transcultural psychiatry ∎∎

Exploring domestic violence and social distress in Australian-Indian migrants through community theater

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Abstract

In many parts of the world, young adult women have higher levels of common mental disorders than men. The exacerbation of domestic violence (DV) by migration is a salient social determinant of poor mental health. Ecological models describe factors contributing to DV as operating at individual, family, cultural, and societal levels. We explored the interplay among these factors in an Indian community living in Melbourne, Australia, in a qualitative participatory action research study using a modified Forum Theater approach. We here present findings on connections between migration, societal factors, and social/family/cultural factors in DV. The study captured the voices of women living in the community as they describe how DV contributes to their emotional difficulties. Improved understanding of the sociocultural dynamics of DV and the associated social distress in this migrant Indian community can be used to guide the development of culturally sensitive prevention and response programs to assist migrant women from the Indian subcontinent who present with psychopathology and suicidal behaviors associated with DV.

Keywords

Australian-Indian migrant women, domestic violence, mental health, psychopathology, social distress, sociocultural factors, suicide

> Culture is … a dynamic system in which stories have power; stories reshape our perception of the world, drive us to action, and imbue every action (and inaction) with meaning.
> (Kirmayer, 2006, p. 133)

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Over the past decade, concerns have been raised worldwide over growth in the rates of mental illness—especially common mental disorders (CMDs) such as anxiety and depression. A World Health Organization (WHO) report on levels of disability (2008) stated that mental illness is the leading cause of disability-adjusted life years (DALYs)—a measure of overall disease burden expressed as the number of years lost due to ill-health, disability, or early death (Murray, 1994)—accounting for 37% of lost healthy years worldwide. Depression alone accounts for one third of DALYs and, globally, women are more likely to suffer from major depression throughout their lives than men (WHO, 2002). According to the same report, the social model of women's mental health posits that women's social positions, as well as their different levels of susceptibility and exposure to risk factors, make them more prone and vulnerable to poor mental health outcomes. According to the WHO (2002), the principal social risk factors for mental illness in women are poverty, domestic violence (DV), sexual violence, occupational status, and the power differences between men and women (Shidhaye & Patel, 2010). Migration seems to advantage some women but disadvantage others (United Nations Development Program [UNDP], 2009). For example, newfound economic independence and the ability to tackle new challenges can enhance confidence in some women, but may also lead to family conflict, including DV (UNDP, 2009).

We live in an increasingly multicultural world in which people migrate for many reasons (Bhugra et al., 2011). The result is the intermingling of many different cultures and ethnicities. Kirmayer (2006) has noted that transnational migration results in the cultural hybridization of many ethnic and cultural traditions. In this rapidly changing world, studying the lives of individuals in moments of migratory transition is crucial to the study of cultural factors, which are increasingly recognized as important determinants of mental health.

Australia is host to migrants from over 200 countries (Australian Bureau of Statistics, 2010) with varied backgrounds and cultures. India has contributed the most migrants to Australia of any country since 2006 (Australian Bureau of Statistics, 2010). This rapid growth in the Indian population has not been matched by a similar increase in migrants' uptake of DV services, the rate of which appears to be far lower than that of the general population (20%; VicHealth, 2005, p. 19).

The World Health Organization (2005) defines DV as the systematic abuse of control and power over a victim, which is exercised through a combination of emotional abuse, physical violence, sexual abuse, and/or financial control. Australian figures suggest that one third of women suffer DV at some point in their lives (VicHealth, 2009). High risks of violence against women, however, have been found in cultural and linguistic groups within Australia. In particular, irrespective of a host country's values, migrants from patriarchal societies may hold long-standing, traditional gender norms, roles, and maintain an unequal distribution of power and wealth between men and women (VicHealth, 2009).

In Indian society, strong cultural continuity has been associated with harmful practices of oppression and violence against women (Sen, 2005). Numerous issues have contributed to India being ranked as the country with the lowest quality of life

for women of any developed or developing G-20 nation (Thomson Reuters Foundation, 2012), including dangerously low female-to-male ratios arising out of the endemic practices of female feticide and infanticide (Sen, 2005); rising rates of murders of recent brides known as dowry deaths; abetting of suicide (Babu & Babu, 2011); child marriages (UNICEF, 2012a); widows' loss of social status resulting in homelessness and violence (Mohindra, Haddad, & Narayana, 2012); male adolescent attitudes of acceptance of high rates of DV against wives (UNICEF, 2012b); male patriarchy (Simister & Mehta, 2010); and DV rates variously recorded as 30–52% (Babu & Shantanu 2009; Kimuna, Djamba, Ciciurkaite, & Cherukuri, 2013).

A strong link between domestic violence and suicidal behavior has been widely observed (see Colucci & Heredia Montesinos, 2013). For example, a 10-country WHO study found that women who had experienced partner violence at least once reported significantly more emotional distress, suicidal thoughts, and suicide attempts than nonabused women (WHO, 2008). Suicide rates in Indian women are reported to be among the highest in the world (Patel et al., 2012). A longitudinal study performed in India (Shidhaye & Patel, 2010) reported DV to be an independent risk factor for depression, anxiety, and suicide. There is an urgent need to assess the impact of domestic/family violence and its contribution to mental illness in Indian migrant communities, particularly in view of the 11 recent suicides/homicides that occurred in four Indian families from Victoria, Australia (Bucci, 2012).

Understanding ethnic variations in the dynamics that perpetuate violence is important in order to design effective treatment and prevention strategies (Alhabib, Nur, & Jones, 2010; USAID, 2012). Moreover, developing such strategies requires a deep understanding of social and cultural dynamics that can be cultivated through qualitative research methodologies. Thus, this study aimed to explore the sociocultural dynamics of gender-based violence and its contribution to social and psychological distress in the Australian Indian migrant community using a novel research methodology.[1]

Methodology

The study used a modified version of the Forum Theater technique originally designed by Boal (1985, 1992). Forum Theatre stems from the work of Brazilian educator Paolo Freire (2005) who worked with marginalized and oppressed populations. Boal envisioned explorations of sensitive issues such as racism and DV through this technique. Beck, Belliveau, Lea, and Wager (2001) describe research-based theater on two spectra—the research and performance continuums—for engaging audience participation. Participatory Theater has also been described as a type of social science methodology (Denzin, 2003), in which performers and audience are engaged in a democratic dialogue to create a narrative of lived experience.

Forum Theater offers several unique methodological advantages. For example, some types of experience and cultural knowledge cannot be expressed in discursive

statements (Fabian, 1990); the Forum Theater methodology offers an opportunity to represent unmentionable secrets through action, enactment, or performance, making visible that which might otherwise be hidden due to shame and avoidance. In this regard, Lev-Aladgem (2003) noted, "the actresses realized their uniqueness as the first battered women to break the conspiracy of silence" (p. 144). Moreover, because it brings the stories of marginalized people onto the stage, Forum Theater offers a rare opportunity to bring people on the fringes into the center (Chilton, 2000 cited in Lev-Aladgem, 2003); being the experts on matters pertaining to their own lives, they can engage in a dialogue with the audience to discover how to deal with their problems collectively.

Several studies have explored DV using this technique, with communities in Israel (Lev-Aladgem, 2003), the US (Mitchell & Freitag, 2011), Uganda (Sliep, Weingarten, & Gilbert, 2004), and Taiwan (Wang, 2010). Moreover, the Forum Theater technique has been used extensively in India; Jana Sanskriti, for example, has utilized Forum Theater to empower and educate thousands of people suffering from oppression, such as marginalization, domestic violence, and political power-lessness in urban and rural regions (Ganguly, 2010). Sonjay Ganguly (2010) reported that men and women from urban, semiurban, and rural regions of India meaningfully engaged in the theater performances. Capilla and Bhalla (2010) also used this technique to educate students in India. More broadly, street theater is familiar to many people from India (UNESCO, 2005). A study in Canada found that Indian migrants to Canada readily engaged in Forum Theater (Sajnani & Nadeau, 2006). Thus, we expected this approach to be well suited to the purposes of our study. The Boalian techniques of Forum Theater offered a methodology that was different from that of interview methods or focus groups (Drummond Street Services, 2010) and provided a powerful tool to achieve the aims of this project.

Procedure

A detailed description of the methodology has been provided elsewhere (Colucci et al., 2013). The project had three stages: focus group sessions, theater workshops, and community theater performances.

Focus group sessions. We used a community outreach model to hold four focus group sessions in four distinct localities of Greater Melbourne with a total of 72 women from Indian background attending. The aims of the focus groups were to: (a) gather information on what women in the Indian migrant community identify as domestic/family violence and (b) introduce some of the Forum Theater games and exercises to the participants in order to recruit them for the theater workshops and performances.

The sessions were semistructured and only a few questions were preplanned. The focus group started with participants introducing themselves, which was followed by opening questions by facilitator (EC) and ensuing discussion. Questions addressed included: What is a happy home? What does an unhappy home look

like? What happens in these homes/families? When participants brought up DV, the facilitator asked: What was the DV and who were the perpetrators?

In the second part of the session, the theater director explained the principles of Forum Theater and facilitated an exercise as an example of the workshop techniques that would lead to the community theater performance. At the end of the session, potential participants were asked to leave their contact information on a form if they wished to continue to participate in the project.

Theater workshops. The workshops were designed to encourage the participants to share their knowledge and lived experiences concerning DV. The participants who agreed to take part in the workshops were not limited to victims of DV, and included women of Indian heritage who represented the broader community. The women came forward during focus group discussions, after which they began to create a sense of ownership of the project. Eight to 12 women took part in each workshop. The workshops were conducted for 6 full days (8 hours/day) over 4 weekends. Each workshop included trust-building exercises and several theater games, which served as metaphors for domestic violence. These techniques were used to provide the participants with a deeper understanding of the topic. The workshops consisted of frank discussions on stories of domestic violence identified in the Indian community and participants' own emotional responses. The workshops were framed as "theatrical investigation" of the research topics. In collaboration with the participants, a script was devised from this "theatrical investigation" and focus group discussions in order to support interactive dialogue with community audiences. To protect their privacy, the script did not specifically represent the personal experiences of the participants (see Colucci et al., 2013).

Community theater performances. Much like the focus group sessions, the interactive theater performances took place in community settings. All performances were open to the public, and each lasted for about two hours. The audiences included both women who were involved in the initial sessions (Stage 1) as well as others new to the project. The primary task of the performances was for the participants to share their understanding and perceptions of the nature of DV in the Indian community.

In community participatory theater, the role of the audience is critical. The audience acts out of impulse, and the community/audience interrogates a "problem story." The spectator becomes a "spect-actor," as described by Boal (1995). The audience probes the circumstances of the various acts that they witness, the power balance, and the potential gains and losses engendered by changing their situations. Forum Theater gives the audience a platform to challenge the idea that the problematic reality is inevitable, thus exposing and exploring the problem while simultaneously promoting awareness of the issues, critical reflection, and consideration of alternative outcomes (Dennis, 2009). In this project, the interactive audience interpreted the scenes of DV occurring on the stage and helped to elucidate cultural narratives of gender-based oppression and violence among the general community

of Indian migrants. Key data were recorded, coded, and are represented below as themes.

Ethical clearance

The Human Research Ethics Committee of The Melbourne Clinic (Project No 192/ 2011) approved this study. Individual informed consent was obtained from all participants. We worked closely with the leaders of the Indian community to monitor safety. A health professional was present in the sessions at all times to assist those in distress.

Data collection and analysis

DV victims were neither sought nor excluded and we aimed to keep the recruitment process broad enough so that no participant could be identified as being a DV victim (although several participants had lived experience of DV, involving either themselves or someone close to them). Recruitment occurred through word of mouth, flyers, ethnic radio announcements, and participating organizations Australia India Society of Victoria (AISV), Tarneit Sikh Temple (TST), and DISHA (Sanskrit word meaning direction to hope. Data were collected over the four focus group discussions ($N = 72$), the six theatre workshops ($N = 14$), and one rehearsal and four community-based theater performances with a total of 114 audience members. The focus group sessions and performances were audio-recorded and transcribed verbatim by an experienced psychologist who was fluent in Hindi, Punjabi, and English. These data formed the bases for the qualitative data analysis. We built our theory of DV inductively through analysis of the data collected in response to ethnographic data collection, which was open-ended. This approach, it has been argued, is ideal for exploring cultural values in multi-layered issues, such as gender oppression and DV (Denizen & Lincoln, 2005). The primary data analysis followed four steps (Miles & Huberman, 2002): (a) EC read through the English translations of the participants' transcripts and took notes on the responses provided in the transcripts; (b) EC and a research assistant separately read through the transcripts again to code the themes initially and collapse themes that appeared similar to one another; (c) the themes were discussed first by these two researchers and then with the rest of the team to evaluate their validity and appropriateness; and (d) the final themes were triangulated with informal field notes to provide the illustrations presented here.

Results

Participants' characteristics

All the female participants were migrants of Indian origin holding different types of visas (e.g., students, temporary residents, and permanent residents). Their length

of stay in Australia ranged from 1 to 40 years. Participants' ages ranged between 18 and 82 years. Key community stakeholders recruited for the project included leaders in three community organizations— DISHA, AISV, and Traneit Sikh Temple (TST) international students, as well as new and established migrants. Four men took part in a single theater performance, and were aged between 28 and 45 years. The male group comprised one student, two professionals, and one TST religious leader. We also recruited Indian-origin female service providers to Indian women migrants including lawyers, social workers, researchers primary care physicians, and medical specialists working in the area ($n = 9$). The remaining women represented all socioeconomic groups, including professionals, academics, students, blue-collar workers, unemployed individuals, and pensioners. The majority of the women spoke English; the older participants spoke Hindi or Punjabi and translations were provided by bilingual members of the team or other bilingual participants.

Findings

This article presents and discusses participants' views about domestic violence among Indian immigrant women in the Australian context (readers should refer to Colucci et al., 2013, for findings about barriers to accessing services in this population).

Participants identified several forms of domestic violence, including emotional/psychological, financial, social, physical, and sexual, which are summarized in Table 1 (Table 1 can be found online with this article).

The audience at the performances largely consisted of women of Indian heritage. Four men took part in one performance. The performance began with a body shaking exercise and deep breathing as a means of relieving tension in both the audience and performers. The play then started with an introduction by the mediator; subsequently, four scenes were acted out depicting various aspects of DV based on the information obtained in focus groups and theater rehearsals. The drama was largely mimed, apart from a few lines introducing the characters' names, occupations, and the number of years they had lived in Australia. Participants introduced their roles in Hindi, Punjabi, and English. The structured moments of silence and miming during the performance were intended to allow for multiple interpretations of body gestures, mannerisms, and roles. Most conversations with the audiences took place in English, and a few in Punjabi and Hindi.

Once the performance began, a trained Forum Theater director and a mediator began acting as the mediator between the actors and the audience, encouraging the audience to verbalize the meanings of the acts they were about to witness through their lived experiences and also propose ways to solve the problems depicted in the acts. One of the scenes, for example, depicted a husband throwing a glass of water into his wife's face when she drew his attention to the dinner she cooked for him. Here, the mediator asked the audience about what was going on in the heads of

both the husband and the wife, what their options were, as well as why the husband chose that particular action. In this case, the audience reacted energetically and identified with the scene, offering multiple interpretations of his behavior and the reasons for his action. The mediator next focused on the gestures and body language of the two characters, directing the discussion towards cultural narratives of gender-based oppression, fear, and violence. The following extract from one of the performances, illustrates the process:

> **Mediator (M):** So this image came from our theater workshop, what do you see?
> **Audience (A):** There is no partnership in marriage if this is meant to depict a marriage. I mean she is telling him repeatedly to come and have dinner. And he is also losing control by actually throwing something at her. That is what it seems by the looks of it. So what was actually a pleasurable meal time has deteriorated into a scenario where domestic violence is being perpetrated.
> **M:** So you feel we are inside a situation of domestic violence.
> **A:** Yes, I feel so and this shouldn't be happening.
> **A**: She is waiting for the partner to come in and have food or dinner together and he feels that he is superior to her, he is showing his loss of control by throwing a glass of water at her.
> **M:** So you think he feels superior to her? So is that legitimate?
> **A:** He thinks his partner should be in subservient role that she is there to serve him.
> **A:** He clearly said that this is why he married. He asked her to bring hot chapatti [an Indian bread served with vegetables, usually a part of daily meal]. She served them and they got cold . . . He answered, "that is why I married."
> **M:** So he said that is why he married so that he can have a hot chapatti cooker?
> **A**: Yes!
> **M:** So in this situation what do you think is happening inside the woman's head?
> **A:** She feels she is being used, emotionless, depressed as well.

In another scene, the husband grabbed the wife's mobile phone out of her hand to stop her from talking to someone. The mediator guided a discussion with the audience members, all of whom identified feelings of isolation, powerlessness, and domination in the scene. The mediator prompted audience members to dig deeper into the motivations of the abusers, their reasons for continuing their harmful practices, the power dynamics, and the intersection of these factors with the migration experience of the women (Sajnani & Nadeu, 2006). Here, many in the audience reflected on these migrant women's lack of freedom in contrast to their Australian counterparts. In another scene, a mother tells a daughter to "put up with it and shut up" in the face of violence from her husband, the mediator invited interpretation and asked why a mother (who lives in India) would ask her daughter to stay in a violent marriage. The audience explored the pressures put on a mother that would cause her to maintain oppressive control over daughters' decisions to exit a violent marriage. One example was that unwed sisters, still residing in India,

would be shunned by potential grooms due to the exposure of their married sister's situation. The mediator questioned the powerful influence of extended family on Indian migrants, whether they lived in Australia or not. Audience responses suggested that migrant Indian women are critically exposed to pressures for maintaining the status quo, thus allowing harmful behaviors to continue. As a solution, one member of the audience suggested a short separation by staying with a friend. The mediator then froze the play and invited the audience member to the stage as an actor to demonstrate her suggestion. She was now a "spect-actor" (Boal, 1995). Once on stage, she acted as a friend and offered to help by inviting the victim to stay for a short while in her home. However, here the drama took an unexpected twist—the friend ultimately refused to help the victim because she feared that the victim's husband would accuse her of breaking up their marriage. She was also afraid that she would be rejected and isolated by her friends and community. Therefore, the audience participation exposed the complex interactions between societal structures and DV. The scene exposed the cultural suppression of the truth of a violent marriage, entrapment with no options, the fear and silence imposed. Thus, several connections between DV, social distress and mental illness, and suicidal behavior unfolded.

Another scene explored the impact of a mother-in-law from India speaking to her daughter-in-law by mobile phone, saying, "Do not imagine that you are so Australian that my son has to do the housework and make his own cup of tea." The rejection of "Western" values as a vehicle for enforcing male dominance and preventing gender equality was discussed and criticized by the audience.

Discussion

In recent years, official migration figures have shown an increase in migration to Western nations (UNDP, 2009). The 2011 Australian census revealed that over one quarter (26%) of Australia's population was born overseas and an additional one fifth (20%) had at least one overseas-born parent. Since 2006, an increase from 0.5% to 1.5% has been recorded in the proportion of Indian migrants to the Australian population (Australian Bureau of Statistics, 2010), with such individuals numbering 295,000, or 5.6% of the population.

Migration can have many positive effects among both migrants and host countries, as it expands economic and employment opportunities and widens perspectives on many social issues (UNDP, 2009). However, migration can also have negative impacts, such as cultural tensions arising from clashes of cultural values. The interplay between the host and migrant cultures plays a significant role in the mental health of migrants (Bhugra et al., 2011).

This study explored how Indian and Australian cultures interact through the exploration of stories of gender-based oppression and their contribution to social distress as well as barriers to accessing services. In the sections that follow, we

discuss several key themes that emerged from our analysis of Indian migrant women's reflections on stories of domestic violence in their community.

Inequality, dominance, and lack of control

Oppression and violence against women appeared to be tolerated and even, in some cases, culturally sanctioned in many of the Indian communities from which participants migrated. Moreover, the participants revealed that concepts of inequality as practiced in their home country were widely accepted within Indian circles in Australia. They stated that there remained significant moralistic pressure in migrant Indian society condemning any deviation from the image of women as subordinate, submissive, and pleasing to others (Jack & Ali, 2010; e.g., as one mother-in-law in India put to her new daughter-in-law in Australia: "Do not imagine that you are so Australian that my son has to do the housework and make his own cup of tea."). Thus moralistic values in the community appeared to enforce and maintain the subservient roles expected of women and may contribute to the acceptance and justification of female oppression through DV (Simister & Mehta, 2010). The women were able to recognize types of behavior included in the definition of DV as problematic (World Health Organization, 2005), but they were unaware of their legal and human rights. Simister and Mehta (2010) have noted that in India, wife beating is seen by some as a normal part of womanhood; many women are acutely aware of their limited options and socioeconomic factors provide them few alternatives to a life of violence.

Several women had expected migration to diminish the inequality and oppression by their husbands and/or by their family members, but this had not occurred. Table 1 reveals the many ways in which dominance, lack of control, and inequality were exercised in everyday life among Indian migrant women. It seemed that inequality was imposed from many directions; in the marital home, participants said that the inequality between Indian men and women was an accepted reality, and at work, the imposed lack of freedom by the women's husbands/families would make them feel unequal to their Australian counterparts. Our findings support the UNDP's report (2009) in indicating that for some women, immigration is associated with greater disadvantage and socioeconomic exploitation. Indeed, although some Indian migrant women experienced awakened or renewed self-confidence due to taking up new challenges, contradicting their identification as subordinate subjects, they often also had to bear the consequences of renewed oppression and inequality.

These findings have implications for mental health, as the predominance of CMDs in women is believed to be determined by not only biological determinants but also social factors, such as inequality (WHO, 2002). According to the WHO, inequality is the most significant contributor to mental illness worldwide (2009). A recent WHO report asserts that mental health is produced socially and that there is

no evidence that people can adapt psychologically to high levels of inequality such as those expressed by many participants in a DV situation.

Multiple perpetrators, powerlessness, and entrapment within the family

In the experience of our participants, DV often involved not only the husband but senior female kin as well; this supports the theory that there is interplay between multiple social hierarchies (i.e., gender- and generation-based ones). Studies have pointed to the significant role played by family hierarchical structure in DV (Krishnan, Subbiah, Khanum, Chandra, & Padian, 2012), wherein mothers-in-law seem to have the power to exacerbate or ameliorate emotional abuse by husbands, bullying and powerlessness, for example, via regular criticism and putdowns (behaviors also classified as DV; WHO, 2005). The present results indicated that the participants' family members who do not live in Australia ("family and friends back in India") could cause violence and abuse.

Specifically, participants indicated that extended family hierarchy can play a significant role in gender oppression in Indian families living in Australia. In Indian society, older women are traditionally given power by the men, including the husband, over the newest entrant to the family. This is typically the young daughter-in-law, who is often financially dependent on the husband and isolated from the family; this drives the arrangement of power hierarchies, with the new arrival bullied as she is taught the rules of the family by her "generational superiors" (Fernandez, 1997). This dominance and suppression of the young bride may be accompanied by a loss of self-esteem and self-confidence. This study's participants also saw this dynamic as a social contributor to demoralization.

Indian law does not recognize mother-in-law violence against daughters-in-law as DV—merely as interwoman violence or dowry-based violence. This may in part explain low rates of conviction against abusive mothers-in-law (Gangoli & Rew, 2011). Moreover, the cultural moralistic pressure to avoid separation may often be at odds with an individual's inner feelings and desires (e.g., of pain, anger, despair, disappointment, and powerlessness). This tension has been said to give rise to a "divided-self," a harbinger of depression (Jack & Ali, 2010).

> I cannot divorce him; divorced women are less respected and are isolated. For a woman, it is like, even (if) this man is physically abusing me, I cannot divorce him, because what would people think of me? I am going to lose friends and my place at work.

The above statement sheds light on the low divorce rate in Indian marriages, quoted variously as 1–7% (Statistic Brain, 2012). Such feelings of entrapment have been associated with loss of the sense of safety, humiliation, learned helplessness, and depression in victims of DV (Brown, Harris, & Hepworth, 1995). Confirming the above association, divorce was found to be a protective factor against suicide in Indian women aged 15–44 years (Patel et al., 2012).

Forced sex and sexual violence within marriage

Sexual violence, defined by participants as unacceptable sexual practices like oral sex, nonconsensual sex, or forcible sex during the menstrual period or when pregnant or unwell, was represented by a few participants as having been caused by migration and the exposure of men to new forms of sexuality. The women seem to comply without awareness of their right to object. Sexual violence within or outside of marriage has been increasingly recognized as a major public health problem and a serious human rights abuse (WHO, 2005, 2008). Indian literature documents that one third of women report forced sex within marriage (UNFPA, 2010). Forced sex has been associated with PTSD, gynecological problems, and chronic stress (Campbell, 2002).

In this study, physical abuse was described by a few women as easier to identify than sexual abuse, which was cited as particularly difficult to identify ("It's my husband; he can do it") and disclose ("the girl cannot go and tell her parents, 'my husband is demanding that I perform oral sex'"; see Colucci et al., 2013). The participants described cultural and societal pressures to suppress their private feelings of self-protection and self-respect. The findings here echo those of UNFPA and International Centre for Research on Women (2004): health care providers in India were found to encounter significant numbers of women who have suffered physical, mental-health-related, and social consequences of sexual violence, but who remained silent due to prevailing societal structures. Illuminating the cultural context surrounding this enforced silence may be critical to understanding the expression and experience of depression among Indian women (Jack & Ali, 2010).

Caught between financial freedom and gender norms

Education, financial independence, and empowerment are widely recognized as protective factors against DV (VicHealth, 2009). However, the present participants observed that there was a contradiction inherent in their situation. A woman might be expected to earn money for the family, but when she goes to work and behaves in an independent manner, the DV begins (Table 1). Some women expressed the view that they must not deviate from the socially mandated "womanly" role, that is, to cook, clean, and bear (male) children, which led to the feeling of being trapped and, as described above, to inner pain, a divided self and, the literature suggests, vulnerability to depression (Jack & Ali, 2010). Simister and Mehta (2010) have noted that this conflict between modern Australian gender norms and traditional Indian culture is also reflected in India, where the increased financial and educational empowerment of Indian women has been accompanied by a backlash of male dominance and patriarchal values; a woman is more likely to experience physical abuse if she is employed, particularly if she experiences significant economic success in her career. Forbes (1998) proposed that if the wife attains a salary close to or above her husband's, the power dynamics of the household begin to shift in favor of the wife. In response, the husband feels a need to reassert his

dominance through an outright expression of patriarchal authority, such as abusive behavior. In this study, the participants experienced multilayered pressure from their husbands, their husbands' families, and society at large—including other women—to "act within womanly roles." This pressure may constitute a form of societal abuse called "over eye" (Jack & Ali, 2010), wherein a sort of cultural super-ego punishes any transgression from the norm with rejection and isolation.

Our study shows how the tension between traditional patriarchal societal expectations and modern Indian women's economic freedom may contribute to individual suffering. In this way, our findings may also offer some insight into the high suicide rates among 15- to 29-year-old Indian women that have been noted globally (Bhugra, 2004). Indeed, Patel et al. (2012) have shown that divorce, separation, and widowhood are protective factors against suicide in Indian women, counter to Western countries, where low socioeconomic status and divorce (Phillips & Cheng, 2012) are important risk factors for suicide for women.

Domestic violence, silence, and mental illness

In many cases social norms prevented the women who had experienced DV from breaking the silence and seeking help. Participants disclosed various ways in which self-silencing (Jack & Ali, 2010) is imposed by Indian society in cases of DV. The women stated that oppression through silencing was imposed by men of multiple generations within the household and reinforced by society more broadly. The community thus deprives the women a chance to break the silence and seek help. As one participant put it: "The silence kills. I used to listen to my husband, then my mother-in-law, and now even my son. I've been listening for three generations" (Colucci et al., 2013, p. 16).

Fear of ostracism by the community and its potential to enforce silence and generate revictimization of DV victims by society was highlighted by the women (e.g., "The fear of society never makes you change what is happening in your life"; see Colucci et al., 2013). Furthermore, some have argued that Indian society being highly collectivist, trains its members not to become too individualistic—this characteristic is deemed to be a facet of Western cultures—and to view oneself primarily through the eyes of others (Jack & Ali, 2010). This concern for the opinions of others may be a hindrance in exposing gender-based suppression and violence.

The cultural value of maintaining family harmony may also encourage self-silencing (Jack & Ali, 2010) in DV situations. For example:

> In case of violence or abuse at home, there is no support or understanding from friends or family (even her parents tell her to compromise). Mother tells daughter to put up with it and shut up in the face of her husband's violence . . . A friend refuses help to the victim because of the fear that the victim's husband may accuse her of breaking up their marriage.

Most cases of DV remain unreported until something serious occurs, such as a homicide. This was the case with the Melbourne Indian community when attention was brought to DV following 11 suicides and homicide cases (Bucci, 2012). Each homicide or suicide case is indicative of many others, in which a victim is suffering in silence. Gracia (2004) urges research that may further enhance understanding of the factors that determine why women affected by DV do not report or seek help (WHO, 2002).

Silencing also leads to low service uptake. According to the Indian Community Organization's Taskforce Against Domestic Violence in Indian and Ethnic Communities, the use of DV services is particularly low among Victoria's Indian women (Drummond Street Services, 2010). In this way, silencing may have mental health implications. Studies show that such failure to disclose may lead to chronic stress and, in turn, to prolonged general ill health in victims of DV (Campbell, 2002; WHO, 2008), while much evidence suggests the therapeutic benefits of disclosing traumatic events (e.g., Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Our findings thus suggest that public education programs that encourage acceptable means of breaking the silence and show the adverse health effects of DV in the Australian Indian community are urgently needed.

Dowry and other marital stressors

As mentioned previously, the dowry system has been associated with homicide and suicide among young women in India. Dissatisfaction at the dowry expressed by the husband is an independent risk factor for depression and suicidal ideation in Indian women (Chowdhary & Patel, 2008). We found that the Indian traditional patterns of dowry are maintained in Australia, where excessive dowry demands can sometimes be seen. This finding suggests that recently married female migrants arriving on a spousal visa may be vulnerable to coercive financial demands.

Migration introduces additional stressors (Bhugra et al., 2011) and has been found to contribute to the risk of developing mental illness in a number of ways, with elevated rates of attempted suicide and suicidal thoughts found among individuals migrating from collectivist and sociocentric cultures such as those of South Asia (Bhugra, 2004). In this study, DV and accompanying distress were heightened by threats of spousal visa cancellation (Colucci et al., 2013). This is in keeping with the results of an American study on Indian women (Raj & Silverman, 2002), which recorded greater levels of DV in noncitizen immigrant women, who were at elevated risk for DV because of their lack of legal rights. The participating women also felt blamed for the men's migration-related stressors, such as finding a home or looking for a job. Participants also described loss, humiliation, entrapment, and social inequality: "If a man is violent and the woman leaves him, he can get another wife in India and bring her here." The participants suggested that in some circumstances, men just need a female companion to provide for their daily needs and to

bear them children for posterity; women felt they had little intrinsic value and were easily replaced, whereas men did not appear to suffer the consequences of their own behavior, reflecting differences in power (Jack & Ali, 2010).

The reasons for the high suicide risk in young Indian women who are married, in contrast to divorced women (Patel et al., 2012), were illuminated by another participant: "When she cannot have children, she is blamed and also replaced with another bride. I have a friend who could not have children, and she committed suicide because her in-laws were looking for another bride for their son."

The above quote by a participant is supported by the point made by Waters (1999, in Colucci et al., 2013) that suicide among Indian women and South Asian women generally is the end point of deep social suffering in the context of a domestic environment and as such is comparable to dowry deaths or murders of new daughters-in-law. Hence, many social activists have claimed, "Every suicide is a murder" (2013, p. 526).

The need to support new migrant women on spousal visas with information on access to health-related and legal services, their human rights, employment, and job retraining is apparent; this should be brought to the attention of relevant government authorities. We recommend that clinicians check for signs of social distress and emotional/physical abuse in newly migrated women. Moreover, they should consider that somatic symptoms are a common expression of mental distress in India (Rao, Horton, & Raguram, 2012).

This study shows the need for medical and mental health practitioners to explore the social and contextual factors that influence every migrant Indian woman using a multilayered approach. Both social and medical approaches are crucial and practitioners are encouraged to avoid therapeutic nihilism towards women who are victims of DV. There is a need to break down the silos of health care by desegregating DV services from mainstream health and psychiatric services and to improve treatment rates (O'Connor, Castle, & Cox, 2014). Finally, as studies of effective interventions for domestic/family violence prevention and treatment of "victims" and "perpetrators" are lacking both in high- and low- and middle-income countries (Colucci & Hassan, 2014), more evaluation and outcome research is also urged.

Conclusion

This pilot research into a community theater project involving community partners and mixed gender audiences shows promise as a culturally safe community engagement model. Our study explored the cultural dynamics of DV and associated social distress among 186 participants (largely women) from the Australian Indian migrant community. Key themes associated with DV that emerged from our analysis include the intersection of cultural contexts (e.g., gender inequality, patriarchal attitudes); societal behavioral norms for women (e.g., self-silencing, submissiveness, and subordination); societal issues (e.g.,

migration stress, isolation from one's own family); and individual factors (e.g., lowered self-esteem, feelings of worthlessness, humiliation, entrapment, and threats of visa status inconsistency). Our results indicate that these factors contribute to deep social distress, which may adversely affect the emotional and mental health of Indian migrant women and their children (Colucci & Hassan, 2014).

This study has several limitations. As indicated by Colucci et al. (2013), to avoid women remaining silent and voiceless in the presence of men, participants were exclusively women (with the exception of one mixed-gender performance). Furthermore, multiple generations were present at the focus groups and performances and some younger women in the audience reported that having their mothers-in-law present inhibited the discussion of intergenerational oppression. Another important limitation of the present study is the lack of assessment of the impact of this project, for example, on primary care service use in the community. The study also did not measure mental health correlates of DV; connections made between our findings and their mental health implications were inferred from existing literature on this topic.

Despite these limitations, this study fills a gap in the literature by exploring the social and psychological factors that may contribute to distress in female Indian immigrant victims of DV. The project identified barriers to help-seeking and culturally appropriate responses to DV as well as social and psychological distress associated with DV that can be used to design early intervention and prevention programs. A multilayered exploration of social, cultural, and contextual issues is required for all women seeking general health care.

This study also suggests the potential utility of the Forum Theater in conducting research on sensitive issues like DV. While there is some existing literature on popular theater as a research tool (Conrad, 2008), ours is the first study to our knowledge to use popular or community theater as a research tool on DV. In pre- and postperformance surveys, pre- and postworkshop interviews, and the theater performances, positive views were expressed by participants regarding the Forum Theater methodology for research, raising awareness and promoting social change. As one participant observed, "Theater is an exploratory experience. It brings reality closer to us and opens up a space for communication. The reason I am here is because in India, theater is a very powerful medium" (Colucci et al., 2013, p. 22).

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Conflict of interest

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Notes

1. In the present study, we further analyze data presented in an earlier article (Colucci, O'Connor, Field, Baroni, Pryor, and Minas, 2013).
2. The first author served as the Chair and the second author as Vice-Chair of the Australia India Society of Victoria's Taskforce Against Domestic Violence in Indian and Ethnic Communities between 2009 and 2013. The taskforce was made aware of lack of service utilization by the Indian community. The taskforce determined there was a profound lack of awareness in the Indian community regarding DV-related services. In the service provider sector a similar lack of knowledge about the nature of DV in Indian community was noted. This project therefore arose out of the expressed needs of both the Indian community and the professionals in Victoria, Australia.

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