

CEHAT Working Paper No. 2

Feminist Response to Attempted Suicide
A Model for Public Health Intervention

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Centre for Enquiry into Health and Allied Themes

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Preface

Domestic violence is a major public health issue in the world. It is linked to poor health & suicidal ideation in victims as suggested by many studies. It is also a common cause of serious injury to women, more than car accidents, muggings, and stranger rapes combined. The range of problems arising out of domestic violence include immediate injuries, chronic pain, disfigurement, miscarriages as well as psychiatric problems, among others. This well-defines the need of health professionals such as the doctors, nurses and midwives to guide and counsel women with suicidal behavior.

This research based paper has taken cognizance of violence and suicide together. Background understanding of domestic violence in relation to ongoing physical, sexual or psychological and economic process in society is well focused in the paper and so is the perspective of feminist approach which is quite innovative. The paper has brought out the gender aspect in terms of understanding domestic violence as a means to humiliate women and force them to conform to gender roles. The research paper illustrates well the magnitude of the problem globally.

The paper particularly focuses on the experience of *Dilaasa: A Hospital-based Domestic Violence Intervention program*. The Dilaasa approach begins at defining "attempted suicide as a consequence of violence". It brings forth sociologically fitting strategies for identifying such women and advocates the need for screening for domestic violence among women who report with attempt to suicide or "accidental consumption of poison/burns". The counselling model addresses the need to document both the recent episodes of violence as well as the history of victimisation. Though Dilaasa has taken the initiative of responding to Domestic Violence in some hospitals, it calls upon examining current methods developed in other hospitals to deal with the issue of "attempted suicides"

While doing so there is a need to take in to account the response from the West. It is a known fact that there are several scales that link Domestic Violence with suicide ideation, such assessment is being routinely done in the west. It would immensely help to adapt those scales and modulate them to the Indian context. The Dilaasa approach is a welcome effort to provide suicide prevention counselling in public hospitals, efforts also need to be made to work closely with mental health professionals to take such initiatives in other set ups too.

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Techniques for reaching out to women are scientifically worked out while highlighting various resources women can avail off. Challenges in such a set up and context are well identified but clinical aspects need to be considered. The challenge of helping a woman to identify suicide as a consequence of violence is factual aspect; the biggest challenge is the huge loss to follow-up. Therefore there is need to consider the diagnostic dimension along with the socio-cultural dimension. Similarly, attempts need to be made to arrive at estimates of the prevalence of attempted suicides amongst women facing Domestic Violence; due to lack of a systematic data base across health institutions, this problem gets further compounded as attempt to suicide is a crime and therefore most people try to hide it.

This paper brings forth the link between Domestic Violence and attempt to suicide, but also paves way for future research into factors that predispose some women (in abusive relationships) to attempt suicide and not other women facing abuse. This calls upon a systematic documentation of the magnitude of attempted suicide amongst women in order to design a robust public health strategy to respond to such women.

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Abstract

Domestic violence is described as a pattern of continuous or intermittent coercive behaviour and control. It is used to humiliate women and force them to conform/adhere to gender roles. Each episode of abuse results in physical and psychological trauma that usually remains hidden. One of the most common effects of violence is the infliction of self-harm. Domestic violence has been associated with suicidal ideation and has been one of the leading causes of attempted suicides amongst women. Dilaasa , India 's first hospital based crisis centre was established to address Domestic Violence and provide services to women within the hospital itself. This counselling endeavour brought to light that several women admitted for "accidental consumption of poison" had essentially attempted suicide, the underlying reason being Domestic violence. In order to address this issue, the centre evolved a counselling model which was informed by feminist principles that challenged the main stream psychiatric model of labeling women as involved in "deliberate self harm" or indulging in "impulsive behaviour" but rather as a reaction to an extremely unbearable situation. This paper presents the feminist counselling methodology and illustrates it with examples from the counselling practice. Thus it makes a case for including a feminist counselling approach in public hospitals to the issue of attempted suicides in women.

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I. Introduction

Of the various forms of violence against women, domestic violence is almost ubiquitous. It is also, unfortunately, accepted unquestioningly in most societies across the globe. Violence arises when an individual or group uses its power or control over another and may take many forms.

Domestic violence is best described as a pattern of continuous or intermittent coercive behaviour and control. It can be physical, sexual or psychological; or it may be economic in nature. It is important to understand that it is ongoing and that the most common pattern is of violence increasing in intensity and severity. Domestic violence is used to humiliate women and force them to conform/adhere to gender roles. There is societal sanction for the use of violence within the family which is considered a private space that brooks no interference from outsiders. Due to this culture of silence and acceptance, women are unable to speak out against the abuse.

Data indicate a high prevalence of domestic violence globally, with the WHO (2005) reporting one in six women as being target of domestic violence. The actual prevalence may be higher. Each episode of abuse results in physical and psychological trauma that usually remains hidden. One in three women aged 15-49 years has experienced physical violence and one in 10 has experienced sexual violence. (NFHS-III, 2006).

Such acts of violence not only cause immediate injuries, but result in chronic pain, disfigurement, miscarriages, as well as stress, anxiety, hypertension, and insomnia. One of the most common effects of violence is the infliction of self-harm. The victims may refuse to eat or drink, wish to commit or actually attempt suicide, and neglect their health. Domestic or family violence is one of the leading causes of female injuries in almost every country in the world and accounts in some countries for the largest percentage of hospital visits by women (Human Rights Watch, Global report on women's rights). Domestic violence has been associated with suicidal ideation.¹ Violence was found to be the leading cause for suicidal behaviour amongst females.² Evidence

¹ In a population-based study on domestic violence, it was found that 64% had a significant correlation between domestic violence of women and suicidal ideation. World Health Organization. World Health Report. Mental Health - New Understanding - New Hope. WHO: Geneva; 2001.

² (Pillai, Andrews, & Patel (2008) Violence, psychological distress and the risk of suicidal behavior in young people in India, *International Journal of Epidemiology*

from a recent study conducted in Sunderbaans, India on non-fatal deliberate self harm underlined domestic violence as a major public health issue. The findings indicated that significantly larger proportion of females (63.6 per cent) inflict Deliberate Self Harm (DSH) than males (36.4 per cent) in all the three years. Focus group discussions with the Panchayat Samities revealed that different gender-specific causes are responsible for DSH attempts by females, such as dowry demands, torture, mental and physical humiliation by the in-laws, and derogatory behaviour by alcoholic husbands or emotional or economic distress resulting from extra-marital relations of the husbands. The lack of information and non-reporting of all attempted suicides by hospitals is a major limiting factor for understanding nature and prevalence of the issue.

Women approach the health care system for the treatment of post-violence traumas. When a victim approaches a health professional, her physical injuries are treated but she does not receive any emotional support unless the health care professional is trained to assess and intervene for domestic violence appropriately. If, at this first contact, the doctor, nurse or midwife could provide her with the much-needed emotional sustenance and refer her for counselling, she would be in a better position to stand up against or otherwise address any future violence.

II. *Dilaasa*: Hospital-based Domestic Violence Intervention

*Dilaasa*³, is the first initiative in India that has worked directly with the health system on domestic violence.

The women's movement in India brought violence against women as an issue into the public domain in the 1970s after a tribal girl was raped by two policemen. The years after that witnessed agitation, mass campaigns, public education, legal reform and advocacy to raise awareness about various forms of violence against women and eliminate them. They used the slogan 'the personal is political' to successfully demystify the 'private' space that is the home. This movement asserted that all women have the right to violence-free lives and that domestic violence inhibits women from realising their rights and full potential in all other aspects of their lives - in their social, economic and political spheres.

Autonomous women's groups as well as NGOs established services to care for and lacunae in the existing health system, for example, the failure to document important

³ *Dilaasa* is a joint initiative of CEHAT, research centre of Anusandhan Trust and Municipal Corporation of Mumbai and is located at Bhabha Hospital, Bandra West

provide support to women victims of violence. While the serious health consequences of domestic violence for women are well-researched and well-established, the role of the public health system in responding to the issue has not received adequate attention. The women's movement and the health movement have highlighted several forensic evidence in the event of rape and sexual assaults that severely limits survivors' ability to attain justice. Similarly, in cases of domestic violence, it is imperative to document both the recent episodes of violence as well as the woman's history of victimisation. But no one had engaged with the health system and health professionals to sensitise them to the issue.

Dilaasa, founded in 2001, was the first such attempt to directly engage and establish a health sector response to domestic violence. It is a counselling centre for women facing domestic violence located within a public hospital. Women reporting to the centre are provided social and psychological support by staff trained in counselling.

Public hospitals offer unique sites for interventions to address domestic violence as these are often the first places where domestic violence gets reported. A survivor may or may not go to a police station or any other place to register her complaint, but she would definitely come to the hospital, or be brought there, for treatment of physical symptoms, injuries and/or psychological assistance. Because domestic violence is a risk factor for many illnesses and can also occur during pregnancy, women experiencing violence may report to any department of a hospital, including antenatal care and the Emergency Department. Hospitals also offer critical medical evidence of the consequences of violence as suffered by the woman. In cases of domestic violence, it is imperative to document both the recent episodes of violence as well as the woman's history of victimisation. Such documentation is critical in divorce and criminal cases to seek compensation. Most often women decide to seek legal action only after the violence has escalated but they have no documentary evidence to prove it.

Health services and health professionals do not usually recognise domestic violence as a health issue. They often perceive it to be a personal matter in which they should not intervene. Even if they recognized it as jeopardising patients' health they don't know how to intervene and take care of the woman. Even though doctors are trained to distinguish between an injury caused by say, a fall, and that caused by assault, they may not probe the cause if a woman reported a fall rather than an assault.

Dilaasa set about sensitising health personnel to understand violence against women as a health issue and addressing their myths on the issue. They were also trained to recognise domestic violence and to provide crisis intervention. *Dilaasa* has identified

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through its work at the hospital possible symptoms associated with domestic violence for each of the hospital's departments. The staff at all levels has been trained to recognise domestic violence amongst patients coming to them and refer them to Dilaasa. This paper presents the learning from Dilaasa's practice on responding to attempted suicides amongst women as a consequence of domestic violence. It highlights the techniques for reaching out to such women and strongly recommends the need for screening for domestic violence among women who report with attempt to suicide or 'accidental consumption of poison/burns', thus making a case for alternate approach to respond to such cases. It is important to understand that women need support in dealing with domestic violence in order to overcome suicidal ideation.

III. Attempt to Suicide and Domestic Violence: Making a Connection

Dilaasa's encounter with cases of 'accidental poisoning' which were all recorded as medico-legal cases led to the discovery that these were not accidental but attempted misrecorded suicide cases.

Confronting "accidental consumption of poison"

In 2001 when the counselling services were set up, the Dilaasa team would go to each ward in the hospital and read the history of women admitted there and probe further for history of domestic violence or abuse. This was a way of training the staff in the wards in recognising abuse. This also enabled the team to understand medical terminology and presenting symptoms of women who were experiencing violence.

At the end of the first year, when a profile of women coming to Dilaasa was drawn up, it was evident that a large number of women were from the medical ward where they were admitted for accidental consumption of poison. Further probing showed that as suicide is a criminal offence, most private hospitals refuse admission to such patients, who then come to public hospitals. All public hospitals that have a Casualty Department admit cases of attempted suicide. The number of such cases is high. At Bhabha Hospital, where Dilaasa is located, 105 cases of organo phosphorous poisoning (or attempted suicide) were admitted in 1996, 149 cases in 1997 and 115 in 1998. Another statistic involving suicide that demonstrates the extent of domestic violence is the total number of cases of homicide/suicide (male killing a female, then killing self) coming to the hospital was 99 in 1996, 118 in 1997 and 120 in 1998.

The data also showed that all women reporting 'accidental consumption of poison' were registered as medico-legal cases (MLCs) and underwent a compulsory psychiatric evaluation. The evaluation was not followed by counselling. The psychiatric evaluation included diagnosis like 'impulsive deliberate self harm' or 'maladjustment'. Women were prescribed anti-depressants. By labelling the problem as 'maladjustment', external factors that cause the symptoms are automatically ignored. Further, the diagnosis could itself be used as an instrument of further domestic oppression. The biggest gap in treatment was the absence of any assessment for domestic violence or provision of psychological support to deal with the consequences of attempt to suicide or for prevention of another attempt.

Intervention by Dilaasa was difficult, as counselling in such cases was not a norm at the hospital. Women were admitted for only two to three days. The first two days were spent in receiving medical treatment. During this time, women were not in a position to talk. As the hospital was concerned only with the physical treatment, women were often discharged even without screening for domestic violence. Dilaasa had to follow up with these women every day. The wards too were very crowded and the women had a friend or relative as bystander making it difficult for the women to speak out and share their history with counsellors.

Dilaasa, therefore requested the hospital authorities to direct the wards to refer women to its counselling centre for screening for domestic violence. This was felt to be necessary because our concern was not only for women who had attempted suicide because of domestic violence but for all women who had made such an attempt. It was decided to gear up to provide suicide prevention counselling to all women.

Analysis of case records of women/girls attempting suicide

Between 2001 to 2006, 16 per cent of all women (N = 1357) registered at Dilaasa, or 216 women, reported after an attempt to suicide. Most of the women reporting after a suicidal attempt were in the age group 18 to 25 years (57 per cent), followed by 26-35 years (28 per cent). Eight per cent (8 per cent) of them were adolescents. With respect to marital status, we found that most women (65 per cent) were currently married and 27 per cent were never married. Only 50 per cent women had finished their secondary school, with eight women being graduates. Sixty nine percent of the women did not have any source of income, and were economically dependent on the abuser. It is important to note fifteen of the women were pregnant when they attempted suicide.

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Of the 216 women, 208 women were admitted after consuming some poisonous substance or overdose of tablets (as pesticides, phenyl, chalk powder and rat repellents), three had tried to burn themselves, while two had consumed poison and also harmed themselves with a knife, two had tried to strangle themselves and one had slit her wrist. The hospital does not have a burns ward so very few cases of self inflicted burns are admitted here. The most common method for attempting suicide among those admitted to this particular hospital is drinking some pesticide/insecticide or an overdose of some tablet. These different means also help us to understand the intent of suicide. The means resorted to can be classified as 'cry for help', 'teaching a lesson', or a serious intent to end one's life. Often women consume half a bottle of phenyl or a strip of crocin which indicates desperate cry for help, but there are also women who have consumed poison and also inflicted an injury thus indicating a resolve to kill themselves.

Significantly, the episode that triggered off an attempt to suicide is mostly emotional abuse. This is true of almost 97 per cent of the women. However, amongst other women registered at Dilaasa who had not attempted suicide, the episode that had brought them to the centre was physical (81 per cent) and emotional (90 per cent). Emotional abuse even if not including physical and/or sexual abuse can drive women to a point where they find it unbearable. The type of emotional abuse is entrenched in the strong gender, caste and community biases that exist in society and families. Whether it is choosing a partner or making a decision of whether to get married or not or facing criticism for performing the roles of a wife/mother/daughter in law. The types of emotional abuse reported by women ranged from verbal abuse in the form of insults, criticism, and sarcasm and constant suspicion. Controlling behaviour in the form of restricting mobility of the women and the male partner threatening to harm himself were also reported by several women.

Young married women constituted a significant proportion of the women reporting to Dilaasa after a suicide attempt. They seemed to find it difficult to accept violence from their partner, because their aspiration of a happy intimate relationship was shattered. Social pressures from natal family and friends about not speaking out, accepting spousal violence as normal behaviour or holding the woman's behaviour responsible for provoking violence, lead to a great deal of turmoil. Amongst married women, it is certain from this that an attempt to suicide is not necessarily a result of long period of abuse as most women have faced violence for less than five years.

For unmarried girls, the experience of facing abuse from their own natal family- father/brother made them feel helpless and caged. Suicide seemed to be the only way out of a

situation that they could not change. As daughters, these women had limited or no say in any matters related to the family or even their own lives. Most women reported that spoken to any body about the violence being faced by them. These responses clearly indicate that women have internalised the violence faced by them. The hospital therefore provides the first space where they can open up and speak out.

Countering a Myth:

Our data showed that only 13 women said that they wanted to threaten the abuser so they attempted suicide. This is important to note as it is common perception that women attempt suicide just to 'attract attention'. This trivialises the woman's problems completely and is seen in the way they are treated by health professionals, family and society at large. The myth is also further perpetuated by the fact that women may have consumed insecticide/pesticide or tablets insufficient to cause death. Such trivialisations can be really damaging as no one responds to the woman's feelings and the abuse remains unquestioned. Fifteen of the 216 women were pregnant and most of them were in their second trimester so one can be sure that they were not trying to attract attention.

IV. *Dilaasa's* Feminist Counselling Practice

Dilaasa's counselling practice is embedded in a strong feminist framework. At the time of evolving a methodology, we were clear that the feminist counselling practice is the only one that questions abuse and puts the onus of abuse on the perpetrator rather than the victim. It also provides the necessary tools and strategies that equip women with skills that facilitate healing and stop violence.

Three beliefs that inform Dilaasa's counselling practice

a. Personal is political

The first belief essentially means that personal problems are not problems of the individual alone but are connected to the social and political environments. The formal system (mainstream psychiatry) focuses only on the intra psychic explanation for problems. This leads to women being diagnosed and labelled based on the medical model which has little understanding of bio-psycho-social factors. Often the problems that women have are reactions to violence or oppression. The focus on the intra-psychic factors makes the counselling look at internal deficiencies only rather than the

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conditions in the environment - household or community or other institutional structures- that are causing the distress. This can be harmful as there is a danger that the counselling could actually promote more gender bias and also victim blaming as the woman is asked to locate faults within her rather than understanding this as a response to oppression. Feminist counselling recognises that the changes that a woman makes within herself have to be accompanied with changes within the family, society and other institutions. Feminist counselling believes that it is essential to explore external and contextual factors that contribute to problems, thus making the connection between the personal and political.

In feminist counselling the counsellor is aware of the socio-economic-political-cultural context and patriarchal norms within which women live and the myriad ways in which these influence and impact her mind and her health. This understanding of the environment is essential in helping her rebuild her life and in her process of healing.

b. Problems and symptoms are the means of communication and coping

The second belief that guides feminist counselling is that symptoms are behaviours that arise out of a desire to change situation and/or resistance to what is happening around. So a woman's distress and helplessness with oppressive environments need to be understood as her way of coping with it and essentially a consequence of exploitation. Symptoms need to be understood in terms of where they are emerging from. This could be the multiple roles that women have to play for example their traditional and non traditional roles, modelling of parents/elders. For example, the common notion is that violence is justified if one commits a mistake. This is absorbed by women and they look within rather than questioning the violent behaviour itself. It could also happen that women may have coped with the situation earlier but those mechanisms are not working right now. Therefore a woman who is seeking services is not seen as one with no agency. Her help-seeking is understood as a temporary breakdown in her coping mechanisms. The counselling is therefore geared towards reconnecting her to older strategies that had helped her and facilitating the learning of new strategies. So each symptom needs to be understood in the context in which it was learnt. Women also need to be prepared for resistance from the perpetrator, family and others when she changes.

c. Recognising diversity: Women's multiple identities and many sources of oppression beyond gender

The third belief is affirming diversity. This recognises that women have varied identities and counsellors have to value the same. Being a woman is only one facet of lived experience for any woman, but she has multiple identities based on caste, religion, class and sexual orientation. It is therefore necessary to understand that gender is not the only form of oppression. This helps the counsellor understand that gender intersects with other aspects of a woman's identity. An understanding of the culture/practices of women from different communities is important in terms of drawing up strategies that would enable her to resist violence and heal from the trauma.

ii. Feminist counselling principles that define Dilaasa's work

- Counsellors examine their own values regularly. They are self-aware and clarify their values and attitudes so that their values are not thrust upon the women.
- Women are competent, that they have their own agency. The role of the counsellor is to facilitate the process of healing; building on a woman's strengths, and helping her take decisions and not take decisions on the woman's behalf as she is an expert of her life.
- Counselling is for change and not adjustment. The counsellor helps to increase the woman's abilities and help her understand that her pain and symptoms are connected to her life situation and the trauma she has endured.
- Power in society is analysed and awareness about how women are socialised to feel powerless is examined. It also propels counsellors to advocate for change on behalf of women.
- Simultaneously the client is helped to learn new skills to deal with her situation and help her remove the pain, manage her physical and mental symptoms, and helped to discover ways in which she can gain power in her personal, interpersonal and social lives.
- The counsellor-counseee relationship is egalitarian and this is both for the process as well as outcome. The counsellor has to recognise the difference in power and work towards reducing/sharing power.
- Counselling is a contract which is based on informed consent.

iii. Techniques for reaching out to women

Women facing domestic violence do not easily speak out about the abuse as it is considered to be an intimate/ personal matter. They also have to battle with the notions

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of honour of the family. This tendency is further heightened amongst women who have attempted suicide. The first and most important step is to help them acknowledge that this was not an accident but intentional self harm. The rapport has to be built quickly so that she can trust and is able to speak out.

The intervention involves:

- Validating the woman's experience, believing her story, and helping her tell her story so that she begins processing the trauma. Conveying to her that she is not to be blamed for the violence, that many women face it as it is because of the social and cultural systems that sanction violence against women by men.
- Making an assessment of the severity and intensity of violence in the woman's life and making a safety plan.
- Drawing her attention to her strengths and focusing on them, increasing her self confidence and assertiveness.
- Helping her manage her physical and mental health symptoms (such as sleeplessness, depression, anxiety) with stress management techniques and cognitive behavioural techniques for depression if severe.
- Helping her reconnect to her life and help her gain control and fight out the powerlessness.
- Establishing social support by connecting her to other groups, sharing it with family and friends.

V. Feminist model for responding to attempted suicide

In this section we describe how we apply feminist principles of counselling to conceptualise a woman's attempt to suicide. We further describe the presenting symptoms amongst women reporting after attempted suicide, the various psychosocial issues that need to be addressed and skills required for reaching out. This is illustrated with a few case studies of the lives and circumstances driving the women to attempt suicide.

Feminist conceptualisation of an attempt to suicide

Feminist beliefs enable us to understand an attempt to suicide as a 'cry for help' as a reaction to a situation that is unbearable for the person. It is her way of dealing with

her circumstances and attracting attention to the abuse in her life. It is not a disorder but coping mechanism. She has to therefore be helped to learn other ways of coping with her situation.

We challenge the intra-psychic focus of the formal system which penalises the woman and blames her for the act. Again maladjustment puts the onus on the woman and her inability to adjust when actually what she is doing is resisting abuse. Often when women question gender norms or resist violence, they are seen as women creating trouble at home.

It is important to understand that an abused woman's attempt to suicide is a coping mechanism, her 'pathology' is rooted in male violence rather than in her personality traits. Although certain mental health problems are associated with suicidal ideation, it is important to understand that all women who have attempted suicide do not have a mental health disorder. Most of them need support in dealing with the violence which has caused this. Crisis intervention therefore becomes a prime focus.

There is an element of trivialising the abused woman's suicide attempt by labelling it an 'impulsive act'. This is based on the quantity of poison/ history as reported by the woman and/or her family. This can alienate the woman from everyone. Feminist counselling recognises her suicide attempt as serious, validates her feeling of misery and pain, her feeling of powerlessness as a consequence of ongoing violence.

Psycho-social issues amongst women presenting after attempted suicide

The first contact with the woman takes place when she is still recovering at the hospital. Usually she is surrounded by relatives, which makes it difficult for her to speak out. In addition to the ongoing abuse in her life, a woman who has to face several difficulties because of her attempt to suicide in rebuilding her life. Physically, the woman is weak, tired and dazed. The stomach wash, repeated vomiting and other medicines take their toll. Emotionally she has several conflicting feelings.

She is scared, guilty, sad, angry, listless and confused.

She is worried about what will happen- who will say what.

She denies that she has attempted suicide and smiles and says it was a mistake.

She blames herself for bringing bad name to her family

She expresses that this is the only way out for her.

She does not speak at all.

She laughs nervously and says it happens in all families.

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In addition to this, she is blamed by family and friends for bringing shame and embarrassment to the family as everyone in the community learns about her attempt. Due to hospitalisation, family incurs huge cost. Above all this, the fact that suicide is a crime in India, poses several other problems. The hospital makes it a medico legal case and as she is admitted in the hospital, the police enter the scene to investigate the case. This puts the woman in a fix and there is a lot of pressure from the family also for not revealing the truth. Most often, the case is therefore recorded as "accidental consumption of poison" which does not help the woman later when she wants to prove violence in her life. At the same, perpetrators have used these papers against the women in order to label them as mentally unstable/ problematic and seek divorce. A few of them even ask for a letter that says that 'he' will not be held responsible for her death in future as a pre-condition to taking her back home.

Hence counselling has to deal with barriers at different levels right from the woman's mindset to the infrastructure of the health setting. The biggest challenge in counselling a woman who has attempted suicide is to be able to provide her adequate emotional support and strategies to increase her safety to prevent a second attempt.

By the time the counsellors meets her, she has been quizzed about the suicide attempt by many persons. It is very important for the counsellor to assure her that there is no coercion for her to narrate the circumstances leading to the incident yet again, but that the counsellor is interested in understanding her full experience, not just the specifics of the incident. The woman is reassured that if she does not feel like confiding in us now, she can do so whenever she feels lonely or wants to visit us anytime in future. We know that she may come after some time, but many women come to Dilaasa only once, and therefore the efforts are to ensure that she is able to take something back even from a first and only visit.

If she is willing, then the counselling proceeds. In order to help women speak out, techniques such as reading out a leaflet that have stories of women who have faced similar predicaments and are now living a violence free life, are useful.

Steps in counselling women

Keeping these challenges in mind, there is a need to evolve a protocol of plans that have to be made with the woman in the post suicide attempt phase. The effort is to provide knowledge and develop skills in problem solving and increasing the sense of self-esteem, belonging and worth in the women. Counselling a woman who has

attempted suicide has to start with placing the woman in the larger context of what has driven her to attempting suicide. The reasons may vary from sheer destitution to domestic violence, to a failed love affair, to failure in examination and need for long term psychological help.

Suicide prevention counselling needs to have empathetic understanding of the woman's social reality. The counsellor has to look at suicide as a way of coping with an unbearable situation, or a cry for help. Hence non-judgmental attitude should reflect while counselling such a woman. The counselling has to gear to helping the woman see that she is not alone, that support is available and counselling is her space to share whatever she feels like. The counsellor needs to help the woman identify the warning signs and when she should turn to someone for help if a feeling of committing suicide comes again. The skill in counselling lies in being able to communicate these different messages while providing her emotional support and also getting to understand her story.

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

- i. Often the attempt is trivialised so the counsellor validates her feeling of helplessness that forced her to take this step.
- ii. Encourage her to recognise abuse in her life and provide language to reframe her experience of oppression.
- iii. Shift the blame from the woman to the circumstances that compelled her to take this step.
- iv. Identify her past coping mechanism and suggest new ones, which would increase her confidence.
- v. Assess the severity of abuse and evolve new strategies to resist and stop abuse.
- vi. Help her establish support from family and neighbourhood and also provide her with information about support groups of women so that she can learn from similar experience and reduce isolation.

Sometimes we come across women who suffer from moderate or severe mental disorders, who may not be facing abuse. In such a case, it is best to refer her to the psychologist and psychiatrist. It is important to have access to mental health status diagnosis procedure coupled with counselling. When the symptoms are under control, the Dilaasa counsellor could talk to the patient, which would be very crucial to be sure that the full context of her life is addressed. Many women who have been diagnosed

with moderate or severe mental disorders are also enduring abuse which often exacerbates or triggers episodes of chronic mental disorders so both issues need to be addressed. Traditional psychiatric treatment generally does not address gender based violence, so it needs to be followed by or accompanied by the kind of counselling that Dilaasa provides. Psychologists and psychiatrists also need to be provided with more training in domestic violence and its relationship to mental health, especially suicide attempts.

We present some illustrations on how the counselling practice at Dilaasa facilitates women's struggle to resist violence and also learn alternate coping skills. We also understand that counselling is only one factor that helps women but as described below through three case studies, it plays a significant role.

Case study 1²

S a 22 year married woman was being treated in the hospital for having consumed poison accidentally. When the counsellor met her in the hospital ward and attempted to explore whether there was a possibility of an underlying history of abuse in the marriage, she denied it. However her body language indicated that she was tutored not to talk to anyone about the incident. At this point the counsellor read out a pamphlet related to why women attempt suicide and its relation to some form of abuse .The counsellor explained to her that she could come to the counselling room at any time in the course of her stay in the hospital.

The initial conversation had been of some help to S, which prompted her to reach the counselling room the next day. The counsellor appreciated the effort made by her to reach the counsellor, because it is was an indication of wanting to seek formal support to resolve issues that she may be facing. The immediate feelings she was battling with, were those related to guilt because she did not know that she was pregnant when she consumed poison. The counsellor validated her feelings about the pregnancy but at the same time said to S that she must have been in a very desperate situation to have consumed poison. By then the ultrasonography report had indicated that the foetus was safe. The counsellor explained to her that often women attempt suicide as a way of coping with a hostile/restrictive environment, therefore she should not feel guilty about what she has done.

² All identifiable information about women has been changed; these are not real cases but have been constructed for demonstrating the counselling process.

In order to draw up a plan of action, the counsellor attempted to understand what may have triggered off such an attempt because just as the counsellor validates her coping mechanism, it is equally important to replace those with another way of coping so that she is able to overcome her feelings of attempting suicide again. The counsellor focused on the dynamics of her intimate relationship. Young married women find it difficult, to accept that the behaviour of their partners amounts to "violence", because it is a new relationship. They also do not speak about their experience related to sexual relationships, as it is forbidden to talk about it. But in S's situation the counsellor probed into it because she knew that young women in particular don't have adequate information about healthy sexual relationships, or they may find it difficult to label forced sex as abusive behaviour by their spouse.

S told the counsellor that her husband would force her to have sex in a house which had 10 family members and no privacy. She said that the minute the lights in the household went off, she had to comply with his demands. Others in the family would taunt her and pass snide remarks about her indicating that they knew what was happening. She found it unbearable to continue this way and that is when she consumed phenyl. The counsellor acknowledged how difficult the situation must have been for her; at the same time the counsellor looked for clues in S's narration about her coping mechanism. The counsellor picked up cues from S's narration and explained to her ways in which she had resisted abuse in the past. She explained to her that it is not she who should feel ashamed but it is her husband who should be ashamed of his behaviour. She helped her to see that she had put her foot down and told the marital family that she would continue to work after marriage; similarly she had also negotiated that she would retain a certain amount of her salary for herself and give a part of it to her husband. The counsellor appreciated her strengths and put those back to her. Counsellor put back to S that, she may harbour feelings of guilt and inadequacies after such an attempt; therefore she has to draw from her strengths. The counsellor also discussed with her that such feelings revisit all women who are struggling against abuse, but they can also be overcome. The counsellor explored her likes and dislikes as well as ways of keeping her engaged when such feelings cross her mind. Suggestions towards calling up a friend in whom she had confided about these problems, calling the counselling centre, engaging in activities she likes such as singing, art, temporarily distract her from her feelings of ending her life. At the same time, the counsellor had to work towards helping S cope with remarks such as she being irresponsible, from family and

neighbours. The counsellor told her that she should remember that circumstances have forced her to take such a step.

What came across through S's history was that she was educated and independent which created a lot of insecurity in her husband. He would monitor her timings, suspect her character and criticise her for anything she did or did not do. S was fed up with her husband, because they were unable to match intellectually, emotionally or sexually. She wanted to quit the relationship but was scared of how her parents would take it. The counsellor contextualised S's experiences by connecting it to a patriarchal structure in which husbands exert control over their wives and whenever they feel a loss of control, beating is used as a method of ensuring that wives stay in control. Such an explanation provided S with an understanding that it is not just "her" who is facing abuse, but women at large face abuse as a result of the patriarchy.

S was encouraged to work through her feelings related to pregnancy as well because this decision had a direct bearing on her desire to end the marital relationship. Without being judgemental, the counsellor encouraged S to discuss her feelings related to pregnancy and at the same time explained to her that wanting to have a child is often determined on the basis of the pressure from not just marital family but also parental family. S mentioned that her parental family has always been supportive of her. So a joint meeting was held with her parents, where both the issue of abortion as well as divorce was discussed. Though the parents wanted to reach out to their daughter, they were afraid of the social criticism that this would evoke.

The counsellor reframed the role of society and conveyed to them that they should view their daughter as a person capable of making decisions. The counsellor explained to the parents the need to validate her experience as well as support her decision. Along with the support of her parents as well as her determination, S was able to overcome the abuse in her life. She finally decided to move out of the abusive home and lived with her parental family. She is struggling to find a job and coping with the separation.

Case study 2

B, a young girl of 17 years was brought to the hospital by her parents in an unconscious state. In the course of her treatment the doctors diagnosed that she may have lost consciousness due to an overdose of some medication. Soon after she regained her consciousness, a call was sent to the counselling centre in the hospital. B was being pestered by the hospital staff as well as her own parents to tell them why she had consumed pills. When the counsellor reached her bed, she automatically assumed that the counsellor too wanted to know the same thing. In such a situation, it is crucial for the counsellor to get across the message that she was not there to ask "why" she had consumed those tablets at all. The counsellor acknowledged that these repeated questions would be causing further distress to her; in fact the counsellor shared with her that many young girls deal with a lot of pressure at home, whether it is related to exams, continuing education or relationship with another person. Not having much of a say in their own life decisions causes a lot of stress and that is why some young girls may think of ending their life. She gave B a suicide prevention pamphlet and was about to leave, when B asked her what can be done in her case.

B was in love with a boy of her age who stays in the neighbourhood. One of her college teachers saw her talking to the boy on a few occasions. He reported this to her father. B's father was furious; he stopped her from going to college, her mother too has threatened that if she meets the boy again she (the mother) will commit suicide. It was obvious that she was battling with too many issues. The counsellor explained to B that the society expects that women and girls should play a conventional role where in the parents decide upon the groom, take decisions pertaining to the extent to which they can allow their daughters to study and the nature of studies that should be undertaken. Due to these strict norms, girls find it difficult to express their true aspirations and desires to their parents. The counsellor told B to look at her problems in this light. B said that she loves her parents a lot; but she expressed that she cannot give up on her relationship with this boy. The counsellor acknowledged that it was difficult for B to make a decision.

The counsellor helped her articulate her feelings. She broke down and said that though she loves her parents, she is also angry about their control on her. She revealed that they have kept her almost locked up in the house for the past two weeks, and when she did not relent, her mother hit her with a stick.

B was able to see that her parents had punished her as she had deviated from the norm. The counsellor helped B use her reflection to see herself as a person who can decide on her own behalf. B's ability to analyse her situation at this age was appreciated by the counsellor. B asked the counsellor to support her decision to marry the boy with whom she was in love and she wanted her parents to approve of the boy. The counsellor explained that she could conduct a joint meeting with her parents but there is no guarantee that her parents would understand her perspective and she may get a sense of frustration. So the counsellor also suggested ways of handling her feelings of frustration and despair. Suicide prevention techniques such as distraction, positive self talk, meeting or calling friends or the counsellor, were also suggested.

The counsellor made up a plan of action for the joint meeting, at the same time it was crucial for B to make a back up plan if the joint meeting does not result in to the expected outcome. The next day, B and her father were called to the counselling centre. The counsellor explained to the father about the role of the counselling centre. He started complaining about his daughter's behaviour and in fact said that she had cheated him. The counsellor spent some time narrating how they as parents have played a crucial role in her life and that this was narrated by B herself to the counsellor. She attempted to explain that they hold a very important place in her life. But at the same time, she is also under a lot of stress and she needs some time to work through these complexities. But B's father was persistent that she would marry the boy chosen by him only. He wanted the counsellor to convince B to quit the relationship. The counsellor emphasised that the parents need to reconsider her marriage because she is not yet an adult but he refused to consider this proposition.

After the father left, she expressed her fear of being sent away or forced to marry. She requested the counsellor to arrange for an alternative place where she could stay till she turned 18 which was a month away. This was a challenge for the centre as she was a minor. This was explained to her and the counsellor also spoke to her about consequences of doing this. Her relationship with the boy was discussed at length, and she was able to analyse her own situation critically and told the counsellor that she was firm on her decision. The boy's family was supportive and they visited her during her hospitals stay and also met the counsellors. Having considered all consequences, she was shifted to a shelter in another hospital on medical grounds for a month. The centre facilitated the registration of her marriage too.

Other women in difficult situations:

In another instance of a 35 year woman, who had attempted suicide, the counsellor had to handle multiple issues. It was her third marriage which had failed, and her husband was refusing to give her custody of any of the children. She was unable to pursue a legal battle. Various events such as these had made her depressed and she would have repeated crying spells. The counsellor worked with her to reduce her guilt for failed marriages as well as loss of child custody and encouraged her to see that whenever she tried to stop the violence, the marriage had failed. She was helped to see ways in which she had resisted abuse. At the same time the counsellor felt the need to reduce her isolation and a feeling of loneliness by referring her for a support group. Simultaneously the counsellor had to collaborate with other agencies for her to receive legal aid for filing her case for access to children and subsequently take up an income generating activity. She gained confidence, got visitation rights for children and picked up a job but soon was battling with abuse from her parents. However, she was able to cope with this, kept in touch with the centre and eventually helped another woman in crisis. This example points to the fact that women need support at multiple levels in order to bring about a positive change in their lives.

In a case of young 22 year old unmarried girl, the centre failed to bring about any change despite efforts at various levels. She had a diagnosed mental disorder, had attempted suicide several times but refused to take any treatment for her illness. Her parents soon got fed up and she was on the streets. All efforts to locate a shelter or seek admission in psychiatric ward were turned down by her. However she continued to follow up at the centre. The counsellor suspected that she was sexually assaulted as she had injuries on her body but she refused to take any treatment. The centre lost her.

Challenges

It is important for women to have some support in the family whether it is the parental home or partner in order to facilitate healing. A lot of effort goes in to help women acknowledge that they attempted suicide. It is difficult for women to admit that they attempted suicide as by doing so the police machinery is activated which most women do not want. It is therefore pertinent for counsellors to establish a rapport and create an environment where she can trust the counsellor and reveal the truth without having to face any legal consequences. Unless this is established, women would rarely speak out.

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The second challenge is in helping her frame her attempt to suicide as a consequence of violence. This further facilitates the recognition of the so called stress in her life as violence. She is then able to understand her attempt in this context. The third challenge is to create belief in her that she can use her internal resources to cope with violence and encourage then to garner support from family and friends.

The biggest challenge is the huge loss to follow up. Only 34 per cent (73 out of 216) of the women followed up at the counselling centre as opposed to 70 per cent in cases of those women who had not attempted suicide. This loss is a huge impediment in facilitating a violence free life for them. As described in the sections above, women and girls who attempt suicide are young and have absolutely no support. Most often they have never spoken about the abuse to anyone and typically, they may not have acknowledged their ongoing experience as abuse to themselves either. Self harm is a serious consequence of domestic violence and needs to be responded to urgently. But because of their peculiar circumstances, they may not be able to follow up. There is a need to therefore strategise on what can be done during their stay in the hospital so that they receive adequate support and the system is able to put in some mechanism by which she can follow up with the hospital. This could be done as a matter of routine follow up after discharge. If it is done by the doctors it would lend value and emphasise that she requires care. The de-stigmatising of the attempt to suicide and a more sensitive response from the health care providers could go a long way in initiating a process of healing or at least triggering off help seeking behaviour amongst these women.

Lastly, there is a need to work towards prevention of such attempts where again the public health system can play a critical role through education and awareness building on domestic violence and its consequences. There is a need for communities to question abusive behaviour and not tolerate it at all.

VI. Conclusion

The *Dilaasa* experience demonstrates that it is possible to initiate and sustain a model that responds sensitively to women reporting after attempt to suicide in hospitals. The crisis intervention model that has been presented can alleviate women's distress, provide them with tools to resist violence and strengthen as well as learn new ways of coping with domestic violence. As illustrated above, this only requires a change in perspective of how such cases are viewed and managed by hospitals. It clearly underscores the need for a feminist crisis intervention services in addition to the medical treatment.

The public health system needs to recognise that domestic violence is an underlying cause for attempted suicide, and that a multi pronged approach is required to address/prevent such suicide attempts because its causes are embedded in gender-power relations in society. An effective response to women attempting suicide has to be based on the premise that her attempt is her way of coping with the violence in her life. This would require intensive training of health providers including mental health professionals on domestic violence and its consequences on women's physical and mental health. This would ensure that the treatment provided to the women is informed of this reality and does not stigmatise them further.

The response needs to go beyond medication and include psychotherapy, group therapy as well as referrals for further support and healing. Thus response would not just be biomedical but include social and other factors into consideration. A public health response would also entail preventive strategies through awareness building within communities and all level of the health system. In addition to carrying out awareness drives through use of IEC material, all health facilities should be able to identify women facing domestic violence so that women are able to speak out sooner instead of being driven to harming themselves.

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ANNEXURE I

Pamphlet that can be read out to the woman

YOUR LIFE IS VERY PRECIOUS. CHOOSE TO LIVE.

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

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



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

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



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

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

Listen to them.

“The support and confidence that I got from my parents gave me the courage to deal with all difficulties”.



“Negative emotions had overtaken me. Now I know, I have to struggle to overcome them and support myself.”

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



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

REMEMBER THIS: No situation is hopeless. Negative emotions can be rechannelised. Coping skills can be restored and strengthened. Your confidence in yourself will return. Like these women, you too can find renewed meaning in life. In fact, you have already been struggling to overcome it courageously and alone.

But now you are not alone. We are here for you.

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

Dilaasa: Dept. No. 101, K.B. Bhabha Hospital, Bandra (W), Mumbai - 400 050.

Ph.: 26400229 (Direct) | 26422775 | 26422541 Extn. 4376 / 4511

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

ANNEXURE II

Types of Violence Faced

(Please tick from each type of violence) (a body map can be used to help the woman talk about where she was assaulted)

Physical	Emotional	Sexual	Financial
Beating, slapping by hand	Verbal abuse	Forced sex	Not allowing her to seek employment
Pinching	Persistent criticism	Painful sex	Denying her access to any money.
Pulling hair	Isolation	Withholding sexual pleasure	Denying right to her own income
Pushing, shoving	Threats to kill her	Sexual advances from other family members	Asking her for an explanations for every expenditure
Twisting the arm	Threats to remarry	Denying her the use of contraceptives	Denying her food and shelter
Banging the head on the wall and floor	Husband not communicating with her	Forcing her to have children	-Demanding money
Punching the face		Forced oral sex	Dowry demands
Punching the chest	Threats against her family	Forced anal sex	Any others
Punching the abdomen	Suspicion	Any others	
Kicking the chest	Restricting Mobility		
Kicking the stomach	Humiliating her in public		
Kicking her on the face	Extra marital affair		
Belting the woman	Any other		
Human bites on different body parts			
Use of blunt instruments			
Use of sharp instruments			
Strangulation			
Forcing her to consume poison			
Any others			

Source: *Establishing Dilaasa: Documenting the challenges by Padma Deosthali; Purnima Maghnani and Seema Malik, 2005*

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ANNEXURE IV

List of helplines offering counselling

1. Aasara Helpline

A-4, Tanwar View, CHS Plot – 43,
Sector – 7, Koparkhairane,
New Mumbai – 400 701.

Helpline: 27546669

Time: 24/7

2. Maitra Helpline

Shri Ganesh Darshan, 9th floor, IPH,
L.B.S. Marg, Opp Maharashtra Flywood
Centre, Hari Niwas Circle, Naupada,
Thane (W).

Helpline: 25385447

Timings: Mon-Sat 9.00 am To 9.00 pm

Sunday 9.00 am To 1.30 pm

3. Sheriff Helpline

Helpline: 1298

Time: 24/7

ANNEXURE V

List of Organisations offering counselling

1. Awaz E Niswan

Rehnuma Library Centre, Darulfala Building,
1st Floor, C Wing, Room No. 102,
Mumbra, Kausa - 25490038

3. Dilaasa

Dept. No. 101, Opp. Casualty,
K.B. Bhabha Hospital, Bandra (W),
Mumbai-400 050.

Ph. 26400229 (Direct) 26422775 /
26422541 Extn. 4376 / 4511

Email: dilaasa@vsnl.net

2. Awaz E Niswan

47/1, Sarbai Hasan Ali Roopwala,
Moreshwar Patankar Marg,
Kurla (W), Mumbai - 400 070.

Tel. : 26523402 / 9819656860 /
9867213298,

Email: niswan@vsnl.net

4. Dilaasa

Dept. No.15, K.B. Bhabha Municipal
Hospital, Belgrami Road, Kurla (W),
Mumbai-400070.

Ph. 26500241 Extn. 212

**5. Stree Mukti Sanghatana Shramik,
Royal Crest**

Lokmanya Tilak Vasahat Road No. 3,
Dadar (East).
Tel. : 24174381

**6. Stree Mukti Sanghatana Family
Counselling Centre**

Near Matoshri Ramabai Ambedkar
Maternity Home,

Ramkrishna Chemburkar Road,
Chembur Naka, Mumbai – 400 071.

Tel. : 25297198

**7. Stree Mukti Sanghatana Family
Counselling Centre**

Sector – 3, Cidco Communication Centre,
Near Vashi Police Station, Vashi.

Tel. : 27821564

8. Swadhar Keshav Gore Smaarak Trust

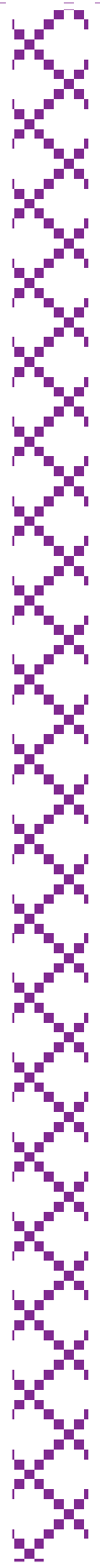
Arye Road, Goregaon (W),
Mumbai – 400 062

Tel. : 28720638

Feminist Response to Attempted Suicide A Model for Public Health Intervention

Other Related Publications of CEHAT

1. Burte, Aruna; Rege, Sangeeta and Deosthali, Padma. Choosing to live : Guidelines for suicide prevention counselling in domestic violence; 57p., 2007
2. Rege, Sangeeta. Guidelines for counselling women facing violence; 48p., 2008
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