CI] = 2.1, 2.4) and abuse of power and control (RR=1.1; 95% CI =1.0, 1.2), but less likely than men to report verbal abuse alone (RR=0.8; 95% CI = 0.7, 0.9). For both men and women, physical IPV victimization was associated with an increased risk of current poor health, depressive symptoms, substance use, and developing a chronic disease, chronic mental illness, and an injury. In general, abuse of power and control was more strongly associated with these health outcomes than was verbal abuse. Our finding that physical and psychological IPV may produce long-term adverse physical and mental health effects for both women and men has important implications for intervention and prevention efforts. If IPV can be identified early, interventions could be developed to reduce the impact of IPV on mental and physical health status. (Coker,A.L., Smith, P.H., McKeown, R.E., and King, M.J 2000)

Estimates from the National Crime Victimization Survey in the United States of America (NCVS) indicate that in 1999, persons age 12 or older experienced about 791,210 violent crimes by a current or former spouse, boyfriend, or girlfriend. Intimate partner violence is primarily a crime against women. During 1999, women experienced 671,110 (85%) such violent victimizations; men, 120,100 (15%). Younger women generally had higher rates of intimate partner violence than older women. Offenders who

committed intimate partner violence were more often a boyfriend or girlfriend of younger victims and a spouse of older victims. Among women victims of intimate partner violence, 94% of those age 16-19 and 70% of those age 20-24 were victimized by a current or former boyfriend or girlfriend. Women aged years 25-34 who were victimized by an intimate partner were victimized by a spouse or by a current or former boyfriend/girlfriend in similar percentages (39% and 44%, respectively). Women aged 35 years or older were more likely to experience intimate partner violence from a spouse than from an ex-spouse or from a current or former boyfriend/ girlfriend. Between 1993 and 1999, 69% of women victims of intimate partner violence age 50 or older were victimized by their spouse; an ex-spouse accounted for 13%; and a current or former boyfriend or girlfriend, 18%. (Rennison C 2003)

In recent years, intimate partner violence (IPV) (also referred to as domestic violence, spouse abuse, and battering) has gained recognition as a serious public health problem. Recent estimates show that 1.5 million women in the United States are physically or sexually assaulted each year by an intimate partner. (Waalen, J. Goodwin, M. Spitz, A. M., Petersen, R. Saltzman, L. E.,2000)

The University of New Hampshire national random survey data showed the finding of fair or poor health status, and also demonstrated that severely battered women had almost twice the number of days in bed due to illness than other women. In a survey of self-identified battered women who had successfully ended the violence, the majority of women had sought help from medical professionals, a higher proportion than from other sources of help. (In Campbell and Lewandowski 2002).

The act of violence, physical or verbal, was the manifestation of demonstrating and maintaining the authority, when it was challenged. Woman's biological structure and less physical strength, as compared to man, have left her more vulnerable and susceptible to violence from the other male counterpart. Our social structure has inbuilt discrimination and oppression against women which has victimized them in exercising physical and emotional injury (Saraswati, M. 2002).

Intimate partner violence (IPV) is a common threat to the health and well-being of pregnant women. In a large review of studies in the United States, Gazmararian and colleagues found that the incidence of IPV during pregnancy ranged between 0.9% to 20%, with most estimates between 4% and 8%; these figures translate into approximately 156,000 to 332,000 pregnant women who experience IPV each year. IPV during pregnancy has been linked in studies with poor maternal weight gain and anemia, bleeding, placental abruption, uterine rupture, chorioamnionitis, vaginal infections, and kidney infection In a systematic review and meta-analysis of eight studies, Murphy and colleagues concluded that women reporting IPV had 1.4 times greater odds of giving birth to a low birth weight infant than non-abused women(In Humphreys, J. 2010).

2.1.4 Physical Health

IPV has a significant effect on victims' health, influencing many aspects of physical and mental health. Individuals affected by IPV consistently are more likely than individuals not affected by IPV to report poor health. Physical and mental health effects of IPV persist for many years beyond the period of abuse, and a longer duration of abuse is associated with worse health outcomes. Physical, sexual, and psychological/emotional IPV all have adverse health effects. The physical and mental health consequences of IPV

occur in male and women victims, but women are more likely to report negative physical and mental health effects. (Zolotor J A, Amy C. Denham, Amy Weil).

Women who are abused are frequently treated within health care systems, however, they generally do not present with obvious trauma, even in accident and emergency departments. Intimate partner violence has long term negative heath consequences for survivors, even after the abuse has ended. These effects can manifest s poor health status, poor quality of life, and use of health services. Battering is significant direct and indirect risk factor for various physical health problems frequently seen in health care settings. Intimate partner violence is one of the most common cost of injury in women. The injuries, fear and stress associated with intimate partner violence can result in chronic health problems such as chronic pain(eg, headaches, back pain) or recurring central nervous system symptoms including fainting and seizures. The exact mechanism of such effects has not been established but could include recurrent injury or stress, alteration in neurophysiology, or both. Battered women also have significantly more than average self-reported gastrointestenial symptoms (eg loss of appetite, eating disorders) and diagnosed functional gastrointestinal disorders (eg chronic irritable bowel syndrome) associated with chronic stress. These disorders may begin during an acutely violent and thus stressful relationship, be related to child sexual abuse, or both. The consequent functional damage to the bowel can last far longer than the violent relationship. Similarly, self reported cardiac symptoms such as hyper tension and chest pain have also been associated with intimate partner violence. Gynaecological problems are the most consistent, longest lasting, and largest physical health difference between battered and non battered women. Differential symptoms and conditions include sexually- transmitted

disease, vaginal bleeding or infection, fibroids, decreased sexual; desire, genital irritation, pain or intercourse, chronic pelvic pain, and urinary tract infections. The combination of physical and sexual abuse that characterizes the experience of at least 40-45% of battered women puts these women at an even higher risk for health problems than women only physically assaulted. (Campbell J 2002).

Abused women tends to have gynecological, central nervous system and stress related problems, with women physically and sexually most likely to report problems. Routine universal screening and sensitive in-depth assessment of women presenting with frequent gynecological , chronic stress related, or central nervous system complaints are needed to support disclosure of domestic violence. There is mounting evidence that domestic violence has long term health consequences for survivors, even after the abused has ended. This can translate into lower health status, lower quality of life, and higher utilization of health services. Domestic violence is a significant risk factor for various health problems frequently encountered in primary care settings. The most common locations for injures among battered women are the face, neck, upper torso, breast, or abdomen. These are the short term consequences of battering that most health care professional associate with DV. Yet, studies of battered women have found that the ,long term aftermath of these injuries and the fear and stress associated with having an abusive intimate partner can result in several less obvious and often long term health problems. When past or current IPV is identified, primary care physicians should obtain a focused history and perform a physical examination aimed at assessing the severity and timing of trauma, injuries and gynecological symptoms, central nervous system problems. When abuse is going on an intervention that conforms to recommended protocols should be

undertaken as described by Parsons et al or warshaw et al . Campbell J et al says that A women may be too embarrassed to volunteer information about GYN problems or may not realize that other problems she is experiencing could be treated. Patients may also be experiencing emotional and psychiatric problems associated with abuse. Knowledge of abuse history will alert physicians to probe for these problems and conditions. It is important for counselors to be aware of the issues associated with domestic violence so that they are able to respond to their clients in the context of the influences of wider society. A specific part of the recovery process for the survivors of such violence lies in being informed of the common patterns and experiences of those affected. In this way we can deal with both individual and society's influences on their situation and not ignore the interplay between them. (Alcock, D. 2011).

Ellsberg stated that the ill-health effects of violence on expectant mothers have been shown to include a range of mental disorders, sexually transmitted diseases, gastrointestinal disorders and gynaecological problems, including vaginal bleeding and vaginal infections, urinary tract infections and various chronic pain syndromes, including chronic pelvic pain. These effects can result in death. (Bowman, B., Matzopoulos , R., Butchart, A., & Mercy, J. A., 2008).

The national health objective for the year 2000 addressing intimate violence specifies that at least 90% of hospital emergency departments should have protocols for routinely identifying, treating, and referring patients who experience sexual assault and spousal violence. Routine screening for IPV in health care settings can be an important measure toward reducing the health consequences of violence. For chronic disease, early detection of partner abuse could lead to an effective intervention, by identifying patients

who have experienced IPV and understanding the complexities of the individual patient's physical and mental well being, physicians have the opportunity to provide more appropriate care, thereby improving the lives of some of their patients. Intervention at any point in the life history of IPV may be effective. Screening for IPV is not however sufficient to reduce the health impact of violence. Effective clinic and community based interventions are needed to address IPV in women's lives.(Coker,A.L., Smith, P.H., McKeown, R.E., and King, M.J., 2000).

2.1.5 Mental-health

Depression and post-traumatic stress disorder, which have substantial comorbidity, are the most prevalent mental-health sequelae of intimate partner violence. Depression in battered women has also been associated with other life stressors that often accompany domestic violence, such as childhood abuse, daily stressors, many children, changes in residence, forced sex with an intimate partner, marital separations, negative life events, and child behavior problems. Some battered women might have chronic depression that is exacerbated by the stress of a violent relationship, but there is also evidence that first episodes of depression can be triggered by such violence, and longitudinal evidence of depression lessening with decreasing intimate partner violence. Even so, the relations between violent experiences and mental-health problems needs further study. (Campbell, J. 2002).

The strongest risk factor for identification of battered women in one of the primary care settings was depressive symptoms. Rath et al found that not only the battered women but also their children used health services six to eight times more often than did controls. (In Campbell and Lewandowski L 2002).

In addition to the physical health effects, victims of IPV frequently suffer chronic mental illness. Although mental health consequences are seen whether abuse is physical, sexual, or psychological, some data suggest that mental health outcomes are the worst for individuals who experience sexual IPV. Individuals who experience IPV are at increased risk for depression, an effect seen with physical, sexual, and emotional IPV. They also are at increased risk for suicidal thoughts and attempts. Alcohol abuse and illicit drug use also are more common among individuals who experience IPV. Posttraumatic stress disorder (PTSD) is prevalent, occurring in 31% to 84% of women exposed to IPV. Symptoms of PTSD, including emotional detachment, sleep disturbances, flashbacks, and mentally replaying episodes of assault, may persist long after the violence is no longer present in a woman's life. Higher rates of PTSD are seen with sexual and physical IPV than with physical IPV alone, and a greater severity and frequency of violence correlates with greater risk for PTSD. The high prevalence of PTSD among survivors of IPV may be a key factor in explaining the relationship between violence and physical health symptoms. (Zolotor J A, Amy C. Denham, Amy Weil nd).

Mental healthcare is especially critical for IPV victims. Posttraumatic stress disorder (PTSD) and depression, among other mental health conditions, are common among women who have experienced partner violence. PTSD and depression is of particular concern as it may lower global functioning of the affected individual which may affect an abused woman's ability or motivation to terminate an abusive relationship or make safety plans. PTSD and depression may also increase the risk of adverse health outcomes, especially among low-income women. (Lipsky, S., Caetano, R., Field, C.A., & Larkin, G.L., 2006).

In the United States, more than one in three women report experiencing rape, physical violence, and/or stalking by an intimate partner in their lifetimes. The Centers for Disease Control and Prevention (CDC; 2003) estimates that IPV against women creates more than $4 billion in direct mental and medical health care costs annually in the United States. Some authors suggest that Connection with community-based services may also be particularly beneficial in IPV cases. Health care providers can be helpful in linking patients with these community-based resources. (In Dichter, M.E., & Marcus, S.C., 2013).

Several definitions of domestic violence emphasize that violence does not merely refer to physical or sexual acts, but that violence can also occur in psychological form. Furthermore, some definitions explicitly note that threats of harm also constitute violence. Despite increasing awareness that domestic violence is a major public health problem, existing studies focus on physical and sexual violence and give little attention to psychological violence. Physical and psychological abuse have a number of unique risk factors which confirms that it is important for future domestic violence research to distinguish between different types of abusive behaviors. Although a great deal of literature has focused on the physical outcomes of domestic violence, more research is also needed to examine the health consequences of psychological violence. The effects of intimate partner violence on mental health should be further studied in order to understand the scope of morbidity resulting from this type of violence. (In Meekers, D., Pallin, S.C., & Hutchinson, P., 2013).

IPV contributes substantially to family instability, divorce, and homelessness. It is also significantly related to depression, substance abuse, and traumatic stress reactions

for both the survivor and the abuser. More severe and frequent exposure to physical violence, including threats against life, use of weapons, sexual violence, and psychological abuse, has been shown to be related to the development of post-traumatic stress disorder. (In Karakurt, G., Dial , S., Korkow , H., Mansfield & Banford, A.,2013).

2.1.6 Effects on children

'Children have often been called ''the silent victims'' of domestic violence. The physical and psychological effects on them may result in economic hardship as well as delinquent behavior like substance abuse, prostitution, and the commission of crimes against people such as sexual assault'. (Miller, C. E., & Mullins, B. K., 2002) .

The consequences of witnessing domestic violence have been compared to the consequences of any form of aggressive parenting by several authors. Witnessing violence places children at a higher risk for a variety of negative outcomes including drug abuse, bullying in schools, post-traumatic stress, running away, suicide, prostitution, teenage pregnancy, sexual assaults, low self esteem, and problems in school. Witnessing violence between parents has the potential to alter a child's psychological development and Groves says it may affect a child's developing brain with changes in hormones and neurotransmitters reported. Children exposed to domestic violence have been found to have ''significantly poorer verbal abilities''. One recent study even found that children who witness domestic violence are more likely to be cruel to animals than are non-exposed children. As criminologists note, those who witness violence as children are more likely to find themselves in abusive situations as adults. According to Agnew, witnessing violence can be seen as a form of vicarious victimization, which has been found to be strongly related to delinquency. Simply being exposed to violence increases

the risk of internalizing (anxiety and depression) and externalizing behavior (aggression and delinquency). (In Payne, B. K., Triplett, R. A., & Higgins, G. E., 2011).

For children who witness violence, according to Geldard and Geldard,the results can be devastating. They are often greatly "traumatized" as they suffer physically, psychologically and emotionally. According to Hughes & Graham-Bermann, depression and low self-esteem are common, and symptoms of post-traumatic stress may also develop, ultimately requiring clinical intervention as a result of living in a state of constant fear. Baumeister found that living in this environment, violence can become a learned response as children begin to emulate the behavior of the perpetrator in an effort to achieve the desired results. The ramifications of adopting this form of problem-solving are unfortunately seen far too often in school settings and also in the community. To quote, McDonald and Brown, "children whose parents are violent towards each other are also more likely to behave violently than children reared in non-violent homes". Many adults in this situation have grown up in an atmosphere of shame, humiliation, intimidation and fear, their rights being constantly violated as they experience the terror of witnessing repeated acts of violence. It would appear that even in later life, when the specific acts of violence have ceased, the fear and associated emotions continue to linger, as visions of the past hauntingly pervade the mind of the individual, and the silent influence of learned behavior patterns and response to conflict significantly govern the life of the victim. Frequently, the victim (initially child, but now adult) will adopt means of coping with conflict that will inevitably ensure their own protection, both physically and psychologically. The desire to avoid conflict is substantial, and can easily lead to excessive levels of concern regarding the actual cause of any specific incident. Victims

often display an inability to objectively allocate responsibility for an incident, and instead accept blame themselves, thereby increasing the personal pressure to “get it right” in the future. Adults who have witnessed domestic violence as children frequently uphold and maintain the code of silence that has encased and ultimately imprisoned them for years. The shame and fear of exposure, and further humiliation either for the family itself or for individual members, continue to loom as an ominous threat, thereby preventing the victim from breaking the silence and seeking the assistance required. These may truly be considered the “forgotten victims” of domestic violence. Adults with witnessing histories often experience difficulty sustaining positive and productive relationships on an intimate level according to Blanchard. In effect, issues such as low self-esteem, anxiety, withdrawal, stress related illnesses, anger and bullying, in addition to a general lack of interpersonal skills, which are exhibited during childhood and clearly acknowledged as possible outcomes associated with the witnessing of domestic violence, are the same issues that ultimately carry over into adulthood and continue to restrict the quality of life available to the individual. (In Baker, M.L., 2011).

Violence within the family also can have significant consequences for other family members who are not directly victimized. IPV has been associated with long-lasting, intense, and negative emotional and behavioral influences on children who witness domestic violence. In particular, as compared with children who have not witnessed violence between their parents, children who have witnessed violence are more likely to assault their siblings and their parents, commit violent crimes outside the family, and assault their own intimate partners. (Karakurt, G., Dial , S., Korkow , H., Mansfield & Banford, A.,2013).

IPV and child maltreatment have many overlapping features, risk factors, and consequences. In many cases, they are final common outcomes from family dysfunction, stress, and societal tolerance of violence. In some cases, the best interest of children and parent victims may not be served in the same way. IPV that occurs between partners, one of whom is a parent, often occurs in house- holds with child maltreatment. Child maltreatment broadly encompasses child physical abuse, psychological abuse, neglect, and sexual abuse. Studies that screened for IPV in a population of families affected by child maltreatment or for child maltreatment in families affected by IPV have clearly demonstrated that IPV and child maltreatment often occur in the same homes. Approximately 26% to 73% of families reported to child protective services for child maltreatment also are affected by IPV. IPV can harm children physically and mentally. Children can be considered ‘‘collateral damage’’ in an assault between intimate partners. Several longitudinal studies have demonstrated important associations between child and subsequent adult mental health. Child reports of witnessed IPV are associated with increased odds of suicidal ideation and 2.6 times increased odds of suicide attempt. Two reports from a high-risk cohort study have shown that witnessing IPV during childhood leads to more mental health symptoms and more clinical depression, anxiety, and anger. (Zolotor J A, Amy C. Denham, Amy Weil nd).

Problems experienced in early childhood are among the numerous psychological and behavioral factors that may predispose youths and young adults to display violent and aggressive behavior and hence the mental health of the mother (for example) is an important factor in the formative stages of a child’s life. In addition, unwanted pregnancy, teenage motherhood and pregnancy complications have also been shown to

predict risk for violence across the lifespan of the child. (In Bowman, B., Matzopoulos , R., Butchart, A., & Mercy, J. A., 2008).

Intimate partner violence (IPV) is a serious public health problem, affecting an estimated 15.5 million children annually. Young children are at an especially high risk for being exposed to IPV, making it critical to understand the effects of exposure in this population. Smith, Elwyn, Ireland, & Thornberry, added Children exposed to IPV are at greater risk for developing problems with substance use/abuse later in life and have challenges with adjustment, including more internalizing and externalizing behavior problems. Notably, they may have elevated symptoms of traumatic stress and higher rates of post-traumatic stress disorder. Emotional avoidance was the most common type of avoidance symptom displayed by the children. Additionally, social withdrawal had a significant amount of overlap with the other domains of avoidance. One possible explanation for this is that PTSD over time, and in particular the expression of avoidance symptoms, may lead to feelings of social isolation from others. This social isolation, in turn, may become a mechanism for avoiding uncomfortable situations, which then could perpetuate a vicious cycle of avoidance. (In Galano, M,M., Miller, L. E., & Bermann, G.S.,2014).

It is widely recognized that family dysfunction is a risk factor for Child Sexual Abuse and that children who come from homes where IPV is present are at a higher risk of experiencing physical, emotional and sexual abuse. Kellogg & Menard (2003) found that 80% of the children and adolescents referred to a CSA evaluation clinic had experienced or witnessed abuse by a male in the home. The majority (58%) of the live-in men who perpetrated sexual abuse against a child also engaged in partner abuse. Of the

entire sample's 176 live-in men, approximately one-third had been sexually violent towards their partner as well as towards a child.(Morgan, W. & Gilchrist, E. 2010).

2.1.7 Social Support

In the new millennium, government promised further action in 'Safety and Justice' which set out an agenda for tackling domestic violence through the strands of prevention, protection and justice and support. Further measures included the Domestic Violence, Crime and Victims Act 2004 and a government National Report (Radford , R., Harne, L., & Trotter, J.,,2006).

Domestic violence intervention policy has been legislated in over 44 countries around the world. A key initiative in this respect was the United Nations (UN) passage of the Elimination of Violence Against Women Declaration in 1993. In the United States, the Violence Against Women Act of 1994 and its re-authorization in the Violence Against Women Act of 2000 served as a catalyst for nationwide implementation of policy changes designed to respond to domestic violence. Mills & Reamer suggest that in order to promote social justice and to protect domestic violence victims in the most equitable manner for all citizens, it is essential to evaluate the impact of existing court processes and services. According to Gelles, the 1985 National Family Violence Survey found that 34 women per thousand were victims of intimate partner violence in the year prior to the survey. These findings suggest that victims may be in need of short-term financial assistance while they learn or improve skills that lead to employment, or that they should be provided with vocational services to help them to continue their education and obtain employment that is at a sufficient income level to support their family independently. For the future, in order to help policy-makers.and service providers make domestic violence

programme and resource decisions, continued research with rigorous design and methodology is needed to evaluate existing programme effectiveness. (In Scott L. D & Kunselman C. J,2007).

Domestic violence involves patterns of violent and abusive behavior over time rather than individual acts. However, the criminal justice system is primarily concerned with specific incidents and it can therefore be difficult to apply criminal justice approaches in relation to domestic violence. Domestic violence situations varied greatly, and the criminal justice system appears more effective in dealing with the less entrenched situations. Court outcomes did not stop chronic repeat offenders from continuing their violence and harassment. A more systematic approach to domestic violence perpetrators is needed throughout the criminal justice system that directly links levels of risk and repeat behavior with outcomes. Criminal justice agencies working with offenders who have committed non-domestic violence crimes need to be aware that domestic violence may also be an issue of concern. Domestic violence, although now considered a crime, still needs to be taken as seriously as criminal offences committed in other contexts. (Hester, M. & Westmarland, N.2006).

Clinicians' needs to be supportive, community resources must be available for women in need, and, as a society, we must acknowledge the magnitude and impact of this problem and commit to a zero tolerance policy for partner violence. (Coker,A.L., Smith, P.H., McKeown, R.E., and King, M.J., E, Roberts 2000).

Physical and sexual violence committed against women by their husbands, ex-husbands, boyfriends, or ex-boyfriends is an enormous public health problem: each year, 2–4 million women are victimized in the USA.1–3 Physicians and other health-care

providers have a unique opportunity to help victims of intimate partner violence, not only in treating but in preventing this devastating problem. In the clinical setting, health-care providers may intervene early as the victim's first and only point of contact concerning the violence in their lives. In the larger community, health-care providers can become spokespersons and educators to help change social norms and can get involved in coordinated community responses to ensure cohesive actions by all societal sectors to prevent IPV in their communities. Health-care providers cannot work in isolation or solve this problem alone. Contrary to most medical situations, it is not the health care provider's role to provide ongoing treatment or cure IPV victims. There are, or should be, professionals in the community specifically trained to assist those experiencing IPV. Safety issues should be the top priority when managing the patient and recommending follow-up services. Because the problem of IPV is complex, it is important for all community sectors to be involved and work together to prevent the complex problem of IPV. Joining a local coalition may help health-care providers more thoroughly understand the issues and their role and provide assistance in solving the problem on a larger scale. Health-care providers should get involved in their community's IPV or domestic violence coalition to bring about coordinated community responses that will ensure cohesive actions by all social sectors to disallow IPV in their communities. They can also become spokespersons and educators in their workplaces, communities, and professional organizations.(Short, L.M., & Rosenberg, M.L., 2001).

Clinicians may see high number of patients who have a history of current or former IPV in medical offices. A recent large study of women enrolled in health maintenance organizations found that 44% had a history of IPV. One study of women in

pediatric clinics found that 14% of mothers screened positive for at least one of three questions related to severe IPV. Using a longer standard instrument, however, 76% of mothers reported a history of being a victim of psychological aggression, 32% reported physical assault, 9% reported resultant injury, and 29% reported sexual coercion within the past year. These data suggest that obstetrics and gynecology physicians should consider patients presenting in an ambulatory care practice setting as having very high risk for current or past IPV. (Zolotor J A, Amy C. Denham, Amy Weil nd).

No one dare to interfere or question the man even if he is seen battering his wife because it is considered purely something his or her affairs. The society also implicitly supports the attitude by leaving the husband and wife to themselves to settle the affairs. On the other hand, if two neighbor gets into a fight, the people around immediately intervene to see justice prevails. But in the case of a husband battering his wife, the neighbors tend to be mute spectators. Wife battering is commonly accepted by society and not many people take much notice to it. If the wife happens retaliate, she is considered a woman of low morals. It is ingrained in the mind of people that no decent woman would beat her husband. Whereas battering one's husband is considered shameful for the husband as well as for the wife, there is no shamed attached to wife battering, society being what it is. (Yudhistar, K., 2003).

Social support might decrease women's likelihood of change if their supports encourage them to stay with their abuser. Alexander et al added that social support could be a motivator, or resource, to help women leave their abusive partner and achieve safety; however, it could also be a deterrent to change. Having frequent socially supportive

experiences might help women recognize their situations as troublesome and therefore increase their readiness for change. In regard to treatment and resource utilization, readiness to change might be an encouraging factor for using mental health treatments. (Johnson, N.L., & Johnson, D.M., 2013).

Several researchers have argued that media representations of violence tend to ignore structural or contextual factors and instead privilege specific, individual problems, which can be problematic. For example, Maxwell, Huxford, Borum, and Hornik argued that media assert a significant role in how IPV is understood as a social issue; in particular, by covering specific incidents of IPV, media moves the responsibility to solve the problem from society to the individual. Maxwell and colleagues found not only that most articles were framed in a way that left the victim responsible for ending the violence in the relationship, but also that social factors perpetuating violence were largely ignored. Indeed, prior research suggests that media coverage of issues with health and legal implications can influence public policy response. By understanding the process by which media coverage is influencing public policy, policymakers, journalists and practitioners can better frame health issues to gain support for a public health response in addition to a criminal justice response, and emphasize society's role in preventing violence. The types of information included in news stories about victims may have what could be construed as unintended effects. By stating that the victim had been drinking and was having an affair, the attributions of responsibility toward the woman increased. In addition, Carlyle, Slater, and Chakroff provide numerous examples of information about the victim that news stories regularly publish; many of which are examples of information that are victim blaming and may lead people to believe there are acceptable

reasons to commit IPV. This emphasizes the need for journalists to carefully consider the questions they are (and are not) asking and what the implications of those choices may be. (In Palazzolo, K.E., & Roberto, R 2011).

IPV victimization has also been found to be strongly associated with mental health symptoms and disorders including anxiety, posttraumatic stress symptoms, depression, and suicidal ideation or attempts. Social services specifically designed to serve individuals victimized by IPV include emergency shelter, advocacy, and counseling. Shelters are designed to help survivors escape violence, and in addition to temporary housing, they may provide advocacy and short-term counseling services. Counseling typically focuses on addressing the impacts of violence and helping survivors recover from trauma and build self-esteem and self-efficacy. Such programs may be helpful for healing and restructuring one's life free from violence. Outside of the shelter, however, women are not necessarily protected from violence. Leaving the relationship does not guarantee safety; however, resources that facilitate independence may help women escape violent situations. Some authors in 2009 found that "tangible interventions, such as day care, housing, education, food bank, and job training" were helpful to women leaving abusive relationships. These economic supports could be protective against further violence by helping women establish independence and physical distance from their partners. In a study of women in domestic violence shelters in Pennsylvania Harding and Helweg-Larsen found that half of the participants said that they had previously left and then returned to violent partners because they did not have a place to live or stay. Lack of financial resources is a barrier to leaving and, therefore, may contribute to risk for re-assault. These findings are not new—the early literature from

more than 30 years ago also indicated that women were “entrapped” in relationships with violent partners due to lack of economic resources to establish independence. It is also critical to have employment policies and practices that support women who have experienced violence not only to obtain, but also to maintain, employment. Employment policies that, for example, provide leave for dealing with the consequences of violence, or allow an employee to transfer to another location to escape from violence, can facilitate a victim’s future safety. Additionally, police and hospital personnel who may encounter IPV survivors may be able to help refer individuals to the services they need, beyond the traditional victim services. Survivors of IPV have a variety of social service needs, many of which are not classically considered funded as domestic violence services. When we think of domestic violence services, we need to think more broadly than shelter, counseling, and advocacy. Services beyond counseling and shelter can be administered and facilitated through domestic violence programs, which may provide support for a wide variety of needed social services, such as transportation, financial support, skills education, substance abuse treatment, child care, job training, medical care, legal service, housing, and parenting needs. These programs, however, are often severely underfunded, and therefore, demand for services typically exceeds supply. (In Dichter, M.E., & Rhodes, K.V., 2011).

One preventive strategy that is widely used is the **restraining order (RO**). It is a risk management strategy originally initiated to prevent IPV, but it can also be used to try to prevent other forms of violence. Restraining orders have been introduced in many countries and are largely similar, although vary in name (also known as a protection order, stay-away order, protection from abuse order, domestic violence restraining order,

intervention order, civil harassment restraining order, or an anti harassment order). As a management strategy for IPV, restraining orders are clearly insufficient if used alone and need to be supported by additional protective actions from police or social services. This is most clearly the case in those situations when the risk for violence remains high over an extended period of time. In these situations, a RO is not the ideal solution, nor will it offer protection to the woman against further IPV. RO may be an important way to make the victim feel more secure, however, it is suggest that that may be a false sense of security unless appropriately targeted and followed up by police. It may be that the application or granting of a RO provides a good opportunity for police to start working with the victim on an individual risk management plan beyond the conditions of the RO. (Strand, S 2012)

2.1.8 Coping

Women with abusive partners also actively seek a wide variety of community resources, including education, employment, housing, child-related needs, legal services, and police. In a population-based survey, Coker et al., found that over one-half of abused women sought community-based or professional services related to IPV, particularly women experiencing more severe violence. McFarlane et al., also found increased resource use related to severity of abuse among abused women during pregnancy and the postpartum period. Women with IPV were significantly more likely to use several of the health services, including alcohol or drug programs, ED care, and hospital care Social service utilization overall was increased among IPV victims, as well as individual services such as social/case worker, police assistance, and housing assistance. IPV victimization has been associated with alcohol abuse and alcohol-related consequences

and problems in a number of studies it is found that women exposed to male IPV were more likely than non-victims to report alcohol problems and drug use. (In Lipsky, S., Caetano, R., Field, C.A., & Larkin, G.L., 2006).

There are many reasons why victims of DV may be ambivalent about actively participating in a criminal prosecution. Emotionally invested in the relationship, a victim may hope that the abuser will not be violent in the future. The victim may be economically dependent on him, or may be under pressure from the abuser, family, friends, and community to stay in the relationship. The abuser knows what makes the victim vulnerable: where she lives and works, her routines, where her children go to school, where her family lives, etc. Even if the victim is ready to end the relationship, her abuser may continue to represent a danger to her and those closest to her. DV victims may stay in violent relationships because they instinctively know that it may be more dangerous to leave the relationship. (Peterson, R. R., Deirdre Bialo-Padin,2012).

Different treatment programmes for the batterers, such as individual therapy, marital and family therapy, psycho-educational or psychotherapeutic group approach, researchers have also suggested community intervention and anger control techniques. It is believed that such programmes are not very successful in checking the abusive behavior of the batterers. Most of the researcher feel that the root cause of wife abuse can be traced to societal values. Unless societal values are changed and women are allowed to have egalitarian way of life, wife abusing in one form or the other would persist. (In Yudhistar, K 2003).

Women who experience IPV often use a variety of mental and behavioral strategies to prevent, withstand, stop, or oppose the abuse. Quoting Black et al., 2011 In

the United States, more than one in three women older than age 18 (35.6%) report experiencing rape, physical violence, or stalking by an intimate partner at some point in their lifetime. The more types of abuse that occurred in the women's lives, the more strategies they engaged in to stop, prevent or escape the abuse. This indicates that women who were in longer relationships and who experienced longer periods of abuse accessed more informal network strategies to cope with the abuse. Women who experienced more types of physical abuse and more frequent physical abuse pursued more safety planning and informal strategies, while women who experienced more types of psychological abuse sought more placating strategies. Women who experienced more frequent psychological abuse reported using more safety planning and fewer resistance strategies. The type of sexual abuse was not associated with greater use of any of the categories of IPV strategies; however, the frequency of sexual abuse was negatively associated with the helpfulness of placating strategies. (Anderson, K.M.,Renner, L.M., & Bloom.T.S.,2014).

Intimate partner violence (IPV) is a social problem associated with significant morbidity; however, victims do not always utilize treatment and resources. One's readiness to change might be one variable impacting his or her pursuit of treatment and other resources. IPV has been linked to the development of posttraumatic stress disorder (PTSD), depression, and substance use dependence. Due to these common experiences, mental health treatment is important for victims of IPV; however, victims might not always seek the treatment they need. A victim's stage of change, or readiness to change, could be one variable impacting his or her pursuit of treatment and other pertinent resources. Prochaska and colleagues suggested that one's level of readiness to change

will impact his or her progress in treatment as well as his or her likelihood of seeking treatment and other resources. In addition to symptom severity, social support has been examined as a factor impacting readiness to change in victims of IPV. However, current literature on social support's role in predicting readiness to change in victims of IPV has again been inconsistent. Alexander et al., found satisfaction with social support to be associated with lower stages of change in victims of IPV. Women higher on readiness to change are likely to have more insight into their current problems which could encourage them to seek resources and treatment to help deal with identified problems. Also, once women recognize they have a problem they might be unsure what steps to take to maintain or begin change; therefore, they might contact IPV-related resources to identify how to proceed (Johnson, N.L., & Johnson, D.M.,2013)

CHAPTER III

METHODOLOGY

This chapter introduces the methodology used in the study. It describes the profile of study area, research design, sampling, sources of Data collection, tools of data collection and analysis. Two study areas were selected as it was intended that one core and one peripheral area will be selected for study. The two areas selected were *Chanmari* (Core) and *Melthum* (Peripheral).

3.1 Profile of the Study Area

3.1(a) Chanmari: Chanmari locality was formally known as *Hmarkaii Nu Veng*, It was back in July 1954, the name was changed to Chanmari. Chanmari is located at the Northern side of the city. It has a population of 5155, consisting of 2591 male and 2564 women. The first High school in Mizoram was established in this locality which was formerly known as North Lushai Hills High School and is now changed to Mizo Higher and Secondary School.

Fig 3.1 Educational Institutions in Chanmari

Government	Primary	1
	Middle	1
	High school	1
Private	Nursery- X	5
	Higher Secondary	2
College		1

Source: Souvenir released on Golden Jubilee of the Presbyterian Church, Chanmari, 2013.

The different Denominations which are working in the area Baptist Church, Presbyterian Church, salvation Army, United Pentecostal Church and Wesleyan Methodist. A separate Village Council was set up in the year 1982 and Chanmari Branch YMA was established on 16th October 1958. The locality also has One library, one community Hall, and it also has 10 financial Institutions, 15 Government Office, 8 ATM booth.

3.1(b) Melthum:

Melthum village was selected as a peripheral area of study. Melthum is situated in the extreme south of Aizawl city under Tlangnuam block with a population of 1101 (672 women and 529 male) and 230 households. It is located on the highway on the 'New World Bank road', which leads to Lunglei, a major district in Mizoram. The different denominations which are working in this village are Presbyterian church with the highest population, followed by Baptist church.

Fig 3.2 (Below) Educational Institutions in Melthum

Sl.no		No of student s	Boys	Girls
Government	Primary	27	16	11
	Middle	64	34	30
	High school			
	Primary	220	80	140

Private	Middle			
	High school			

Source: Compiled from Interviews with Key informants

Fig 3.3 (Below) Infrastructure and Public amenities

Electricity	Yes
Hospital	-
Sub Centre	1
Public Water Reservoir	1
Community Hall	1
Public Urinal	4
Public toilet	-
Market	-
Public Bathroom	-
Recreational Centre	-

Source: Compiled from Interviews with Key informants

Fig 3.4 Occupational Structure

Government Service		Agriculture		Carpentry		Trade and commerce		Daily Manual Workers		Animal Husbandry
Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	
49	23	40	27	8	6	8	6	91	18	26

Source: Community records, Melthum, 2014

3.2Research Design

This study employs exploratory design and is cross-sectional in nature. Mixed methods research was applied which involves philosophical assumption and an approach to enquiry that contains qualitative and quantitative forms. Both qualitative and quantitative Data was collected.

3.2.1 Sources of Data

Primary data was collected from two Urban communities (One Peripheral and one Core) through semi-structured interview schedule; Case vignettes were conducted among the victims of Intimate Partner Violence. Focus group discussions were also conducted among the male population and unmarried women population.

Available records from Organizations working with women in town as well as relevant literature search provided secondary data.

3.2.2 Sampling

Multi stage sampling was used. At the first stage, Aizawl District was selected using *purposive* sampling. At the second stage, One core and One peripheral area in Aizawl city were selected based on objective criteria. At the third stage, a list of all households was drawn using *systematic random sampling*. In the final stage, one woman and one man from each of the selected households was drawn as respondents based on the following inclusion criteria.

Inclusion criteria

i) Men and women between the ages of 18 to 40 years.

ii) Who has been currently involved in an intimate relationship for a minimum period of two years.

iii) Literate

iv) Willing to give informed consent both on perceptions and experiences if any on Intimate Partner Violence.

In all 80 respondents formed the final sample.

3.2.3 Tools of Data Collection

1. Observation: Observation was done in urban settings in Mizoram, to explore the cases registered as well as of the home environment.

2. Interview Guide for Case vignette: The interview guide consisted of items to seek information on socio-demographic particulars, history of intimate partnership,

experiences of violence, social support and coping used. Two case studies were conducted on women who have experienced violence to document their experience in an in-depth manner.

3. Interview Schedule: A structured interview schedule was administered to collect data from both men and women respondents on Socio-Demographic Data and perceptions related to violence against women, PWDVA(2005), Rights of women, knowledge on Prevention efforts and Social Support related to women who experience Intimate Partner Violence.

4. Interview Guide for Focus Group Discussion: A guide was constructed among women and men to explore perceptions related to Causes and consequences of Intimate Partner violence against women and administered on two groups of women.

3.2.4 Data processing and Analysis: Data of all variables were processed through the use of SPSS and data was presented in the form of simple percentages. Data from FGD's and case vignettes are presented in narratives.

CHAPTER IV

RESULTS AND DISCUSSION

The following chapter will present the results and discuss the findings of the study conducted on 80 respondents (40 men and 40 women). The chapter is presented in the following sequence. Demographic Profile, Intimate Partners relationship history, Perceptions on Intimate partner Violence, perceptions on PWDVA,2005, Experiences of Violence, Social support and Coping. Following these, the results from the Focus Group Discussion that were conducted with two groups is presented. Two case vignettes that illustrate the findings in reference to IPV are also presented.

Table 1 : Demographic profile

Sl no		Gender		Total N= 80
		Men N=40	Women N=40	
I	**Age group (in years)**			
	18 - 30 years	23 (57.5)	19 (47.5)	42 (52.5)
	31 – 40 years	17 (42.5)	21 (52.5)	38 (47.5)
II	**Marital Status**			
	Unmarried	16 (40)	8 (20)	24 (30)
	Married	24 (60)	31 (77.5)	55 (68.8)
	Widowed	0 .0	1 (2.5)	1 (1.2)
III	**Nature of relationship**			
	Spouse	25 (62.5)	30 (75.0)	55 (68.8)
	Live in Partner	0 .0	1 (2.5)	1 (1.2)
	Partner	15 (37.5)	8 (20.0)	23 (28.8)
	Any other	0 .0	1 (2.5)	1 (1.2)
IV	**Form of Family**			
	Stable	39 (97.5)	38 (95.0)	77 (96.2)
	Broken	1	2	3

		(2.5)	(5.0)	(3.8)
V	**Religion**			
	Christian	40 (50.0)	40 (50.0)	80 (100)
VI	**Denomination**			
	Baptist	16 (40.0)	9 (22.5)	25 (31.2)
	Presbyterian	15 (37.5)	21 (52.5)	36 (45.0)
	Roman catholic	1 (2.5)	3 (7.5)	4 (5.0)
	Salvation	1 (2.5)	4 (10.0)	5 (6.2)
	Seventh day	4 (10.0)	1 (2.5)	5 (6.2)
	United Pentecostal Church	3 (7.5)	1 (2.5)	4 (5.0)
	Any other	0 .0	1 (1.2)	1 (1.2)
VII	**Economic status**			
	APL	25 (62.5)	27 (67.5)	52 (65.0)
	BPL	15 (37.5)	12 (30.0)	27 (33.8)
	AAY	0 .0	1 (2.5)	1 (1.2)

Source: Computed Figures in parenthesis are percentages

In a study that documents sensitive information on intimate behavior, it is essential to know the demographic particulars to understand the population being studied.

Age : Age is an important variable in any research. The age group of the respondents was classified into two groups (18- 30years) and (31-40 years). The finding shows that more than half (52.5%) of the respondents belongs to the age group of 18-30 years. The remaining respondents belong to age group of 31-40 years.

The United States Department of Justice statistics show that ‘a woman is beaten every 15 seconds’ and ‘domestic violence is the leading cause of injury to women between ages 15 and 44 in the United States indicating that younger women are more likely to be abused than older women. (Miller, C. E., & Mullins, B. K., 2002). This is the reason why younger respondents were asked about their perceptions.

Marital Status : More than two-thirds of the respondents (68.8%) were married. More women respondents (77.5%) were *married.* Of the total, less than a third (30%) were *unmarried* and one only was *widowed*. According to the latest National Family Health Survey (NFHS), a plan-India survey conducted by 18 research organizations (including the International Institute for Population Sciences), observed that more than a third (37.2%) of married Indian women regularly experience spousal violence.

Nature of relationship: Intimate Partner Violence (IPV) is a common, serious, and preventable public health problem. IPV includes psychological, physical or sexual harm by a current or former partner or spouse. It occurs between married and unmarried couples. In this study , it was observed that more than two-thirds were living within the confines of marriage and had spouses. One was widowed. Only one respondent has a live-in partner however more than a quarter(28.8%) were in an intimate relationship with a partner(boyfriend/girlfriend).

Form of family: Almost all respondents(96.2%) were from a *stable family*. Another 3.8% of the respondents belonged to a *broken family*. Many studies reveal that perceptions on violence are influenced by stability in the family one belongs to.

Religion : Mizos are predominantly Christian. Religiosity strongly determines the perceptions of individuals in Mizo society. Religion is often used as a coping

mechanism by its people and therefore information on this aspect is considered essential. In this study , all respondents are Christians.

Denomination: Presbyterians constituted almost half the respondents(45%) followed by almost a third (31.2%) belonging to Baptist church. Salvation and Seventh Day constituted 6.2% each of the respondents each while Roman Catholic and United Pentecostal Church were a smaller number each (5%).

Economic status : . Poverty is inherently stressful; it has been argued that intimate partner violence may result from stress, and that poorer men have fewer resources to reduce stress.

In this study on intimate partner violence in Mizoram, almost two-thirds (65%) of the respondents belongs to APL family and one-third (33.8%) belong to BPL family. The remaining belong to AAY family. Gelles stated that men living in poverty were unable to live up to their ideas of “successful” manhood and that, in the resulting climate of stress, they would hit women. (Jewkes R, 2002). However, multiple factor causes violence and linear causality is not used in reference to issues related to human behavior.

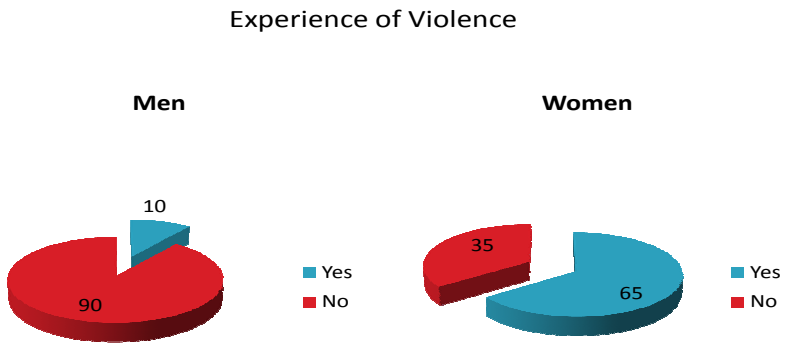

Fig 4.1 (Above)

It is important both to distinguish between male-to-women and women-to-male partner violence and to understand that male-to women violence represents the more serious public health concern. Information on Relationship History was asked with this intention. Almost two-thirds (62.5%) reported no incidence of violence with more men (90%) than women(35%) reporting the same, which is not too surprising. More than one-third of the respondents who are drawn from communities and not institutions (37.5%) report having experienced violence in their relationships with five times higher number of women than men. This finding is corroborated by other studies .Male-to-women partner violence is more often repeated and is more likely to result in injury and death than women-to-male partner violence. For instance, women are victims of intimate partner homicide at a rate approximately 8 times that of men, and women are assaulted by armed intimates at a rate approximately 7 times higher than that of men." (Schafer J, Caetano, and L Catherine 1998).

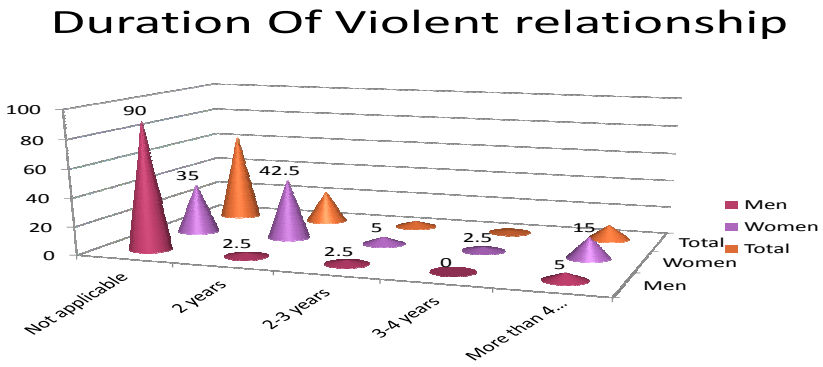

Fig 4.2 (Above) Duration of violent relationship

Almost two-thirds of the respondents (62.5%)are free from violence in their relationship. Of the remaining more than half of the respondents have stayed in their relationship for a period of 0-2 years. A tenth of these respondents report a duration of more than four years. A small number (3.8%) of the respondents were in a relationship that was violent for 2-3 years while one had lived in such a relationship for 3-4 years.

Table 2 Violence and Relationship particulars

Sl.No		Gender of the Respondents		Total N= 80
		Men N= 40	Women N= 40	
I	**When did the violence take place**			
	Not applicable	36 (90.0)	14 (35.0)	50 (62.5)
	Past	2 (5.0)	11 (27.5)	13 (16.2)
	Present	1 (2.5)	14 (35.0)	15 (18.8)
	Both	1 (2.5)	1 (2.5)	2 (2.5)
II	**Present relationship status**			
	Good	29 (72.5)	21 (52.5)	50 (62.5)
	Very good	8 (20.0)	7 (17.5)	15 (18.8)
	Bad	2 (5.0)	11 (27.5)	13 (16.2)
	Very bad	1 (2.5)	1 (2.5)	2 (2.5)

Source: Computed Figures in parenthesis are percentages

When did the violence take place

Almost a fifth (18.8%) of the total respondents are presently experiencing violence in their relationship. An almost equal number (16.2%) reported that they have experienced violence in their past relationship and a small number (2.5%) reported violence in both past and present relationship.

Present relationship status

A majority (62.5%) of the respondents claimed that their present relationship status is *good*. Nearly one-fifth (18.8%) of the population claimed their relationship status as *Very good* whereas less than a fifth (16.2%) of the respondents claimed their relationship status as *Bad.* And one respondent said that their relationship status is *very bad*. Despite the fact that majority had never experienced violence only a fifth interestingly claim that their relationship is ‘very good”. Also, although more than a third had experienced violence in the past or present, they have stated their relationship as good.

Table 3 Stress experience

Sl.No		Gender of the Respondents		Total N= 80
		Men N= 40	Women N= 40	
I	**Experiences of stress in relationship**			
	Always	2 (5.0)	11 (27.5)	13 (16.2)
	Rarely	25 (62.5)	24 (60.0)	49 (61.2)
	Never	11 (27.5)	1 (2.5)	12 (15.0)
	Sometimes	2 (5.0)	4 (10.0)	6 (7.5)
II	**Areas contributing to stress**			
	Not applicable	11 (27.5)	1 (2.5)	12 (15.0)
	Family	18 (45.0)	11 (27.5)	28 (35.0)
	Financial	6 (15.0)	7 (17.5)	13 (16.2)
	Sexual	1 (2.5)	2 (5.0)	3 (3.8)
	Personal	4 (10.0)	6 (15.0)	10 (12.5)
	Partner indulging in Substance abuse	0 0.0	13 (32.5)	13 (16.2)

Source: Computed Figures in parenthesis are percentages

Stress experience

More than half of the respondents *rarely* experience stress in their relationship. Of all the respondents, a sixth (16.2%) reports chronic stress experience in their relationship. A smaller number (15%)of the respondents said they *never* experience stress in their relationship while 7.5% reported that they *sometimes* experience stress in life.

Areas Contributing to common form of stress

It is important to understand the areas of stress experienced by those who do report stress. More than a third in this study (35.0%) of the respondents experience stress related to family. These include problems like disturbed relationships, poor communication, rivalries etc. A sixth (16.2%) each reported financial stress and the stress of a partner indulging in substance abuse. Less than a quarter of the respondents experienced stress related to personal issues such as personality linked, intra-psychic etc while 3.8% reported stress experience related to sex.

Table 4 Perceptions on Intimate Partner Relationship

Sl.No		Gender of the Respondents		Total N= 80
		Men N= 40	Women N= 40	
I	**Who gets Angry first**			
	Self	8 (20.0)	15 (37.5)	23 (28.8)
	Partner	13 (32.5)	11 (27.5)	24 (30.0)
	Either	5 (12.5)	12 (30.0)	17 (21.2)
	Neither	38 (95.0)	28 (70.0)	66 (82.5)

II	**Can be fearful when angry**			
	Not applicable	0 .0	1 2.5	1 1.2
	Self	20 (50.0)	1 (2.5)	21 (26.2)
	Partner	8 (20.0)	20 (50.0)	28 (35.0)
	Both	4 (10.0)	7 (17.5)	11 (13.8)
	None	8 (20.0)	11 (27.5)	19 (23.8)
III	**Argumentative**			
	Not applicable	0 .0	1 2.5	1 1.2
	Self	5 (12.5)	16 (40.0)	21 (26.2)
	Partner	21 (52.5)	4 (10.0)	25 (31.2)
	Both	3 (7.5)	10 (25.0)	13 (16.2)
	Neither	11 (27.5)	9 (22.5)	20 (26.2)
IV	**Uses physical force**			
	Not applicable	0 .0	1 (2.5)	1 (1.2)
	Partner	1 (2.5)	8 (20.0)	9 (11.2)
	Neither	39 (97.5)	31 (77.5)	70 (87.5)
V	**Substance abuse leads to violence**			
	No Response	0 .0	1 2.5	1 1.2
	Self	2 (5.0)	0 0.0	2 (2.5)

	Partner	0 0.0	10 (25.0)	10 (12.5)
	Both	0 0.0	1 (2.5)	1 (1.2)
	Neither	38 (95.0)	28 (70.0)	66 (82.5)
VI	**Inferiority leads to violence**			
	Self	0 0.0	5 (12.5)	5 (6.2)
	Partner	1 (2.5)	1 (2.5)	2 (2.5)
	Both	0 0.0	3 (7.8)	3 (3.8)
	Neither	39 (97.5)	30 (75.0)	69 (86.2)

Source: Computed Figures in parenthesis are percentages

A study on Intimate Partnership and Violence with regard to the relationship is a sensitive one and it is often difficult to assess actual experiences of violence. The sampling in this study involves drawing respondents from general communities with the objective of assessing perception regarding violence in intimate relationships.

Table 4 documents perceptions related to violence in intimate Partnerships. The table discusses characteristics related to anger, fearfulness, argumentativeness, and causes of violence as perceived by respondents. As is evident less than a third (30%) report that the partner tends to get angry first in the case of arguments. This perception was greater among men(32.5%) than women (27.5%). This finding could be attributed to the fact that both men and women tend to lay the blame of anger on the other partner. However, interestingly enough, more than a quarter(28%) of the respondents confessed that they themselves got angry first. Gender distribution of this indicates that while more than a third of the women (37.5%) confessed that they are easily angered , only a fifth of the men (20%) reported the same.

In the case of violence, emotions are often mixed and studies done elsewhere report a range of emotions that are expressed in relationships that include fear, anger, frustration, annoyance, argumentativeness, sadness etc. Therefore respondents were asked about the nature of their anger and whether they had experienced fearfulness along with anger in intimate partner relationships. To this, half the women respondents (50%) and overall more than a third of them (35%) reported that in anger ,the partner tends to be someone who creates fear in them .Half the men respondents (50%) interestingly have self perceived that they can be fearful while angry and that women tend to get scared when men exhibit anger. Only one woman respondent felt that her anger can create fear in her partner.

Some researcher found that *arguments* often leads to partner violence. Therefore information on this was sought. Men (52.5%) claimed that their partners are more argumentative in their relationships.

Physical abuse is regarded as one of the most common form of partner abuse. 20% women respondents reported that their partners use physical force in intimate relationship.

Substance abuse as one of the major reason for partner abuse was enquired. 25% women said that their partner use violence as a result of substance abuse, while there was no such report by men on substance abuse resulting in partner violence.

A small number of women in the study claimed that the feeling of inferiority made them vulnerable to violence.

Table 5 Perceptions related to Violence

Information and response was sought on some commonly held perceptions in society. Most of these perceptions are also held in Mizo society.

Sl.No		Gender of the Respondents		Total N= 80
		Men N= 40	Women N= 40	
I	**Poverty and Economic inequalities leads to violence**			
	Strongly disagree	19 (47.5)	14 (35.0)	33 (41.2)
	Disagree	4 (10.0)	12 (30.0)	16 (20.0)
	Strongly agree	6 (15.0)	6 (15.0)	12 (15.0)
	Agree	11 (27.5)	8 (20.0)	19 (23.8)
II	**Violence is an expression of power**			
	Strongly disagree	14 (35.0)	9 (22.5)	23 (28.8)
	Disagree	5 (12.5)	9 (22.5)	14 (17.5)
	Strongly agree	7 (17.5)	10 (25.0)	17 (21.2)
	Agree	14 (35.0)	12 (30.0)	26 (32.5)
III	**Blackmailing and *guilting* are deployed to gain something**			
	Strongly disagree	17 (42.5)	8 (20.0)	25 (31.2)
	Disgree	5 (12.5)	13 (32.5)	18 (22.5)
	Strongly agree	1	4	5

		(2.5)	(10.0)	(6.2)
	Agree	17 (42.5)	15 (37.5)	32 (40.0)
IV	**Verbal abuse leads to violence**			
	Strongly disagree	14 (35.0)	15 (37.5)	29 (36.2)
	Disagree	4 (10.0)	2 (5.0)	6 (7.5)
	Agree	22 (55.0)	23 (57.5)	45 (56.2)
V	**Women's low social status are prone to violence**			
	Strongly disagree	9 (22.5)	12 (30.0)	21 (26.2)
	Disagree	13 (32.5)	7 (17.5)	20 (25.0)
	Agree	18 (45.0)	21 (52.5)	39 (48.8)
VI	**Women's low social status are prone to violence**			
	Strongly disagree	9 (22.5)	12 (30.0)	21 (26.2)
	Disagree	13 (32.5)	7 (17.5)	20 (25.0)
	Agree	18 (45.0)	21 (52.5)	39 (48.8)
	Strongly agree	7 (17.5)	9 (22.5)	16 (20.0)
	Agree	20 (50.0)	17 (42.5)	37 (46.2)
VII	**Violence in childhood teaches them that it is normal**			
	Strongly disagree	17 (42.5)	18 (45.0)	35 (43.8)
	Disagree	1	6	7

		(2.5)	(15.0)	(8.8)
	Strongly agree	1 (2.5)	2 (5.0)	3 (3.8)
	Agree	21 (52.5)	14 (35.0)	35 (43.8)
VIII	**Violence is a means to resolve conflict**			
	Strongly disagree	1 (2.5)	2 (5.0)	3 (3.8)
IX	**Witnessing violence**			
	Strongly disagree	11 (27.5)	8 (20.0)	19 (23.8)
	Disagree	3 (7.5)	9 (22.5)	12 (15.0)
	Strongly agree	6 (15.0)	0 .0	6 (7.5)
	Agree	20 (50.0)	23 (57.5)	43 (53.8)

Source: Computed Figures in parenthesis are percentages

Economic Inequalities leads to violence

Studies reveal that economic inequalities often upset the balance of power and leads to or is a contributory factor in violence. The table above also reveals that financial difficulties are responsible for stress in the relationship. Therefore information on this was sought in detail. In this study of 80 respondents in Mizoram**,** more than a third (41.2%) of them strongly disagree that economic inequalities leads to violence This perception was *strongly disagreed* more by men (47.5%) than women(35%) . A small number each (15%) among men and women strongly however agreed with the statement

that violence may be caused by economic inequalities. No gender difference was observed. Nearly a quarter (23.8%) of them *agreed.*

Violence is a form of power play

Almost one third(32.5%) of the respondents agree that violence is a form of power play. More than a quarter(28.8%) of them *strongly disagree* and more than a sixth (17.5%) *disagree*. A fifth (21.2%) of the total respondents *strongly agree* that violence is a form of power play. Of the respondents who strongly agree more women than men tend to do so.

***Guilting* is used for one's own gain**

Almost half(40%) of the respondents *agree* that making ones partner feel guilty is used for one's own gain. Almost a third (31.2%) *strongly disagree* and more than a fifth disagree. The remaining *strongly agree*.

Verbal abuse leads to physical violence

More than half (56.2%) of the respondents *agree* that verbal abuse leads to physical violence. More than a third (36.2%) respondents *strongly disagree* to it and 7.5% *disagree*. The frequency of verbal disagreements and of high level of conflict in relationships is strongly associated with physical violence. Violence is often deployed as a tactic in relationship conflict as well as being an expression of frustration or anger.

Women with low social status are more prone to violence

Almost half (48.8%) of the respondents *agree* that women with low social status are more prone to violence than those who are not. More than half the respondents

disagree either strongly or otherwise. A cross-national study by Archer (2006) found that women empowerment was associated with levels of individualism and that women were less frequently victims of violence in countries in which they were more empowered. (Bowman, B., Matzopoulos , R., Butchart, A., & Mercy, J. A., 2008).

Violence is a learned social behavior

Almost half (46.2%) of the respondents *agree* that violence is a learned social behavior while 26.2% *disagree* with it.

Violence experience in childhood teaches them that it is normal

Almost half (43.8%) of the respondents each *agree* and *strongly disagree* that violence experience in childhood teaches them that it is normal. Experiences of violence in the home in childhood teach children that violence is normal in certain settings. In this way, men learn to use violence and women learn to tolerate it or at least tolerate aggressive behavior.(Jewkes R, 2002).

Violence is a means to resolve conflict

More than two-thirds (67.5%) respondents *disagree* that violence is a means to resolve conflict.

Witnessing violence causes violent behavior

More than half (53.8%) of the respondents agree that witnessing violence makes it easier for one to use violence while almost a quarter (23.8%) *strongly disagree*. 15% *disagree* and 7.5% *strongly agree*. Gelles observes that children whose family of origin is

violent frequently continue to exhibit similar patterns of abuse in their family of procreation. (In Baker, M.L (2011).

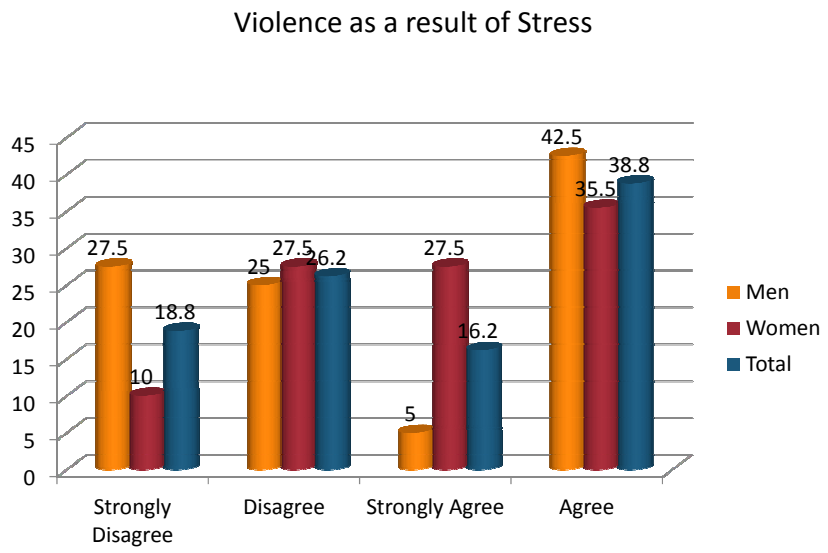

Fig 4.3 (Above) **Violence is a result of stress**

Almost two -fifths (38.8%) of the respondents agree that violence is a result of stress, while more than a quarter (26.2%) *disagree*. Almost a fifth (18.8%) *strongly disagree* and 16.2% *strongly agree*.

High level of women's education is associated with violence

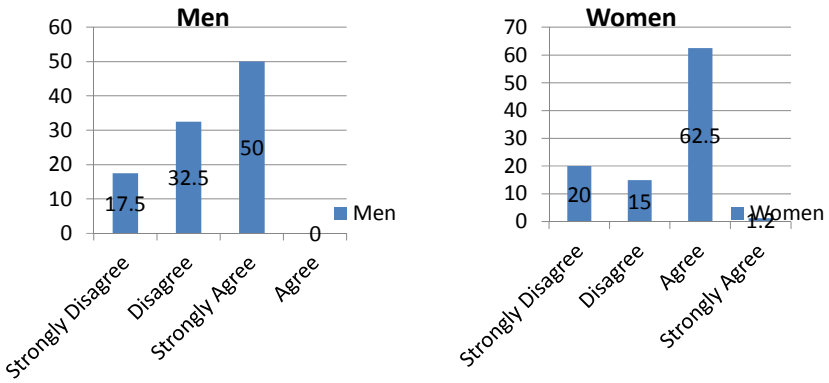

Fig 4.4 (Above) Women's education is highly associated with low level of violence

More than half (56.2%) *agree* that woman's education is highly associated with low levels of violence. Almost a quarter (23.8%) of them disagree whereas a smaller number (18.8%) *strongly disagree*. Only one respondent *strongly agreed*. Intimate partner violence also appears to be closely related to some development indicators. Research conducted in Chile, Egypt, India and the Philippines showed that increased levels of women education and general household wealth were related to decreased levels of intimate partner violence (Bowman, B., Matzopoulos , R., Butchart, A., & Mercy, J. A., 2008).

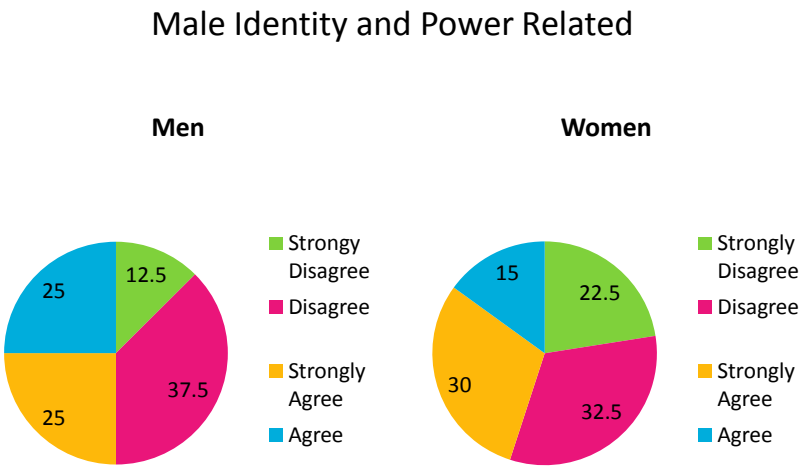

Fig 4.5(Above) Being a man is highly associated with power

More than one- third (35%) *disagree* that male identity is associated with power. More than a quarter(27.5%) *strongly agree* and a fifth *agree*. The remaining *strongly disagree*."Challenges to the exercise of power by men can be perceived by them as threats to their masculine identity. An inability to meet social expectations of successful manhood can trigger a crisis of male identity". (Jewkes R, 2002).

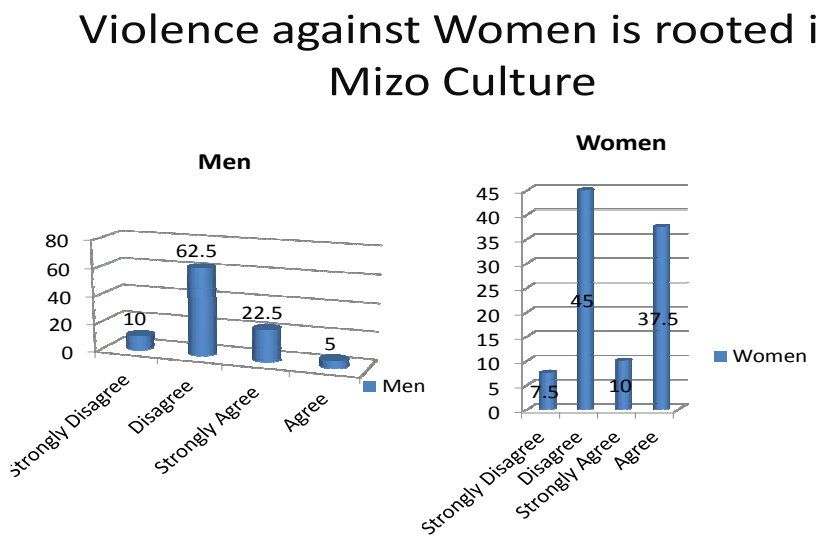

Fig 4.6 Violence against women is rooted in Mizo culture

More than half (53.8%) respondents *disagree* that violence is rooted in mizo culture. More than a fifth(21.2%) *agree* to it while a sixth (16.2%) *strongly agree* to it.

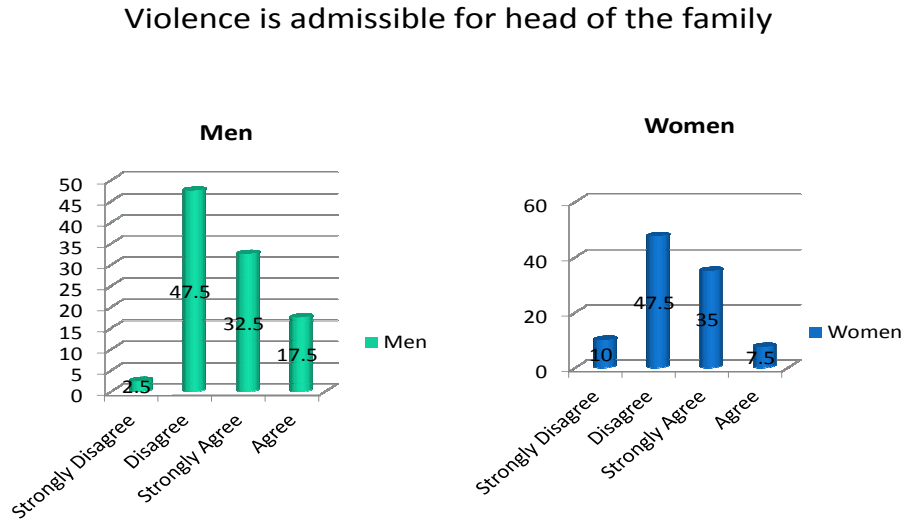

Fig 4.7(Above) Violence is admissible when perpetrated by head of the family:

Almost half (47.5%) *disagree* that violence is admissible for head of the family. One-

third (33.8%) of the respondents *strongly agree* and 12.5% agree. Only 6.2% *strongly disagree.* This finding is rather alarming as it condones the violence by head of the family and accepts that it is considered quite natural for a head to use violence.

Table 6 Awareness on Protection of Women from Domestic Violence Act (PWDVA), 2005

Sl.No		Gender of the Respondents		Total N= 80
		Men N= 40	Women N= 40	
I	**Are you aware of PWDVA**			
	Yes	4 (10.0)	13 (32.5)	17 (21.2)
	No	36 (90.0)	27 (67.5)	63 (78.8)
II	**If Yes, Where from ?**			
	Not applicable	36 (90.0)	27 (67.5)	63 (78.8)
	Friends	1 (2.5)	3 (7.5)	4 (5.0)
	Educational Institution	1 (2.5)	1 (2.5)	2 (2.5)
	Society	0 .0	3 (7.5)	3 (3.8)
	Media	2 (5.0)	6 (15.0)	8 (10.0)
III	**What do you understand from PWDVA**			
	Not applicable	36 (90.0)	27 (67.5)	63 (78.8)
	Means to protect womens rights	2 (5.0)	10 (25.0)	12 (15.0)
	Means to empower women	2 (5.0)	3 (7.5)	5 (6.2)

Source: Computed Figures in parenthesis are percentages

More than three-quarters (78.8%) of the respondents have no knowledge on PWDVA where a fifth were aware of the PWDVA 2005.

Sources of knowledge on PWDVA, 2005

Of the fifth or more who were aware of the PWDVA (21.3%), half of them had learnt through Media, a quarter (5%) of the respondents got the knowledge from friends. A small number each of the respondents learnt from society or from their educational Institutions.

What do you know about PWDVA

From the people who were aware of PWDVA, 2005 it was regarded as a *means to protect women rights* while some saw it as a *means to empower women*.

Table 7 Causes of Violence

Sl.No		Gender of the Respondents		Total N= 80
		Men N= 40	Women N= 40	
I	What in your opinion causes violence	Male n = 40	Female n = 40	Total N=80
	Status in Society	1 (2.5)	3 (37.5)	4 (5.0)
	Economic inequalities	0 .0	3 (7.5)	3 (3.8)
	One's own behavior	37 (92.5)	30 (75.0)	67 (83.8)
	Social norms	0 (.0)	3 (7.5)	3 (3.8)
	Pride	37 (92.5)	35 (87.5)	72 (90.0)
	Self centered	1 (2.5)	0 .0	1 (1.2)
	Poverty	1 (2.5)	0 .0	1 (1.2)
	Substance abuse	0 (.0)	1 (2.5)	1 (1.2)
	Behavior	1 (2.5)	1 (2.5)	2 (2.5)

Opinion on what causes Violence in their relationship

Information on this item revealed sharp distinction between what they perceived may be general causes and what were actual causes in their relationship. An Over-whelming majority of respondents (87.5%) with more women (92.5%) than men (90%) attributed that in their relationship '*pride*' on the part of the partner is likely to be a major cause for violence.

Table 8 Experiences if any on IPV

Sl.No		Gender of the Respondents		Total N= 80
		Men N= 40	Women N= 40	
I	How common is violence in Mizoram ?			
	Very Common	17 (42.5)	23 (57.5)	40 (50.0)
	Not common	5 (12.5)	14 (35.0)	19 (23.8)
	Common	10 (25.0)	0 .0	10 (12.5)
	Not at all	8 (20.0)	3 (7.5)	11 (13.8)
II	Violence experience in relationship			
	Not applicable	36 (90.0)	14 (35.0)	50 (62.5)
	Physical	0 .0	5 (12.5)	5 (6.2)
	Emotional	4 (10.0)	11 (27.5)	15 (20.0)
	Sexual	0 .0	4 (10.0)	4 (5.0)
	Economic	0 .0	5 (12.5)	5 (6.2)
	Verbal	0 .0	1 (2.5)	1 (1.2)
III	How do you feel when you are violated?			
	Not applicable	36 (90.0)	14 (35.0)	50 (62.5)
	Malfunction	1 (2.5)	5 (12.5)	6 (7.5)
	Depressed	1 2.5	9 (22.5)	10 (12.5)
	Health problems	1 (2.5)	6 (15.0)	7 (8.8)

	Lack of confidence	0 .0	3 (7.5)	3 (3.8)
	Passive endurance	1 (2.5)	1 (2.5)	2 (2.5)
	Shameful	0 .0	2 (5.0)	2 (2.5)

How common is the problem of violence in Mizoram

Majority of the respondents perceived violence *Very Common* while some respondents (23.8%) perceive differently saying *not common.*

Which type of violence have you experienced

Of all the respondents who experienced violence in relationship, emotional abuse was the highest (20%) followed by physical and emotional abuse (6.2%). Rarely does one form of domestic violence occur in isolation (Barnett and LaViolette 1993; Barnett et al 1997) and emotional abuse typically occurs more frequently than physical abuse (Walker 1979).

How has it affects you

Violence results in many forms. 12.5% respondents reports that they are depressed resulting from violence and this was the highest percentages on affects of violence reported by respondents. The respondents (8.8%) also report health Problem as an affect of violence.

Table 9 Social Support and Coping

Sl.No		Gender of the Respondents		Total N= 80
		Men N= 40	Women N= 40	
I	**How do you respond when you are violated?**			
	Not applicable	36 (90.0)	14 (35.0)	50 (62.5)
	Crying	0 .0	2 (5.0)	2 (2.5)
	Keep it to self	2 (5.0)	7 (17.5)	9 (11.2)
	Share with friends	1 (2.5)	11 (27.5)	12 (15.0)
	Self harm	0 .0	1 (2.5)	1 (1.2)
	Displacement on others	1 (2.5)	5 (12.5)	6 (7.5)
II	**Do you seek for help**			
	Not applicable	36 (90.0)	14 (35.0)	50 (62.5)
	Yes	1 (2.5)	16 (40.0)	17 (21.2)
	No	3 (7.5)	10 (25.0)	13 (16.2)
III	**If yes, where do you seek for help?**			
	Not applicable	39 (97.5)	24 (60.0)	63 (78.8)
	Friends	0 .0	6 (15.0)	6 (7.5)
	Family	0 .0	7 (17.5)	7 (8.8)
	Community	0 .0	2 (5.0)	2 (2.5)
	Church leaders	1 (2.5)	0 .0	1 (1.2)
	In laws	0	1	1

		.0	(2.5)	(1.2)
IV	**If no, why ?**			
	Not applicable	37 (92.5)	30 (75.0)	67 (83.8)
	Shameful	1 2.5	4 10.0	5 6.2
	Not necessary	1 2.5	1 2.5	2 2.5
	Not helpful	0 .0	3 7.5	3 3.8
	Personal issue	0 .0	2 5.0	2 2.5
	I'm a man	1 2.5	0 .0	1 1.2
V	**Who is most helpful**			
	Not applicable	37 (46.2)	18 (22.5)	55 68.0)
	Friends	1 (1.2)	6 (7.5)	7 (8.8)
	Family	0 .0	10 (12.5)	10 (12.5)
	Community	0 .0	2 (2.5)	2 (2.5)
	church leaders	1 (1.2)	1 (1.2)	2 (2.5)
	In laws	0 .0	3 (3.8)	3 (3.8)
	NGO's	1 (1.2)	0 .0	1 (1.2)
VI	**Ready to help ?**			
	Yes	31 (77.5)	34 (85.0)	65 (81.2)
	Maybe	8 (20.0)	4 (10.0)	12 (15.0)
	Don't know	1 (2.5)	2 (5.0)	3 (3.8)

Source: Computed Figures in parenthesis are percentages

Response to violence

More than a tenth **(**15.0%) of the respondents shared their violent experience with friends while 11.2% kept it to themselves. A small number (7.5%) admitted to *displacing their feelings on others* and respondents who use crying as coping mechanism are very few (2.2%). Only one respondent admitted to harming themselves as a response.

Help-seeking

A fifth (21.2%) seek help in times of experiencing violence. Many respondents (16.2%) do not look for help related to violence experience**.**

Support during violence

Less than a tenth (8.8%) seek help from their families, a smaller number from friends, or from community. Both Church leaders and In laws are used as source of help by one respondent each.

Reason for not seeking help

A small number of respondents feel that it is shameful to look for help, while an even smaller number (3.8%) says that it is *not helpful to seek help* from others. A small percentage each feel that it is not necessary to look for help or that it is a personal issue therefore it is not necessary to seek for help. One of the men respondents said that it was not a 'masculine" makes them feel unnecessary to seek for helpful

Who is the most helpful?

A tenth **(**12.5%) of the respondents said that family is most helpful, and less than a tenth (8.8%) reported that friends are *most helpful*. A small number said that in laws are most helpful. Few each reported that community and church leaders are the most helpful.

Only one respondent said that NGO's are most helpful indicating that tertiary support was considered helpful**.**

Willingness to help victims of violence

Majority (81.2%) of the respondents said that they are ready to help person experiencing violence. Almost a fifth were unsure or undecided.

4.1 Focus Group Discussion :

4.1.a) Focus group discussion with Married Men on Perceptions of Violence against women.

One Focus Group Discussion was conducted among men to probe into their perceptions on violence against women. The discussion was held at Village Council President residence, Melthum. *Eight members* participated in the discussion whose age ranged between **18-30 years.** From the discussion it was found that Mizo men have begun considering violence against women as a serious crime. Recognition of women's role in family and society is emerging. The participants stated that it is men who create problems and violence in any relationship although women , in their perception, had a role to play in it. " *Mipate hian mipatna tak tak chu tute nge an thununa an tihduhdah theih tih lamah ni lovin, tute nunah nge a tha zawngin nghawng a neih theih tihah a in nghat zawk ani tih an hriat a tul ani*". (Men need to realize that true masculinity is not about who you can control and violate: that it emanates from who you can positively affect), said one of the participants. The statement clearly shows that consciousness of

responsibility by men is present and that there is recognition that the intimate relationship is one of power relations.

The next sub-theme discussed was to do with *women empowerment*, the group members believed that the patriarchal system is prevalent in Mizo society and hence a very few women are empowered. However, some of them expressed that womens' empowerment is not necessary in patriarchal society and that Men should always be head of every relationship and women play a secondary role living by the rules set by men. The group members also mentioned that Mizo women are more empowered compared to women who live outside the state. " *Khawtlang hian hmeichhiate tih chak lam hi a ngaihtuah luatah hmeichhe tam tak chuan an dikna leh an thilpek dawn te chu hmun tam takah harsatna chawh chhuahna hmanruaah an hman phah mek ani*". (The society pays too much attention for women empowerment that many women misuse their gifts and rights thus create problems in many Institutions.)

Since theories of violence discuss the root causes as being embedded in Family and parenting, information was sought on the same. Half of the members agreed that *witnessing violence in childhood teaches children that Violence is normal,* and they are likely to become a perpetrator in adulthood. On the other hand, half of them argued saying : "*Kan thil hmuh hi kan nihna a ni ngailo. Kan thil tum hi a pawimawh zawk ani. Nunkawng hruaitu tha neite chuan an thil hmuh apiang an zawm ve kher hran lo*". (We don't become what we see, but our morals are important. People don't always tend to repeat what they saw if they have clear principles in life.

Some of the participants strongly stated that as men and being a head of the family they have power and control that they can use them against their partner. They also stated that women with higher education and status in society are respected by men and are *less likely* to experience violence in relationship.

The result of group discussion with men clearly suggest that immediate steps needs to be taken to reduce violence against women. Men in society need to learn that being a man does not give them the right to violate women. There should be mutual share of rights and power across gender.

4.1 b)Focus Group discussion with unmarried women.

One focus group discussion on Violence against Women was held with unmarried women between the age of 18-30 years. The group had 8 participants who raised their voices on the said topic. They believed that *a society teaches Men that Women are weak p*hysically , as well as mentally. Women must accept abuse as normal and are expected to stay under men's control. Wrong education and messages by the media and society and also the attitude of some men create unsafe and unhealthy relationship for women. " *Hmeichhe rilru na taka awm te leh kut tuar te hi, khawtlang mipui te hian a chochhuah alawm tiin emaw,a phu tawk a hmu a ni mai alawm ti a kan sawi zui hian, kan nghaisak belhchhah thin ani*". (Society oftentimes punishes women who get hurt or violated by saying she asked for it so she got what she deserved). The participants also believed that " *Hmeichhia te hian an chakna chu chhunglam atanga chhuak ani tih an hriatchhuah a hun takzet tawh a, kawppui te laka kut tawrh pumpelh nan hmeichhia ten mahni hlutna an hriat a tangkai hle ang*".(Women need to wake up to the fact that their personal power

is internal, recognition of self worth would be helpful to some extent in order to avoid violence in relationship).

The participants agreed to “having been inculcated with messages that violence against women is just part of the way life is, we give less weight to the reports, sometimes even placing the blame on the victims “. The main coping strategy used by these women was *passive endurance*. They considered being a victim of violence is shameful and that none of them shared their experiences with their families. Though some participants shared their violence experience with friends it is not very helpful when the problem is big. Discussing the coping and social support aspect, unmarried women agreed that *emotional support* is most helpful in a violent relationship as per their experienced. Since women in the group are unmarried they don’t go looking for help from families, neighbors and society. When they are in abusive relationships they tend to keep it to themselves and continue to suffer. The realization is that it is a man’s world and their (women’s) rights would not be recognized, according to them.

The discussion revealed that unmarried women in abusive and violent relationship needs to exercise their rights and the worst part according to them is that most people are unaware of it. *“ Hmeichhe tam tak chu fing in thiam thil tha tak neiin, hlutna ngah tak niin thilpek bik te poh dawng tha hle mah se, mipa aia hnuaihnung zawk ah an in ngai tlat a. Hmeichhe nihna ang in mahni tan leh midangte tana dinchhuah a tul hle ani”*. (Many women learn that they are the subordinate gender regardless of their intelligence, their talents, their worth and their gifts. As a woman, it is essential to stand up for oneself and for each other), they said.

4.2 Case Vignette 1

4.2a) Ms X

Ms X was born in 1976. She belongs to a family of 8 members. Their family belongs to middle class and she hails from the district of *Kolasib*. She has two brothers and 3 sisters who are all married. She got married when she was 26 years old and resides in Aizawl since the time of marriage. Ruati came from a very good Christian family. Her father is one of the Presbyterian church elders and she grew up in a healthy family environment. She has 4 children (2 boys and 2 girls) with her ex husband who is a year older than her. She works in government settings while her ex husband is unemployed though he is a fairly well educated man. During the initial years of marriage they stayed with her husband parents, and left her husband's family after a few months of marriage and continued to stay in a rented house.

As the husband remained unemployed he was compelled to depend on the earning of his wife. This issue seemed to be the major reason of all the conflicts in their marital affairs. Since her husband got no work during the day, he spends his leisure time for consuming alcohol. After a year her husband became regular drinker while still depending on his wife income for purchasing alcohol. As he began to increase his consumption he eventually began to get more aggressive and violent in his behavior. He started beating up his wife related to a talk regarding his expenditure on alcohol. Ms x laments " the reason of his violent behavior towards me could be he not earning income

and that violence is used as defense mechanism. The result of his husband violent behavior compelled Ms x to leave the house without proper channel of divorce.

Discussion of the case 1: This case illustrate the challenged faced by a woman whose husband was unemployed. The effects of such unemployment have contributed to his excessive leisure time subsequent resort to alcohol consumption and dependence on his wife's income. The source of conflict due to which violent behavior began is attributed directly to his need for money to sustain his alcohol consumption. As is evident, despite the fact that woman has a large family and social support, violence has destroyed the marriage and rendered her vulnerable.

4.2 b) Case vignette 2

Ms Y

Ms y was born in 1989. She had two brothers and one sister. Her father work as driver in the Government Department and her mother is a housewife. They originated from their present locality. They belong to Presbyterian church. Her father is a regular drinker and often abuse his wife physically and emotionally. The family environment was not very healthy as she (MsY) and her siblings witness violent behavior at home almost every day. Staying in unhealthy family with violent behavior of her father, she lose her moral and dropped out from school. She has no interest in studies thus got married at an early age.

She got married in 2008 and MsY was 19 year old at the time of her marriage. In the initial years of marriage, she stayed in her ex husband parents house. Since her husband got a job in private company, they left the parents house and settle on their own.

Ms Y said " Even before their marriage , her husband used to force her to marry him by saying "*Min neih loh chuan ka in tihlum ang*" (If you don't marry me I'l commit suicide). Though she wanted to break up their relationship due to personality clash, the guilty feeling for her partner coupled with their unhealthy family environment compelled her get married.

She has 2 children who are both illiterate. Ms Y mentioned, though the relationship with her husband was normal at the beginning, the clash started to grow daily. Her husband came home late from work almost every night, and she also heard the rumours that he had extra marital affairs. MsY continues to bear the emotional pain silently as she don't want to go back to her family where her drunken father beaten up his wife daily. She ignores the misbehavior of her husband hoping he'll change later. But the situation got worse as the husband became more aggressive and violent. She asked him to clarify the rumours that he had an extra marital affairs. But her husband would get angry instead and labeled her as the one who had an extra marital affairs. This results in verbal abuse and physical abuse by her husband.

The result of her husband's violent made her leave the marriage. They divorced in December 2013. Ms Y went back to her parents with her 2 children. With two of her children and having no income she started to feel inferior towards her parents and siblings. As she dropped out from school at early age she could not find good job. So she started going for training "beautician" under one NGO in town. The training would get over after 6 months and she planned on opening a beauty parlour in her locality.

Fictitious name to conceal the identity.

Discussion of the case 2 :

The case presented above shows that a young women dropped out from school at an early age because there was no support and care from parents. The violent family environment act as a force to get her married at an early age. The situations gave her no option to get married to a violent person. MsY has been emotionally abuse at her parents home and continued to suffer violence in her marriage. She said " leaving marriage is no good at all as we take vows before God, but I also believe God would not allow me suffer lifetime . The abuse I've gotten taught me a lesson and that I am ready to make a new start "

Having witnessed in her home, she herself got vulnerable in her marriage. Extra marital affairs on the pair of the spouse and subsequent violence has destroyed her family and her own self confidence. She is left with little education, no income and children whom she is unable to help through education.

CHAPTER V

CONCLUSION AND SUGGESTIONS

The research title, " Intimate Partner Violence against Women: Perceptions Across gender in Aizawl city" is an attempt to study the perceptions of both male and women on intimate partner violence against women, to see their knowledge on PWDVA and how they perceived it, the available social support and coping pattern of the victims. Information has been sought through quantitative and qualitative means.

The study is the first of its kind and documents perceptions on Intimate Partner Violence against Women. The objectives of the study were to explore perceptions related to Intimate Partner Violence across Gender, to understand perceptions related to PWDVA, 2005 and to examine experiences, if any, on IPV, exploring the social support available for the victim women and to understand the efforts made in prevention of Intimate Partner Violence against women.

The study is descriptive in design and cross sectional in nature. Mixed methods have been used to gather data on socio-demographic particulars, details about the victims of intimate partner violence and information pertaining to coping strategies and the availability and utilization of social support.

Multi stage sampling was used. *At the first stage*, Aizawl District was selected.

In the second stage, One core and One peripheral area in Aizawl city was selected based on objective criteria

At the third stage, a list of all households was drawn using systematic random sampling

In the final stage, one woman and one man from each of the selected households was drawn as respondents based on the following inclusion criteria.

Inclusion criteria

i) Men and Women between the ages of 18 to 40 years.

ii) Currently involved in an intimate relationship for a minimum period of two years.

iii) Literate

iv)Willing to give informed consent on perceptions and experiences ,if any, on Intimate Partner Violence.

The following tools were used in the study. a) Structured interview schedule was used to collect primary data. The schedule contains different sections providing information on the socio-demographic particulars, the present intimate relationship status of the respondents. Perceptions on Violence, perception on PWDVA, Violence experience if any, social support and coping. b) Focus group discussions were conducted among men and women to explore perceptions related to Causes and consequences of Intimate Partner violence against women. c) Two case vignettes were conducted from women who have experienced violence to document their experience in an in-depth manner.

In conclusion the following have been observed.

- In the study conducted, the socio-demographic profile of the respondents shows that *more than half of the respondents belong to the*

age group of 18-30 years. It was also observed that *more than two-thirds were living within the confines of marriage* and had spouses, however more than *a quarter were in an intimate relationship with a partner*(boyfriend/girlfriend).

- Almost all respondents were from a stable family which at the same time reveals that perceptions on violence are influenced by stability in the family one belongs to. Religiosity strongly determines the perceptions of individuals in Mizo society. In this study, all respondents are Christians.

- In this study, more than one-third of the women report having experienced violence in their relationships with five times higher number of women than men. Men-to-women partner violence is more often repeated .For instance, women are victims of intimate partner homicide at a rate approximately 8 times that of men, and women are assaulted by armed intimates at a rate approximately 7 times higher than that of men." (Schafer J, Caetano, and L Catherine 1998). A*lmost a fifth of the total respondents are presently experiencing violence in their relationship. A tenth of the respondents report a duration of more than four years. Despite the fact that majority had never experienced violence only a fifth interestingly claim that their relationship is 'very good'*. Also, although more than a third had experienced violence in the past or present, they have stated their relationship as good.

- More than a third of the respondents experience stress related to family. These include problems like disturbed relationships, poor communication, rivalries etc. Less than a quarter of the respondents experienced stress related to personal issues .Such issues were likely to be ones where they had to deal with by themselves and were problems related to uncertainty over the future etc.
- Information was sought on expression of anger by respondents and their partners and results were fairly revealing. The respondents report that the partner tends to get angry first in the case of arguments. This perception was greater among men than women dispelling the myth that men are the more likely gender that expresses anger.
- The above question raised the need to delve into what caused violence in families. In this study of 80 respondents in Mizoram**,** more than a third of them strongly disagree that economic inequalities leads to violence although several studies highlight the same. It is apparent that in this small study people see other reasons as being responsible for violence. Many respondents perceive that Violence is a form of power play .Of the respondents who strongly agree more women than men tend to do so. Almost two -fifths of the respondents agree that violence is a result of stress faced in the various fronts across home and work. More than a quarter *of the men* believe that 'being Male' inherently gives them the right to exercise power over women particularly in their families and, in general in society. Challenges to the exercise of such power can be

perceived by them as threats to their masculine identity. Studies reveal that there is a relation between increase in levels of women education and decrease in levels of intimate partner violence. More than half of the study population also perceive that women's education is negatively related to low levels of violence. Another reason loosely attributed to violence is that of patterns of patriarchy in society. More than a fifth in this study perceive that violence is rooted in Mizo culture. The study also found that some respondents accepted violence if head of the family is the perpetrator as it was considered as 'normal' for a head to use violence.

- Perceptions regarding the PWDVA, 2005 were sought as it is important to understand the awareness levels of respondents on the legal literacy. Majority of the respondents report that they are not aware of PWDVA. Of the respondents who were aware of it, Media was the main source of information. PWDVA was regarded by them as a *means to protect women rights* or a *means to empower women*.
- The respondents were interviewed with their consent regarding experience of violence in intimate relationship. As mentioned earlier, more than a third have had an experience of violence. Of the abused respondents, the highest percentage of them shared their violent experience with friends as a means of ventilation, while some of them respond to the experience by crying, displacing on other forms of passive endurance. A fifth sought help from friends, families, communities, church leaders, In laws or NGO's. It was reported by them that, of all the

sources of help, families are the most helpful in terms of providing help to the victims although tertiary support was also considered helpful by the respondents. Although there are respondents who don't feel the necessity of seeking help when they are violated, majority of the respondents said that they are ready to help person experiencing violence.

- The focus group discussion conducted among the two groups (married men and Unmarried women) reveals the different perceptions on violence against women. It may be concluded that many women are unaware of their rights in abusive and violent relationship and have to learn the need to exercise their rights. Many women perceive themselves as the subordinate gender regardless of their intelligence, their talents and their worth. The main coping strategy used by women in their perception was *passive endurance*. Being a victim of violence is considered shameful by them to the extent that even when they are in abusive relationships they tend to keep it to themselves and continue to bear the pain silently. This was attributed to the beliefs held in society. On the other hand, although recognition of women's role in family and society is emerging among men, some of them expressed that woman's' empowerment is not necessary in a patriarchal society where Men are the head of every relationships in society and women must live by any rules set by men. It was also added that Mizo women are so much empowered and the advantages are often misused by them. Some male participants in the group discussion strongly stated that as men and being a head of the

family they have power and control that they can use against their partner. It was further exclaimed that women with higher education are respected in society especially by male citizens and are likely to escape violence due to their social status.

Case Vignettes: The case vignettes illustrate the helplessness of women who are subjected to violence. Violent partner in each of the cases has had a history of alcohol/substance use as well as extra marital affairs and in both the cases violence has led to break down of the marriage leading to divorce. The consequences of such violence on the women include low self esteem, lack of self confidence and inability to raise their status to become independent earning members. Divorce, lack of social support and lack of employability have also led the children drop out of schools, remain illiterate and are brought up in relatively unstable environment.

The suggestions that emanate from the study are grouped under three major headings based on the focus or thrust area of the research. These include suggestions related to i)Awareness levels in the general community and awareness generation on rights and protection ii) Perceptions and how to bring about perceptual change iii) Addressing mental health and social support based on actual experiences reported.

1. Awareness generation on rights, protection of women and prevention of violence
   i) As most of the respondents are not aware of the issues related to protection and PWDVA, 2005 there is tremendous scope to raise awareness at the community level in the state of Mizoram. Networking

with Government and Non Government Organization is indicated in order to generate awareness on legal and other aspects for women.

ii) This study in a general community setting has still revealed that a number of women continue to suffer from violence perpetrated by an intimate partner. Towards this end, social work intervention may be addressed through mezzo and macro levels to prevent violence basically though appropriate awareness generation.

iii) This study suggests that women need to be made aware of provision of protection guaranteed under the law and tertiary support for those women who do not have primary or secondary support needs to be assured. People need to be specifically aware of available NGOs, FBOs, and CBOs that provide help to women who experience violence.

2. Perceptions and Perceptual change

i) As violence is often regarded as an extremely personal issue and further, since there is a lot of shame and guilt surrounding the issue, most victims of violence do not seek help or talk about it. Particularly in the case of intimate partners this is true. The suggestion here is that awareness needs to be increased to make communities more sensitive and supportive so that a woman may feel more confident in help and support seeking.

ii) Women experiencing intimate partner violence are often accused of having provoked the violence by the way they behave, failure as a wife, or infidelity. Girls or women who have been assaulted are frequently said to have “asked for it” by the way they were dressed or behaved. This attitude

of society is in requirement of change and the suggestion is to begin this change by intervention in educational institutions as well as in communities.

iii) This study observed the perception that women's unequal status in society makes them vulnerable to violence and intimate partner violence is often used to demonstrate a man's position as head in the relationship. Both men and women in this study believed that a man is always a head and it is not disapproved that he uses his power to control a woman, even if such power leads to violence. The suggestion involves bringing about an attitudinal change in men through appropriate interventions. Such drastic attitudinal changes may be better brought about by church elders and community leaders. Social work intervention therefore may be directed at influencing church elders and community leaders.

iv) Community level interventions are required so that people realize that they need to be involved and that they can make a difference in supporting women and reducing violence. The general perception that their involvement is an ‘interference’ in the intimate, personal affairs of an individual have to be changed.

3. Prevention efforts: As indicated by the case vignettes and focus group discussion, alcohol and substance abuse are common reasons for marital conflicts which inturn lead to violence. Therefore, efforts needs to be directed at helping communities free of Substance/Alcohol use.
4. Mental health and social support

i) Needs related to mental health particularly anxiety and depression, low self confidence and suffering by victims of violence require to be addressed. As a lot a woman do not necessarily go to mental health professionals, the suggestion is to increase social support available through training of counselors at community level as well as introduce social support groups that are peer-led.

5. Policy implications

i) In the course of the study it is observed that th PWDVA,2005 has not been very effective because of certain provisions. For eg, women have been very hesitant to use the provision of reporting repeated offence in fear of the outcome (as men are imprisoned for a very short duration and will return eventually to the home, angered further by the fact of imprisonment). Suggestions include more protective measures for the women so that they may fearlessly pursue the ends of justice.

6. Research Implications :

i) There are several indications for research that emanate from this study. Studies across Mizoram, documenting rural-urban differences are indicated. Research on victims of domestic and on intimate partner violence is required. Further, studies on sexual violence and on incest are also indicated.

BIBLIOGRAPHY

Abbott, P. (1999). Women, Health and Domestic Violence. *Journal of Gender Studies*, 8(1), 83–102

Alcock, D. (2011). Counseling survivors of domestic violence, Practice: Social Work in Action, 13(3), 45-54.

Anderson, K.M.,Renner, L.M., & Bloom.T.S., (2014) Rural Women's strategic Responses to Intimate Partner Violence, Health Care for Women International, 35:4, 423-441.

Baker, M.L (2011).Domestic Violence: Every child does matter. *International Journal of Disability, Development and Education*, 58:2

Bowman, B., Matzopoulos , R., Butchart, A., & Mercy, J. A., (2008): The impact of violence on development in low- to middle-income countries, *International Journal of Injury Control and Safety Promotion*,15:4, 209-219

Campbell J. (2002,April 13). Health Consequences of intimate partner violence. *The Lancet*, 359.

.

Campbell J, Lewandowski L 2002: Mental and physical health effects of intimate partner violence on women and children. *Psychiatric Clinics of North America,* Volume(2),353-374.

CID (crime) Branch. (2014). *Crime Against Women,* [Television Broadcast]. Aizawl:India.

Coker,A.L., Smith, P.H., McKeown, R.E., and King, M.J., : Frequency and Correlates of Intimate Partner Violence by Type: Physical, Sexual, and Psychological Battering. *American Journal of Public Health, 90,(4).*

Coker,A.L., Smith, P.H., McKeown, R.E., and King, M.J., E, Roberts *(2000)*: Physical health consequences of Physical and Psychological intimate partner violence. *American Medical Association*

Dichter, M.E., & Marcus, S.C., (2013) : Intimate Partner Violence Victimization Among Women Veterans: Health, Health Care Service Use, and Opportunities for Intervention, Military Behavioral Health

Dichter, M.E., & Rhodes, K.V., (2011) Intimate Partner Violence Survivors' Unmet Social Service Needs, Journal of Social Service Research. Physical intimate partner violence in Chile, Egypt, India and the Philippines, *Injury Control and Safety Promotion, 11(2), pp. 111–116.*

Galano, M,M., Miller, L. E., & Bermann, G.S., (2014): Avoidance Symptom Presentation of Preschoolers Exposed to Intimate Partner Violence in a Group Therapy Setting, Child Care in Practice

Goetz, A.T., Shackelford, T.K., Starratt,V. and Mckibbin, W.F., (2008): Intimate Partner Violence

Hassan, F et al(2004): Physical intimate partner violence in Chile, Egypt, India and the Philippines, Injury Control and Safety Promotion Injury Control and Safety Promotion,11(2), pp. 111–116.

Hester, M. & Westmarland, N.(2006): Domestic violence perpetrators, Criminal Justice Matters, 66:1, 34-35.

http://en.wikipedia.org/wiki/Protection_of_Women_from_Domestic_Violence_Act_2005.

Humphreys, J.(2010) Sexually Transmitted Infections, Pregnancy, and Intimate Partner Violence, Health Care for Women International.

Jewkes, R. (2002). (2002, April 20),Intimate partner violence: causes and prevention. Violence against women III. *The Lancet*, 359.

Johnson, N.L., & Johnson, D.M., (2013) Correlates of Readiness to Change in Victims of Intimate Partner Violence, *Journal of Aggression, Maltreatment & Trauma* 22:2, 127-144.

Karakurt, G., Dial , S., Korkow , H., Mansfield & Banford, A., (2013): Experiences of Marriage and Family Therapists Working with Intimate Partner Violence, Journal of Family Psychotherapy, *Journal of Family Psychotherapy*, 24:1–16.

L Heise; Moreno G, Violence by intimate partners.

Lal Neeta (2007 April 17). Violence Against women in India. *The Brunei Times.*

Lipsky, S., Caetano, R., Field, C.A., & Larkin, G.L., (2006) The Role of Intimate Partner Violence, Race, and Ethnicity in Help-Seeking Behaviors, Ethnicity & Health,11(1), pp. 81-100.

Meekers, D., Pallin, S.C., & Hutchinson, P., (2013) Prevalence and correlates of physical, psychological, and sexual intimate partner violence in Bolivia, Global Public Health: *An International Journal for Research, Policy and Practice,8(5), 588-606.*

Mercy ,J. A., Butchart, A., Rosenberg ,L. R., Dahlberg, L. & Harvey, H. (2008): Preventing violence in developing countries: a framework for action, *International Journal of Injury Control and Safety Promotion*, 15:4, 197-208

Miller, C. E., & Mullins, B. K., (2002) Lifelong Learning to reduce Domestic Violence.*International journal of lifelong education,*21,(5), 474–484.

Moreno C G, Jansen H, Ellsberg M, Heise L, Watts C, Prevalence of intimate partner violence. (2006 October 7-13). Findings from the WHO multi-country study on women's health and domestic violence *The Lancet,* pp.1260–1269.

Morgan, W. & Gilchrist, E. (2010) Risk assessment with intimate partner sex offenders, Journal of Sexual Aggression: *An international, interdisciplinary forum for research, theory and practice, 16(3), pp. 361-372* .

North East Network .(2004):Violence Against Women, Shillong, Meghalaya: Author.

Nussbaum, M.C. 2005. Women's Bodies: Violence, Security, Capabilities.*Journal of Human Development*, 6(2).

Palazzolo, K.E., & Roberto, R (2011) Media Representations of Intimate Partner Violence and Punishment Preferences: Exploring the Role of Attributions and Emotions, [Electronic version]. *Journal of Applied Communication Research Vol.39(1), pp. 1-18.*

Payne, B. K., Triplett, R. A., & Higgins, G. E., 2011. The Relationship Between Self-Control, Witnessing Domestic Violence, and Subsequent Violence. Deviant Behavior, 32: 769–789

Peterson, R. R., Deirdre Bialo-Padin.(2012).Domestic Violence Is Different: The Crucial Role of Evidence Collection in Domestic Violence Cases. *Journal of Police Crisis Negotiations*, 12:2, 103-121

Radford , R., Harne, L., & Trotter, J., (2006): Disabled women and domestic violence as violent crime, Practice: Social Work in Action, 18:4, 233-246

Rennison C. February 2003: *Intimate Partner Violence, 1993-2001*. Bureau of Justice Statistics Crime Data Brief. U.S. Department of Justice Office of Justice Programs.

Saraswati, M. 2002 : *Status of Indian Women*, Gyan Publishing House, New Delhi

Schafer J, Caetano, and L Catherine (1998) : Rates of Intimate Partner Violence in the United States. *American Journal of Public Health, 88(2).*

Scott L. D & Kunselman C. J (2007): Social Justice Implications of Domestic Violence Court Processes, *Journal of Social Welfare and Family Law, 29(1), 17-31.*

Short, L.M., & Rosenberg, M.L., (2001) Intervening with victims of intimate partner violence, *Injury Control and Safety Promotion*, 8(2), pp. 63–69.

Starmer, K. (2011): Domestic violence: The facts, the issues, the future. *International Review of Law, Computers & Technology* , 25, 1–2.

Strand, S. (2012) Using a restraining order as a protective risk management strategy to prevent intimate partner violence, Police Practice and Research: *An International Journal 13(3),254–266.*

Waalen, J. Goodwin, M. Spitz, A. M., Petersen, R. Saltzman, L. E., (2000) : Screening for Intimate Partner Violence by Health Care Providers: Barriers and Interventions. Violence Prevention and Intervention in Health Care and Community Settings. *American Journal of Preventive Medicine,19(4).*

Yudhistar, K. 2003: *Violence Against Women*, Reference Press, New Delhi

Zolotor J A, Amy C. Denham, Amy Weil. Intimate Partner Violence, pp 167-79.

Interview Schedule
Intimate Partner Violence Against Women
(Confidential and for Research Purpose Only)
(English version)

Research Investigator:
Ms. Catherine Lianhmingthangi
Research Scholar
Dept of Social Work
Mizoram University

Research Supervisor:
Dr. KalpanaSarathy
Associate Professor
Dept of Social Work
Mizoram University

Schedule No. Date: Time:

I Socio Demographic Profile

Sex : 1 Male 2 Female
Age :
Marital status: 1 Unmarried, 2 Married, 3 Divorced, 4 Widowed, 5 Remarried, 6 Any other (Specify)_____

Nature of Intimate Relationship: 1. Spouse 2. Live-in Partner 3. Partner 4. Any Other

Form of family : 1 Stable/2 Broken/3 Reconstituted Step/Others (specify)_____

Religion : 1 Christian/ 2 Hindu/ 3 Muslim/ 4 Buddhist/ 5 Others(Specify)_____

Denomination : 1Baptist/ 2 Presbyterian/ 3Roman Catholic/ 4 Salvation/ 5 Seventh Day UPC/ 6 any other (Specify)_____

Socio-economic category : 1 APL/ 2 BPL/ 3 AAY/ 4 No category

II. Violence and Relationship particulars:

1. Have you ever been in an intimate relationship in which you have experienced violence ?

   1) Yes . 2) No (If no . skip to question 4)

2. Is the intimate relationship with Violence in the past or present?

   1) Past 2) Present 3) Both 4) Multiple

3. How long was the duration of the relationship in which you experienced violence?

1) 0- 2 years (2) 2- 3 years (3) 3-4 years (4) more than 4 years

4. How would you describe your relationship with your current partner?

1) Good (2) very Good (3) poor (4) very poor

III. Experience of Stress in relationship

1.Have you come across experiences of stress during your relationship?

1) Always (2) Often (3) Rarely (4) never

2. If so, what areas contributes to stress in your relationship ?

1) Problems related to family (2) Financial difficulties (3) Sexual (4) Personality clashes (5) Partner indulging in substance abuse (6) Any Other , Specify

IV (a) Perceptions related to IPV across Gender

1. Tend to lose temper very easily

i) Self	ii) Partner	iii) Both	0) N. A

2. When really angry, other people are fearful

i) Self	ii) Partner	iii) Both	0) N.A

3. Tend to be very argumentative

i) Self	ii) Partner	iii) Both	0) NA

4. Physical force is used to resolve arguments

i) Self	ii) Partner	iii) Both	0) NA

5. Substance abuse causes violence

i) Self	i) Partner	iii) Both	0) NA

6. Low self-esteem/ Inferiority makes one vulnerable to violence

i) Self	ii) Partner	iii)Both	0) NA

IV (b)

1. Poverty and economic inequality are the key contributors to IPV

i) Strongly agree	ii) agree	iii) disagree	iv)Strongly disagree

2. Violence is just an expression of power over the another partner

i)Strongly agree	ii) agree	iii)disagree	iv)Strongly disagree

3. Blackmail and Guilting are often deployed in relationships to gain something

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

4. Verbal disagreements are strongly associated with physical violence

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

5. Women who attain respect and power outside the home are less likely to be abused than those who do not

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

6. IPV is a learned social behavior

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

7. . Experience of violence in childhood teaches children that violence is normal

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

8. Violence is a means of resolving conflicts

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

9. Witnessing violence likely to have subsequent result in partner abuse

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

10. Partner violence is a result of stress

i)Strongly agree	ii) agree	iii)disagree	iv)Strongly disagree

11. High level of women's educational attainment is associated with low level of violence

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

12. Male identity is associated with power

i)Strongly agree	ii) agree	iii)disagree	iv)Strongly disagree

13 . Violence against women is rooted in mizo culture

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

14. As the head of a family men are allowed to exercise power and use violence

i)agree	ii)Strongly agree	iii)disagree	iv)Strongly disagree

V. Perceptions related to Protection of Women from Domestic violence Act, 2005

1. Are you aware of the " Protection of Women from Domestic Violence Act?

   i) Yes (ii) No

2. If yes, where from ?

   i)Family (ii) Friends (iii) Educational Institutions (iv) Neighborhood (vi) Media

3. What do you understand from the PWDVA, 2005?

   i)A means to secure women's rights (ii) To empower women (iii) To punish men (iv) Any Other

VI. Perception on Causes of Violence

1. What in your opinion causes Violence?

i) Status in Society

ii) Economic Inequalities

iii) I am wrong

iv) Social norms

v) Pride

v) Self Centeredness

vi) Poverty

vii) Substance Abuse

viii) Behavioral Problems

VII Experiences, if any of IPV among women

1.How common is the problem of violence in Mizoram?

i) Fairly common (ii) Very common (iii) Uncommon (iv) Not common at all

2. What are the forms of violence in the relationship?

i) Physical (ii) Emotional (iii) Sexual (iv) Economic (v) Verbal

3. How do you feel when you are violated?
   i) Malfunction
   ii) Depressed
   iii) Health problems
   iv) Lack of Confidence
   v) Passive Endurance
   vi) Shameful

VIII Social Support and Coping

1. How do you respond when you are violated in any form?
   i) Cried out (ii) keep it to self (iii) Talk to friends (iv) Self harm (v) Displacing on others

2. Did you seek help?

i) Yes (ii) No

3. If yes, where did you seek help from? If No, Why not?

   i) Friends ii) family iii) neighbours iv) church leaders v) community leaders vi) NGOs vii) In laws

4. When there is violence in the family, who are the people found to be most supportive?

i) Friends ii) family iii) neighbors iv) church leaders v) community leaders vi) NGOs vii) In laws,

5 When a person is experiencing violence in the neighborhood, can you be of any help/?

i) Yes definitely ii) No definitely not iii) Maybe iv) Don't Know

Interview Schedule

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(Mizo Version)

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Research Supervisor:
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Associate Professor
Dept of Social Work
Mizoram University

Schedule No. Date: Time:

I Socio Demographic Profile

Sex : 1 Mipa 2 Minu
Kum :
Kawppui Chungchang: 1 Neilo, 2 Nei, 3 Inthen, 4 Hmeithai, 5 Nei tha leh, 6 AnyThil Dang (Sawi chiang rawh)_____

Inlaichinna Chungchang: 1. Nupui/Pasal 2.Innei lo a cheng dun 3. Kawppui 4. Thil dang

Chhungkaw nihphung : 1 Nuclear/2 Joint/3 Extended

Sakhuana : 1 Christian/ 2 Hindu/ 3 Muslim/ 4 Buddhist/ 5 Others(Specify)_____

Kohhran : 1Baptist/ 2 Presbyterian/ 3Roman Catholic/ 4 Salvation/ 5 Seventh Day UPC/ 6 any other (Specify)_____

Socio-economic category : 1 APL/ 2 BPL/ 3 AAY/ 4 No category

II Inlaichinna Chungchangah:

1. Inlaichinnaah i laka hleilenna i tawng tawh em?

   1) Aw. 2) Aih (If no . skip to question 4)

2. Hleilenna i lo tawn tawh te chu tun huna I tawn mek nge tunhma lam ami tawh?

   i) Tun hma ii) Tunah iii) A ni ve ve iv) a vaiin

3. Hleilenna i lo tawn tawhna inlaichinna chu engtia rei nge I lo kalpui?

   i) Kum 2 chin ii) Kum 2 atanga kum 3 iii) Kum 3 atanga kum 4 iv) kum 4 aia tam

4. Tuna i kawppui nena in inlaichinna hi eng ang nge ni a I hriat?

   i) Tha ii) Tha lutuk iii) Tha lo iv) Tha lo lutuk

III. Inlaichinna a Harsatna/Mangana tawh chungchang

1. In inlaichinna ah rilru lama harsatna/manganna nasa tak i lo tawng tawh em?

   i) Englaipawh in ii) Ngai vaklo iv) Ngai lo

2. I lo tawrh tawh chuan a hnuaia tarlan te zingah hian eng ber hian nge chu chu thlen che?

   i) Chhungkaw lam harsatna. ii) Sum leh pai dinhmuna harsatna
   ii) Mipat/hmeichhiatna lam iv) Mahni dinhmuna harsatna v). Kawppuite ruihtheih thila an talbuai vang vi) He'ng bak a nih chuan han sawi chiang teh.

_____

IV. (a)Mipa leh hmeichhe kara inlaichinna kara hleilenna I hmuh dan:

1. Tunge thin ram zawk? Tunge thinrim hma zawk?

1) Mahni	2) Kawppui te	3) Ni ve ve	0) N. A

2. Thinrim tak tak lai chuan midang te paw'n an hlau chawk

1) Mahni	2) Kawppui te	3) Ni ve ve	0) N.A

3. Hnialhrat tak.

1) Mahni	2)Kawppui te	3) Ni ve ve	0) NA

4. Inhnial changin kut thawh thin.

1) Mahni	2)Kawppui te	3) Ni ve ve	0) NA

5. Ruihtheih thil hmansualin hleilenna a thlen thin

1) Mahni	2)Kawppui te	3)Ni ve ve	0) NA

6. Mahni indah hniam avanga mi hleilenna laka awlsam taka intulut thin

1) Mahni	2)Kawppui te	3)Ni ve ve	0) NA

IV(b)

13. Retheihna leh sum leh pai dinhmun inthlauhna hi mipa leh hmeichhe inlaichinna kara hleilenna thlentu ber a ni.

i) Pawm thlap	ii) Pawm	iii) Pawmlo	iii) Pawmlo tawp

14. Hleilenna hi kawppuite laka chungnunna lantirna mai a ni.

i) Pawm thlap	ii) Pawm	iii) Pawm lo	iv)Pawmlo tawp

15. . Kawppuite anmahni inthiamlo taka siam hi an laka eng emaw hlawkna hmuhna'na hman a ni thin.

i) Pawm thlap	ii) Pawm	iii) Pawmlo	iv)Pawmlo tawp

16. Tawngka a intihthiam lohna hian kut tawrhna a thlen fo

i)Pawm thlap	ii)Pawm	iii)Pawmlo	iv)Pawmlo tawp

17. Hmeichhia, pawn lama zah kai leh thiltithei te chuan, chutiang ni ve lem lo te aiin hleilenna an tuar mawh bik.

i) Pawm thlap	ii) Pawm	iii) Pawmlo	iv)Pawmlo tawp

18. Kawppuite laka hleilenna hi khawtlang nun atang kan zir chhuah a ni.

i)Pawm thlap	ii)Pawm	iii)Pawmlo	iv)Pawmlo tawp

19. Naupan laia hleilenna tawrh hian naupang rilruah hleilenna hi thil kalphung pangngaiah a ngaihtir.

i)Pawm thlap	ii)Pawm	iii)Pawmlo	iv)Pawmlo tawp

20. Hleilenna hi innghirnghona chinfelna hmanrua a ni.

i)Pawm thlap	ii)Pawm	i) Pawmlo	iv)Pawmlo tawp

21. . Hleilenna mita lo hmuh tawh chuan mahni kawppuite laka hleilenna chhuah mai a awlsam bik.

i)Pawm thlap	ii)Pawm	iii) Pawmlo	iv) Pawmlo tawp

22. Kawppuite laka hleilenna hi rilru lama harsatna/manganna rahchhuah a ni.

i) Pawm thlap	ii) Pawm	iii) Pawmlo	iv)Pawmlo tawp

23. Hmeichhia te an zir san poh leh an lakah hleilenna a thleng tlem

i)Pawm thlap	ii)Pawm	iii) Pawmlo	iv) Pawmlo tawp

24. Mipa nihna hi theihna leh chungnunna nena inkawp tlat a ni.

i) Pawm thlap	ii) Pawm	iii) Pawmlo	iv)Pawmlo tawp

25. Hmeichhiate laka hleilenna hi Mizo hnamzia a in tuh nghet tlat a ni.

ii) Pawm thlap	ii) Pawm	iii) Pawmlo	iv)Pawmlo tawp

26. Chhungkaw hotu an nih angin mipate tan thuneihna leh hleilenna hmanrua a hman a thiang.

i)Pawm thlap	ii) Pawm	iii)Pawmlo	iv)Pawmlo tawp

V. Protection of Women from Domestic violence Act, 2005 I hmuh dan

4. Protection of Women from Domestic Violence Act hi ilo hre tawh ngai reng em?

   i) Aw(ii) Aih

5. I lo hriat tawh chuan, khawi atangin nge I hriat?

a) Chhungte hnen atangin b) Thiante hnen atangin c) Zirna lam atangin
d) Thenawm khawvengte atangin e) TV, chanchinbu, radio, fm,

6. Protection of Women from Domestic Violence Act 2005 hi enge I hriat dan?

a) Hmeichhiate dikna chanvo venhimna hmanrua b) Hmeichhiate chawikanna
(c) Mipate hremna d) Thil dang.

VI Hleilenna lo thlen chhan hmuh dan

1. Hleilenna hi eng ber hian nge thlen ni a I hriat?
   a) Khawtlanga thil tih theih vang b) Sum leh paia inthlauhna c) Mahni dikhlelh vang
   d) Khawtlang kalphung e) Mahni indahsanna f) Mahni inngaihpawimawhna g) Retheihna h) Ruihhlo Hmansual i) Nungchang Diklo.

.VII. Kawppuite laka hleilenna lo tawn tawh a awm chuan:

1. Hleilenna hi Mizoramah eng anga hluar nge a nih?
   a) hluar pangai b) hluar lutuk c) hluar lo d) hluar ti a sawi tham a ni lo

2. Hleilenna hi eng kawng zawngin nge I lo tawn tawh?
   i) Taksa lamah ii) Rilru lamah iii) Mipat hmeichhiatna iv) Sum leh pai v) Tawngka

3. Hleilenna I tawn in en gang takin nge a nghawng che ?

   i) Nunphung Buai ii) Rilru lam harsatna iii) Hriselna tlachhia iv) Mahni inrin tawkna bo v) Tuar tlawk tlawk vi) Zak ngawih ngawih

VIII. Khawtlang chhawmdawlna leh mahni insiamremna chungchang:

1. I lakah eng ang hleilenna pawh a thlenin eng angin nge I lo hmachhawn thin?
   a) Ka tap chhuak hawm hawm thin b) Ka pai zam mai thin c) Thiante ka hrilh thin
   d) Mahni leh mahni ka in tina thin e) Midang chungah ka tuan thin f) Kawppuite chungah ka tuan thin

2. Puihna I zawng thin em?
   a) Aw b) Aih

3. Puihna I zawn thin chuan, khawi atangin nge I zawn thin?

   a) Thiante b) Chhungte c) Thenawm khawvengte d) Kohhran hruaitute e) Khawtlang hruaitute f) Nupui/pasala chhungte g) Tlawmngai pawlte

4. Puihna I zawn ngai loh chuan enge a chhan?

   _____

5. Chhungkuaah hleilenna a thlenin tute hi nge pui thin tu ber che?

   a) Thiante b) Chhungte c) Thenawm khawvengte d) Kohhran hruaitute e) Khawtlang hruaitute f) Nupui/pasala chhungte g) Tlawmngai pawlte

6. In khawtlangah mi tu in emaw hleilenna a lo tawrhin pui turin I inhuam em?
   a) Tehlul mai b) Teuh lo mai c) Maithei d) Ka hre lo lec

PARTICULARS OF THE CANDIDATE

NAME OF THE CANDIDATE	:	Catherine Lianhmingthangi
DEGREE	:	M.Phil
DEPARTMENT	:	Social Work
TITLE OF DISSERTATION	:	Intimate Partner Violence Against Women: Perceptions Across Gender in Aizawl City
DATE OF PAYMENT OF ADMISSION	:	5th Sepetember 2012
COMMENCEMENT OF SECOND SEM	:	18th Feb. 2013
1. BOARD OF PROFESSIONAL STUDIES	:	22nd April 2013
2. SCHOOL BOARD	:	23rd October 2013
3. REGISTRATION NO. & DATE	:	MZU/M.Phil/143 of 22nd 2013
4. DUE DATE OF SUBMISSION	:	30th June 2014
5. EXTENSION	:	AC:25:4(23)III.1
6. DATE OF COMPLETION OF COURSE WORK	:	7th December 2012

(Dr. KANAGARAJ EASWARAN)

Head,& Associate Professor,
Department of Social Work

Mizoram University

BIO-DATA

NAME : Catherine Lianhmingthangi

DATE OF BIRTH : 25th April 1991

FATHER'S NAME : ACL Khawngaiha

E-MAIL ID : kathy3chhangte@gmail.com

PERMANENT ADDRESS : C-67, Zonuam, Aizawl, Mizoram 796009

EDUCATIONAL QUALIFICATION

CLASS	BOARD/UNIVERSITY	YEAR OF PASSING	DIVISION	PERCENTAGE
H.S.L.C	Mizoram Board of School Education	2005	Second Division	56
H.S.S.L.C	Meghalaya Board of school Education	2007	First Division	61
Bachelor of Social Work	North Eastern Hill University	2010	Second Division	51.45
Master of Social Work	Mizoram University	2012m	First Division	60.27

Field Work (B.S.W)

Field Work at Women for Integrated Sustainable Empowerment (WISE) : The main focus during the field work was to understand the nature of work performed by women for income generation activities. A small study on "Violence against women published in the news paper of Meghalaya" was also conducted. Working at Observation home, studying the children and their problems was also a part of the field work.

Field Work at Voluntary Health Association of Meghalaya (VHAM): The main focus was to study the nature of Injecting Drug Users/abusers and people living with HIV/AIDS. Awareness generation on causes and prevention of HIV/AIDS was also conducted during the field work.

Field Work at World Vision Meghalaya: Child rights was the main focus during the field work. It also involves studying the nature of agency and the different work carried out by World Vision India. Sensitization programme on Child Rights was also conducted in different schools in Meghalaya.

Field Work (M.S.W)

Field Work at Protective Home: Understanding the nature of work performed by the agency, conducting case studies and focus group discussion was the main focus at the field.

Field Work at Integrated Child Development Scheme (ICDS) Urban: Studied the nature of ICDS programme under ICDS Urban area, the function of different Aganwadi Centers under ICDS urban and assessing the progress of such centers was the focus of the study.

Field Work in a community (ITI,Mualpui): Understanding the community structure, work distribution of the population and decision making pattern, identification of the needs and problems of the community, Survey on Socio-Economic Status of the community. Awareness on Child rights and Human Trafficking was conducted.

Project Work at ITI: Conducted a project on “Youth and Livelihood”.

Related Experience

I have been an invited speaker and panelist for several media campaigns including chat shows in relation to women’s issue, status of women and Domestic Violence during the period of my M.Phil.

INTIMATE PARTNER VIOLENCE AGAINST WOMEN: PERCEPTIONS ACROSS GENDER IN AIZAWL CITY

Catherine Lianhmingthangi

Department of Social Work

Submitted in partial fulfillment of the requirement of the Degree of Master of Philosophy to the Department of Social Work, Mizoram University, Aizawl.

MIZORAM UNIVERSITY

2014

1.1 Introduction

According to Platform of Action 1995, World Women's Conference, Beijing 1995 *Violence against women is a manifestation of the historically unequal power relations between men and women,* which have led to domination over and discrimination against women by men and to the prevention of women's full advancement. (North East Network 2004).

The United Nations Declaration on the Elimination of Violence against Women (1994) defines violence against women as *''any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life''.* (Nussbaum, M.C. 2005).

According to estimates from the National Crime Victimization Survey (NCVS), there were 691,710 nonfatal violent victimizations committed by current or former spouses, boyfriends, or girlfriends of the victims during 2001. Such crimes — *intimate partner violence* — primarily involve women victims. About 588,490, or 85% of victimizations by intimate partners in 2001 were against women. Intimate partner violence made up 20% of violent crime against women in 2001. (Rennison C, 2003).

1.2.1 Review of Literature

One of the most common forms of violence against women is that performed by a husband or an intimate male partner. The fact that women are often emotionally involved with and economically dependent on those who victimize them has major implications

for both the dynamics of abuse and the approaches to dealing with it. Women's organizations around the world have long drawn attention to violence against women, and to intimate partner violence in particular. Through their efforts, violence against women has now become an issue of international concern. Initially viewed largely as a human rights issue, *partner violence* is increasingly seen as an important public health problem. (L Heise,nd).

Intimate partner violence, which describes physical or sexual assault, or both, of a spouse or sexual intimate, is a common health care issue. In review of US and Canadian population-based surveys during 1985-98, between 8 and 15% of women of all ages reported physical assault in the previous year by a husband, boyfriend, or ex partner, the lifetime prevalence was 25 and 30%. (Schafer J,Caetano, L Catherine,1998).

Population-based estimates demonstrate that 32 million Americans have been affected by IPV. The prevalence and incidence of IPV can be measured on a continuum from rare events, such as death, to more common events, such as self- reported pushing, slapping, and intimidation. It also is useful to consider how this pervasive phenomenon affects clinical practice. The ecologic model of IPV considers IPV a result of a complex set of circumstances from risk factors that occur at the level of the victim, the perpetrator, their relationship, the family, the community, and society. Risk factors at the level of individual victims include women gender, young age, history of IPV, history of sexual assault, history of child abuse victimization, heavy alcohol or drug use, unemployment, depression, and racial or ethnic minority status. Relationship level risk factors include income or educational disparity and male control of relationship (eg, psychologic or economic). Community level risk factors include poverty, poor social cohesion, and weak

sanctions, including minimal legal penalties or rare successful prosecutions. Societal level risk factors include traditional gender norms and general acceptance of violence for conflict resolution. (Zolotor J A, Amy C. Denham, Amy Weil nd).

The National Family Violence Surveys of 1975, 1985, and 1992 conducted in the US estimated that nearly *1 in 6 couples had experienced 1 or more episodes of intimate partner violence in the previous year*. Intimate partner violence is especially problematic for women, because 1 in 3 will be assaulted by an intimate male partner during her lifetime. Male-to-women partner violence is more often repeated and is more likely to result in injury and death than women-to-male partner violence. For instance, women are victims of intimate partner homicide at a rate *approximately 8 times that of men*, and women are assaulted by armed intimates at a rate approximately 7 times higher than that of men. Therefore, it is important both to distinguish between male-to-women and women-to-male partner violence and to understand that male-to women violence represents the more serious public health concern. The reason for this sex difference is not known, but men and women may vary in their habituation to, memory of, and willingness to disclose violent episodes, either as perpetrator or victim. Certainly, given that women are more likely to be repeatedly abused, to be injured, and to die as a result of intimate partner violence, it seems adaptive for women to be especially concerned about this potential health risk. (Schafer J, Caetano, and L Catherine 1998).

In recent years, intimate partner violence (IPV) (also referred to as domestic violence, spouse abuse, and battering) has gained recognition as a serious public health problem. Recent estimates show that 1.5 million women in the United States are

physically or sexually assaulted each year by an intimate partner. (Waalen, J. Goodwin, M. Spitz, A. M., Petersen, R. Saltzman, L. E.,2000).

1.2.2 *Mizoram Scenario:* In the year 2010 to April 2014, 730 cases of the following have been filed through FIR: i) Rape ii) Kidnap iii) Molestation iv) Cruelty by husband v)Human Trafficking. In the past four years, Rape case was the highest record on crime against women in 2012. 92 cases in 2010, 77 cases in 2011, 103 cases in 2012, 89 cases in 2013 were reported. (CID (crime) Branch Record 2014).

1.3 Statement of the Problem

Violence against women is not only a legal problem, but represents a substantial public health issue and is one of the most overlooked social problems in contemporary society. Violence is an enormous global public health problem that increases the risk of injury, disease and poor mental health while also impeding economic and social development. Unlike many health problems, there are few social and demographic characteristics that define risk groups for Intimate Partner Violence. Violence is used as a strategy in conflict. Relationship is full of conflict and especially those in which conflicts occur about finances, jealousy, and women's gender role transgression are more violent than peaceful relationships. Women who are more empowered educationally, economically and socially are most protected, but below this high level the relation between and risk of violence is a nonlinear. Violence is frequently used to resolve a crisis of male identity, at times caused by poverty or an inability to exercise control over women. Risk of violence is greatest in societies where the use of violence in many situations is a socially- accepted norm.

Women from all kinds of background and of all ages experience violence. Violence can occur while a woman is at work, on the street or at home. In a patriarchal society such as Mizoram, it is not uncommon and is unfortunately emerging as a major social Problem .The number of cases that have been filed at the service provider agencies representing women is also reflective of the same trend. When women experience violence the repercussions on them, their families and society are huge. Women lose confidence, have lowered self- esteem and often receive grievous injuries of physical and psychological nature.

While Domestic violence, a broader concept has received due attention through legislation and law enforcement agencies, Intimate Partner Violence is a part of Domestic Violence which is yet to receive its due attention.

Understanding the causes of intimate partner violence is substantially more difficult than studying any other health problem. For example, diseases usually have a biological basis and occur within a social context, but intimate partner violence is entirely a product of its social context. Consequently, understanding the causes of such violence requires research in many social contexts.

In addition, Violence and aggression deny access to rights fulfillment. The profession of Social Work aims to protect people's Rights, promote rights and prevent rights violation. Thus, this study aims to understand how women perceive their rights and their access to Rights fulfillment in relation to Intimate Partner Violence. The study also seeks to understand perceptions related to domestic violence in Mizoram and explore if there are gender differentials that exist.

1.4 **Objectives**

1. To Explore Perceptions related to Intimate Partner Violence across Gender.
2. To understand perceptions related to PWDVA , 2005.
3. To examine experiences, if any, of Intimate Partner Violence among women.
4. To understand the social support available for women who experience Intimate Partner Violence.
5. To understand the efforts made in prevention of Intimate Partner Violence against women.

1.5 Chapterization

I Introduction

2 Review of Literature

3 Methodology

4 Results and Discussion

5 Conclusions and Suggestions

1.6 **Methodology**

This study employs exploratory design and is cross sectional in nature. Mixed methods research was applied which involves philosophical assumption and an approach to enquiry that contains qualitative and quantitative forms. Both qualitative and quantitative Data was collected.

- Primary data was collected from two Urban communities (One Peripheral and one Core) through semi-structured interview schedule; Case studies were conducted among the victims of Intimate Partner Violence. Focused group discussions were also conducted among the male population and unmarried female population.

- Available records from Organizations working with women in town as well as relevant literature search provided secondary data

- Multi stage sampling was used. At the first stage, Aizawl District was selected using *purposive* sampling. At the second stage, One core (Chanmari) and One peripheral area in Aizawl city(Melthum) was selected based on objective criteria. At the third stage, a list of all households was drawn using *systematic random sampling*. In the final stage, one woman and one man from each of the selected households was drawn as respondents based on the following inclusion criteria.

  Inclusion criteria

  i) Male and female between the ages of 18 to 40 years.

  ii) Who has been currently involved in an intimate relationship for a minimum period of two years.

  iii) Literate

  iv) Willing to give informed consent both on perceptions and experiences if any on Intimate Partner Violence.

- Observation: Observation was done in urban settings in Mizoram, to explore the cases registered as well as of the home environment.

- Interview Schedule: A structured interview schedule was administered to collect data from both men and women respondents on Socio-Demographic Data and perceptions related to violence against women, PWDVA(2005), Rights of women,

knowledge on Prevention efforts and Social Support related to women who experience Intimate Partner Violence.

- Interview Guide for Focus Group Discussion: FGD's was conducted among women and men to explore perceptions related to Causes and consequences of Intimate Partner violence against women.

- Interview Guide for Case vignettes: Two case studies were conducted from women who have experienced violence to document their experience in an in-depth manner.

1.7 **Results and Conclusion**

1.7.1 In the study conducted, the socio-demographic profile of the respondents shows that *more than half of the respondents belong to the age group of 18-30 years*. It was also observed that *more than two-thirds were living within the confines of marriage* and had spouses, however more than *a quarter were in an intimate relationship with a partner*(boyfriend/girlfriend).

More than one-third of the women report having experienced violence in their relationships with five times higher number of women than men. Men-to-women partner violence is more often repeated .For instance, women are victims of intimate partner homicide at a rate approximately 8 times that of men, and women are assaulted by armed intimates at a rate approximately 7 times higher than that of men." (Schafer J, Caetano, and L Catherine 1998). A*lmost a fifth of the total respondents are presently experiencing violence in their relationship. A tenth of the respondents report a duration of more than four years. Despite the fact that majority had never experienced violence only a fifth interestingly claim that their relationship is 'very*

good'. Also, although more than a third had experienced violence in the past or present, they have stated their relationship as good.

In this study of 80 respondents in Mizoram**,** more than a third of them strongly disagree that economic inequalities leads to violence although several studies highlight the same. It is apparent that in this small study people see other reasons as being responsible for violence.

Many respondents perceive that Violence is a form of power play .Of the respondents who strongly agree more women than men tend to do so. Almost two -fifths of the respondents agree that violence is a result of stress faced in the various fronts across home and work. More than a quarter *of the men* believe that 'being Male' inherently gives them the right to exercise power over women particularly in their families and, in general in society. Challenges to the exercise of such power can be perceived by them as threats to their masculine identity.

Studies reveal that there is a relation between increase in levels of women education and decrease in levels of intimate partner violence. More than half of the study population also perceive that women's education is negatively related to low levels of violence. Another reason loosely attributed to violence is that of patterns of patriarchy in society. More than a fifth in this study perceive that violence is rooted in Mizo culture.

The study also found that some respondents accepted violence if head of the family is the perpetrator as it was considered as 'normal' for a head to use violence.

Perceptions regarding the PWDVA, 2005 were sought as it is important to understand the awareness levels of respondents on the legal literacy. Majority of the respondents report that they are not aware of PWDVA. Of the respondents who were

aware of it, Media was the main source of information. PWDVA was regarded by them as a *means to protect women rights* or a *means to empower women*.

The respondents were interviewed with their consent regarding experience of violence in intimate relationship. As mentioned earlier, more than a third have had an experience of violence. Of the abused respondents, the highest percentage of them shared their violent experience with friends as a means of ventilation, while some of them respond to the experience by crying, displacing on other forms of passive endurance.

1.7.2 Focus group Discussion

The focus group discussion conducted among the two groups (married men and Unmarried women) reveals the different perceptions on violence against women. It may be concluded that many women are unaware of their rights in abusive and violent relationship and have to learn the need to exercise their rights. Many women perceive themselves as the subordinate gender regardless of their intelligence, their talents and their worth. The main coping strategy used by women in their perception was *passive endurance*. Being a victim of violence is considered shameful by them to the extent that even when they are in abusive relationships they tend to keep it to themselves and continue to bear the pain silently. This was attributed to the beliefs held in society. On the other hand, although recognition of women's role in family and society is emerging among men, some of them expressed that woman's' empowerment is not necessary in a patriarchal society where Men are the head of every relationships in society and women must live by any rules set by men. It was also added that Mizo women are so much empowered and the advantages are often misused by them. Some male participants in the group discussion strongly stated that as men and being a head

of the family they have power and control that they can use against their partner. It was further exclaimed that women with higher education are respected in society especially by male citizens and are likely to escape violence due to their social status.

1.7.3 Case Vignettes

The case vignettes illustrate the helplessness of women who are subjected to violence. Violent partner in each of the cases has had a history of alcohol/substance use as well as extra marital affairs and in both the cases violence has led to break down of the marriage leading to divorce. The consequences of such violence on the women include low self esteem, lack of self confidence and inability to raise their status to become independent earning members. Divorce, lack of social support and lack of employability have also led the children drop out of schools, remain illiterate and are brought up in relatively unstable environment.

1.8 **Suggestions**

The suggestions that emanate from the study are grouped under five major headings based on the focus or thrust area of the research.

1.8.1 *Awareness*

Awareness at the community level in the state of Mizoram. Women need to be made aware of provision of protection guaranteed under the law and tertiary support for those women who do not have primary or secondary support needs to be assured.

1.8.2 *Perceptions and Perceptual change*

As violence is often regarded as an extremely personal issue and further, since there is a lot of shame and guilt surrounding the issue, most victims of violence do not seek help or talk about it. The suggestion here is that awareness needs to be increased to make communities more sensitive and supportive so that a woman may feel more confident in help and support seeking. Women experiencing intimate partner violence are often accused of having provoked the violence by the way they behave, failure as a wife, or infidelity. Girls or women who have been assaulted are frequently said to have "asked for it" by the way they were dressed or behaved. This attitude of society is in requirement of change. Community level interventions are required so that people realize that they need to be involved and that they can make a difference in supporting women and reducing violence. The general perception that their involvement is an 'interference' in the intimate, personal affairs of an individual have to be changed.

1.8.3 *Prevention efforts:* As indicated by the case vignettes and focus group discussion, alcohol and substance abuse are common reasons for marital conflicts which inturn lead to violence. Therefore, efforts needs to be directed at helping communities free of Substance/Alcohol use.

1.8.3 *Mental health and social support*

Needs related to mental health particularly anxiety and depression, low self confidence and suffering by victims of violence require to be addressed. As a lot a woman do not necessarily go to mental health professionals, the suggestion is to increase social support available through training of counselors at community level as well as introduce social support groups that are peer-led.

1.8.4 *Policy implications*

i) In the course of the study it is observed that the PWDVA,2005 has not been very effective because of certain provisions. For eg, women have been very hesitant to use the provision of reporting repeated offence in fear of the outcome (as men are imprisoned for a very short duration and will return eventually to the home, angered further by the fact of imprisonment). Suggestions include more protective measures for the women so that they may fearlessly pursue the ends of justice.

1.8.5 *Research Implications*

There are several indications for research that emanate from this study. Studies across Mizoram, documenting rural-urban differences are indicated. Research on victims of domestic and on intimate partner violence is required. Further, studies on sexual violence and on incest are also indicated.

BIBLIOGRAPHY

Abbott, P. (1999). Women, Health and Domestic Violence. *Journal of Gender Studies,* 8(1), 83–102

Alcock, D. (2011). Counseling survivors of domestic violence, Practice: Social Work in Action, 13(3), 45-54.

Anderson, K.M.,Renner, L.M., & Bloom.T.S., (2014) Rural Women's strategic Responses to Intimate Partner Violence, Health Care for Women International, 35:4, 423-441.

Baker, M.L (2011).Domestic Violence: Every child does matter. *International Journal of Disability, Development and Education*, 58:2

Bowman, B., Matzopoulos , R., Butchart, A., & Mercy, J. A., (2008): The impact of violence on development in low- to middle-income countries, *International Journal of Injury Control and Safety Promotion,*15:4, 209-219

Campbell J. (2002,April 13). Health Consequences of intimate partner violence. *The Lancet*, 359.

Campbell J, Lewandowski L 2002: Mental and physical health effects of intimate partner violence on women and children. *Psychiatric Clinics of North America*, Volume(2),353-374.

CID (crime) Branch. (2014). *Crime Against Women,* [Television Broadcast]. Aizawl:India.

Coker,A.L., Smith, P.H., McKeown, R.E., and King, M.J., : Frequency and Correlates of Intimate Partner Violence by Type: Physical, Sexual, and Psychological Battering. *American Journal of Public Health, 90,(4).*

Coker,A.L., Smith, P.H., McKeown, R.E., and King, M.J., E, Roberts *(2000)*: Physical health consequences of Physical and Psychological intimate partner violence. *American Medical Association*

Dichter, M.E., & Marcus, S.C., (2013) : Intimate Partner Violence Victimization Among Women Veterans: Health, Health Care Service Use, and Opportunities for Intervention, Military Behavioral Health

Dichter, M.E., & Rhodes, K.V., (2011) Intimate Partner Violence Survivors' Unmet Social Service Needs, Journal of Social Service Research. Physical intimate partner violence in Chile, Egypt, India and the Philippines, *Injury Control and Safety Promotion, 11(2), pp. 111–116.*

Galano, M,M., Miller, L. E., & Bermann, G.S., (2014): Avoidance Symptom Presentation of Preschoolers Exposed to Intimate Partner Violence in a Group Therapy Setting, Child Care in Practice

Goetz, A.T., Shackelford, T.K., Starratt,V. and Mckibbin, W.F., (2008): Intimate Partner Violence

Hassan, F et al(2004): Physical intimate partner violence in Chile, Egypt, India and the Philippines, Injury Control and Safety Promotion Injury Control and Safety Promotion,11(2), pp. 111–116.

Hester, M. & Westmarland, N.(2006): Domestic violence perpetrators, Criminal Justice Matters, 66:1, 34-35.

http://en.wikipedia.org/wiki/Protection_of_Women_from_Domestic_Violence_Act_2005.

Humphreys, J.(2010) Sexually Transmitted Infections, Pregnancy, and Intimate Partner Violence, Health Care for Women International.

Jewkes, R. (2002). (2002, April 20),Intimate partner violence: causes and prevention. Violence against women III. *The Lancet*, 359.

Johnson, N.L., & Johnson, D.M., (2013) Correlates of Readiness to Change in Victims of Intimate Partner Violence, *Journal of Aggression, Maltreatment & Trauma* 22:2, 127-144.

Karakurt, G., Dial , S., Korkow , H., Mansfield & Banford, A., (2013): Experiences of Marriage and Family Therapists Working with Intimate Partner Violence, Journal of Family Psychotherapy, *Journal of Family Psychotherapy*, 24:1–16.

L Heise; Moreno G, Violence by intimate partners.

Lal Neeta (2007 April 17). Violence Against women in India. *The Brunei Times.*

Lipsky, S., Caetano, R., Field, C.A., & Larkin, G.L., (2006) The Role of Intimate Partner Violence, Race, and Ethnicity in Help-Seeking Behaviors, Ethnicity & Health,11(1), pp. 81-100.

Meekers, D., Pallin, S.C., & Hutchinson, P., (2013) Prevalence and correlates of physical, psychological, and sexual intimate partner violence in Bolivia, Global Public Health: *An International Journal for Research, Policy and Practice,8(5), 588-606.*

Mercy ,J. A., Butchart, A., Rosenberg ,L. R., Dahlberg, L. & Harvey, H. (2008): Preventing violence in developing countries: a framework for action, *International Journal of Injury Control and Safety Promotion,* 15:4, 197-208

Miller, C. E., & Mullins, B. K., (2002) Lifelong Learning to reduce Domestic Violence.*International journal of lifelong education,*21,(5), 474–484.

Moreno C G, Jansen H, Ellsberg M, Heise L, Watts C, Prevalence of intimate partner violence. (2006 October 7-13). Findings from the WHO multi-country study on women's health and domestic violence *The Lancet,* pp.1260–1269.

Morgan, W. & Gilchrist, E. (2010) Risk assessment with intimate partner sex offenders, Journal of Sexual Aggression: *An international, interdisciplinary forum for research, theory and practice, 16(3), pp. 361-372* .

North East Network .(2004):Violence Against Women, Shillong, Meghalaya: Author.

Nussbaum, M.C. 2005. Women's Bodies: Violence, Security, Capabilities.*Journal of Human Development*, 6(2).

Palazzolo, K.E., & Roberto, R (2011) Media Representations of Intimate Partner Violence and Punishment Preferences: Exploring the Role of Attributions and Emotions, [Electronic version]. *Journal of Applied Communication Research Vol.39(1), pp. 1-18.*

Payne, B. K., Triplett, R. A., & Higgins, G. E., 2011. The Relationship Between Self-Control, Witnessing Domestic Violence, and Subsequent Violence. Deviant Behavior, 32: 769–789

Peterson, R. R., Deirdre Bialo-Padin.(2012).Domestic Violence Is Different: The Crucial Role of Evidence Collection in Domestic Violence Cases. *Journal of Police Crisis Negotiations*, 12:2, 103-121

Radford , R., Harne, L., & Trotter, J., (2006): Disabled women and domestic violence as violent crime, Practice: Social Work in Action, 18:4, 233-246

Rennison C. February 2003: *Intimate Partner Violence, 1993-2001*. Bureau of Justice Statistics Crime Data Brief. U.S. Department of Justice Office of Justice Programs.

Saraswati, M. 2002 : *Status of Indian Women*, Gyan Publishing House, New Delhi

Schafer J, Caetano, and L Catherine (1998) : Rates of Intimate Partner Violence in the United States. *American Journal of Public Health, 88(2).*

Scott L. D & Kunselman C. J (2007): Social Justice Implications of Domestic Violence Court Processes, *Journal of Social Welfare and Family Law, 29(1), 17-31.*

Short, L.M., & Rosenberg, M.L., (2001) Intervening with victims of intimate partner violence, *Injury Control and Safety Promotion,* 8(2), pp. 63–69.

Starmer, K. (2011): Domestic violence: The facts, the issues, the future. *International Review of Law, Computers & Technology* , 25, 1–2.

Strand, S. (2012) Using a restraining order as a protective risk management strategy to prevent intimate partner violence, Police Practice and Research: *An International Journal 13(3),254–266.*

.

Waalen, J. Goodwin, M. Spitz, A. M., Petersen, R. Saltzman, L. E., (2000) : Screening for Intimate Partner Violence by Health Care Providers: Barriers and Interventions. Violence Prevention and Intervention in Health Care and Community Settings. *American Journal of Preventive Medicine,19(4).*

Yudhistar, K. 2003: *Violence Against Women*, Reference Press, New Delhi

Zolotor J A, Amy C. Denham, Amy Weil. Intimate Partner Violence, pp 167-79.