CASE STUDY RESPONSE

Dealing with spousal violence: the counsellor's dilemma

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Violence by husbands against their wives, commonly called domestic or spousal violence, is one of the most common forms of gender-based violence experienced by women across the world (1). It varies from country to country but its presence is hidden but recognised by all. It is a serious public health issue with implications for the individual and for society. It can lead to serious injury to the woman and, at times, even her death. Most violence against women is perpetrated by their intimate male partners. A WHO study in 11 countries found that between 15% and 71% of women, depending on the country, had experienced physical or sexual violence by a husband or partner in their lifetime (2) and two out of five currently married Indian women age 15-49 have experienced spousal violence in their current marriage; among women who have ever experienced such violence, more than two in three have experienced violence in the past year (3). The husbands' consumption of alcohol significantly increases the risk. Further, recent research points to both short- and long-term detrimental effects of domestic violence on the health and welfare of women and their children (4,5).

This form of violent behaviour can be connected to a gender-based socio-cultural paradigm that has been painstakingly constructed and preserved over the centuries. Gendered relations in our society are looked upon as God ordained. Son preference, sex selection, low nutrition of adolescent girls, early marriage, multiple pregnancies, foetal wastages and the sidelining of women from the developmental processes - all of these are accepted in our way of life. The patriarchal system weighs women down, making it difficult for them to survive with dignity. Several social legislations exist for the betterment of women and the latest in the basket is the Domestic Violence Act of 2005. Legislation may provide the direction; but that alone is not the answer. Mere awareness may not bring about an attitudinal change. The complexity of the issue lies here.

Let me deal with the case of Mrs C first.

Some of the primary objectives of every counselling process are to help the client to gain an insight into the situation, move on in emotional maturity and build coping capabilities, so that, at the end of the counselling process, the client will be independent enough to take charge of her life.

In this case, the counsellor with all her training and experience, in a very diligent manner, went out of her way to help Mrs C. All efforts were made, but the problem persisted and a closure was attained by labelling the client "difficult". The following points are to be noted:

- Each time the client came to the centre her demands increased and the counsellor tried to comply with them. The counsellor unwittingly encouraged the client to be dependent on her to solve her problems. Both of them were caught in a mesh.
- The client did not take on the suggestions/advice of the counsellor. The client was playing a psychological power game of "Yes...but" over the counsellor. It was a typical situation described in transactional analyses.
- When a joint meeting was held, the relatives, who were supposed to help the victim, took the side of the perpetrator and isolated the client. The victim remained a victim.
- The client was ambivalent (typical of any Indian woman where social norms are strongly entrenched) from the beginning. She wanted to resolve her problem but did not want to move away from the very context that was contributing to it. She refused to leave her husband or her home, or go to work. She even went to the police station to withdraw the case against her husband.

A clear analysis of the case could include not only the client's version but also that of the immediate family members, by making visits to the client's home, talking to the husband, family members and neighbours before drawing up a strategy. Of course, immediate medical attention is needed as also moving the client and her daughter to a safer place - both of which are critical and should have been a priority.

The focus of the counselling sessions should help the client to gain an insight into her situation and how her behaviour, to a certain extent, is actually escalating the problem. The need for economic independence for the client and referring the husband to a de-addiction centre should have been emphasised repeatedly, during the course of counselling sessions, as the client was not willing to move away. The counsellor knew that the husband was not in a position to provide minimum maintenance as prescribed by the court. Yet, much time was wasted on this. The two important tools that the counsellor could have used were assertiveness and confrontation. Both if used judiciously would have yielded the desired outcomes. At some point this becomes important to do, without antagonising the client.

Each case is challenging and needs a multi-pronged approach. The counsellor need not handle them alone and must have a good network to function effectively. Handing the client over to other colleagues makes it even harder for the client. Labelling Mrs C "difficult" is against professional ethics. Unconditional positive regard for the client would be the best approach. Such family problems are complicated and a client who experiences them is traumatised. They seek outside help as a last resort, when all known sources have run dry.

Case 2

Mrs S is a determined lady who wanted to leave her husband, move out of the abusive situation and lead an independent life. She filed a first information report (FIR) to teach her husband a lesson. Thinking that this would resolve her problem, the client went back to live in the same situation. But the community only chided her husband and nothing changed for the client. Nothing will change as long as social control over women is still embedded in patriarchal bedrock. The problem of Mrs S is not one of counselling ethics alone, but a social one as well.

Assuming that the Medical Termination of Pregnancy Act (MTP Act) had more teeth and the doctors were sensitive to the client needs and had performed an abortion, it would have given the client temporary but much needed relief, but the basic problem would persist. The counsellor could have pursued other options:

- After filing the FIR, divorce proceedings could have been initiated so that the husband would have been put on guard.
- The significant people in the client's life could have been taken into confidence about all important decisions to be taken by the client, whether it is filing an FIR, getting a divorce or having an abortion. After all, individual self determination is a less travelled road in our society, as most decisions are outcomes of a collective consensus.
- When the client did not turn up on the appointed day, the counsellor could have made a home visit, traced the client and brought her to the hospital.

Gender sensitivity programmes should be made a part of the medical curriculum. The sheer callousness of the doctors and their insensitivity to the client is appalling. Their behaviour -- turning away the client on flimsy grounds, proceeding with the unwanted pregnancy in spite of the patient's poor health and its implications on pregnancy and long term health of the mother and child is in total violation of the conditions laid in the MTP Act and the centre could sue them for this. The counsellor could have been more assertive and complained to the head of the institution for appropriate action rather than persuading the doctor to perform a timely abortion. Should the doctor be educated on this? What if the client died due to premature delivery complications? Who would be to blame: the client, her husband, her community, the doctors or the counsellor?

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