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A Cry from the Darkness: Women with Severe Mental Illness in India Reveal Their Experiences with Sexual Coercion

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Abstract

This study used qualitative research methods to investigate the problem of sexual coercion among female psychiatric patients in India. Consecutive female admissions (n = 146) to the inpatient unit of a psychiatric hospital in southern India were screened regarding coercive sexual experiences. Women who reported coercion (n = 50; 34%) participated in a semi-structured interview to learn more about their experiences. Among these women, 24 (48%) reported that the perpetrator was their spouse, 13 (26%) identified a friend or acquaintance, and 10 (20%) identified a relative such as an uncle or cousin. Most experiences occurred in the women's homes. Thirty of the 50 coerced women (60%) reported that they had not disclosed their experience to anyone, and that they had not sought help. Women revealed a sense of helplessness, fear, and secrecy related to their experiences. The problem of sexual coercion is seldom addressed in mental health care in India; the prevalence and severity of such experiences warrant immediate clinical attention and continued research.

INTRODUCTION

Severe mental illness (SMI) refers to a major mental illness – such as schizophrenia, schizoaffective disorder, bipolar disorder and major depression – that involves pervasive impairment of function and a chronic course (Schinnar, Rothbard, Kanter, and Jung 1990). Studies from western countries reveal that women living with a SMI are disproportionately vulnerable to sexual coercion (Davies-Netzley et al. 1996; Goodman et al. 1995; Goodman et al. 1997; Weinhardt et al. 1999). Studies focusing on sexual coercion vary with regard to definitions of coercion, sampling strategies, and other methodological features. Nonetheless, this research has consistently found that *at least* one-third and as many as three-quarters of women with a SMI report a history of sexual coercion (Beck and van der Kolk 1987; Bryer et al. 1987; Carmen et al. 1984; Goodman et al. 1995; Goodman et al. 2001; Jacobson and Richardson 1987). Given this elevated prevalence, there is an urgent need to understand the correlates of such experiences to facilitate prevention and treatment programs. Research on the correlates of sexual coercion among women with a SMI has focused on two broad categories, namely, (a) psychological and behavioral symptoms, and (b) sociodemographics.

Most studies have focused on the effects of childhood sexual coercion and abuse. Three studies reported that a history of childhood physical and sexual abuse plays a major role in adulthood psychiatric illnesses (Beck and van der Kolk 1987; Bryer et al. 1987; Muenzenmaier et al. 1993). In these studies, a self-reported history of abuse in childhood was frequently associated with somatization, sexual delusions, interpersonal sensitivity, depression, anxiety, paranoid

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ideology, and psychoticism. A study that investigated people diagnosed with schizophrenia found that respondents who reported a history of child abuse were more likely to report positive symptoms of schizophrenia, including ideas of reference, commenting voices, paranoid ideation, thought insertion and visual hallucination (Ross, Anderson, and Clark 1994).

Some research has addressed the experience of sexual abuse as an adult. One recent study found that 40% of female inpatients with physical abuse over the past year met the criteria for Post Traumatic Stress Disorder (PTSD) (Cascardi et al. 1996). A second study investigated the impact of dimensions of lifelong victimization, and found that frequency of violence across life span, recentness of violence, and child sexual abuse were associated with a broad range of psychiatric symptoms-including levels of depression, hostility, anxiety, dissociation, somatization and PTSD (Goodman et al. 1997).

Many authors have hypothesized that the psychological and behavioral manifestations of chronic abuse reflect extraordinary damage to the self, which then becomes the object of the victim's hatred and aggression (Carmen et al. 1984; Herman 1992). These victims will have extreme difficulties with anger and aggression, self-image and trust. After years of abuse, victims blame themselves as they come to believe that the abuse can be explained only by their essential “badness.” Abused females often direct their hatred and aggression against themselves, expressed with a range of behaviors from resignation to depression to repeated episodes of self-mutilation and suicide attempts. Self-destructive behaviors were related to feelings of worthlessness, hopelessness, shame, and guilt (Carmen et al. 1984).

Hypothesized relationships between victimization and schizophrenia suggest that trauma and symptoms are related in complex and reciprocal ways. For example, it is likely that cognitive and behavioral manifestations of schizophrenia, such as limited reality testing, impaired judgment, planning difficulties, and difficulty in social relationships, increase an individual's vulnerability to coercive or exploitative sexual relationships (Fetter and Larson 1990; Kelly et al. 1992). Abuse is also a stressor that could precipitate the onset of schizophrenia in vulnerable individuals or trigger relapses in women already diagnosed with schizophrenia, consistent with the stress-vulnerability model of schizophrenia (Ventura et al. 1989). Third, some abuse survivors may be misdiagnosed as having a schizophrenia-spectrum disorder, whereas a diagnosis of PTSD or a dissociative disorder is more appropriate due to the manifestation of certain acute and chronic psychotic symptoms, including hallucinations, delusions and bizarre behaviors (Butler, Mueser, Sprock, and Braff 1996; Goodman et al. 1997; Oruc and Bell 1995).

Research on the sociodemographic correlates of adult physical and sexual assault in general community samples has identified three domains of variables potentially related to recent victimization in persons living with a SMI (Goodman et al. 2001). These domains reflect the view that people with a SMI are vulnerable to victimization because of the impoverished social conditions in which they live, traumatic experiences they have endured, and their psychiatric disability, all of which may decrease their ability to avoid dangerous situations or otherwise protect themselves. A study of 331 discharged psychiatric inpatients (male and female) found that being an urban resident, using alcohol or drugs, and experiencing transient living conditions before hospitalization were associated with violent victimization (Hiday et al. 2002a). Overall, research has shown that being divorced or unmarried, unemployment, ethnic minority status, poverty, homelessness and substance abuse are associated with interpersonal assault in adulthood (Amaya-Jackson et al. 1999; Bassuk et al. 1998; Byrne et al. 1999; Switzer et al. 1999).

The majority of the research on sexual coercion comes from developed countries. It can be argued that the greater recognition of (and research about) the problem of sexual coercion

mirrors improving freedoms afforded to women. Therefore, in settings where women's rights are less well advanced, one might expect both a higher prevalence of sexual coercion *and* less research attention devoted to the problem.

Within the last few decades, gradual improvements in women's status due to women's activism throughout the world has helped to enhance the visibility of this issue as a global concern (Jewkes 2002a; Jewkes 2002b; Wathen and MacMillan 2003). In India, research has demonstrated the vulnerable status of women relative to men. For example, one study conducted surveyed 130 women regarding women's perceptions of their rights (Sharma et al. 1998). Fifty-eight percent of the women reported that they did not have the power to refuse sexual activity; 19% reported that their husbands forced them into sexual activity if they refused, and another 19% said that in such situations the husband tended to 'go to someone else' (usually a commercial sex worker). Many noted that their husbands' reaction to their refusal to have sex including shouting, abusive language, and going to sleep in bad temper.

Another study indicated that social, religious, and cultural constraints serve to perpetuate the gender inequality and provide a type of 'justification' for sexual abuse of women (Khan et al. 2000). Women are 'taught' to believe that they are inferior to men, are expected to serve and obey their husbands, and to satisfy their sexual needs. Many women believe that their men have the right to beat them if they do not perform their expected duties 'properly.' Men, on the other hand, believe that they have the right to have sex whenever they want and any refusal from their wives is a challenge to their authority and denial of their 'right.' Mentally ill women are clearly among the least powerful members of society and are highly vulnerable to sexual victimization. This is particularly so in countries such as India where community mental health issues are few and the stigma related to mental illness is high.

To our knowledge, only one study has reported on sexual coercion among psychiatrically ill women in India (Chandra et al., 2003). In this study, conducted at the National Institute of Mental Health and Neuro Sciences in Bangalore, 7% of women reported sexual coercion during childhood, 16% as an adult, and 7% reported both. The most commonly reported experience involved sexual intercourse involving threatened or actual physical force, which was reported by 14% of the sample. Involuntary intercourse resulting from continual pressure was also reported by 11% of women. These events were not isolated incidents, and occurred on multiple occasions for the majority of women. Unwanted non-penetrative sexual activities were reported by 12% of women, and unwanted penetrative sex was reported by 7%. Women reported that they experienced abuse most commonly from their husband or intimate partner, a person in a position of authority in their community, or a relative other than their husband (e.g., brother-in-law). Sexual abuse from more than one perpetrator was not uncommon.

Research exploring the prevalence of sexual coercion among non-western women living with a SMI is urgently needed. Also needed is information regarding the subjective experience of coercion, the context in which it occurs, and mentally ill women's response to the experience of coercion, topics that have received much less research attention. Therefore, the current study uses a qualitative research design to assess the following issues related to sexual coercion among Indian women living with a SMI: (a) the context of the sexual coercion, including their relation to the perpetrator(s); (b) the factors contributing to vulnerability for coercion in relation to the mental illness; and (c) the women's reaction to coercion.

METHODS

Participants

Participants were female inpatients from the admissions unit at the National Institute of Mental Health and Neuro Sciences (NIMHANS) in Bangalore, India. NIMHANS is a 700-bed teaching

hospital with training and research facilities in Psychiatry and other Neurosciences. Women were admitted through both voluntary and involuntary means. Voluntary admission occurred if a woman had insight into her psychiatric problems and the need for hospitalization. Involuntary admissions were initiated either by concerned family members or by the police (i.e., if a woman was found wandering in the street or creating disturbance in public places). In all cases, two psychiatrists examined each patient, made a tentative diagnosis, and certified the need for admission into the psychiatric hospital for inpatient care.

Measures

Sociodemographic information—Chart review was done to obtain information regarding age, place of residence (rural, semi-urban, or urban), living arrangement, marital status, education, income, and employment status.

Sexual Experiences Survey (SES) (Koss and Oros 1982)—The SES is a 10-item instrument designed to identify instances of sexual aggression and victimization. This scale has 10 questions scored on a 5-point scale (0−5), denoting the number of times that particular act has occurred. The SES assesses coercive experiences ranging from unwanted non-penetrative sexual contact to forced penetrative sexual acts in a progressive sequence. The first five items inquire about non-penetrative sexual acts with various degrees of coercion, threat, and force. The next five items ask about coercive intercourse. The SES is internally consistent (alpha = 0.74), and stable (test-retest agreement rate between two administrations one week apart was 93%). The validity of the SES has also been demonstrated. In addition to the 10 SES items, age at which the coercive experience occurred was recorded to ascertain whether the coercion occurred in childhood (below 16 years of age), adulthood, or both.

For the purpose of this study, childhood sexual abuse was defined as a coercive sexual contact occurring before the age of 18 years that was initiated by a peer or a sibling at least two years older than the subject or by anyone else at least five years older than the subject. Adult sexual assault included rape and other non-consensual sexual acts.

Qualitative interviews—The research questions involved sensitive emotional and personal themes well suited to an individualised qualitative approach. Moreover, qualitative method was characterised by was found to be suited to this study. Its characteristics of holism, contextualism, focus on process, detail and people's perception, flexibility, and relative lack of structure complemented and supplemented the study objectives (Hiday et al. 2002b; Padget 1998). From the range of qualitative research methods available, keeping in mind the time and resource constraints, as well as the sensitive nature of the research problem, the in-depth interview method was thought to be the best suited option and was selected for the purpose of data collection.

An interview guide was developed, covering the key topics to be explored with the respondents. The qualitative interviews were done by one of three female assessors, all of whom had postgraduate qualifications in clinical psychology, and received additional training in sexual history taking interviews and recording. All assessors were supervised by the first author (PSC), a psychiatrist with two decades of clinical experience and a longstanding interest in the care of women living with a SMI.

The interviews followed a semi-structured format, using open-ended questions in a face-to-face ‘conversational’ style rather than a formal question-answer format. Though the interview guide was flexible in nature, some direction was given when the focus was lost, and probes were used when necessary. The interviews elicited information about sexual coercion in the following areas: (a) How, when and where the coercive incident happened? (b) Who was the perpetrator? (c) How did the subject feel about the incident? (d) How did she cope with the

situation and what does she hope to do to avoid such situations in the future? (e) Did she disclose the incident to anyone? If yes, to whom and what were the consequences of disclosure?

Procedures

The data collected were recorded as first person narratives. All interviews were conducted by a female assessor in complete privacy. The location of the interview was in an interview room within the hospital itself. Though the interviews were initially planned as a single session of 45 minutes to 60 minutes, in certain cases we needed two sessions to complete the interviews. Following rapport building and soliciting participant cooperation, each woman was asked to sign a consent form that informed them about the details of the study and their rights as respondents. They were told that their participation in this study was voluntary and they have the freedom to refuse to answer a particular question or to withdraw from the study without giving any reasons. They were also informed that withdrawal from the study would not jeopardize their treatment in this hospital. The treating doctors were also consulted and their approval to conduct the interview was obtained. However, the elicited information was not recorded in the case file in order to maintain confidentiality. In cases were the assessors felt the need to inform the treating team, consent was obtained from the woman prior to disclosure.

Data Analysis

The data were recorded in the form of narratives in first person in the respondent's language (Kannada, Hindi, Tamil, or English). The narratives were translated into English, and were then entered into the qualitative software program ATLAS-ti (Scientific Software Development) for analysis. A content analysis extracted the significant themes, with codes provided only after repeated readings. These codes helped to identify significant themes, categories and patterns relevant to the research questions.

RESULTS

All women (n = 258) admitted between September 25 and December 31, 2001 were eligible. However, women who stayed in the hospital for less than a week (n = 61) and those who were too ill to be interviewed (n = 47) were excluded. Of the 150 patients who were admitted and eligible, four declined our invitation to participate; thus, 146 (97%) of the eligible female patients participated. Of these 146 women, 50 (34%) women reported sexual coercive experiences and participated in the qualitative interview.

Patient Characteristics

The sample of coerced women (n = 50) comprised 28 (56%) married, 12 (24%) single and 10 (20%) widowed/separated women. The mean age of the sample was 30 years (SD = 9.77, range 18−57). Of the 50 respondents 4 (8%) of them never had any formal schooling, 17 (34%) had studied up to primary school level, 12 (24%) had completed high school, 17 (34%) had attended college. Most (78%) were housewives, although six (12%) were qualified laborers, and five (10%) were casual laborers.

Diagnoses included recurrent depressive disorder (n = 13, 26%), schizophrenia spectrum disorder (n = 13; 26%), bipolar disorder (n = 17; 34%), and other disorder (n = 7; 14%). Thirty-four of the women had chronic illnesses (i.e., duration more than one year) whereas 16 women were presenting with acute illnesses. We have no reliable data regarding the exact duration of the disorder, and we did not find any relationship between specific disorders and the experience of sexual coercion.

Adult Sexual Abuse

All 50 women reported at least one episode of coercive sex. Sixty-seven episodes of coercive sexual experiences were reported; of these, 44 (66%) involved intercourse. The remaining episodes (n = 23; 34%) involved touching, caressing, kissing or fondling. In 12 cases the respondent herself described the sexual experience as 'rape.'

Some of the narratives revealed the nature and severity of these experiences:

> "Three years ago I was in my sister's house for a few days. My brother-in-law is not all right. He is very crazy about women. I think even my sister is aware of this, but she keeps quiet. She has two children and has to bring them up. She does not work and that is why I think she is scared. He had an eye on me also. But I never realised. One day I was alone at home. My brother-in-law came. That day he got an opportunity. He did not care, however much I requested. He raped me." (22 year old, psychosis not otherwise specified)

> "Another time, a few people took me to a school. They opened my mouth and forcefully poured alcohol. Then they all raped me one-by-one. In the morning I was lying there with all my clothes torn. Somebody sent me home." (28 year old, bipolar disorder, mania with psychotic symptoms)

Thirty-three out of 50 respondents reported multiple episodes of coercive sexual experiences. The perpetrators in these cases were the spouse, strangers, or relatives. In 17 out of 50 cases (34%), the coercive experiences occurred *after* the onset of mental illness. In the remaining cases (33 of 50; 66%), the coercive experience *preceded* the onset of the mental illness.

Childhood Sexual Abuse

Eighteen out of 50 respondents reported a history of sexual abuse before the age of 18. In three cases, there were repeated incidents of sexual abuse during childhood. The nature of sexual abuse ranged from fondling to actual penetration.

> "When I was 8−9 years old, my cousin came to our house. He was an adult that time. He came behind me to a room where I went. It was dark there. He tried to grab me from behind. I just pushed him away and ran away from there. I found it bad, he was doing it with sexual feelings ... another incident I remember was when I was 4−5 years old, and a boy in the neighborhood used to come to my house. He was 10−12 years old. One day he said 'hold my penis and you will feel better.' I did not know what to do. I just held it and then left it and ran away." (42 year old, obsessive-compulsive disorder)

Perpetrator

In 48% of the events, the perpetrator was the spouse; in 26%, it was a friend, employer, or acquaintance; in 20%, it was a relative (uncle, cousin, or brother-in-law); and in the remainder it was a stranger. One woman reported that her own brother was the perpetrator.

> "Even in my mother's house my elder brother beat me up asking me why I came here leaving my husband. I have bruises all over my body. Even when I was a kid he would hit me and sometimes when no one was there at home he would do thing like touching my breasts, vagina and make me touch his genitals and so on. I did not know anything at that time. I was scared of him. Hence I would keep quiet." (20 years old, severe depression) One-half of the women reported multiple coercive experiences from different people.

Context

The majority of the coercive experiences reported occurred within respondent's home; the next most frequent setting was a relative's house during the time of occasional visits for a festival or celebration. Coercive experiences that occurred at the workplace or in public places were relatively rare (8% of cases). Some events occurred during the symptomatic phase of mental illness when the woman living in the street.

> "I had become 'mental' at that time. I could not understand anything. I would go anywhere I liked and roam around. During that time many people have 'spoilt' me. Some would take me to the grove and would talk to me until it was dark and then would rape me and go away. They would get me eatables and take me to movies. I used to feel very happy ... These kinds of things happened many times. I do not even know who they were and what they did. I was very crazy about clothes, eatables and movies. If anybody got me those I would go behind them." (28 year old, bipolar disorder, mania with psychotic symptoms) One woman reported being abducted by one of her neighbors, kept in various places, and raped repeatedly. Although they eventually married, the episodes of forced sexual contacts continued.

> "When I was younger, my neighbor would always say things and even tried to touch me at times. I did not like it. I used to get very angry. He had an eye on me always. Once he somehow planned and abducted me. No one knew in our house. I was alone. So what could I do? He dragged me to so many places. I don't know those places. He took to me to many villages and kept me in houses. Whenever he got an opportunity he would forcefully do it. I did not know all this. I used to feel somewhat disgusted. I used to get lot of pain. He used to torture me. It may not be new to him. I feel he had other relations also...even after all this he would tell me that he loves me. I tolerated all this for about two months. After that we were found out. After we came back he started threatening me that if I did not marry him, he would murder my mother. I was very scared. That is why I married him, only the torture did not stop even after marriage. He would trouble me not only in the nights but also beat me up. My mother-in-law is very quarrelsome. She would tell him many things. At such times he would beat me up. I became pregnant at this time. Even then he would not leave me. Whenever he wanted he would do it. I don't know what habits he has; I have got sores in that area (vagina). There is a lot of burning and pain." (20 year old, severe depression)

Disclosure

Thirty out of the 50 respondents (60%) reported not having disclosed their experience of sexual abuse to anyone and had not sought any help. Only four respondents voluntarily revealed the incident to anyone; in a few instances, other people came to know about the incident indirectly. In one case the perpetrator was the separated husband and the woman became pregnant. Hence she felt that she did not have a choice but to tell her father.

In other two instances the coercion happened in the workplace and the women shared their experiences with their friends who also reported similar experiences from the employer. In another case the perpetrator was her teacher; in this case, when the women reported the incident to her parents, they reprimanded the teacher. However, in many other cases, the women kept the incident secret and the interviewer was the first person to whom they revealed the episode.

The reasons for non-disclosure included fear of the perpetrator or threat from the perpetrator (8 out of 50), resignation based on the belief that abuse is common and happens to all women (10 out of 50), and fear of being blamed for the incident (8 out of 50) instead of finding sympathy and understanding.

> "Two years ago we were getting our house repaired ... there were a few construction workers ... There was one among them, seeing the opportunity he came to me and raped me. Not only that, whenever he got an opportunity, he would caress my breasts. I used to get scared but I did not tell anyone. He would always threaten me saying that he would tell everyone that I only went to him. I felt if I tell anyone they would scold and beat me. That is why I didn't tell anyone. I don't have anyone at home who is close to me to tell all this. He got the courage since I did not tell anyone the first time." (20 year old, psychosis not otherwise specified)

> "After the incident of 'rape' I was scared for a long time. What if I became pregnant? I started worrying as to how to show my face to everyone? Luckily nothing happened. That is why I did not open my mouth about this to anyone. If I told them they would say that I liked all that and that is why I agreed. Can I go around talking about such things? We will lose our self-respect. Who will marry me if they come to know about this? The whole family will have to face the shame." (19 years old, severe depression with psychotic symptoms) Only 6 of the 50 women reported that no one had ever asked them anything about these issues till the time of the study and therefore had never discussed it.

> "No one has ever asked me these questions earlier, so I have never told anyone. Now I feel OK and don't feel distressed about these experiences." (42 year old, obsessive-compulsive disorder)

> "This I have not told anyone until now. But today you are asking me, that is why I told you. But I am not scared. Let anyone come to know about it. I will only say it loudly." (23 year old, bipolar disorder, mania with psychotic symptoms)

Another reason for non-disclosure was that in many cases the perpetrator was the husband and women did not want others to know about their private lives. These women also believed that because this happens in the life of all married women, it is shameful to discuss these issues in public.

> "All women suffer like this. What to do? We have to swallow everything. If we say anything in front of grown up children we lose our respect. So, it is better to keep quiet. (39 year old, severe depression with psychotic symptoms)

> "Our people are all like that. They get their children married early. There will be many children. There are so many people like me. But no one talks about such difficulties. They tolerate all this with their mouths shut. If we tell anyone we will be losing our own respect. They would say, "Is she the only person suffering like this?" That is why I have not told this to anyone." (33 year old, acute psychosis)

Reactions to Coercive Sex

Women reported a variety of reaction towards their own sexual experiences. Only four women felt that there was any connection between their mental illness and the sexual experiences. One woman explained her sexual experience this way:

> "My mind is not all right for the past 3 years. My mother always says that I roam around everywhere removing all my clothes. I don't remember now. But I like new clothes and jewelry. I like to dress up well. Once I was in the house alone in the night. May be I had not closed the door properly. Some 3−4 people just barged in, removed my clothes, played with my body and 'did it' one after the other. One fellow pressed my breast hard, biting it and my face. But I don't know who they are because it was very dark. I think they do not belong to our town. They are some rogues. After that my stomach has become somewhat big. I feel I have become pregnant. I have not told that to anyone. If I tell anyone they will scold me only. As it is they always scold me

and call ‘mad’. Everyone looks down upon poor people like us. Also, if I tell anyone they will not believe me. What is the use of telling anyone now? Is it not wrong whatever men do? They only blame us. My husband has left me. From here I have to go to my mother's house. He will not let me stay with him. But I want to go there and live. But everyone thinks I am mad. So will he allow me? If I stay alone also it is a problem. When a woman lives alone men try to take advantage. [With] a woman like me, it is very easy for them. I am very scared.”(25 years old, bipolar disorder, mania with psychotic symptoms)

Married respondents who were coerced by their own spouses expressed a certain amount of acceptance and resignation to their fate. One married woman who was forced to have sex every day expressed her views this way:

“My husband is a very strict man. I have to listen to him. Whenever he wants I have to agree otherwise he will beat me up. I am scared that he may go to other women. What to do? Men can do anything. We women will have to do what they say. That is our fate. Sometimes I would cry and other times I would get angry. Now I have got used to all this.” (30 years old, bipolar disorder with mania and psychotic symptoms)

“My husband always thinks of sex. He would not leave me even when I was pregnant. After marriage, one or two years he would force me every day. If I did not agree he would beat me. What to do? I would agree. He does not have any habits like smoking, beedis, or drinking. This is the only thing. It is all right if he was like others. But he has got peculiar habits. Many times he would do it from behind. He likes that a lot. It used to be very painful to me. I would tolerate it with difficulty. Later I got used to it. With all this, in five years I have been pregnant 4 times. My body has dried up.” (25 years old, acute psychosis)

DISCUSSION

This study provides an estimate of the lifetime prevalence of sexual coercion among Indian women living with a mental disorder as well as qualitative information about the experience of sexual coercion. In this sample, sexual coercion was reported by 34% of 146 Indian women interviewed. This prevalence rate is very troublesome but not unprecedented; that is, prior results obtained with western samples of women with a SMI (Briere and Zaidi 1989; Bryer et al. 1987; Eckert et al. 2002; Goodman et al. 2001) have reported similarly alarming rates. Collectively, the current and prior research findings confirm that women presenting to psychiatric hospitals with acute psychological distress or disorder frequently have a history of one or more types of interpersonal victimization.

In lieu of a matched control sample of non-mentally ill women, we can compare the current results to those obtained with the general population of women in India. One large-scale study surveyed 6,632 married men in India found that 22% reported that they had sexually abused their wives without physical force, and 7% reported sexual abuse with physical force (Martin et al. 1999). A study of university students in western India found that 26% reported sexual coercion experiences ranging from unwanted kissing to sexual intercourse (Waldner, Vaden-Goad, and Sikka 1999); a study of 130 women from Gujarat, India, found that 19% had been forced into sexual activity by their husbands (Sharma et al. 1998). Thus, across these three studies, 19% to 29% of women from the Indian general population reported coercive sexual experiences, a rate that is only somewhat lower than the rate observed in the current sample of female psychiatric patients (34%). However, based on these data, it seems likely that Indian women with a mental disorder may be somewhat more vulnerable than non-mentally ill women to sexual coercion. Continued research using matched control groups and longitudinal designs can help to address this issue with greater certainty.

Results from the current study also indicated that the majority of coercive experiences came from the spouse or partner in the woman's home. One explanation for this may be that majority of our sample was married and were living alone with their spouses at home. An equally important reason may be cultural norms and the nature of families in Indian society. In India, family is expected to be the primary caretaker of any member regardless of the nature of illness. Indian norms prescribe a family's duty to provide a safe and protective environment for sick family members, and any deviation from this norm is strongly discouraged. Hence, unlike the western societies, sexual coercion and victimization resulting from homelessness is observed less frequently. However, once on the street, the experiences reported by this group of women were also similar to that reported from the west (Goodman et al. 2001).

The finding that a large number of respondents reported sexual abuse from a relative – more often a spouse but occasionally from an uncle, cousin, or brother-in-law – is contradictory to the popular belief that the safest place for a woman is her own family. Moreover, the high rates of child sexual abuse involving family members illuminates the fact that, although many homes provide the socially approved love, support and bonding, they can also be the venue for violent victimization and sexual abuse. Women and girls are the primary victims of this abuse and the tradition of household privacy has kept this abuse against females hidden. This finding warrants continued investigation and vigorous efforts to prevent such abuse and to treat its victims.

It is important to point out that women who reported coercive sexual experiences from their spouses did not always recognize it as ‘abuse.’ The traditional Indian attitude regarding marriage and the duties of a wife make a large number of women accept and believe that providing sex to their spouses as and when demanded (irrespective of one's own desire and health status) is their duty and hence needs to be tolerated. Many of them even believe that their spouses will ‘*wander away*’ from them to other women if they do not provide sex whenever it is requested. Many of them have accepted it as their way of life or fate, and even consider it shameful to disclose or discuss these matters with anyone in the family or outside.

According to the women's self-report, approximately two-thirds of the sexually coercive experiences occurred prior to the onset of the mental disorder. The retrospective and uncontrolled nature of the design of our study does not allow for strong inferences about the causal role of the coercion experience. Nevertheless, many authors have hypothesized that sexual and physical abuse can predispose and/or trigger the onset of mental distress and illness (Goodman et al. 1999; Herman 1992).

There were fewer reports of workplace sexual coercion than found in general population samples. However, it should be noted that reports of coercive experiences at the work place were probably underrepresented, owing to the fact that the majority of our respondents were unemployed due to psychiatric illness.

Only 20% of women had previously disclosed their coercive sexual experiences to others. Some women mentioned that they did not know whom to talk to about it whereas others considered it shameful to reveal it to anyone. These findings emphasize the need for developing adequate supportive services for women with a SMI, and opportunities for mentally ill women to share their most intimate concerns and problems. The inaccessibility and the cost of legal and supportive services, especially for rural women, is another barrier that prevents a large number of women from disclosing their experiences. If this is true for women in the general population, then it is even more in women with a stigmatized mental illness.

This study also revealed the relationship of sexually coercive experience to the disability caused by mental illness. As is evidenced by several narrative quotes, having a manic or psychotic illness predisposed some of these women to abuse because of a lack of judgment, disinhibition, and lack of self-awareness. In addition, women with a SMI often lack the interpersonal skills

needed to avoid unwanted sexual contact, to disclose their experiences, and to obtain help when they are coerced.

These findings need to be interpreted mindful of the limitations of the study. These include the absence of a matched control group, and the exclusion of women who were too mentally ill to participate. It is quite possible that the prevalence and severity of sexual coercion among these (excluded) women would have been even greater than it was among those we were able to include. Also, because this was a cross-sectional study, we cannot determine whether the nature of the relationship between mental illness and sexual coercion was causal.

Important issues that were not addressed in the study but that require investigation include the temporal relationship between mental illness and coercive experiences particularly related to symptom severity or acute exacerbations; the relationship of psychopathology among women with a SMI to either childhood or adult coercive experiences; and factors related to help seeking in the context of mental illness itself (e.g., stigma, not being taken seriously, role of family reactions). There is also a need to compare the context and pattern of sexually coercive experiences of the mentally ill with women in the general population to delineate factors that might increase their vulnerability of severely mentally ill women. Every effort must be made to reduce the prevalence and impact of sexual coercion among women with a mental illness.

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