INDIAN PSYCHIATRIC UPDATE

Gender Trauma

Editors :
Aruna Yadiyal
Endumathi R
Niveditha Samala

Indian Psychiatric Society
South Zonal Branch

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MESSAGE FROM PRESIDENT IPS-SZB

IPSSZB , a front runner not only in clinical psychiatry but also in socio-cultural and legal issues is bringing out a book on GENDER TRAUMA. This hitherto untouched but very relevant issue of GENDER TRAUMA is being addressed by IPSSZB Women Empowerment Committee , SAMANWI (South zonal branch of IPS Advocates for the Mental health and Awareness of the Newer challenges in Women's Issues) in this book. Needless to say ,the gender inequality in the society starts from the UNBORN state to DEATH in a women's life which is seen both in urban and rural settings and is common both in developed and developing countries. The understanding of trauma in various walks of life has been nicely brought out by this illustrious group of women writers. I complement all the authors and everyone involved in bringing out this very important book which I am sure will have a great impact on the society and help in guiding all human beings to lead a harmonious life.

Long live IPSSZB

JAI HIND

Dr Abhay Matkar
President, IPS-SZB

MESSAGE FROM THE CHAIRMAN, PUBLICATION COMMITTEE, IPS-SZB (2023-2024)

It is a matter of great pleasure to write a message for the book on GENDER TRAUMA, a growing field.

It is heartening to see IPS-SZ coming up with a lot of books on Psychiatry; the current one is Vol 9 in the Indian Psychiatric Update series. These are books on many specialty topics and niche areas. There is a need for a book on Gender related Trauma, its effects and management with special emphasis In the Indian context; not just for students but also forall mental health professionals and researchers.

Psychiatry is now not limited to treating mainly severe mental illness in mental hospitals. Psychiatrists now handle varied illnesses, and many are related to children, adolescents, women, perinatal period, geriatric population and so on. I feel glad to highlight that this unique book on Gender Trauma covers every aspect in great detail by experts in the field.

The editors and their team members have put in real hard work to make this book a reality. The publication committee congratulates them on bringing out this book which is the need of the hour.

I on behalf of the publication committee thank the IPS-SZ office bearers for their continued support and cooperation. I am sure this book will be hugely popular and will make a mark in the field of Gender Trauma

Dr. Anil Kakunje
Chairman - IPS-SZB Publication Committee (2023-2024)
On Behalf of The IPS-SZB publication committee (2023-2024)
Indian Psychiatric Society, South Zonal Branch.

PREFACE



"A woman with a voice is by definition a strong woman" said Melinda Gates. And it is this voice which we have tried to bring out in the volume 9 of Indian Psychiatric Update titled ' Gender Trauma" . This book has been the brain-child of team Samanwi(South zone branch of IPS Advocates for the Mental health and Awareness of the Newer challenges in Women's Issues), the Women Empowerment Committee of IPS-SZ , in which the whole of content creation has been done by WOMEN , with all the editors and authors of each and every chapter being women! We are both happy and proud in equal measures, as we believe that this endeavor is in keeping with the core motto of Samanwi, which aims to empower women in general, and enhance the potential and academic credibility of women in mental health in particular , by providing meaningful academic opportunities to them . This book titled 'Gender Trauma ' brings out the focus on trauma in the mental health landscape , albeit with a gendered lens. It seeks to provide a much needed ,nuanced approach towards the notions of trauma and its intricate nexus with gender. We sincerely hope that this book will be an important addition to the existing fund of knowledge and to the sizeable treasure of books published by IPS-SZ over the years.

The authors of each chapter have put in their best efforts and brought out their expertise and experience in their content , which we hope would make for a great read. From conception to delivery , this idea of an " All-Women" book had the unwavering support of past presidents like Dr Ramakrishanan, Dr Ramanan Earat , Dr Udaykumar and current office bearers like President Dr Abhay Matkar , President-Elect Dr Umashanker , Secretary Dr Lokeshwar Reddy , Editor Dr Rajashekar Bipeta , Treasurer Dr N. Arun Kumar, for which we are sincerely grateful. We truly appreciate the encouragement and faith, bestowed upon us, by the whole IPS-SZ team and publication committee members. We thank all our authors who made this collective work possible. We thank Chetana Printers, Mangalore for designing and Darpan Screens, Bengaluru for printing this book.

Hope you have a great read !

Dr Aruna Yadiyal
Dr Endumathi R
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INDIAN PSYCHIATRIC SOCIETY SOUTH ZONAL BRANCH

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GENDER TRAUMA

Dedicated To

All those, whose gender has somehow engendered them towards painful trauma

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CHAPTERS IN BRIEF

Chapter 1. Trauma and mental health: The interface

Throughout psychiatry's history, there has been a rise and fall in the understanding of the role that psychological trauma plays an important role in the development of various psychiatric issues. Since it can be challenging for both the medical professional and the person who has experienced the trauma, clinical investigation of a traumatic event or the suspicion of its existence is frequently avoided. While post-traumatic stress disorder (PTSD) is still the most commonly recognized disorder, there are many other types of chronic post-traumatic psychiatric disorders that are less spoken of. People have varying reactions when they are exposed to something that either directly threatens them or is believed to do so which can be understood by various vulnerability and resiliency factors associated with it. In this article, we want to focus on the various aspects of trauma, its psychological effects and coping strategies.

Chapter 2. Trauma Under A Gendered Lens

Trauma is a complex and multifaceted phenomenon that affects individuals across the gender spectrum. This chapter examines the intersection of trauma and gender, highlighting the unique ways in which different genders experience, process, and cope with traumatic events. Recognizing the nuanced differences in the manifestation and impact of trauma among diverse gender identities is essential for a comprehensive understanding of this critical issue, as it allows researchers and practitioners to develop more effective, tailored interventions that address the specific needs of individuals. This chapter also examines the Indian context, providing an in-depth analysis of the domestic landscape and its influence on the global understanding of gender-related trauma.

Chapter 3. Trauma Related Disorders In Women : Impact And Intervention

This chapter explores the profound impact of trauma-related disorders on women, emphasizing the common reactions and domains of life affected by trauma and how these experiences lead to a spectrum of disorders, including post-traumatic stress disorder (PTSD), depression, anxiety, and substance use disorders. The consequences extend beyond individual suffering to affect interpersonal relationships, social functioning, developmental domain and overall quality of life. Effective intervention strategies are crucial and should be tailored to address the unique needs of women, considering factors such as gender roles, societal expectations, and cultural influences. Trauma-informed approaches emphasize safety, empowerment, and resilience-building, aiming to restore autonomy and trust in recovery. By integrating trauma awareness into healthcare and support services, we can enhance outcomes for women affected by trauma-related disorders, fostering healing and promoting long-term well-being.

Chapter 4. Post Traumatic Stress Disorder In Women: A Gendered Approach

Post traumatic stress disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or circumstances which may

be experienced as emotionally or physically harmful or life-threatening. Although women are exposed differently to traumatic events in their lifetime than men, they have a higher lifetime risk of developing PTSD. This preponderance of PTSD in women may be attributable to factors other than trauma type such as sensitization of stress hormone system in response to early adverse experiences, inherent neuroendocrine factors, interpretation of the event and peritraumatic dissociation which make the female gender more susceptible. Women with PTSD experience a greater symptom burden, longer course of illness and worser quality of life outcomes than men. These imply a substantial need for early and gender -sensitive intervention and management of the psychological effects of trauma among women.

Chapter 5. Pubertal Trauma: Menarche and Beyond

Puberty is a time of immense transition, involving changes that are both physiological and psychological. This is a time that can become traumatic for youngsters, especially those with pre-existing vulnerabilities. It is thereby vital to identify those who may be at higher risk of developing emotional and behavioral disorders during this time, and plan strategies for prevention and intervention. With the help of case vignettes, we have elucidated the various factors that may predispose an individual to experience pubertal trauma, the impact of the same and interventions that may benefit those who are struggling.

Chapter 6. Trauma of Preconception Period

The pre-conception period is crucial for maternal and child health. Psychological, reproductive and social trauma of any intensity significantly impact the health of both mother and child. Hence this article aims to provide some insight into the various traumas affecting the pre conception period and some of the important interventions like trauma informed care and therapies apart from reducing stigma and promoting mental and physical health and addressing social determinants of health. Integrating these approaches into preconception care, is important for improving the overall quality of life of the present and future generations.

Chapter 7 . Natal Trauma: Spanning Pregnancy to Childbirth

Natal trauma can arise from various stressors and adverse experiences, ranging from complicated pregnancies and traumatic birth events to domestic violence. The impacts of psychological trauma during this time can manifest in conditions such as antenatal and postnatal anxiety and depression, post-traumatic stress disorder (PTSD) and mother-infant bonding disorders. Maternal trauma has far-reaching effects even across generations, influencing birth outcomes, brain development, and mental health. Trauma can be either directly related to pregnancy and its complications or traumatic events that are not directly related to pregnancy like Intimate partner violence. Negative childbirth experiences including disrespect and abuse during childbirth can also add to natal trauma. Addressing the psychological aspects of the natal period, healthcare providers can offer more holistic care, ensuring that mothers' emotional and mental well-being is prioritized alongside their physical health.

Chapter 8 . Postnatal Trauma: Postpartum And Motherhood

Postnatal trauma, encompassing both postpartum and broader motherhood experiences, presents significant challenges to maternal mental health. Trauma from childbirth experiences can significantly affect women's emotional well-being and bonding with their infants. Traumatic childbirth events can evoke distressing emotions, leading to short- and long-term adverse effects on health. Between 9% and 50% of women face traumatic childbirth, with some developing posttraumatic stress disorder (PTSD). The most substantial risk factors during birth were a negative subjective birth experience, having an operative birth (i.e. assisted vaginal or caesarean section), lack of support during birth, and dissociative experiences. PTSD was associated with poor coping and stress and is comorbid with depression. As a consequence, postnatal depression, anxiety disorders, and PTSD affect both mother and child. Assessment tools and prevention strategies like trauma-informed care and therapy can help manage trauma. Healthcare providers must recognize and support women to prevent long-lasting consequences for both mother and child.

Chapter 9 . Navigating Organizational Trauma in women : The Interplay between Childbearing Age and Career Progression

This chapter delves into the complex interplay between organizational trauma and women of childbearing age, examining the challenges they face in navigating their careers amidst systemic inequalities, biases, and societal expectations. Organizational trauma encompasses a range of adverse experiences within the workplace, including discrimination, harassment, and work-life conflict, which disproportionately impact women in the reproductive age group. Through an examination of structural, cultural, and interpersonal factors, we illuminate the ways in which organizational trauma undermines women's well-being, professional advancement, and sense of belonging within the workforce. The chapter also identifies strategies and interventions for addressing organizational trauma, including promoting diversity and inclusion, implementing supportive work-life policies, and fostering a culture of respect and empathy. By understanding the complex interplay between organizational trauma and women in childbearing age, we can work towards creating more equitable and supportive work environments where all individuals can thrive.

Chapter 10. Traumas Related To Reproductive And Bodily Agency In Women

Traumas related to reproductive and bodily agencies of women lead to physical and psychological consequences. Trauma related to reproductive agency leads to loss of autonomy over one's own reproductive choices. It can be in the form of legal and government policy restrictions on abortions and sterilization, reproductive coercion which involves coerced childbearing and coerced abortions, and trauma in medical setting related to medical procedures with or without proper informed consent. Such traumas could result in symptoms as evidenced in PTSD, anxiety and depression along with a feeling of being violated by agencies that ought to be protecting their autonomy. The trauma related to bodily agency on the other hand results in the disturbed sense of bodily agency leading to the perception of a body as an unsafe place. The resultant body image disturbances may act as a mediator between trauma and other conditions like eating disorders,

body dysmorphic disorders, personality disorders (borderline, paranoid, anankastic) and sexual dysfunctions (like female orgasmic disorder, female sexual interest/ arousal disorder, genito-pelvic pain/penetration disorder, change in their sexual orientation). Any treatment focusing on alleviating symptoms associated with such traumas need to focus not only on the cognitions related to that trauma but also need to focus on the unique circumstances in which it occurred. This is essentially important for the victim(s), especially where the individual's bodily sensations are not addressed which are reminiscent of the somatosensory experiences that occurred during the trauma.

Chapter 11 . Menopausal Trauma: Women Beyond Reproductive Years

Menopause is a natural process in a woman's life marked by significant biological,psychological and social changes. This phase is characterized by an increase in her vulnerability to various psychological issues, with resurfacing of her traumatic experiences at times. Symptomatic perimenopause and menopause can impact overall psychological well-being and quality of life. The exacerbation or emergence of psychological ill-health in menopausal women depends not only on the frequency and severity of menopausal symptoms but also on the trauma faced, and individual attitudes towards the process of aging and loss of fertility. Cultural beliefs regarding menopause and the ability to cope with oncoming somatic and social changes play an important role in pathogenesis of the psychological issues arising during menopause. Holistic management involving hormone replacement, anti-depressant medications, lifestyle modification, and psychotherapy is essential to reduce psychological distress and improve the quality of life in a woman undergoing menopause.

Chapter 12 . The Mental Health Impact of Sexual Violence

Sexual violence remains a pervasive and deeply entrenched issue in India, affecting countless women across diverse socio-economic backgrounds. This type of violence is not only a severe violation of human rights but also has profound implications for the mental health of survivors. In India, the incidence of sexual violence has been alarmingly high, as reported by the National Crime Records Bureau (NCRB), which documented around 32,000 cases of rape in 2022 alone, indicating a critical public health crisis that demands urgent attention .

Chapter 13. Intimate Partner Violence: Mental Health Impact

Violence against women is a major concern, especially Intimate Partner Violence (IPV) and sexual violence. It may cause a number of physical, reproductive and mental health related problems and more importantly, violate a person's human rights. Very few women victims of IPV seek help, especially in India and still fewer seek help for mental health issues related to IPV. The most common mental health disorders associated with IPV are depression, post traumatic stress disorder (PTSD), anxiety disorders and substance use. IPV is faced more by women having lesser education and being financially dependent. This chapter aims to highlight key issues of IPV which includes its definition, epidemiology , perpetuating factors , mental health outcomes, screening and interventions.

Chapter 14 . Marital Rape : Socio-cultural And Legal Scenario In India

Marital rape refers to rape committed when the perpetrator is the victim's spouse. In India, the Bharatiya Nyaya Sanhita(BNS) and the erstwhile Indian Penal Code(IPC) do not consider marital sexual act without the woman's consent as rape, except when the couple are separated. In the latter situation, the rape does not fall under definition of rape in section 63 of BNS and the punishment is less severe. Cultural and social sanctions for marital rape in our patriarchal society are under the presumption that the marriage is a sacred union and the wife is 'subservient' in position. This causes trauma and adverse health outcomes to women. There are opposing court judgements regarding criminalization of marital rape, though there is a progressive move to validate marital rape, with the JS Verma committee report being the landmark one. The reality needs to be acknowledged and victims of marital rape be treated with dignity, empathy and with recourse to law, which should be rooted in truth and justice for all genders.

Chapter 15 . Legal and Social Constructs of Sexual trauma in Women

Social constructs influence laws of any land, invariably influencing perception and experience of sexual trauma and violence. Gender too appears to be inextricably linked to sexual trauma and how it comes to be defined. Sexual trauma with its layered socio-cultural underpinnings is often mired with controversies, gender-laced stereotypes, complex socio- cultural and health consequences. Prevalence of sexual violence is found to occur more commonly in cultures that fosters unhealthy gender biases. Analyzing the history of social constructions, varied definitions, controversies, legal constructions, prevalence of sexual violence and the role of gender and stereotyping in its manifestations, is essential for a holistic comprehension of this intricate issue. This chapter attempts to shed light on these areas, while also examining the socio-cultural consequences and socio-sexual processes underlying sexual trauma.

Chapter 16 . Trauma In Sexual Minorities

The LGBTQIA+ community, representing diverse sexual orientations and gender identities, faces unique challenges that often result in significant trauma. Discrimination, stigma, and violence against sexual minorities can lead to profound emotional distress and psychological issues such as anxiety, depression and PTSD. The sociopolitical landscape in India has historically marginalized these communities with only recent legal advances, such as the decriminalization of Section 377, providing some protection. However, the need for trauma-informed care is critical. Mental health professionals must employ culturally competent, inclusive and empathetic strategies to address the specific needs of sexual minorities. These strategies include creating safe spaces, understanding minority stress and providing personalized, intersectional care. The implementation of these approaches can significantly improve the mental health and well-being of sexual minorities, ensuring that they receive the support and affirmation necessary to thrive in society .

CHAPTER 1

Trauma and mental health: The interface

Abstract:

Throughout psychiatry's history, there has been a rise and fall in the understanding of the role that psychological trauma plays an important role in the development of various psychiatric issues. Since it can be challenging for both the medical professional and the person who has experienced the trauma, clinical investigation of a traumatic event or the suspicion of its existence is frequently avoided. While post-traumatic stress disorder (PTSD) is still the most commonly recognized disorder, there are many other types of chronic post-traumatic psychiatric disorders that are less spoken of. People have varying reactions when they are exposed to something that either directly threatens them or is believed to do so which can be understood by various vulnerability and resiliency factors associated with it. In this article, we want to focus on the various aspects of trauma, its psychological effects and coping strategies.

[**Keywords**: Trauma, PTSD, Psychiatric disorders, Mental health, Resilience]

Introduction:

Trauma is defined as an event that involves actual or threatened death or serious injury or a threat to the physical integrity of self or others (American Psychiatric Association, 2004). An event that may be brought about by internal or external circumstances that endanger an individual's basic autonomy as well as their physical, social, or personal identities is considered as trauma and psychiatric illnesses frequently develop after being exposed to such trauma.[1]

Three important concepts need to be understood regarding trauma.: the event, the experience, and the effects.

Event-It can be of three types: Acute, chronic, and complex. "An event, sequence of events, or collection of circumstances that an individual perceives as physically or emotionally harmful or life-threatening is what causes individual trauma and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being.' (Substance Abuse and Mental Health Services Administration 2014: p. 7). A single event or a sequence of events amplified over time can cause trauma. Physical and sexual abuse, child maltreatment and neglect, natural disasters, and acts of community violence (such as bullying, war, gang culture,

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and rape) are among the commonly recognized types of traumas. Historical trauma (the legacy of entire populations having undergone violence such as slavery, the Holocaust, or genocide) and racism, urbanization, poverty, inequality, and oppression are less well-understood forms of trauma. Trauma can also be classified into Type 1 and Type 2 traumas. Type 1 trauma is defined as single traumatic event, which is life threatening (For example, Road Traffic Accident) and Type 2 trauma is repeated or protracted traumatic events happening over an extended period of time. (For example, Domestic Violence)

Experience- Individual responses to the same situation can vary. Different people may or may not percieve the same event as traumatic. Trauma needs to be comprehended in light of the individual's perspective of the incident. Trauma experiences can cause feelings of humiliation , guilt , and betrayal that can destroy trust. Experience with and interpretation of trauma are influenced by a wide range of circumstances, including gender, age, social supports, individual and cultural views, and a host of other variables.

Effects- Trauma's negative impacts can manifest right away or take years to manifest.

The effects may last a short while or a lifetime. An increasing amount of research indicates that trauma can impact a person's brain development, interpersonal skill development, and physical, mental, and emotional well-being. Disruptions to cognitive processes can affect thinking, memory, and attention. Effects of trauma include fear, hypervigilance, psychosis including paranoia, numbness, and dissociation; these tire people out and induce exhaustion. Even the most severe reactions, despite their range in intensity, are adaptive mechanisms for coping with trauma and do not indicate psychopathology.[2]

The incidence of psychiatric disorders in trauma patients ranges from 20% up to 26%.[3] The World mental health surveys with around 70,000 participants from 24 countries, ranging in socioeconomic level from low to high ,have showed that, 70.4% of the respondents had at some point in their lives gone through at least one kind of traumatic event. Traumas experienced by loved ones (e.g., serious illness of a child) accounted for 35.7% of the specific rates, followed by accidents or injuries (34.3%), unexpected or traumatic death of a loved one (34.1%), physical violence (22.9%), Intimate partner or sexual violence (14%) and war-related events (13.1%) .[4] Unrecognized and unmanaged adverse emotions and maladaptive reactions can raise the likelihood of developing a variety of psychiatric problems. Routine follow-up and inpatient screening can improve recovery and offer additional assistance to trauma survivors.[5]

Neurobiological Basis:

Experiencing trauma triggers a series of physiological alterations and stress reactions. These consist of:

- Modifications in limbic system
- Variations in cortisol levels cause alterations in the hypothalamic-pituitary-adrenal axis[1] functioning.

- Dysregulation of the endogenous opioid and arousal systems caused by neurotransmitters like dopamine, norepinephrine, and serotonin.

Emotional trauma can set off a series of neurobiological processes that affect gene expression and have long-term effects.[6] Two key hormones in mood and stress management are serotonin and cortisol, and an allele or specific form of their transporter genes severely impacts these chemicals' ability to operate. It was discovered that the 5-HTTLPR S-allele, which is 44 bp shorter than the L allele, is linked to a higher risk of depression in the presence of stressful events in the past.[7]

Early maltreatment and neglect can cause a child's neurobiological system to become less resilient to stressful situations, which can subsequently cause issues with emotional regulation. Early adversity can cause incorrect responses to environmental cues, such as informational processing bias for unfavourable or irrelevant stimuli, and it can also result in the development of negative schemas about oneself and other people.[8]

According to the scar hypothesis, behavioural sensitization theories, and electrophysiological kindling theories, emotional traumas can leave behind trace effects that last long after the depression has subsided and make a person more susceptible to the start of new episodes even in the face of mild psychosocial stress. It has been demonstrated that prolonged exposure to emotional stressors increases dendritic retraction in the hippocampus leading to atrophy, synapse development in the basolateral amygdala, and activation of the limbic system. Hypoactivity in the frontal lobe, anterior cingulate, and thalamic areas have been discovered in neuroimaging investigations of PTSD patients, suggesting the impact of PTSD on executive function, attention, cognitive, memory, emotional, and somatosensory integration.

TRAUMA AND PSYCHIATRIC DISORDERS:

Although Acute stress disorder and post-traumatic stress disorder are the most frequently diagnosed conditions linked to trauma, it is also linked to the onset of other mental illnesses, including substance use disorders, mood disorders, anxiety disorders, psychotic disorders, and personality disorders.

Acute Stress Disorder

Acute stress disorder is a natural reaction to stress. Within a few hours of the event, symptoms appear and can be extremely distressing. Common symptoms include intrusion, negative mood, dissociation, stupor, avoidance, and arousal. This usually resolves within 2 days.

Posttraumatic Stress Disorder

This is the most frequently identified trauma-related illness, and over time, its symptoms may become extremely severe. It consists of three categories of symptoms -reexperiencing of event, avoidance, and hyperarousal. ICD-11 includes complex post-traumatic stress disorder , where in , people must meet all diagnostic criteria for PTSD and additionally express difficulties in affect regulation, self-worth, and relationships.[2]

Post-traumatic depression, bereavement, and suicidal risk

The DSM-5 has included depressive symptoms as a PTSD criterion. These symptoms include unpleasant thoughts and feelings about oneself or the outside environment, a loss of interest in activities, feelings of loneliness, and difficulty feeling happy. Post-traumatic bereavement occurs when the painful experience is connected to the loss of loved ones like that of close friends or family members. The risk of self-harm and suicide is increased by bereavement and post-traumatic depression.[9]

Post-traumatic phobic and anxiety disorders

During and right after the traumatic occurrence, intense anxiety is frequently experienced. Later on, anxiety is associated with re-living experiences with anxious reactivity being heightened by hyper-arousal and anticipatory anxiety increased by avoidance techniques. It can present as generalized anxiety, panic attacks, agoraphobia, obsessive-compulsive disorder, and separation anxiety.[9]

Post-traumatic psychotic and bipolar disorders

Individuals with schizophrenia report higher rates of abuse and trauma than the general population and childhood traumatic events are risk factors for developing bipolar disorders.[10]
Based on themes connected to the trauma and its aftermath, delirious and hallucinatory occurrences may manifest.

Somatoform, psychosomatic, and conversion disorders

A traumatic event influences how one subjectively perceives one's physical well-being. Conversion disorder can present as aphonia, amnesia, stupor, fugue, depersonalization, derealisation, or motor symptoms after a significant traumatic event.

Personality disorders

Early, severe, and persistent trauma like abuse, neglect, parental conflicts, and sexual violence is associated with more complicated symptoms such as impaired impulse control, increased difficulties regulating emotions, forming stable relationships, disturbances in consciousness, memory, identity, and/or perception of the environment. They play an important role in personality development as in the case of borderline personality.

Substance use disorders

Alcohol consumption and drug abuse are a common findings after undergoing psychological trauma. The "self-medication" theory postulates that people with PTSD turn to drugs or alcohol to help them cope with their symptoms and in turn are more susceptible to trauma.

RISK FACTORS AND VULNERABLE POPULATIONS:

For instance, the chance of suffering from specific traumas differs depending on an individual's

sex, age, race/ethnicity, and sexual orientation.[4] Individuals who belong to minority groups, more likely to be young males, and live in inner cities. They are more likely to experience assaultive violence throughout their lives. Men experience more accidents, whereas women and children experience more of sexual and domestic violence. Social backwardness, poverty, illiteracy, unemployment, and lack of social support are among the risk factors. The most catastrophic trauma is the sudden death of a loved one. There is also a link found between a person's preexisting mental illnesses, early conduct issues, family history of mental illness, neuroticism, and extroversion personality qualities and their susceptibility to traumatic events.[11]

ASSESSMENT AND SCREENING FOR TRAUMA:

In routine clinical settings ,just asking earnestly a simple question about any trauma should encourage the client to reveal the experience. Many a time clinicians are seen to be not encouraging even when the patient gives a hint about the traumatic experience. A patient empathetic listening skill is the best clinical assessment tool and also acts as mode of ventilation for the client.

Here are few Trauma related measures:

Life Events Checklist for DSM 5 (LEC-5)

Brief Trauma Questionnaire (BTQ)

Trauma Assessment for Adults (TAA)

Adverse Childhood Experiences Questionnaire (ACE-Q)

International Trauma Questionnaire (ITQ)

The Impact of Event Scale – Revised (IES-R)

PTSD Checklist 5 (PCL-5)

Dissociative Experiences Scale – II (DES-II)

Freely usable screening and assessment scales are available in this website:

https://novopsych.com.au/assessments

EVIDENCE-BASED TREATMENTS FOR TRAUMA:

In the same way that collaborative care interventions have enabled primary care providers to offer mental health services, the implementation of early collaborative care interventions in trauma care systems could facilitate the integration of acute care providers into the delivery of posttraumatic mental health services.[12]

- Every trauma victim needs to be evaluated for PTSD from prior traumas, suicidal thoughts, self-harm, and Acute stress disorder.
- Guilt and self-blame are common emotions among trauma survivors, particularly in situations involving sexual assault and interpersonal violence.
- Tell patients straight out that they are not to blame for what other people do; rather, they must realize that they are the victims of someone else's wrongdoing.

- It is important to discuss coping mechanisms and support networks with patients at all times.
- Hospitalization and medications might be required if the victim is psychotic, suicidal, stuporous or incapable of taking care of themselves.

Psychotherapy treatment choices for traumatized individuals are diverse and include support groups ,group therapy, and individual psychotherapy.

There are several kinds of evidence-based treatments available.

1. **Trauma-Focused-Cognitive Behavioural Therapy (TF-CBT):** This concentrates on changing ideas and behaviours associated with trauma and teaches breathing techniques and relaxation. This therapy has been suggested for the treatment of ASD.
2. **Eye Movement Desensitization and Reprocessing (EMDR):** This emphasizes processing of bodily memories, negative self-beliefs, and dysfunctional stored emotions in addition to teaching emotional stability skills.
3. **Exposure Therapy:** This concentrates on confronting the painful memory of the incident repeatedly and reduce the person's sensitivity to recollections of trauma over time.

TRAUMA-INFORMED CARE:

When providing care, a trauma-informed approach views trauma as a formative experience rather than just a past occurrence. On the other hand, trauma-specific services are created specifically to address the signs and symptoms of recent or previous trauma.

The principles of trauma-informed approaches are,

1. **Safety**: The treatment setting, as well as the provision of care, must ensure physical and emotional safety. The assurance of safety is a necessary precondition to any effective therapeutic work with trauma survivors because an atmosphere that is respectful of survivors' need for safety, dignity, and acceptance is fundamental for building trust and therapeutic engagement.
2. **Trustworthiness and Transparency**: It may be necessary to win the victims' trust as well as foster transparency in the therapeutic relationship, considering the betrayal that many trauma survivors have endured in their previous relationships.
3. **Choice**: It is important to prioritize and promote choice and control in the client's treatment, including giving them the ability to make decisions about some aspects of the services they can get.
4. **Collaboration and Mutuality**: Collaboration between practitioners and clients as well as power sharing are integral to trauma-informed practice. When the client is regarded as the authority in their own life, the collaborative experience is most likely to occur. In such an environment, the client and the practitioner collaborate rather than using the more conventional therapy strategy of doing things for or on behalf of the client.

5. Empowerment: It helps in uplifting the clients by highlighting thier resilience in addition to investigating coping mechanisms and prior sources of inner strength. The therapist can assist the client in using these resources to deal with the difficulties they encounter by acknowledging the abilities and skills that the clients bring to their experience.[13]

RESILIENCE AND COPING:

The capacity to successfully adjust in the face of stress and hardship is known as resilience. The brain's structure and function can be significantly impacted by traumatic experiences, stressful life events, and chronic adversity. Mental health issues including depression and posttraumatic stress disorder (PTSD) may result from this.

However, the majority of people are regarded as resilient because they do not suffer from these disorders as a result of stressful life experiences. An integrated approach to generating and modifying resilience involves the interplay of several interacting elements, such as neurochemicals, developmental environment, psychosocial factors, genetics, and epigenetics.[14]

Sources of Resilience:

- **Personal Factors:** Openness, extraversion, and agreeableness as personality qualities; internal locus of control; mastery; and self-efficacy, self-worth, cognitive appraisal, optimism, and other factors all clearly support resilience.[15] Maintaining physical fitness improves overall health and strengthens the autonomic nervous system, which reduces anxiety and depressive symptoms.
- **Biological Factors:** It has been repeatedly demonstrated that exposure to stressful events during childhood and adolescence results in long-lasting changes to the HPA axis, which may increase susceptibility to mood and anxiety disorders.[16] Children who are nurtured and have positive relationships with their parents do better in the face of high-risk environments, according to a synthesis of key data on protective variables acquired by a review of advancements in the field of resilience science. These variables include safety and security, along with tenderness, warmth, and self-control; empathy, paying attention to the child's emotions, acknowledging the child as unique and different from the adult; appreciation of the child's developmental stage, emotional openness, and controlled proximity to the child; and facilitation, which involves finding resources to support and further the child's development and demonstrating a commitment to providing these opportunities.[17]
- **Environmental Factors:** Resilience is influenced by a variety of elements, including cultural aspects, spirituality and religion, schooling, community services, sports, and artistic activities, along with a lack of exposure to violence. As positive support from others lowers stress levels, social support and interdependence can also serve as a basis for resilience.

FUTURE DIRECTIONS AND CHALLENGES:

Understanding the risk and protective factors that affect trauma and its aftermath at different levels of impact and creating chances for prevention at each of these levels is crucial.

The main goal of preventative measures should be to stop trauma exposure. The goal of secondary prevention should be to stop the after-effects of trauma, especially post-traumatic stress disorder. The advancement of illnesses and disabilities linked to trauma should be slowed down through tertiary prevention. Using a public health approach to trauma has the benefit of including families, communities, and policymakers, who become more knowledgeable, engaged, and supportive of efforts to prevent and treat trauma.[4] Collaborative care should be provided and maintenance of the long-term relationship with the patient is important. Universal screening of all patients for trauma histories is also fundamental to a trauma-informed care, as early traumatized people with mental illnesses are more challenging to treat than those who had "healthy" childhoods. Additionally, they have a greater chance of developing chronic conditions, low social functioning, lower quality of life, and higher symptom severity and comorbidities.[18] In situations where trauma-specific treatments are not offered, a comprehensive screening for trauma history might raise practitioner awareness of potential concerns that should be taken into account when designing treatment plans.

CONCLUSION:

Patients frequently conceal or minimize traumatic events and their effects, for reasons related to the condition itself, such as stigma. So, to conclude, it is important to screen for mental health issues in survivors of major trauma, as well as for follow-up and treatment of those issues. Doing so could significantly improve these survivors' recovery and well-being and ensure that expensive and limited mental health resources are allocated with due care.

Key Messages

- Trauma affects everyone differently.
- Trauma exposure can result in psychiatric morbidity.
- Positive adaptation to one's circumstances is a key component of resilience.
- Understanding traumatic stress reactions is essential for providing trauma-informed care (TIC).

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CHAPTER 2

Trauma Under A Gendered Lens

Abstract:

Trauma is a complex and multifaceted phenomenon that affects individuals across the gender spectrum. This chapter examines the intersection of trauma and gender, highlighting the unique ways in which different genders experience, process, and cope with traumatic events. Recognizing the nuanced differences in the manifestation and impact of trauma among diverse gender identities is essential for a comprehensive understanding of this critical issue, as it allows researchers and practitioners to develop more effective, tailored interventions that address the specific needs of individuals. This chapter also examines the Indian context, providing an in-depth analysis of the domestic landscape and its influence on the global understanding of gender-related trauma.

[**Keywords**: Trauma and gender, gendering of trauma, gender socialization, gendered trauma, intersectionality, gender specific interventions, gender responsive care]

Introduction: Overview of Trauma and Gender

Trauma is a universal human experience that transcends cultural, social, and geographical boundaries[1]. Emerging research has consistently demonstrated that the prevalence, nature, and consequences of trauma can differ markedly across gender identities. These disparities reflect the complex interplay between gender norms, power dynamics, and vulnerability to traumatic experiences. People's experiences, processing, and coping with trauma are often shaped by their gender identity and the sociocultural norms and expectations associated with it. Incorporating a gendered perspective in the study of trauma is crucial, as it validates the unique challenges and resilience strategies that individuals of diverse gender identities demonstrate when faced with traumatic experiences. This chapter aims to explore the nuanced relationship between trauma and gender, delving into the implications for research, clinical practice, and societal change.

Relevant Definitions:

Definitions of gender are evolving, recognizing the existence of a spectrum of gender identities beyond the traditional binary classification. Biological sex and gender are distinct concepts that play discrete roles in shaping individuals' experiences of trauma.

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Biological Sex:

Refers to the physical and physiological characteristics that usually categorize individuals as male, female, or intersex based on reproductive anatomy, determined at birth[2].

Gender: Refers to the socially defined roles, behaviours, and attributes that a society assigns to people based on their perceived biological sex. It exists dynamically on a spectrum, encompassing a range of identities and expressions that may or may not align with the assigned sex[2].

- **Gender as a Social Construct:** Gender is a socially fabricated concept that dictates the roles, behaviours, identities and expectations a society imposes on individuals based on their perceived sex. Unlike biological sex, which is rooted in anatomy and genetics, gender is fluid and varies across cultures and historical contexts. Gender embodies personal identity and social standing, influenced by both, psychological and sociocultural factors[3].
- **Gender Socialization:** This process, by which individuals learn and internalize societal norms associated with their gender, significantly influences the ways in which trauma is perceived, expressed, and coped with[4].

Gender Diverse: Refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.

Gendered Spaces: Areas in which particular genders of people, and particular types of gender expression, are considered welcome or appropriate, and other types are deemed unsuitable[5].

Gendered Lens: An analytical framework that works to make gender and the powers associated with it, visible; asking if, how, and why social processes, standards, and opportunities differ systematically for women and men[6]. In the context of trauma, it examines how societal power dynamics modulate the experience and impact of trauma on different genders. It emphasizes the difference between *equity* and *equality*, which is pivotal in thoroughly comprehending trauma.

Importance of a Gendered Lens in Trauma Studies:

Conventional trauma studies often overlook gender-specific experiences, leading to limited understanding of the full scope of trauma and suboptimal treatment outcomes. A gendered lens enables researchers to better identify and characterize the diverse patterns of trauma across the gender spectrum, culminating in more impactful interventions and enhanced care[4]. Notably, this also helps mental health professionals overcome any covert biases they may have due to their own social conditioning, consequently fostering equitable approaches in care delivery.

Historical Context:

A gendered examination of trauma necessitates exploring the historical context of gender roles and the evolution of gender-specific trauma experiences. Societal structures and norms have historically shaped the nature of trauma for both men and women.

Evolution of Gender Roles and Expectations

Gender roles reflect societal expectations of masculinity and femininity. Men historically bore expectations of stoicism and protectorship, contrasting with women who were traditionally tasked with nurturing and relational roles. These societal constructs not only dictated daily life but also profoundly shaped how communities perceived and tackled trauma.

Historical gender norms dictated that men should endure physical hardships and engage in warfare, exposing them to traumas associated with combat, violence, and physical danger due to their roles as protectors and primary breadwinners. From ancient wars to the World Wars, men faced extreme violence, loss, and moral injury, with the psychological impacts, like "shell shock" and PTSD, poorly understood and inadequately treated[7]. Returning soldiers were expected to reintegrate without addressing their deep psychological scars, as emotional suppression was glorified, and vulnerability stigmatized. The internalization of such societal expectations continues to contribute to this day to the underreporting and denial of emotional distress following trauma.

Conversely, historical conventions have confined women to roles of domesticity, caregiving, and subservience, making them highly susceptible to interpersonal trauma, sexual violence, and oppressive societal dynamics. The trauma women face, such as sexual violence, domestic abuse, reproductive control, and economic disadvantages, stem from entrenched gender inequality and patriarchal structures. These societal systems customarily positioned women in subordinate roles, perpetuating power imbalances and creating environments where women were disproportionately vulnerable to exploitation, violence, and systemic discrimination[8,9].

Though gender roles have certainly evolved over time, reflecting shifts in cultural norms, historical imprints of traditional gender roles continue to influence contemporary societies, albeit with varying degrees of persistence and adaptation.

The Indian Context

While the historical patterns of gender and trauma have global relevance, India offers a compelling case study; where gender is deeply rooted in religious and cultural ideologies. India's trauma landscape is shaped by complex sociocultural factors, including economic exploitation, poverty and income inequality, social stratification in addition to patriarchal norms, gender-based violence, and the marginalization of certain gender identities[10]. This complexity is heightened by the diversity of religious and ethnic communities, each with distinct gender norms and power dynamics. These factors perpetuate gender inequality, reinforced by interpretations of religious texts that uphold female subservience, chastity, and familial duties. Conventions relegate women to secondary status, defining their existence as servitude to husbands and reinforcing dependency on men[11]. Patriarchal structures normalize violence and control as means of maintaining authority and conformity to gender norms, perpetuating cultural beliefs that justify discrimination and hinder women's ability to challenge abuse and exploitation[12].

The British colonial rule further intensified the existing norms and patriarchal structures by codifying traditional customs and imposing Victorian moral values that emphasized female

domesticity and chastity[13,14]. These policies solidified gender segregation and restricted women's participation in public life, intensifying existing inequalities. The Colonial era saw strict regulation of sexual behaviour, with laws like Section 377 criminalizing homosexuality[15,16]. Despite reformers like Raja Ram Mohan Roy and Ishwar Chandra Vidyasagar who advocated for women's education and the abolition of Sati, the colonial legacy continues to shape contemporary gender dynamics and sexual rights in post-colonial India, despite progress like the decriminalization of Section 377 in 2018.

Certain forms of trauma that have been particularly prevalent in India include dowry-related violence, honour killings, acid attacks, sexual violence, sex-selective abortion and discrimination based on gender and sexual orientation. Rigid gender roles and expectations have led to a culture of silence around victimization and trauma, further exacerbating mental health challenges. The experiences of gender-based violence in India have been exacerbated during periods of social and political upheaval, as seen during the COVID-19 pandemic[17,18]. With mobility restrictions and economic strain, women faced heightened risks of domestic violence, exploitation, and limited access to support systems.

Indian researchers, such as Paranjape and Sharma, have highlighted how trauma manifests and is perceived locally. Their studies explore the unique coping mechanisms and resilience strategies among Indian women facing domestic violence, influenced by cultural beliefs, familial duties, and social support systems[19]. Integrating these insights into the broader discourse on trauma and gender allows for a more culturally relevant approach to addressing these critical issues.

Gender Differences in Trauma Exposure and Outcomes:

The existing research on trauma and gender consistently reveals significant variations in the types of traumatic experiences and subsequent psychological, emotional, and behavioural outcomes across different gender identities[20].

Gendered Patterns of Trauma Exposure

Men often encounter trauma through accidents, physical assaults, and combat-related incidents which involve threat to life and physical integrity. Conversely, women frequently endure interpersonal traumas such as sexual assault, domestic violence, and child sexual abuse, which are characterized by betrayal, violation, and loss of control[21,22]. Patriarchal norms that objectified women's bodies and limited their autonomy have contributed to this disproportionate exposure to gender-based violence.

Non-binary and transgender individuals confront a distinct array of traumas, including discrimination, social exclusion, identity-based violence, barriers to gender-affirming healthcare, family and community rejection, increased risk of homelessness and financial instability, and higher rates of mental health challenges. These compounded experiences have severe psychological, emotional, and social impacts, creating significant barriers to seeking necessary support[23].

Gendered Responses to Trauma

Gender also significantly influences the psychological, emotional, and neurobiological responses to traumatic experiences, beyond the disparities in exposure[20].

Women are more likely to develop posttraumatic stress disorder (PTSD) and other internalizing trauma-related disorders, while men are more prone to externalizing disorders, such as substance abuse and aggression. However, high-risk events like sexual assault can equalize or reverse this trend. Interestingly, studies show that veterans, first responders, and police officers exhibit similar rates of PTSD across gender groups[24, 25]. This suggests that our initial understanding of biological sex differences in PTSD may oversimplify nuances in hormone influences and psychological responses to specific traumas.

Gender Differences in Neurobiological Responses

Men show greater amygdala activation in response to trauma, the region associated with threat-related noradrenergic-sympathetic arousal, contributing to increased aggression and externalizing behaviours. Women demonstrate heightened activity in the hippocampus and prefrontal cortex, the areas linked to memory integration and emotion processing, contributing to higher prevalence of internalizing disorders[20].

Distinct functioning of the hypothalamus-pituitary-adrenal axis, which regulates stress response, is observed. Men have a differentially responsive HPA axis, alleviating acute distress but impairing stress recovery, while women's HPA axis is often highly sensitized or dysregulated, increasing vulnerability to PTSD and intrusive symptoms[26-28].

A Note on Acute Stress Response

Most research on acute responses have centred on men, culminating in the prevalent fight-or-flight model that reflects male physiology involving heightened sympathetic nervous system and HPA axis activation. Although this typical stress response is common in women too, they can exhibit a distinct 'tend-and-befriend' response, characterized by a tendency to seek social support or experience dissociative reactions. This alternative response is regulated by the parasympathetic nervous system and entails suppressed HPA axis reactivity. This divergence is driven by the influence of female hormones, particularly elevated oxytocin levels, which can provide a buffer against stress but may also foster an overdependence on social connections as a primary coping mechanism[29].

Understanding gender differences in initial stress responses is crucial for grasping trauma progression, as these differences likely influence the transition from adaptive stress responses to PTSD.

Gender Differences in Psychological Responses

The ways in which men and women process and navigate traumatic events are also disparate with women engaging in self-reflection, rumination, and emotion-focused coping; potentially leading

to internalizing disorders, and men typically employing problem-focused coping or avoidance, which can escalate into externalizing behaviours such as substance abuse and aggression.

These gendered patterns are a result of an interplay of multitude of factors, like varying cognitive appraisals and emotional experiences, socialization, access to resources, power dynamics, and neurobiology.

Differences in Cognitive Appraisals[30]

From a cognitive standpoint, men are inclined to interpret traumatic experiences through a framework that emphasizes their own sense of control and competence. They typically ascribe traumatic events to external factors, prompting them to aggressively tackle the perceived threats or escape them entirely as opposed to introspective or emotion-focused approaches.

Women tend to analyse traumatic experiences through the lens of personal susceptibility and disrupted relationships, engaging in more introspective cognitive processing. They frequently scrutinize their own contributions and perceived culpability in the traumatic event, which can cultivate self-blame, vulnerability, and a diminished sense of control, while accentuating the emotional and interpersonal repercussions.

Differences in Emotional Experiences

Men and women have different emotional experiences in response to traumatic stress due to a combination of biological, psychological, and sociocultural factors.

Men tend to display heightened physiological arousal, manifesting in symptoms such as aggression, irritability, and hypervigilance. They are also socialized to repress fear or sadness due to cultural norms, instead manifesting emotional distress through anger or aggression[31].

Women often exhibit intense emotional responses to trauma, such as heightened fear, anxiety, depression, helplessness, and guilt, and are more likely to experience dissociation from their personal identity or surroundings when the threat is appraised as inescapable[32].

Differences in Behavioural Responses

Behavioural responses and coping mechanisms are closely related but not identical. Behavioural responses are the observable actions exhibited in reaction to trauma, while coping mechanisms encompass both these behaviours and the underlying internal strategies used to overcome trauma.

Men intuitively engage in immediate problem-solving, seeking practical solutions that can include substance use to remove distress. Women instinctively turn to interpersonal connections and intentional sharing to seek validation, deriving comfort from collective engagement.

While both genders can avoid confronting their traumatic experiences, strategies differ; with men engaging in more externalizing avoidance behaviours (e.g., substance abuse, risk-taking) and women employing more internalizing avoidance (e.g., emotional numbing, dissociation).

Gendered Pathways to Recovery:

Empirical studies have illuminated the distinct trajectories through which the recovery process may unfurl for different genders[33].

Through the use of active and confrontational coping strategies for trauma, men sublimate their distress with actions like seeking justice or retribution, which can lead to substance abuse and aggression but also makes them responsive to interventions focusing on regaining control and problem-solving.

Women, due to gendered socialization, are more prone to introjection, resulting in self-harm and suicidal behaviours, exacerbated by unmet social support needs and cultural pressures to appear resilient. Nevertheless, their focus on relational and emotional processing renders them responsive to trauma-focused psychotherapies as described in the following sections.

Outcomes And Sequelae:

Trauma-Related Disorders and Gendered Prevalence Rates

Beyond the initial responses, gender variations become more evident in long-term consequences and the journey towards recovery.

PTSD (Post-Traumatic Stress Disorder)

- **Prevalence Rates:** PTSD is significantly more prevalent among women, with a lifetime rate of 10-12%, compared to just 5-6% for men[28]. Intriguingly, how PTSD symptoms manifest also displays gender-based variations. Men report higher levels of anger, substance abuse, and antisocial behaviour, whereas women with PTSD commonly exhibit self-blame, distorted self-perception, eating disturbances, self-injury, impulsivity and dissociation.
- **Contributing Factors:** The chronic environmental strain that women endure additionally can result in sustained activation of the stress response system, increasing their propensity to developing PTSD.

Substance Use Disorders

- **Prevalence Rates:** Approximately 15-20% of women and 30-35% of men with trauma histories develop substance use disorders[34].
- **Contributing Factors:** Men use substances to manage trauma and conform to societal masculinity norms. Women turn to substances as a means of self-medicating the symptoms of their trauma-induced mental health conditions[35].

Depression

- **Prevalence Rates:** Women are twice as likely to experience depression, whereas men, though less frequently diagnosed, may manifest depression through irritability and substance use[36].

- **Contributing Factors:** Gender socialization pressures women to internalize distress, while stigmatizing men's open expression of trauma, leading to underreporting among men.

Anxiety Disorders

- **Prevalence Rates:** Women have a higher lifetime prevalence of anxiety disorders, at 30.5%, compared to men at 19.2%[37]. Comorbid anxiety disorders are linked to lower recovery rates and a chronic course of PTSD[28].
- **Contributing Factors:** Women's tendency to ruminate and experience stress from relational or caregiving roles, in contrast with men's inclination to express anxiety through aggression, may contribute to distinct diagnostic patterns.

While PTSD is directly linked with trauma exposure, the other trauma-related disorders often manifest as co-occurring conditions or dual diagnoses, complicating the recovery trajectory.

Implications for Treatment and Recovery:

Gender-specific variations in trauma responses and outcomes have significant implications for designing and implementing tailored treatment approaches. However, empirical evidence on gender differences in treatment effectiveness is currently indefinite, limited by small sample sizes and methodological constraints.

Differences in Response to Psychotherapy

Gender differences in learning and conditioning impact PTSD development and treatment. Trauma-focused cognitive behavioural therapy is notably effective in the treatment of PTSD, as it can eliminate conditioned fear responses via systematic exposure to the memories, facilitating their integration with cognitive reframing.

Owing to their tendency to prioritize emotional expression and disclosure, women tend to thrive in therapy approaches that emphasize emotional processing, such as imaginal exposure, cognitive processing, and narrative therapy[38]. Additionally, the well-established influence of oestrogen on fear extinction learning, mediated through its receptors in critical brain regions like the amygdala and prefrontal cortex, further enhances their responsiveness to these therapeutic interventions.

Men's tendencies for cognitive avoidance and defensive behaviours can undermine engagement in trauma-focused treatments, leading to higher dropout rates. Skills-based therapies, like stress inoculation training, and interventions emphasizing practical strategies to manage symptoms, such as problem-solving, anger management, and substance abuse treatment, are more effective for them. This approach may facilitate engagement before gradually introducing deeper trauma processing, if deemed necessary for a comprehensive recovery[33].

Group therapy benefits both genders through social support and shared experiences[39]. Women gain from relational support and emotional expression, while men benefit from camaraderie, peer support, coping skills, and normalization of inner experiences.

Differences in Response to Pharmacotherapy

Gender-based differences in the stress response systems and pharmacokinetics significantly impact the efficacy of pharmacological treatments for trauma-related disorders. The contribution of gonadal hormones to distinct therapeutic outcomes is frequently disregarded, despite its pertinence[20]. Oestrogens independently exhibit antidepressant-like properties and also enhance the mechanisms through which antidepressant drugs operate. Women ergo experience more positive outcomes with antidepressants, a trend that declines in postmenopausal women, underscoring the key role of hormonal factors in shaping the therapeutic benefits[40,41].

With respect to drug class, women respond better to selective serotonin reuptake inhibitors, whereas men tend to see greater benefits from tricyclic and tetracyclic antidepressants. Gender differences extend to anxiolytics, with oral contraceptives altering the effectiveness of certain benzodiazepines. Prazosin, an adrenergic blocker, is the only drug prescribed more to men, possibly due to its efficacy in reducing aggression. Interestingly, the widely used drug Propranolol has shown divergent effects, decreasing PTSD severity in men but increasing it in women[20].

Gender differences in tolerability and adherence are also noted. Women experience more adverse effects with tricyclic antidepressants leading to its discontinuation, while men tend to stop SSRI treatments prematurely. Taking gender-specific factors into account helps in proactively addressing barriers to adherence, resulting in superior outcomes.

Although beyond the scope of this chapter, it's imperative to note that gender-based disparities in prescription patterns and clinician biases considerably influence pharmacotherapy outcomes, warranting a refined approach to gender dynamics in clinical settings[42,43].

Trauma and Intersectionality:

Intersectional perspectives illuminate how multifaceted social identities, beyond just gender, converge to shape individuals' traumatic experiences. Trauma-informed care in India must consider the compounded effects of social hierarchies that exacerbate traumatic experiences and incorporate culturally competent interventions in gender-responsive care to be truly effective.

Gender and Caste

As an illustration, Dalit women endure compounded trauma from gender and caste discrimination, with high rates of sexual violence underscoring pervasive societal biases. Statistics from the National Crime Records Bureau show a troubling 45% increase in reported rapes against Dalit women from 2015 to 2020, with an average of 10 such cases reported daily[44].

Class and Urban-Rural Divide

Women in lower socioeconomic backgrounds, especially in rural areas, often lack access to healthcare and legal support, heightening their vulnerability to trauma. In contrast, urban women, though better resourced, face unique stressors like workplace harassment and managing dual professional and domestic roles[45,46].

Religion and Ethnicities

Individuals from religious and ethnic minorities, such as Muslims and tribal communities, experience disproportionate trauma stemming from communal violence, forced displacement, and structural oppression, in addition to gender-based abuses.

Sexual Orientation and Gender Identity

Despite the NALSA judgment of 2014 recognizing transgender rights, LGBTQ+ individuals, particularly transgender people, still face significant societal stigma, discrimination, higher rates of violence, and barriers to healthcare[47].

To fully grasp the Indian trauma landscape, intersectionality is vital. Incorporating community support, family networks, and indigenous healing practices is indispensable for marginalized communities contending with systemic barriers to mental health services. Collaboration among clinicians, policymakers, and local communities is imperative to forge trauma-informed interventions that genuinely honour diverse lived experiences[48].

Gendered Spaces and its Implications:

Gendered spaces can either impede or facilitate trauma recovery, contingent upon their dynamics and societal contexts. They are seen to uphold gender hierarchies, leaving women and gender minorities vulnerable to harm despite purported claims of preserving social organization. Such spaces, whether public or private, often mirror and reinforce power structures, resulting in repercussions like social ostracization and violence for those challenging gender norms[5]. Exclusive gatherings consolidate power and resources within dominant groups, perpetuating gender inequalities.

Conversely, gendered spaces can also liberate marginalized groups, providing platforms to assert identities, challenge norms, and forge sustaining communities that empower trauma survivors with solidarity and agency.

Yet, the salience of gender-based violence in these spaces reveals the pernicious shadow cast by gender hierarchies, even in settings intended to be emancipatory.

Domestic Settings

The home, perceived as a private sanctuary is seen to harbour pervasive trauma, disproportionately impacting women and children. Domestic violence, emotional abuse, and incest frequently transpire in this purported safe haven, often by dominant male family members, wherein patriarchal violence can be normalized. The sanctification of family as the bedrock of Indian society compels women to preserve this institution, perpetuating cycles of abuse.

Workplaces

These also mirror societal power dynamics, where gender-based harassment, discrimination, and microaggressions threaten female employees' well-being. Perpetrators often use sexual

advances to intimidate and disrespect women, leveraging their authority to exert control over both personal and professional lives.

Conflict zones

Women endure sexual violence, humiliation, and exploitation under patriarchal dominance, reflecting broader gender inequalities and objectification. During war, this extends to forced marriages and sexual exploitation, denying women bodily autonomy. Conversely, men face trauma from combat injuries and psychological impacts, with their experience of sexual violence being lesser and also under-reported. These gender disparities underscore how patriarchal dynamics heighten vulnerability and sustain cycles of trauma, even in war.

Public Spaces

Public spaces remain stubbornly gendered, profoundly shaping how individuals of various genders navigate and perceive them. Women and gender non-conforming individuals frequently encounter rampant street harassment, and assault, highlighting entrenched power imbalances. This limits their mobility and access to public life, restricting their full participation in social, economic, and political spheres.

Analysing how micro-level factors like work and family roles interact with macro-level gender ideologies can help us better understand the power dynamics within gendered spaces that continue to shape trauma experiences, especially in India's rigid social context. It is crucial to examine how these spaces affect access to resources and, consequently, recovery pathways. Transforming these environments can improve recovery outcomes and disrupt the intergenerational cycle of trauma prevalent in many communities.

Special Considerations:

Gender Dynamics in Childhood Trauma and Abuse

Preliminary evidence suggests traumatized female children may exhibit a stronger schizotypal tendency, particularly in cases of emotional abuse[49]. Apart from that, the patterns observed in adult trauma victims are largely shared by child and adolescent trauma victims. However, the power dynamics underlying childhood trauma have a far more profound impact than those seen in adult trauma, cutting across gender lines.

Children's dependence on adults makes them susceptible to unique forms of mistreatment and abuse by adults, distinct from those faced by more autonomous individuals. Child abuse, a form of relational trauma inflicted by adults on minors, has enduring consequences such as disrupting attachments and relationships, often leading to complex PTSD and personality disorders. Unaddressed child abuse can perpetuate intergenerational cycles of trauma, a complex dynamic beyond this discussion's scope. Patriarchal attitudes intensify this disparity, often resulting in biased attitudes and responses towards male child survivors.

A gendered lens is essential for understanding childhood trauma, particularly relational abuse,

as it illuminates the role of profound power imbalance and acknowledges societal contributions to patterns of abuse and victimization. This approach avoids 'othering' victims and perpetrators, recognizing trauma's systemic origins in patriarchal structures and norms. Instead of marginalizing perpetrators, we must confront how victimhood drives perpetration. A gendered viewpoint recognizes masculinity as socially created, influenced by patriarchal standards and internalized aggressiveness. This troubling narrative of masculinity lays bare how trauma cascades through generations, emphasizing the imperative to confront the insidious abuse woven into gender expectations to mitigate intergenerational trauma[50].

Gender Identity and Gender Dysphoria

While trauma doesn't determine gender identity, it can influence its formation. Gender-based trauma can impact normative development in the formative years, prompting coping mechanisms like adopting different identities for safety. Internalized stigma and negative self-perceptions following gender-based violence can further complicate the developmental trajectory. Trauma's physical and emotional impacts can intensify body dysmorphia and dysphoria.

For individuals with gender dysphoria or transitioning, gender-based trauma can intensify psychological distress, complicating the navigation of their gender identity journey.

Societal discrimination following negative gender-related events can reinforce covertly internalized transphobia, undermining self-acceptance and amplifying gender dysphoria. Fears of harassment may lead individuals to suppress their gender identity, exacerbating internal conflict and feelings of incongruence. Limited access to inclusive support systems can impair coping, predisposing individuals to PTSD and depression.

Actively exploring and embracing one's gender identity can empower trauma survivors, fostering a profound sense of personal agency, control, and self-affirmation that significantly facilitates their recovery process. Understanding these links is important for providing care that supports both trauma recovery and the journey of gender identity formation.

Resilience And Recovery Determinants:

Research into gender disparities in resilience is extensive, yet the specific determinants of the same across the gender spectrum beyond mere functional aspects remain elusive. Central to this discussion are narratives, which vary significantly in defining resilience and recovery across genders. Female narratives include reduced emotional turmoil and the ability to form safe interpersonal connections, while male narratives may emphasize regaining control over external circumstances. Non-binary narratives similarly diverge in their conceptualisation of recovery. Narratives of resilience are also influenced by an individual's personality and lived experiences, with some individuals needing profound introspective clarity for healing, while others prioritize social action and advocacy. Hence it would be too reductive to generalize determinants objectively along strictly gendered lines, without considering subjective variables.

Role of Policies and Legal Reforms:

Integrating gender-specific strategies into legislative and policy reforms is essential for building a healthcare system that effectively addresses trauma. Globally, efforts to develop gender-sensitive policies, advocate for inclusivity, and leverage legislation to address gender disparities have created safer environments for marginalized individuals to access trauma-informed care, which is crucial given the amplified vulnerability from intersectionality. Advocating further for gender-responsive legislative frameworks is now warranted to inform policymakers about the nuanced experiences of trauma survivors, facilitate mandates and accountability that shape public discourse, and enhance trauma care delivery across all sectors.

For instance, The Istanbul Convention in Europe and the Violence Against Women Act (VAWA) in the U.S. are successful legal frameworks for combating violence against women. The former is an international treaty that requires ratifying countries to align their national laws with its comprehensive standards for gender equity, whereas VAWA is a federal law within the U.S that provides funding and guidelines for local implementation. The Istanbul Convention places a stronger emphasis on protection and preventive measures whereas VAWA has a robust focus on penalties and prosecution. The transformative potential of legislative action is seen in the reduction of gender-based violence in these regions.

Legislative Policies in India:

India has significantly advanced legislative frameworks to address diverse trauma and PTSD needs, prioritizing gender-specific considerations.

The Mental Healthcare Act of 2017

This landmark legislation affirms universal access to mental healthcare free from gender, sexual orientation, or socioeconomic discrimination. It guarantees patients the right to informed consent before treatment, safeguarding personal autonomy and dignity, and prioritizes confidentiality which is particularly important to those facing stigma. The gender-neutral language employed fosters sensitivity and inclusivity[51].

Protection of Women from Domestic Violence Act, 2005

This legislation offers legal recourse to women who have endured domestic violence. It empowers individuals to acquire protection orders limiting ongoing trauma, provides refuge, healthcare, and therapy, and guarantees free legal assistance for easier access to justice and support services[52].

The Sexual Harassment of Women at Workplace Act, 2013

A groundbreaking Act directly confronting gendered trauma in Indian workplaces, it emphasizes the importance of creating safer, more respectful work environments. By recognizing sexual harassment as a uniquely female trauma, it empowers women through robust grievances procedures, mandated internal complaints committees, and remedial actions[53].

Transgender Persons (Protection of Rights) Act, 2019

This Act marks a significant victory for India's transgender community by prohibiting all forms of discrimination, particularly in healthcare. It mandates comprehensively tailored services and prioritizes specialized welfare programs to catalyse the upliftment of this long-oppressed community[47].

The Protection of Children from Sexual Offences (POCSO) Act, 2012

A child-centric law with broadened definitions of sexual abuse and judicial procedures that consciously minimize re-traumatisation, it mandates reporting of suspecting abuse, and shifts the burden of proof to the accused. This Act shows a deep recognition of trauma's intersectional impact in India[54].

Criminal Law (Amendment) Act, 2013 (Nirbhaya Act)

Enacted in response to growing public alarm over sexual crimes, this legislation introduced stringent penalties and protective measures. It expanded the definition of rape to encompass diverse forms of sexual violence and ensures comprehensive support services specifically designed for survivors of sexual assault[55].

Evidently, India's evolving legal framework demonstrates a strategic shift towards integrating gender-responsive trauma-informed approaches. Continuous refinement, robust implementation, and streamlining coordination are crucial next steps to strengthen the societal response.

Challenges:

Despite progressive legal frameworks, societal prejudices and implementation shortcomings often diminish the transformative impact of these laws, especially in accessing essential mental health services. Limited resources and a shortage of trained professionals further undermine these legislative efforts. Robust measures are crucial to bridge this gap, including intensified training for care providers in gender-sensitive and trauma-responsive approaches, increased funding for mental health infrastructure, and fostering strong collaborations among government, civil society, and affected communities[56].

Success Stories Utilizing A Gendered Lens:

World Scenario

Globally, innovative programs and interventions have leveraged a gendered lens to address trauma more effectively.

Scotland's Equally Safe strategy leads the way in this regard with a gender-sensitive approach that combats trauma from violence against women and girls. Through bold policies, amplified advocacy, and specialized clinical services, it has made significant strides, most notably in catalysing a strong societal rejection of gender-based violence. The initiative's impact is evidenced

by increased awareness, improved support systems, and cultural shifts towards condemning such violence[57]. Another women-responsive example is seen in the Women's Mental Health Services program at McLean Hospital, Belmont. It utilizes relational-cultural therapy, validated by research for its effectiveness in women, harnessing their responsiveness to cultivating empowering relationships and attachment-oriented interventions[58].

Recognizing that male veterans often experience trauma differently, the Veterans Health Administration in the U.S. has developed specialized treatment modalities that consider the unique contexts shaping male veterans' experiences of PTSD, substance abuse, and other mental health challenges, improving outcomes.

Fenway Health in Boston implements a novel, academically-informed model for trauma care curated for non-binary and gender non-conforming individuals. By embracing a strengths-based, affirmative approach and rejecting pathologization of transgender identities, the center achieves remarkable success. Staff undergo extensive training in cultural competency and trauma-informed practices, ensuring compassionate, tailored support that respects patients' identities[59]. The Fenway Health model has been so influential that it has significantly shaped the most recent standards of care articulated by the World Professional Association for Transgender Health[60].

The highlighted examples powerfully showcase how contextualized, gender-responsive frameworks can yield transformative outcomes and set new benchmarks for best practices.

Indian Scenario

India's gender-tailored trauma interventions have yielded mixed results, heavily shaped by contextual realities on the ground.

The Prajwala Foundation, Telangana and Udaan Project by Mumbai Smiles boldly champion gender-responsive approaches to support individuals who have endured the harrowing experiences of human trafficking and sexual violence. Prajwala focuses on psychological rehabilitation along with economic and civic support, while Udaan emphasizes empowerment through self-sufficiency and community integration, removing barriers to the same via literacy and vocational training[61]. Other promising models include the 'One-Stop Crisis Centre' (OSCC) and the Jagori initiative. Supported by the Nirbhaya Fund, OSCC offers comprehensive medico-legal services and temporary shelter for women facing gender-based violence. The Jagori Rural Charitable Trust empowers local women as frontline responders, training them in trauma-informed counselling and self-defence and bridging gaps in professional care accessibility[62]. These programs have catalysed transformative changes, empowering survivors to come forward, expanding access to multifaceted support, and fortifying cross-sector partnerships that better serve the needs of the community.

Simultaneously, organizations such as SNEHA, Positive Women's Network in Tamil Nadu and Sama Resource Group for Women and Health have spearheaded advocacy for models that are responsive to the intersectional needs of women.

Curated for the non-binary population, initiatives such as Humsafar Trust and Sangama employ

community-based models to uphold the rights of diverse identities, continually enhancing staff expertise through training, active community involvement, and on-the-job support and supervision. Their success is evidenced by positive feedback, rising program engagement, and recognition from other organizations[63].

However, gender-specific initiatives for men appear limited. MAVA (Men Against Violence and Abuse) in Mumbai stands out by engaging young boys and men, challenging harmful gender norms, promoting healthy masculinity, and advocating cultural change through direct intervention and youth education. It aims to redefine men's roles as partners and stakeholders in addressing gender-based violence, underscoring that social conditioning, not inherent nature, moulds behaviours[64].

While many centres offer psychological support to men, trauma care that is specifically tuned to the male-narrative is scarce, impacting recovery trajectories unfavourably. This paucity stems from a societal inclination to downplay trauma's impact on men. While acknowledging the disproportionate trauma burden faced by women and gender minorities is important, neglecting men's needs reinforces harmful assumptions that they are immune to psychological suffering or must stoically repress emotions, discouraging access to essential care.

Clearly, India has made policy-level strides in promoting gender-sensitive trauma care, although these efforts have often been reactive, responding to gender-based violence incidents rather than proactively tackling the issue. Regrettably, progress remains patchy, hampered by inadequate funding and implementation and deeply entrenched patriarchal norms.

Nonetheless, the examples highlighted also point to deeper, underlying deficiencies within the clinical approach to trauma care, as evidenced by the scarcity of gender-responsive clinical success stories, despite the legislative progress. This suggests a concerning disconnect between the policy-level reforms and their meaningful translation into improved clinical outcomes and patient experiences. The persistent gap reflects a troubling combination of limited clinician expertise and awareness, resource scarcity, and stifling social taboos that suppress open dialogue around these critical issues.

While it's premature to consider the aforementioned as instances of success, it is surely safe to say that gender-specific trauma care in India has grown to recognize women and gender minorities' distinct trauma experiences and provide targeted interventions, albeit unevenly. Addressing male perspectives and standardizing trauma care delivery in clinical settings are still lacking. This highlights the need for inclusive approaches that go beyond social constructs to address diverse trauma experiences across genders. Upscaling promising practices, addressing systemic hurdles, and sustaining meaningful change require collaboration. We need to refine these approaches, enhance accessibility, and consciously integrate them into clinical and community settings to advance equitable and impactful trauma care for all gender identities in India.

Future Directions:

Towards Gender-Responsive Trauma Care

Moving forward, addressing trauma through a gendered lens requires a concerted effort across several key areas.

To begin with, enhancing research is paramount to further elucidate the influence of gender on trauma responses, incorporating interdisciplinary perspectives from biological, psychological, and sociological domains. In the Indian setting, it is essential to embrace an intersectional approach that delves deeply into how diverse social markers, beyond just gender, powerfully converge to mould individuals' trauma narratives in intricate and multifaceted ways. Policy development must prioritize legislative frameworks that enforce gender-responsive practices robustly and allocate sufficient resources to trauma support programs. Equally important is integrating gender sensitivity and trauma-informed practices into professional training across relevant sectors, like healthcare, social services, and the justice system. Gender-specific community initiatives must be scaled up to enhance their relevance and reach. Harnessing the power of pioneering technological solutions can significantly boost accessibility, ensuring that all survivors receive the care they need. International collaboration and knowledge sharing are indispensable for developing a unified global approach while acknowledging cultural differences. Finally, continuous and rigorous evaluation of trauma care programs and policies, drawing on survivor input and data-driven insights, is vital to drive ongoing improvements and maintain the relevance and effectiveness of interventions.

Conclusion

Recognizing the gendered dimensions of trauma is pivotal for driving meaningful healing. Trauma responses are inherently shaped by gender, underscoring the critical necessity for customized interventions that account for these nuances. Nevertheless, it is essential to consider individual variations that can transcend gender-based tendencies. Developing relevant policies and legislative frameworks proactively enhances trauma care by cultivating empowering ecosystems, and catalysing broader societal change. As the field of trauma care evolves, steadfast commitment to gender-responsive programs, intersectional research, and collaborative action will be vital in addressing the multifaceted realities of trauma.

Ultimately, addressing trauma through a gendered lens is not merely an academic exercise - it is a moral imperative. By centring the unique experiences and needs of diverse gender identities, we can work towards creating a more equitable, compassionate, and healing-centred world for all.

Key messages:

- Gender significantly influences the experience, expression, and recovery from trauma.§ Intersectional identities amplify the complexities of trauma experiences.
- Equitable trauma care requires deconstructing socialized gender constructs.
- Designing impactful gender-responsive trauma interventions demand a keen awareness of the distinct coping strategies and recovery trajectories typical of different gender identities.

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CHAPTER 3

Trauma Related Disorders In Women : Impact And Intervention

Abstract

This chapter explores the profound impact of trauma-related disorders on women, emphasizing the common reactions and domains of life affected by trauma and how these experiences lead to a spectrum of disorders, including post-traumatic stress disorder (PTSD), depression, anxiety, and substance use disorders. The consequences extend beyond individual suffering to affect interpersonal relationships, social functioning, developmental domain and overall quality of life. Effective intervention strategies are crucial and should be tailored to address the unique needs of women, considering factors such as gender roles, societal expectations, and cultural influences. Trauma-informed approaches emphasize safety, empowerment, and resilience-building, aiming to restore autonomy and trust in recovery. By integrating trauma awareness into healthcare and support services, we can enhance outcomes for women affected by trauma-related disorders, fostering healing and promoting long-term well-being.

Keywords: Trauma, Post traumatic stress disorder (PTSD), Interventions

"There are wounds that never show on the body that are deeper and more hurtful than anything that bleeds." — Laurell K. Hamilton

Introduction:

Trauma can be described as an ''events or circumstances that an individual perceives as physically or emotionally harmful, life-threatening, and resulting in lasting adverse impacts on their functioning and overall well-being—physically, mentally, socially, emotionally, or spiritually''[1]. Traumatic events often occur unexpectedly, affecting individuals through direct experience, witnessing, feeling threatened, or learning about an event that impacts someone they know. These events can be caused by human actions like disasters, war, terrorism, sexual abuse, or violence, or by natural phenomena such as flooding, hurricanes, or tornadoes. Trauma can happen

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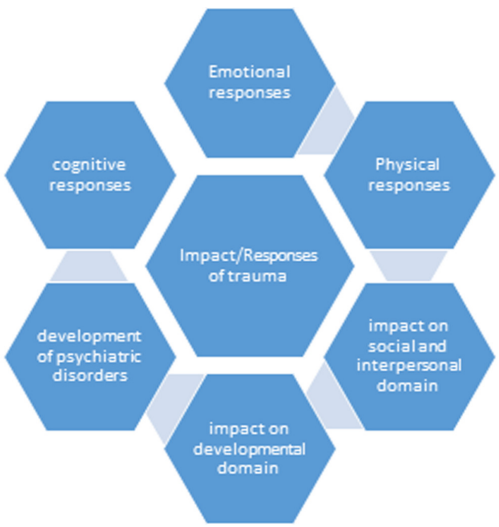
at any age, and events occurring outside expected life stages (like the death of a child before a parent or serious illness at a young age) are often perceived as traumatic. The impact of trauma is not solely determined by the event itself but also by how individuals experience and interpret it. Biopsychosocial and cultural factors significantly influence immediate responses and long-term reactions to trauma. Despite the severity, many individuals also demonstrate resilience, managing to overcome or confront challenges with strength.

Trauma and Women:

Women are indeed more vulnerable to experiencing trauma across their lifespan compared to men. Trauma research have consistently shown that women and girls are more likely to experience higher rates of sexual violence like rape and sexual assault, intimate partner violence (IPV), childhood abuse and neglect, sexual harassment at work and public places and are disproportionately affected by human trafficking, forced labor, sexual exploitation, structural and societal factors, such as gender inequality and discrimination, all of which can have profound and long-lasting effects on their mental health. Some women may experience "complex trauma," with exposure to multiple traumatic events over time, such as chronic abuse or interpersonal violence, further exacerbating their suffering. Biological factors, such as hormonal fluctuations and differences in brain structure and function, may also influence women's responses to stress and trauma. This heightened vulnerability experienced by women highlight the need for gender-sensitive approaches in trauma care and support systems. Recognizing these predispositions can help clinicians understand mental health issues better and tailor interventions accordingly to meet the needs of women in a better way.

Common Responses to Trauma

Reactions and responses to trauma vary widely in their intensity and duration, among individuals with either temporary or prolonged symptoms ranging from acute distress to more severe mental



health issues like posttraumatic stress disorder, anxiety disorders, substance use disorders, and mood disorders. Additionally, some medical problems such as arthritis, headaches, or chronic pain can have trauma hidden in their causality. Though most trauma survivors initially show these reactions, symptoms diminish over time without causing significant long-term issues. Sometimes, resilience stems as a byproduct of their effective coping mechanisms, often through support from their social networks. Recovery might however be incomplete with some still exhibiting mild symptoms that may not meet the criteria for a full-blown psychiatric disorder, but often result in poor quality of life, thereby highlighting the need to understand the wide spectrum of responses to trauma [2,3]. Responses to trauma can be physical, cognitive, emotional and behavioral with impact on developmental, social and interpersonal domain, further leading to development of psychiatric disorders.

Common Reactions to Trauma

- Numbness and detachment
- Heightened startle reactions, difficulty concentrating, hyperarousal, sleep disturbances, and physical complaints
- Re-experiencing of the trauma with nightmares, flashbacks, trauma-related hallucinations, intrusive thoughts, and memories
- Emotional dysregulation, anxiety (including panic attacks), and mood disorders
- Avoidant behaviors including self-medication through substance use
- Cognitive changes regarding beliefs about future, self and the world

Emotional responses: The emotional responses can encompass a broad spectrum of reactions with common reactions being anger, fear, sadness, and shame, although some may struggle to identify or express these feelings due to personal or socio-cultural factors. Emotional dysregulation, particularly prevalent when trauma occurs at a young age, can lead individuals to seek emotional control through behaviors like substance abuse or high-risk activities. However**,** others may find constructive outlets such as physical activity or community engagement to manage their emotions effectively. Numbing, a biological response where emotions become detached from thoughts and memories, is another typical reaction to trauma. This can manifest as a limited emotional range and a sense of a foreshortened future, impacting personal interactions and emotional well-being. It is essential for therapists to recognize numbing as a significant trauma response, as it may obscure the true severity of emotional distress specially during initial phases[4] .

Physical responses: Physical symptoms, at times can be the primary reason trauma survivors seek medical assistances, highlighting the interconnectedness between trauma and physical health. Somatization, where emotional distress is expressed through bodily symptoms, is common, especially in certain cultural contexts where emotional and physical health are perceived as interconnected or it is stigmatizing to talk about only emotional issues. It is crucial to differentiate between somatic symptoms needing medical attention and those arising from emotional distress, ensuring appropriate referrals for further evaluation when necessary[5].

Cognitive responses: Traumatic experiences often profoundly impact cognitive processes, challenging core beliefs about personal safety and the predictability of the world. Cognitive errors like misinterpreting harmless situations as dangerous due to past traumatic experiences are common along with excessive or survivor's guilt, feeling responsible for events beyond their control. There may also be idealization or justification of perpetrators' behaviors, especially if they were caregivers[6].Trauma can also lead to hallucinations, illusions or delusions linked to the traumatic content, such as mistaking someone's appearance for that of an abuser. Intrusive thoughts and memories can unexpectedly resurface and trigger intense emotional responses similar to those experienced during the trauma itself. This flooding of memories can be overwhelming and disrupt daily life, particularly when triggered by situations reminiscent of the trauma. Trauma may often alter a woman's perceptions of safety and her beliefs about herself, others, and the future. This cognitive triad can become skewed, leading to feelings of incompetence, viewing the world as unsafe, and foreseeing a hopeless future. Such cognitive patterns while exacerbating symptoms of depressive and anxiety, may also serve as protective factors against psychological distress in some cases[7].Feelings of alienation and isolation may also be common among trauma survivors, who often perceive their experiences as uniquely profound and incomprehensible to others. This can hinder seeking support from those who have not experienced similar trauma, further intensifying feelings of difference and isolation[8].Triggers (sensory stimuli that evoke memories of the trauma) and flashbacks (reexperiencing the traumatic event as if it were happening in the present moment) are frequent responses which can be unpredictable and varying in intensity, significantly affecting daily functioning and emotional well-being. By addressing these cognitive distortions and reactions sensitively and effectively, therapists can support survivors in reclaiming a sense of safety and control in their lives.

Cognitive Changes Due to Traumatic Stress

Cognitive Errors	Misinterpreting harmless situations as dangerous due to past trauma
Idealization	Justifying or rationalizing perpetrators' actions, particularly if they were caregivers
Excessive or Inappropriate Guilt	Assuming responsibility or feeling survivor's guilt for traumatic events affecting others
Trauma-Induced Hallucinations or Delusions	Experiencing hallucinations or delusions related to trauma, where perceptions align with traumatic experiences
Intrusive Thoughts and Memories	Unexpectedly recalling trauma-related thoughts and memories, often triggered by reminders or situations resembling the trauma

Behavioral responses:

Varying behavioral responses to traumatic stress can include avoidance, self-medication (like alcohol abuse), compulsive actions (such as overeating), impulsivity (engaging in risky behaviors, aggression), re-enactment and self-injury. Common trauma response of avoidance, while initially providing relief, can reinforce perceptions of danger and hinder recovery. Self-medication to avoid difficult emotions associated with unresolved trauma may lead to problematic substance use behavior. Reenactment, where survivors repetitively recreate aspects of their trauma in daily life scan manifest as self-harm, hypersexuality, risky behaviors, or destructive relationships. These reactions are often learned or a direct consequence of experiencing trauma. Self -harm, when present may or may not have suicidal intent and differentiation between the two is crucial to manage both effectively. However, sometimes, women may exhibit resilience by finding positive ways to cope, such as strengthening family bonds, finding new purpose, or engaging in charitable activities. Overall, understanding these varied responses to trauma is crucial for developing effective therapeutic interventions to support individuals in healing and promoting resilience[9-14].

Impact on social/Interpersonal relationships

The impact of trauma on the social and interpersonal aspects of women's lives is profound. Trauma not only disrupts personal relationships but also undermines the formation and maintenance of protective factors like supportive networks, which are crucial for recovery. Trauma survivors may find themselves withdrawing from emotional exchanges required for forming close relationships. They may fear burdening others with their needs or feel distrustful of others' understanding and support and may thus isolate themselves further, out of fear of their own unpredictability and the potential impact on others. For many women who have survived childhood abuse or interpersonal violence, the trauma often involves betrayal by trusted individuals, complicating their ability to form new trusting relationships or rely on existing supports, such as peer groups or counseling. The fear of being hurt again leads to heightened vigilance and difficulty in connecting with others, including mental health professionals, obstetricians during antenatal care or other family members for care giving of children. Overcoming these barriers is essential for recovery, as supportive relationships play a critical role in healing from traumatic stress[15].

Developmental impact

The impact of trauma varies across different age groups, young children may exhibit generalized fear, nightmares, heightened arousal, confusion, and physical symptoms like stomachaches and headaches. School-age children might display aggressive behavior, anger, regression to earlier behaviors, repetitive traumatic play, difficulty concentrating, and poorer academic performance. Adolescents could show symptoms such as depression, social withdrawal, rebelliousness, engaging in risky behaviors like sexual acting out, a desire for revenge, disturbed sleep, and changes in eating patterns[16].

Research in developmental psychobiology indicates that early childhood trauma can have

enduring negative effects on brain development disrupting neurotransmitters such as cortisol, norepinephrine, and dopamine, which escalates the stress response and interferes with critical neural growth during sensitive developmental periods, potentially leading to neuronal cell death. Elevated levels of cortisol and catecholamine can contribute to maturational failures in the prefrontal cortex, affecting cognitive and emotional regulation. Additionally, decreased levels of oxytocin, crucial for social bonding and stress management, in maltreated individuals, correlate with higher levels of anxiety[17-20]. The Adverse Childhood Experiences Study further demonstrates that cumulative exposure to trauma increases the risk of negative outcomes across affective, somatic, substance abuse, memory, sexual, and aggression-related domains , impacting long-term mental and physical health[21].

Impact of trauma on psychiatric disorders

Trauma often leads to the onset or exacerbation of various psychiatric disorders among women. These include substance use disorders, mood disorders, anxiety disorders, and personality disorders. Trauma can trigger these conditions either concurrently with the traumatic event or sometime thereafter[22].

Trauma related disorders

Acute Stress Disorder (ASD) is a typical response to trauma, with symptoms emerging within 4 weeks of the event, causing significant distress. Symptoms include hypervigilance, avoidance of trauma reminders, and partial amnesia about the event. Most do not progress to PTSD as ASD symptoms typically resolve within 2 to 4 weeks, whereas PTSD persists beyond this period[23]. *Posttraumatic Stress Disorder (PTSD*) which often occurs after exposure to life-threatening events have intrusion symptoms, avoidance, negative mood alterations, and increased arousal. It can develop immediately after trauma or manifest years later, often triggered by reminders or life changes. It profoundly affects daily life, relationships, and overall well-being. Women are twice likely to develop PTSD as compared to men due to heightened susceptibility because of biological, psychological, social and endocrinal factors unique to women. 10 to 20 % of women who experience sexual assault develop PTSD, justifying the recent changes in categorization by DSM-5, where PTSD was moved from fear-based anxiety disorder to, "Trauma- and Stressor-Related Disorders[24]."

Impact of trauma on pre-existing psychiatric disorders: After experiencing trauma, individuals with pre-existing mental disorders can function relatively well if essential services remain uninterrupted while others may require additional mental health support. Women with PTSD are also particularly vulnerable to other disorders like major depressive disorder (MDD), generalized and other anxiety disorder, obsessive-compulsive disorder and substance use disorders. While PTSD can exacerbate symptoms of anxiety disorders, pre-existing anxiety symptoms and disorders can also increase vulnerability for developing PTSD. Co-occurring PTSD and other mental health disorders are associated with more severe symptoms and greater impairment, making effective intervention for trauma in early stages an important strategy[24,25].

Trauma related disorders and substance use disorders

The interplay between PTSD and substance use disorders is considered bidirectional and cyclical: substance use heightens trauma risk, while trauma exposure escalates substance use as a coping mechanism[26]. Trauma related disorders and substance use disorders may mask symptoms of each other, impeding complete recovery, where misinterpretation of trauma-related symptoms in substance abuse settings could elicit exaggerated negative emotional responses from trauma survivors. Chilcoat and Breslau's seminal work outlines three causal pathways clarifying the relationship between traumatic disorders and substance use[27]:

1. The "self-medication" hypothesis suggests individuals with PTSD use substances like alcohol, cocaine, barbiturates, opioids, and amphetamines to alleviate symptoms such as intrusive memories and physical arousal.
2. The "high-risk" hypothesis posits that substance use places individuals in precarious situations that increase vulnerability to events leading to PTSD.
3. The "susceptibility" hypothesis proposes that substance users are more prone to developing PTSD post-trauma due to inadequate stress management skills, alterations in brain chemistry, or damage to neurophysiological systems from prolonged substance use.

Sleep disturbances are also a common link between traumatic psychopathology and substance use onset. Women may use alcohol or prescription benzodiazepine tablets as an aid to sleep disturbances. However, initial relief from substances is short-lived, resulting in rebound effects that worsen sleep quality. Alcohol dependence exacerbates sleep problems, including reduced REM and slow wave sleep, prolonged sleep onset, increased nightmares, and diminished sleep efficiency. These sleep disturbances persist during withdrawal, contributing to daytime fatigue and increasing the likelihood of relapse. Women may even start using prescription opioids to alleviate pain following injuries related to domestic violence or associated somatic symptoms which can be a gateway for other drug dependence[26,28].

Subthreshold symptoms

Many women who have survived trauma may experience symptoms that do not meet the full diagnostic criteria for ASD or PTSD. However, these symptoms can still significantly impair their daily functioning, such as their ability to regulate emotions, maintain stable relationships, perform well at work, or sustain recovery from substance use. These symptoms may arise in specific contexts, appear intermittently over weeks or months, or be persistent but not severe enough to meet DSM-5 criteria for a disorder. Clinically, these patterns are often referred to as "subthreshold" trauma symptom[29]. Understanding these complex relationships is crucial for effective treatment and support, as trauma can significantly impact a woman's mental health across her lifespan.

Screening for Trauma in mental health Practice

Undetected and unaddressed trauma symptoms can lead to reduced engagement in treatment, early termination of therapy, increased risk of relapse for both psychological symptoms and

substance use, and overall poorer treatment outcomes. Screening for trauma is crucial as it helps prevent misdiagnosis and ensures appropriate treatment planning. A positive screening result necessitates prompt action. When a woman screens positive for trauma-related symptoms, it is essential to conduct a comprehensive trauma assessment. Scales like Primary Care Posttraumatic Stress Disorder Screen (PC-PTSD) can be helpful here[30,31].

Key areas that should be screened among women with trauma histories include:-

Symptoms related to trauma.
Past and current mental health disorders (like depression, anxiety, sleep disorders).
Details about the type and nature of trauma experienced.
Presence of substance use disorders.
Evaluation of social support systems, coping mechanisms, and access to resources.
Assessment of risks related to self-harm, suicide, and potential for violence.
Other Health screenings.

Intervention:

As trauma and stress related disorders profoundly impact various domains of a women's life, it is imperative that a multidisciplinary approach targeting various deficits and responses should be the method of treatment. The SAMHSA's Women, Co-occurring Disorders, and Violence Study (WCDVS) represents the first major federal effort to address the lack of appropriate services for women with co-occurring mental health and substance use disorders with history of physical or sexual abuse. The primary goals of the WCDVS were to develop new service approaches and to evaluate their effectiveness for women with these problems. The intervention included eight core services, such as resource coordination and crisis intervention, empowering staff with knowledge about trauma, holistic treatment of mental health, trauma, and substance use issues, and the involvement of consumers in service planning and provision[35].

Psychological interventions most often used to treat trauma-related disorders like PTSD in women are exposure-based therapies, where the goal is to extinguish conditioned fear to cues associated with trauma by desensitization to fearful stimuli and learn that the trauma is not reenacted in real time. Some of the other effective treatments include:

- Trauma-focused Cognitive behavioral therapy (TF-CBT): It aims to change existing thought patterns (targeting cognitive responses to trauma) in the patient that are causing distress.
- Eye movement desensitization and reprocessing (EMDR): It combines eye movements with exposure therapy and help the patient process traumatic memories and change their reactions to the events.
- Coping skills therapy
- Psychological first aid
- Psychoeducation
- Normalization
- Psychological debriefing

Caregivers can also support women recovering from trauma by countering the stigma around mental health, learning about manifestations of PTSD and its care with the victims permission, creating a safe environment and breaking the cycle of childhood abuse and neglect whenever possible.

Principles of Trauma-Informed Care Interventions: The principles of trauma-informed care focus on providing treatment that recognizes and addresses the impact of trauma . These principles ensure that care provided is holistic, sensitive to woman's experiences, and supportive of healing and recovery from trauma-related issues[32]. The principles are as follows -

1. Raise awareness and understanding of trauma. Acknowledge the prevalence of trauma and its potential impact on your client's life.
2. Understand that trauma-related symptoms and behaviors stem from adaptations to traumatic experiences. Interpret women's difficulties, behaviors, and emotions as responses to surviving trauma.
3. Contextualize trauma within the women's environment. Consider the circumstances surrounding the traumatic experiences.
4. Mitigate the risk of re-traumatization or reenacting past trauma. Review treatment strategies, program procedures, and organizational policies to avoid causing distress or replicating traumatic experiences.
5. Establish a safe environment. Adapt the treatment setting to promote the women's physical and emotional security.
6. Prioritize recovery from trauma as a primary objective. Recognize that long-term recovery hinges on addressing the impact of trauma.
7. Support autonomy, choice, and control. Offer opportunities for empowerment to bolster the women's sense of competence, which is often diminished by trauma and ongoing stress.
8. Foster collaborative relationships and involvement opportunities. Shift from a patronizing approach to a collaborative one, emphasizing the importance of partnerships between providers and clients. Incorporating peer support services reinforces the value of consumer input.
9. Familiarize women with trauma-informed services. Explain the purpose and nature of trauma-related inquiries during intake, normalize reactions to trauma, and discuss the rationale behind specific interventions.
10. Implement routine screenings for trauma universally. Regular screening serves as a reminder to remain vigilant regarding past traumatic experiences and their potential influence on women's interactions and service engagement.
11. Consider trauma through a sociocultural lens. Acknowledge that cultural factors shape how traumatic events are perceived, the meaning assigned to symptoms, and attitudes towards seeking support and assistance.
12. Emphasize strengths and resilience. Adopt a strengths-based perspective that focuses on

the women's resources and resilience. Shift the focus from "What is wrong with you?" to "What has happened to you? What strengths have helped you cope?"

13. Foster skills that resist trauma's impact. Promote the development of self-care strategies, coping mechanisms, supportive networks, and a sense of personal competence.
14. Offer hope and convey that recovery is achievable. Encourage optimism and reinforce the belief that healing and recovery are possible outcomes of trauma-informed care.

Objectives of trauma-informed approaches

1. Establish a sense of safety.
2. Prevent re-traumatization.
3. Educate about trauma, common traumatic stress reactions, and treatment options.
4. Provide trauma-informed peer support.
5. Normalize symptoms of traumatic stress using appropriate strategies.
6. Identify and manage trauma-related triggers.
7. Help clients understand the connections between their trauma histories and current challenges.
8. Foster emotional and psychological balance.
9. Cultivate resilience in coping with trauma.
10. Address mental and physical health disorders effectively.
11. Build trusting relationships between clients and providers.
12. Support empowerment of individuals in their recovery.
13. Acknowledge and address grief and bereavement if any.
14. Offer culturally-sensitive and gender-responsive services tailored to individual needs.

Pharmacotherapy:

Medications can also help with trauma related disorders like PTSD by helping people stop thinking about and reacting to what happened, have fewer nightmares and flashbacks, and feel more positive about life. Antidepressants, particularly recent rapid-acting antidepressants, exert complex effects on brain function and structure that build on novel aspects of the biology of PTSD. A dual pathology model of (1) stress-related synaptic loss arising from amino acid-based pathology, and (2) stress-related synaptic gain related to monoamine-based pathology, can explain stress-related synaptic dysconnectivity in the neurobiology and treatment of PTSD. Pharmacotherapy may have the potential to address some of the challenges like difficulty in engaging the patient in psychotherapy and also when there is partial response to psychotherapy. The rationale behind this approach is that these medications can catalyze the psychotherapeutic process by increasing the capacity for emotional and cognitive processing through pharmacologically diminishing fear and arousal, by strengthening therapeutic alliance through increased trust and rapport, by targeting processes of fear extinction and memory consolidation and also help to treat the comorbid conditions like depression, anxiety disorder or psychosis[36].

Almost all the guidelines and few systematic reviews and metanalyses have found SSRIs (like Fluoxetine, Paroxetine, Sertraline, Escitalopram), SNRIs (like Venlafaxine), tricyclic antidepressants (amitriptyline and isocarboxazid); mood stabilizers (Divalproex and lamotrigine); atypical antipsychotics (aripiprazole and quetiapine) to be effective in treatment of PTSD symptoms. The complexities of symptom presentation as well as the neurobiological diversities of trauma related disorders indicate towards an inefficiency of psychotropics targeting single neurotransmitters. Hence, a symptom-based treatment is the way forward. The treatment of PTSD may require more than pharmacologically targeting dysregulated molecules and pathways associated with developing and sustaining PTSD symptom severity and may benefit from pharmacologically induced changes in the capacity to engage with traumatic material in psychotherapy. Some guidelines like International Society for Traumatic Stress Studies (ISTSS), the United Kingdom's National Institute for Health and Care Excellence (NICE), the Institute of Medicine (IOM) of the National Academies of Sciences, Engineering, and Medicine, have found evidence in support of several trauma-focused psychological interventions as first-line treatments for adults with PTSD, and all, with the exception of the IOM report, recognize at least some benefit of pharmacologic treatments for same. There is also role of complementary and alternate medicine and yoga as found in some small studies[37].

Holistic approach of treatment: Hence, a holistic approach to treatment which involves crisis intervention, psychotherapy, pharmacotherapy, community-based therapies, social support systems and adopting culturally sensitive and gender -responsive services tailored to individual needs is needed to address this multi-dimensional problem in a wholesome way.

Indian Scenario:

The National Mental Health Survey revealed prevalence of PTSD in India at 0.2%, which is significantly lower than global averages of 3.9 to 24%. Factors associated with PTSD included female gender, middle age (40-49 years), and urban residence. The study also highlighted a high rate of comorbid mood and anxiety disorders, substantial disability, poor treatment-seeking behavior, and significant suicidal risk among individuals with PTSD. Cultural nuances, stigma, and the use of western-derived diagnostic instruments could have contributed to the under identification and undertreatment of PTSD in India. The low prevalence of PTSD in India can also be attributed to the cross-cultural diversity in symptom presentation of trauma or stress and also social support system. With collectivist societies like in India, there may be strong societal bonds that promote open communication about trauma. Importantly, avoidance symptoms may not be noticeable if the traumatic circumstances are related to or within the families or at work places or circumstances linked to the livelihood of the individual. Considering the existence and exposure of various traumatic incidents like natural calamities, and the low prevalence of PTSD in India, the diagnostic stability and validity of PTSD as a construct is a big question. The westernization of diagnostic criteria and manifestation of trauma in India are another concern. The external locus of control in Indian population (like many things are created by God) may shape their reaction to trauma differently as compared to western population. In Indian settings the manifestation of trauma or stress is more of somatization than hyperarousal symptoms. Culture specific coping strategies may also be playing a key role in the low prevalence of PTSD in India [39-41].

Conclusion: To summarize, trauma and stress related disorders in women has wide-ranging clinical presentations with significant cross-cultural implications. Post traumatic stress disorder, acute stress disorder, adjustment disorder are some common trauma related disorders identified with a prevalence of 4-50% globally with low prevalence of PTSD in India (0.2%) according to NMH survey. The response to trauma can be psychological, social, behavioral as well as developmental and it can lead to variety of comorbid conditions like depression, anxiety disorder, substance use disorder as well as psychosis. The mainstay of treatment is psychotherapy with trauma focused CBT along with judicious use of pharmacotherapy for trauma related psychiatric disorders. As consequences extend beyond individual suffering to affect interpersonal relationships, social functioning, developmental domain and overall quality of life, a more holistic approach which also involves crisis intervention, community-based therapies, social support systems and adopting culturally sensitive and gender -responsive services tailored to individual needs will be needed to address this multi-dimensional problem fully. By integrating trauma-informed approaches and awareness into healthcare and support services, we can hope for better outcomes for women affected by trauma everywhere.

Key messages

1. Responses to trauma: Trauma can have varied presentation ranging from emotional, physical, cognitive, behavioral, and interpersonal issues

2. Impact on mental disorders: Trauma can exacerbate pre-existing mental disorders, lead to development of trauma related disorders like Acute stress reaction or Post Traumatic Stress Disorder or can have comorbid depression, anxiety or substance use disorders

3. Tailored Intervention Strategies: Effective interventions must be tailored to address the unique needs of women, considering factors such as gender roles, societal expectations, and cultural influences. Trauma-informed approaches that emphasize safety, empowerment, and resilience-building are essential.

4. Importance of Awareness and Support: Increasing awareness of trauma-related disorders in women and promoting accessible, trauma-informed care services are critical to improving outcomes and facilitating healing and recovery

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CHAPTER 4

Post Traumatic Stress Disorder In Women: A Gendered Approach

ABSTRACT:

Post traumatic stress disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or circumstances which may be experienced as emotionally or physically harmful or life-threatening. Although women are exposed differently to traumatic events in their lifetime than men, they have a higher lifetime risk of developing PTSD. This preponderance of PTSD in women may be attributable to factors other than trauma type such as sensitization of stress hormone system in response to early adverse experiences, inherent neuroendocrine factors, interpretation of the event and peritraumatic dissociation which make the female gender more susceptible. Women with PTSD experience a greater symptom burden, longer course of illness and worser quality of life outcomes than men. These imply a substantial need for early and gender -sensitive intervention and management of the psychological effects of trauma among women.

[**Keywords:** PTSD, Trauma, Gender, Women]

INTRODUCTION:

Trauma can affect millions of people around the world every year and can cause psychological distress with long lasting consequences. Traumatic events may include being a victim or witness to a violent accident or crime, like being kidnapped, being involved in a natural disaster, being diagnosed with a life-threatening illness, or experiencing physical or sexual abuse.[1]During the last 40 years, there has been a substantial increase in trauma research with several global traumatic events like wars and terrorist attacks generating greater public interest in the risk and protective factors for PTSD.

PTSD is characterized by re experiencing the traumatic event in the form of vivid dreams, disturbing memories, flashbacks, or nightmares, along with overwhelming emotions of fear or horror, and intense physical sensations causing significant impairment in personal, family, social,

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educational, occupational, or other important areas of functioning. These symptoms are more accentuated and intense in women necessitating a gender-sensitive trauma care in the aftermath of a trauma.

EPIDEMIOLOGY:

Trauma leading to PTSD may be different for different genders. While men experience trauma like being witnesses to violent deaths or injuries, being in a life-threatening accident or being threatened by a weapon, women are more likely to be exposed to traumatic events like natural disasters, witnessing killings or injuries to others, sexual abuse and physical assaults.[1] Global estimates by World Health Organization suggests 1 in 3 women are likely to experience physical or sexual violence in her lifetime, usually by an intimate partner.[2] Women are more likely than men to be survivors of child sexual abuse, with 25% of girls experiencing this form of abuse during childhood.[2,3] Results based on the CDC and National Intimate Partner and Sexual Violence Survey conducted in 2010 indicate that nearly 1 in 5 women (18.3%) in United States have been raped at some time in their lives.[4] Sexual trauma, including sexual assault and harassment can have profound effects on their mental health and overall well-being. These women are at a higher risk of developing PTSD, depression, anxiety and other mental health conditions.

DIFFERENTIAL MANIFESTATION OF PTSD IN WOMEN:

Most research in the developed world point towards a 2-3 times higher risk of developing PTSD in women when compared to men. Statistics from European countries show life time prevalence of PTSD in women as 10 % to 12 % compared to 5% to 6% for men.[2] Prevalence of lifetime PTSD from National Co Morbidity Survey in USA shows 9.7 % for women versus 3.6 % for men. Various other studies estimate the risk of developing PTSD in the aftermath of a trauma to be in the range of 8-13% for men and between 20-30% in women.[4,5]

Women may be more likely to internalize symptoms and experience personal distress, anxiety, depression, and emotional numbing while men are more likely to exhibit aggressive behavior and substance abuse and this difference may have both biological and psychosocial explanations behind it. Hormonal influences like fluctuations in estrogen and progesterone levels may affect PTSD symptoms in women, particularly during the menstrual cycle or menopause. Due to social and cultural factors women may face additional stigma and shame related to their trauma, making it harder to seek help. Women are more likely to experience comorbidities like depression, anxiety disorders, dissociative disorders and eating disorders. Women have also shown to benefit more from psychotherapy then men in the reduction of PTSD symptoms. The proclivity to develop PTSD more frequently and severely in women may be partially explained by greater exposure to specific types of traumas relative to males (e.g., intimate partner violence). However, such an explanation is too simplistic and fails to consider relevant biological (sex) and psychosocial (gender) substrates of PTSD in females that could provide further clarification as to why females develop PTSD at higher rates than males, and why some females develop PTSD while others do not.[5]

FACTORS AFFECTING PTSD IN WOMEN:

Genetic Factors – Euro-American studies done on females in particular, point towards almost a third (29 percent) of those developing PTSD to be influenced by genetic factors.[6] Over 50 gene variants have been linked with PTSD, involved in the function of HPA axis, noradrenergic, dopaminergic and serotonergic system and neurotrophins.[7]Several common genetic variants are associated with PTSD, including polymorphisms in FKBP5,PACAP 1,COMT,DRD2,GABA alpha 2 receptor, G-protein signaling2 (RSG2) an SNP in an intergenic region of chromosome 4,and an estrogen response element on ADCYAP R1.[8]

Neurobiology behind Female PTSD: This neurobiology involves a complex interplay of brain regions, neurotransmitters, genetic and hormones.[7,8] Varying rates of PTSD among females have also been related to the neuroendocrine system, wherein oestradiol regulation through the hypothalamus has been identified as a protective factor against developing PTSD following a traumatic event. Thus, the likelihood of females developing PTSD may be partially dependent on the phase of the menstrual cycle at the time of exposure.[9,10]

Societal Factors – Studies from low- and middle-income countries like India have reported PTSD rates of 12-15% in adult women who have history of either intimate partner violence or child sexual abuse. When women experience trauma, they may feel isolated, stigmatized, or marginalized, leading to the lack of social support. This lack of social support in the form of emotional isolation, lack of validation, along with limited resources, skewed gender roles and expectations, cultural and societal factors, trauma- related stigma, caregiver burden and lack of emotional expression can further exacerbate symptoms of PTSD.[9]

Further, demographic variables like younger age, ethnic minority status, lower socio-economic class, lower intelligence or education level act as risk factors for development of PTSD in women. Other risk factors include previous trauma, childhood adversity, a personal or family history of anxiety or depression. Severity of a stressor also plays a significant role in the symptom manifestation where in prolonged and repeated trauma and harmful events to their children are more likely to lead to PTSD.

CLINICAL FEATURES:

For a definitive diagnosis of this disorder symptoms must be experienced for at least one month. These symptoms include re-experiencing the traumatic event either through flashbacks, recurring dreams or memories, avoiding places, things or reminders of the event, having reactive responses like startling easily or feeling tense and experiencing mood related symptoms, like feeling negative about self, others or the world, with feelings of guilt, shame, betrayal and sadness. A classic intrusion symptom is flashbacks, in which the individual may act and feel as if the trauma were reoccurring. Other intrusion symptoms include distressing recollections or dreams and either physiological or psychological stress reactions upon exposure to trauma-linked stimuli. Insomnia, irritability, hypervigilance and exaggerated startle are commonly listed symptoms of hyperarousal. Symptoms of avoidance include efforts to avoid activities or thoughts related to the

underlying trauma, blunted affect, anhedonia, reduced capacity to remember events related to the trauma, feelings of detachment or derealization. These symptoms manifest more intensely among women in general and among sexual violence victims in particular. [11,12]

COMPLEX PTSD: Complex PTSD is a more severe disorder comprising of more symptoms, greater functional impairment with repetitive and prolonged stressors from which escape seems difficult or impossible. It is characterized by the three core symptom clusters with problematic affect regulation, negative self-concept and relationship difficulties. These severe traumas could be exposure to torture, concentration camps, slavery, genocide, other forms of organized violence, prolonged domestic violence and repeated childhood sexual or physical abuse. Complex PTSD has greater comorbidities of depression, anxiety and dissociation and has a longer course. There is activation of neural networks implicated in dysfunctional emotional regulation and processing of self-constructs. Functional impairment is significantly worse. [13,14,]

COMORBIDITIES: About 90 percent of people with PTSD have at least one life time co morbid mental disorder. Depression is one of the most common comorbidities seen in women who suffer with PTSD and Complex PTSD along with higher levels of anxiety and somatic complaints. They are also more likely to experience internalizing symptoms, such as emotional numbing and avoidance. Borderline personality disorder and related cluster B personality traits associated with impulsivity may put the person at risk of exposure to traumatic situations. Suicidal behavior is found to be associated with PTSD and traumatic events, though what drives these associations remain unknown.

INSTRUMENTS FOR ASSESSMENT

The Clinician Administered PTSD Scale (CAPS)[15] and the Anxiety Disorders Interview Schedule for DSM -IV (ADIS- IV) [16]is the most commonly used diagnostic interviews that assess symptom severity as well as help in establishing the diagnosis of PTSD. Impact of Event Scale (IES)[17] is one of the most widely used self- report measure which further was expanded to include an additional hyperarousal scale (IES-R)[18]Post- traumatic Stress Diagnostic scale (PDS)[19] or the PTSD checklist (PCL)are commonly used in research studies.

DIAGNOSTIC CRITERIA

ICD-10 classifies PTSD (F43.1) among the reactions to severe stress and adjustment disorders (F43) that primarily are caused by stressful events. Although the exact definition of PTSD has varied across the different editions, four core features of PTSD have remained stable that is experiencing or witnessing a stressful event, re-experiencing symptoms of the event that include nightmares and flash backs, efforts to avoid situations and people that are reminders of the traumatic event and hyper arousal symptoms such as irritability, concentration problems and sleep disturbances.

Current classificatory system (ICD-11) has classified PTSD, Complex PTSD, Prolonged grief Disorder, Adjustment Disorder and Acute Stress Reaction under the category of Disorders

Specifically Associated with Stress. PTSD is diagnosed by the presence of three core symptom clusters namely re-experiencing the event in the "here and now" usually accompanied by the flashbacks and repetitive dreams or nightmares, deliberate avoidance of reminders of the event leading to internal avoidance of trauma-related thoughts and external avoidance of people, and heightened perception of current threat in the form of hypervigilance and startle reaction. Symptoms can begin immediately after the traumatic event but must last for several weeks and be severe enough to cause significant impairment in functioning. In contrast Diagnostic and Statistical Manual, 5th edition (DSM-5) states that PTSD can also occur alone, or more commonly, with other co-occurring disorders, such as substance use disorder, mood disorder, or anxiety disorder. Additionally, PTSD is strongly associated with functional difficulties, reduced quality of life, and adverse physical health outcomes.

COURSE AND PROGNOSIS

PTSD usually develops early within one week or unusually as late as 30 years after a traumatic event. Delayed onset is found in a minority (11% or less) of cases. Irrespective of treatment, about 30 percent recover completely, 40 percent continue to have mild symptoms, 20 percent continue to have moderate symptoms and 10 percent remain unchanged or become worse. A good prognosis is predicted by rapid onset of symptoms, short duration of symptoms, good premorbid functioning, strong social supports, and the absence of other psychiatric, medical or substance-related disorders. PTSD that is comorbid with other disorders is often more severe and perhaps more chronic and may be difficult to treat, irrespective of the gender. The extremities in the age group, like the very young and the very old have more difficulty to deal with traumatic stressors than do those in midlife. Long term outcome also depends on initial symptom severity.[25]

PTSD in females tends to follow a distinct course and prognosis compared to males, influenced by a combination of biological, psychological and social factors. Hormonal changes during different life stages like menstrual cycle, pregnancy and menopause can also influence the severity and course of PTSD. Women often experience stronger initial reactions to traumatic events, more intense symptoms of acute stress, tend to have a more chronic course with frequent relapses, when compared to men. Early intervention and treatment with good social support aid in better recovery. Personal resilience and coping strategies are also significant predictors of a better prognosis. Hence a gendered treatment approach which focuses on these factors help in improving prognosis in women with PTSD.

DIFFERENTIAL DIAGNOSIS:

As patients often exhibit varied reactions to trauma, clinicians must be careful to exclude other disorders when evaluating patients presenting in the wake of trauma. Epilepsy, alcohol use disorder and other substance related disorder can also either cause or exacerbate PTSD symptoms with intoxication or withdrawal stages presenting a confusing clinical picture that is difficult to distinguish from PTSD until the effects of the substance have worn off.

Acute stress reaction, enduring personality change after a catastrophic experience, adjustment

disorder and other anxiety or depressive disorders are the most common differential diagnoses to be considered. Acute stress disorder is distinguished from PTSD with symptom pattern is restricted to one day to one month following exposure to traumatic event. Adjustment disorder manifests with less severe stressor or different symptom pattern.

In women, symptoms of PTSD are difficult to distinguish from both panic disorder and generalized anxiety disorder as all three are associated with prominent anxiety and autonomic arousal though careful review of the time course relating to symptoms will help diagnose PTSD better. Also, symptoms of intrusions and avoidance are not associated with panic disorder and GAD. Depressive disorders usually manifest with the absence of a traumatic stressor or symptoms precedes stressor. Patients with dissociative disorder do not usually have the same degrees of avoidance and arousal that PTSD patients do. Borderline personality disorder can be difficult to distinguish as the two disorders can co-exist or even be causally related.

INDIAN PERSPECTIVE

While worldwide estimates of prevalence range from 3.9% to 24%, little research has been conducted to identify the prevalence of PTSD in India.[29,30] A pioneering large scale study in India (National Mental Health Survey, 2015 2016), found a remarkably low prevalence of PTSD at 0.2%. Risk factors linked to PTSD included being female, of middle age, and residing in urban areas. Also, individuals grappling with PTSD displayed prolonged symptom duration, limited treatment seeking behaviour, substantial disability, a high incidence of comorbid psychiatric disorders, and a significant risk of suicide.[31,32]

TREATMENT APPROACH

It is important to note that not everyone who experience trauma develops PTSD and for some people, symptoms of PTSD subside or disappear with time and good support system. However, women who experience PTSD more intensely need professional help to recover from psychological distress following trauma. Both psychotherapy and pharmacotherapy provide effective evidence-based treatment for PTSD especially when provided early.[32]

Pharmacotherapy: SSRIs (particularly sertraline and paroxetine) and SNRIs (venlafaxine) remain first-line pharmacotherapeutic treatment options for PTSD with most robust evidence for efficacy. Atypical antipsychotics lack robust studies demonstrating evidence and have more potentially severe adverse effects, making them last-line treatment options or for treatment resistant cases. Mood stabilizers are limited to treatment of comorbid illness because of their lack of data. While many patients continue to receive benzodiazepines for both PTSD related anxiety and sleep disorders associated with PTSD, they are better avoided. Prazosin can be recommended for those with PTSD-associated nightmares, with proper education regarding its efficacy and blood pressure monitoring. There are promising initial findings about Risperidone, Topiramate, Buspirone, Amitriptyline and Imipramine to be efficacious in treatment of PTSD in a number of well controlled studies conducted recently.

Psychotherapy: Variations of Cognitive Behavior therapy (CBT) like Cognitive processing therapy, Prolonged exposure therapy and Trauma focused therapy are found to be useful in treatment of PTSD. Cognitive processing therapy emphasizes correcting faulty attributions post trauma like over generalizations of the world as dangerous, uncontrollable and unpredictable. Prolonged exposure therapy uses repeated detailed imaging of the trauma or progressive exposures to symptoms in a safe, controlled way helping patients to face and gain control of fear and distress and learn to cope. Eye movement Desensitization and Reprocessing (EMDR) for PTSD is a trauma focused psychotherapy which is administered over approximately 3 months. This therapy helps a person to re-process the memory of the trauma so that it is experienced in a different way. It involves repeatedly recalling distressing images while receiving sensory inputs. Psychodynamic psychotherapy with reconstruction of traumatic events, associated abreaction and catharsis, may be therapeutic in some cases. In addition to individual therapy techniques, group therapy and family therapy may prove to be effective for PTSD especially when it includes sharing of traumatic experiences and support from other group members.[33]All these treatment approaches when delivered in a gender-sensitive and culture-specific manner, tend to be more effective for women suffering from PTSD.

CONCLUSION

PTSD in females often involves a chronic and complex course, influenced by the nature of trauma, co morbid conditions and available support systems. PTSD in women can lead to significant impairments in daily functioning, relationships, and overall quality of life. Prognosis can be improved through timely and effective treatment, strong social support and addressing co morbid conditions and socio-economic factors. Stigma, lack of access to mental health care and cultural factors can impede women from seeking and receiving appropriate treatment. Addressing these barriers involves increasing awareness, providing accessible services and integrating trauma informed and gender-sensitive approaches in all healthcare settings. Understanding and addressing PTSD in women requires a multifaceted and gendered approach that considers biological, psychological, and social factors unique to women.[34] Fostering gender-sensitive, culture-specific and socially -relevant therapeutic approaches will pave the path for a holistic recovery in women who suffer from the vagaries of trauma and its painful aftermath.

Key Messages

Women are exposed differently to traumatic events in their lifetime than men and have a higher lifetime risk of developing PTSD.PTSD in females often involves a chronic and complex course, influenced by the nature of trauma, co morbid conditions and available support systems.Stigma, lack of access to mental health care and cultural factors can impede women from seeking and receiving appropriate treatment.A multifaceted and gendered approach that considers biological, psychological, and social factors unique to women along with fostering gender-sensitive, culture-specific and socially -relevant therapeutic pathways will help in holistic recovery of women who have been victims of trauma.

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CHAPTER 5

Pubertal Trauma: Menarche and Beyond

ABSTRACT:

Puberty is a time of immense transition, involving changes that are both physiological and psychological. This is a time that can become traumatic for youngsters, especially those with pre-existing vulnerabilities. It is thereby vital to identify those who may be at higher risk of developing emotional and behavioural disorders during this time, and plan strategies for prevention and intervention. With the help of case vignettes, we have elucidated the various factors that may predispose an individual to experience pubertal trauma, the impact of the same and interventions that may benefit those who are struggling.

[**Keywords**: Pubertal trauma , Behavioural disorders, Vulnerabilities, Adolescents]

Introduction:

Pubertal trauma refers to the psychological and emotional challenges that can arise during puberty, a time marked by significant physical, hormonal, and social changes. This period of adolescence often involves a heightened vulnerability to peer pressure[1] and body image issues against the background of evolving self-identity, which can be exacerbated by external stressors such as familial conflicts or social isolation. Adolescents may struggle with anxiety, depression, or other emotional difficulties as they navigate these changes, highlighting the need for supportive environments and mental health resources to help them through this critical developmental stage[2].

Nature of pubertal trauma: Navigating the normal milestone of puberty itself causes a lot of physiological, sexual and emotional upheaval in a girls' life. Additional trauma during this period strikes at a vulnerable time, when she's under much scrutiny, both by herself and by the society that surrounds her, including her peers, family and teachers.

Vulnerabilities to pubertal trauma: Both intrinsic factors, unique to a girl and extrinsic variables linked to her environment can contribute significantly, predisposing her to and perpetuating the impact of pubertal trauma.

Internal factors: This includes both predisposing and perpetuating factors.

Predisposing factors: Any condition that predisposes a girl to psychological distress can make puberty a more vulnerable time for her. This includes genetic history of mental illness,

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childhood mental health issues, neurodivergence and/or pre-existing trauma. Sensitisation to stress in gestational, neonatal and childhood years can all be contributory factors. Early pubertal onset is often triggered by early trauma, and conversely, early pubertal onset can itself lead to psychological distress, shame and stigma (3), as depicted much clearly in the case vignette presented below (See Box .1).

Box 1:Case Vignette: P is a 24 year old woman with OCD. She attributes the onset of her compulsive behaviours around the age of 9, when she had her first period in school, well before her peers. She was unaware of the menstruation process at that time and was shocked when her friends pointed out the blood stain on her skirt. Her mother was called, who furtively escorted her home and did not allow her to return to school for the rest of the week. She was confused and embarrassed initially and when she returned to school she had also become the focus of a lot of teasing and bullying. This resulted in persistent feelings of shame and disgust with her body, which might have kindled the need to indulge in certain compulsive behaviours

Perpetuating factors: Sex differences in adolescence can make girls more vulnerable to mental health issues during puberty. Gender dysphoria also usually manifests around puberty when biologically born girls who identify as boys, can find the appearance of secondary sexual characters and menarche extremely distressing. On the other hand, pubertal changes can be very distressing for biologically male boys as well (4).

External factors: This includes the broader sociocultural milieu and the more proximal family environment surrounding the individual .

Socio cultural factor : Adolescence is a time of transition, where self identity develops by pushing the boundaries set culturally by the family and socially by the community. However, the majority of Indian girls struggle with the ability to safely rebel and take acceptable risks that can help with identity formation. One of the common clashes that occurs is around cultural practices related to behaviour during menstruation, ways of dressing in public, choice of activities engaged in and nature of peer interactions (8). Even in an otherwise less oppressive environment, menarche marks the onset of increased restrictions for a young girl. This is further perpetuated by the lack of safety in the community for young girls increasing the need for restrictions by the family. Unfortunately restrictions can also limit awareness and knowledge in girls, making them more vulnerable to exploitation and trauma. Although previously tabooed topics are increasingly being addressed by both government and non government organisations (such as healthy menstrual practices, safe touch, domestic violence, women's rights, etc), many young girls still remain ignorant and succumb to trauma. Sexual harassment such as eve teasing, groping, touching, pinching, grabbing of private parts in crowded public places is often normalised (9). When sexual offences against girls are attributed to the young girl's looks or choice of clothes, rather than being viewed as a crime committed by the perpetrator, the victims experience significant shame , guilt and the unfair burden of blame. This is especially heightened around the time of puberty when the girl is still transitioning between her old ways of dressing to a more adult or "modest"

style. Body shaming by peers and adults among school going adolescents is higher in India than elsewhere globally as reflected in studies done worldwide (10).

While the above described negative beliefs and practices can certainly contribute to pubertal trauma, what is more dangerous, however, are some normalised cultural practices that can be equally traumatic for a young girl especially in communities dominated by patriarchy where awareness programmes may have limited impact. Many cultures still marry their girls very young, against their wishes, and menarche is a milestone when they get "promised" to their future husbands. Often education is stopped during this period and most rights taken away. Another worrying aspect is the acceptance and sometimes glorification of male dominance, which is seen as protective for a young girl and intensifies during adolescence. Popular media, such as movies and TV shows, normalise problematic behaviours by the male protagonist such as stalking, violating personal boundaries, controlling relationships, actions suggestive of toxic masculinity, financial and even physical abuse. Young girls often believe these to be acceptable ways of behaving by the opposite gender and may not even realise the impact of abuse till much later.

Family environment: Despite the above mentioned cultural factors, girls who safely navigate these challenges are those with a supportive family environment. Pubertal trauma can manifest when adolescent girls are left to manage these stressors on their own; or when they are perpetuated by family members as well. Various factors may exist in the family that contribute to them inflicting trauma especially during adolescence. Lower level of education in the mother is correlated to higher risk of abuse and trauma in adolescents (11). Sociopathy, narcissism and obsessive rigidity with religious rules in parents are also correlated with negative outcomes in adolescents. Girls living in joint families are more prone to stigma, emotional and sexual abuse. Studies from India have shown that majority of sexual abuse occurs in girls aged 16-18 years and most commonly by someone known to her (12). Under resourced families are more likely to want to marry their daughters earlier as marriage is seen as a protective factor against sexual abuse. Higher education and/or professional success may be viewed as deterrents to securing a good alliance. Hence during adolescence, focus often shifts to grooming, improving external appearance, and domiciliary skills rather than education or career (13). Also an over emphasis on marriage and the viewing of marriage as a parameter of a successful and " settled" life for girls deters them further from their professional goals. This can be seen more clearly by studying the case vignette provided below (See Box 2)

Box 2: Miss S is a young woman now, studying in university for a professional degree. One of her presenting complaint is binge eating especially during exam times when she is most stressed. This is followed by guilt and shame and a strong desire to induce vomiting. She recalls the first few years of her adolescent period as a very traumatic time. Especially in her interaction with her mother, who would often criticise her eating habits, ask her to watch her weight with the constant rejoinder being that 'otherwise she won't find a suitable match'. She recalls a particularly traumatising incident when her mother and maternal grandmother had forced her to induce vomiting to lose weight.

Impact of pubertal trauma: Pubertal trauma, or trauma experienced during adolescence, can significantly disrupt mental health, with statistics highlighting its profound impact (14). Research shows that adolescents who experience trauma are at an increased risk for developing mental health issues. For example, studies indicate that approximately 8% of adolescents exposed to traumatic events develop post-traumatic stress disorder (PTSD) with a higher risk in those not living with both biological parents and those exposed to interpersonal violence. (15). In some cultures where the exposure to interpersonal violence and violent crime is high, the PTSD prevalence in adolescents has been estimated to be as high as 25%. (16). Additionally, trauma during puberty is linked to a higher prevalence of depression, with up to 25% of traumatised adolescents reporting depressive symptoms. (17). Exposure to multiple traumatic events is associated with a higher severity of PTSD and depressive symptoms. (16). Moreover, trauma during this critical developmental phase can interfere with the normal process of identity formation and affect future resilience, making early intervention and support crucial for mitigating long-term effects. (18). This impact can be realised more starkly when one peruses various case vignettes depicted in this chapter (See Boxes 3 , 4 , 5).

Box 3: Ms A is a 14 year old girl who presented with depressive symptoms. Her parents had separated five years ago, and she lived with her father, paternal grandparents and older sister. She was able to cope with her parents' separation as she had close friends and several talents including dancing and athletics. Following puberty a couple of years ago, her father insisted that she stop dancing and pay more attention to her studies. He would be critical and often punitive if her exam results were not meeting his expectations. Initially she would keep dancing on her own and making dance reels with her cousin, but over time even she started feeling uncomfortable and self-conscious especially when she sweated, eventually making her give up dancing altogether. Additionally at the time when she first came to the clinic, her paternal grandmother's health was poor and she was extremely troubled by this as she shared a close relationship with her grandmother. Interventions that helped her were individual therapy focussing on her strengths and her notions of self and identity, and attachment focussed interventions with her family. Over time she was able to feel more comfortable in her body and could return to dancing. Parallelly, her mood improved as well. Her father was also able to reflect that allowing her to individuate with some gentle guidance and limit setting was important for her overall emotional well being.

Box 4: Master I is a 13 year old biologically male child who presented with severe gender dysphoria at the onset of puberty. In retrospect, he said that he had always preferred female ways of dressing, liked to keep his hair long and liked dancing and singing as opposed to more rough and tumble activities. He was not able to tolerate the emergence of facial hair, and his voice becoming deeper at which point he looked through content on Instagram and understood that he was probably transgender. At the time when he presented to the clinic, he was very distressed and his parents had brought him as his grades had been declining. Interventions included facilitating communication between him and his parents regarding his gender dysphoria,

and enabling him to 'come out' to them. When he felt that his parents understood and were supportive, some of his distress came down. He felt more relieved when they allowed him to grow his hair and completely remove his facial hair. They were also guided to seek a consultation with a paediatric endocrinologist who suggested GnRH analogues to delay puberty. He began to see a therapist who helped him navigate stresses related to the bodily and social transitions associated with puberty.

Box.5 : Ms M is a 15 year old girl who came with episodes of feeling intensely anxious and distressed. She had been diagnosed with ADHD and dyscalculia previously, and was receiving remedial education. She had been severely bullied in her previous school in 7th standard for her academic challenges, and had also been molested by a boy in her class around the same time. Thereafter she was not able to return to school and was being homeschooled. On exploration, there were clear triggers for her emotional outbursts, most of them in interpersonal contexts. Her mother was extremely anxious and her father very strict and punitive. She would often be severely scolded by her father for not putting in enough effort towards her academics, especially when he was under the influence of alcohol. Her father and brother would also body shame her saying she was unattractive and would never get a boyfriend. She began to hate her body and would restrict her eating. Around exam time, she would experience severe anxiety and panic attacks. She would tend to get into turbulent, short lasting friendships and relationships with other emotionally troubled youngsters who had experienced childhood trauma. Individual therapy (mentalization based therapy) was initiated for her. She was someone who was very 'other' focussed, and would get deeply impacted by others' statements and comments. Her own sense of self was shaky and unstable. She would usually resort to automatic, emotional mentalizing. Through therapy, she was helped to build her reflective capacity and learn to understand her own emotional states (mentalizing 'self') especially in connection with body image, academic abilities and self worth. Family interventions focussed on identifying mentalizing breakdowns within the family, and helping family members to address them in a right way.

Deliberate self harm and suicide: Young girls who attain menarche early are at higher risk of deliberate self harm (19) with or without a history of trauma. This risk increases in those with a history of trauma (20). Many of these can go on to suicidal behaviour or completed suicides. Isolation from supportive peers and exposure to the internet, increases the vulnerability of young girls already at risk. Mental health issues and trauma are the most common causes of suicide in adolescents in India (21), making this an issue of urgency and high sensitivity.

Interventions for pubertal trauma

Interventions for adolescents who have been affected by trauma during the time of puberty would need to be individualised to each teenager depending on their unique clinical profile and biopsychosocial vulnerabilities. Young girls are vulnerable but they are also receptive to rewarding stimuli and emotional and cognitive reasoning, making this an ideal time for education and guidance

(22). Life skills training for middle schoolers has gained momentum both in India and worldwide as an excellent preventive intervention that can bolster a youngster's resilience during this critical time. Through interactive and experiential pedagogies, life skills training imparts vital skills like self-awareness, emotional regulation and effective communication to young people. In India, Dr Srikala Bharath and her team from NIMHANS have done extensive work in this field (23).

For those who have already developed clinically significant symptomatology in response to trauma, evidence-based interventions like trauma focussed cognitive behavioural therapy, mentalization based therapy and attachment-based family therapy can be used all of which have proven efficacy in the adolescent population (24). Family interventions are of critical importance when working with young people. Restoring open and honest communication between family members can alleviate much of an adolescents distress, and has a marked protective impact on self-harm behaviours as well.

Priority should be to address the social and psychological factors first, but in extreme cases, management of acute psychiatric illness may be necessary to facilitate engagement. Medical management should be reserved for such cases and even then, should be done alongside the psychosocial management as mentioned above. Collaborating with all healthcare professionals involved and developing a common treatment plan is crucial for girls with a history of pubertal trauma. This may include school counsellor, NGO support worker, psychologist, family therapist, social worker, psychiatrist, etc (25).

Conclusion

In conclusion, puberty is a time of immense transitions, both physiological and psychological. Lack of knowledge and preparedness about pubertal changes, and myths and misconceptions surrounding adolescent sexuality may contribute to guilt, shame and body image issues that many youngsters experience around this time. Pre-existing vulnerabilities like ADHD, autism, learning disabilities and gender nonconformity make it more likely for children to experience traumatic experiences like bullying and corporal punishments, which often intensify in middle school around the time of puberty. Trauma could also hasten puberty which then becomes an additional risk factor for an individual to develop internalising problems like depression and anxiety during adolescence. It is thereby of paramount importance that parents, teachers and clinicians work together to help young people tide over this sensitive and critical phase in their lives. Enabling children to participate in open conversations around puberty, sexuality and mental health would go a long way to dispel the stigma, taboos and misperceptions surrounding puberty and pubertal trauma.

Key Messages

Puberty is a time of immense transition, involving both physiological and psychological changes, which can become traumatic for youngsters, especially those with pre-existing vulnerabilities.Trauma could also hasten puberty which then becomes an additional risk factor to develop internalising problems like depression and anxiety during adolescence.Both intrinsic

factors and extrinsic variables can contribute significantly and predispose young girls to the impact of pubertal trauma.It is of paramount importance that parents, teachers and clinicians work together to help young people tide over this sensitive and critical phase in their lives by being cognizant of strategies for prevention and intervention.

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CHAPTER 6

Trauma of Preconception Period

Abstract

The pre-conception period is crucial for maternal and child health. Psychological, reproductive and social trauma of any intensity significantly impact the health of both mother and child. Hence this article aims to provide some insight into the various traumas affecting the pre conception period and some of the important interventions like trauma informed care and therapies apart from reducing stigma and promoting mental and physical health and addressing social determinants of health. Integrating these approaches into preconception care, is important for improving the overall quality of life of the present and future generations.

[**Keywords**: Pre-conception period, Traumas , Trauma-informed care, Epigenetics]

Introduction:

The pre-conception period refers to the lifespan of women before potential pregnancy. It encompasses both the time before a woman's first pregnancy and the interpregnancy interval. The health behaviours of women of reproductive age are key determinants of a healthy pregnancy and have far-reaching consequences for the health and development of the next generation as well. 2018 *Lancet* [1] series on preconception health posited three perspectives upon which to conceptualize the preconception period. The biological perspective (days to weeks before embryo development), the individual perspective, (conscious intention to conceive), the public health perspective, which occurs over the longer period of months to years to address preconception risk factors.

Pre-conception care (PCC) is an intervention that aims to identify and modify biomedical, behavioural, and social risks to women's health and pregnancy outcomes[2]. It involves the assessment of the females in the pre-pregnancy as well as inter-pregnancy period with the administration of evidence-based interventions to optimize their health to withstand the pregnancy and to reduce foetal complications. To provide optimum preconception care all the aspects of preconception are to be understood in detail by applying the bio psychosocial model.

Pre-conception Trauma:

Pre-conception trauma is a crucial factor negatively affecting the mental state of a potential

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mother. The concept of pre-conception trauma refers to the impact of trauma experienced by women before conception, which can influence the health and development of their future children. This trauma can be psychological, social, reproductive, and economical. This idea is rooted in epigenetics, where the prenatal environment along with the foetal genome is said to shape foetal development and the maternal environment determines the prenatal environment which in turn affects offspring's health over their life course [3]. The period around conception (two to three months before and after) is a *critical period* for optimizing gamete function, and early placental development. Experiences before conception may affect the quality of the oocyte and subsequently the embryo at a cellular level [4]. Dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis in the mother can lead to dysregulation in the foetus leading to the intergenerational transmission of this traumatic stress from conceivers to the foetus [5].

This chapter aims to cover some of the major traumas on various aspects of pre-conception period and recommendations related to trauma informed care during this period.

The many faces of preconception trauma:

Trauma during the preconception phase of a woman are myriad and many, which include abuse during childhood, domestic violence, bereavement, marriage, pressure to conceive, infertility, pregnancy losses, traumatic birth experiences, inadequate support systems and trauma arising due to socio-cultural and economic factors.

Abuse during Childhood:

Physical, emotional, or sexual abuse experienced during childhood has long-lasting effects on various aspects of ones behaviours, physical and mental health. For individuals in their reproductive years, trauma may play a role in sexual risk taking such as having sex without using a condom, low self-assertion to refuse sex, and having sex under the influence of drugs or alcohol and unplanned pregnancies [6,7,8,9,10]. Emotional dysregulation has also been found to account for much of the relationship between childhood trauma and sexual risk taking, which was partially explained by difficulty identifying and expressing feelings and the tendency to behave impulsively to deal with negative affect, which was again associated with greater alcohol use[6]. Consistent with the greater presence of risk factors found that adults who reported experiencing two or more adverse childhood events were more than twice as likely to report an unplanned pregnancy later in their lives[11]. childhood trauma exposure in women before conception, measured via standardized interviews and scales like the Parent-Child Conflict Tactics Scale found that infants of mothers exposed to childhood emotional abuse were more likely to demonstrate low emotional reactivity. Infants of mothers exposed to childhood emotional neglect demonstrated heightened emotional reactivity, even after controlling for postpartum depressive symptoms[12].

Domestic Violence:

Exposure to intimate partner violence or domestic abuse can cause severe psychological stress. Domestic violence (DV), which includes sexual violence and intimate partner violence

(IPV) is a serious public health issue that affects individuals of all ages, but is most prevalent among women of reproductive age[13] with a worldwide prevalence rate of 35%[14]. To face violence at the most trusted place by the most trusted person and not being able to gain support even from their maternal household leaves a profound impact on the mental health of the women. Social acceptability of certain levels of DV has become a norm and is frequently trivialized when it should be condemned at all levels. The social taboo of bringing out marital problems to public/social spheres contributes to the growing instances of DV as the perpetrator is confident to get away with such behaviour without any consequences. Surprisingly the victims of DV/IPV are more socially ostracised rather than the abuser. Fearing the outcome of a complaint against DV, many women enter a state of learned helplessness to maintain peace at home which in turn boosts the impunity of the abuser. Many cases of DM/IPV extend from the preconception period to throughout the pregnancy. Some women believe conceiving may provide a break from DV but DV reported during the one year before pregnancy is considered to be a strong predictor for experiencing DV during pregnancy as well. Moreover, a significant association was identified between physical DV one year before pregnancy and unintended pregnancy.[15]

Bereavement:

The loss of a loved one, such as a close family member, can cause intense emotional distress. Maternal bereavement - defined as the death of a parent, sibling, or previously born child, in the months before conception or during pregnancy is linked to increased infant mortality and psychiatric morbidity in those women.[16]

Age at time of marriage

Women, especially in patriarchal societies, often face pressure to marry and conceive early. Conception immediately or within a year of marriage is considered as a norm in Indian setting, where the women is neither physically nor mentally prepared for it. In India women of childbearing age (15 to 44 years) constitute 22.2 per cent of the total population. The median age of marriage for women is 19.2 and the average age of first birth is 21.3 years with a very narrow preconception period to intervene[17]. Age at marriage is a population control measure, and marrying at an early age exposes a woman to an increased fertility span resulting in early pregnancy[18] often acknowledged as a detrimental and gender discriminatory socio-cultural global practice requiring attention as a Human Rights concern.

Pressure to conceive:

Prevailing Social norms in India regarding family planning and sex preference of offspring, such as early marriage, preference for sons, pro-fertility norms, and toxic masculine ideology, exacerbate the pressure to conceive early and more depriving women of their bodily agencies.[19] These norms can further lead to violence and reproductive coercion by husbands and in-laws, intensifying the reproductive challenges faced by young women. Pressure to be 'fertile', from in-laws may be a particular concern, especially for adolescent wives who are more likely to be in joint families or residing with or near in-laws[20] and might lead to fear of being labelled as barren if

they do not conceive quickly. This pressure can cause substantial emotional distress and impact their mental and reproductive health.[21]

Infertility:

Infertility among women most often happens to be a silent struggle as majority of infertile women do not share their struggle and are increasingly psychologically vulnerable while struggling with infertility or undergoing fertility treatments. 1 in 8 couples (or 12% of married women) have trouble getting pregnant or sustaining a pregnancy naturally[22]. The inability to reproduce naturally can cause feelings of shame, guilt, and low self-esteem and can be emotionally taxing. These negative feelings may lead to varying degrees of depression, anxiety, distress, and a poor quality of life. Depression levels in patients with infertility are as high as that with patients who have been diagnosed with cancer.[23] Apart from this, the medications used to treat infertility including clomiphene, leuprolide, and gonadotropins act on the hormonal imbalance, and are associated with psychological symptoms like anxiety, depression and irritability.[24]

However patients getting pregnant quite easily from ART and conceiving on their first cycle of treatment is an exception and for many, it may take years, or not happen at all. With each cycle the couple faces emotional upheaval with increasing expectations followed by distress, more so in women, until they have a positive outcome. This distress continues with each cycle leading to more financial and social pressures also.

Pregnancy loss:

Pregnancy losses like miscarriages, abortion, foetal or neonatal death, or still births are one of the most psychologically stressful pregnancy outcomes, which is often underestimated in terms of severity. More than half of the women presented with symptoms of depression, with up to one-fourth experiencing perinatal grief, and over one-sixth reporting moderate anxiety[25]. Risk factors for these conditions include low socioeconomic status, being childless, having a low level of education, and having had a miscarriage less than six months prior. Repeated pregnancy loss leads to feelings of despair and emotional pain, often resulting in psychological symptoms like anxiety, depression, grief, guilt, and anger.

Traumatic Birth Experiences:

Previous traumatic experiences during childbirth can affect mental health in subsequent preconception periods. For some women, the birthing experience can lead to feelings of victimization, betrayal, or loss, causing significant emotional and psychological damage. Given the powerful nature of childbirth, a traumatic birth can have profound effects, influencing choices and decisions in subsequent pregnancies[26]. This has been elaborated further in a whole chapter dedicated to the said topic (see Chapter 7)

Socio-Cultural and Economic Trauma:

Cultural and social trauma such as gender discrimination in the preconception phase of women

leads to chronic stress and accumulative emotional pain. Social isolation, being cut off from family and friends of pre-marriage times, family conflicts or dysfunctional family dynamics, prevailing patriarchy and difficulty in adjusting to new household can all exacerbate stress and trauma, deeply affecting an individual's mental health during this vulnerable period of their lives. Financial pressures too can contribute to mental health issues reducing the ability of women to seeking professional care when in need. The treatment for mental health issues may cause extra financial burden to the household leading to non-compliance or discontinuing of needed medications, risking relapses of a previously controlled illness. Lack of financial independence and economic stressors directly affect stress levels in these women too.

Inadequate Support Systems:

Partner support is described as all the supportive actions or attitudes that someone exhibits to their partner and perceives to receive from their partner in order to meet their need. It involves both an active role (providing support) and a passive role (receiving support) [27]. Unfortunately, Women in India do not receive adequate partner support to meet their emotional needs. Though the number of financially independent and working women is increasing, the men are still considered the breadwinners and do not share the household duties putting excess stress on the women to strive to attain a work-life balance, thereby increasing their vulnerability to trauma further during their preconception phase of life.

Trauma and Mental Health:

There is a lack of awareness about mental health issues and their impact on reproductive health. Mental health issues during preconception phase are often stigmatized, leading women to avoid seeking help for conditions like depression, anxiety, and stress. There is a cyclical relationship between mental and reproductive health problems wherein adverse outcomes in one dimension increase the risk of developing health concerns in the other, including in fertility and pregnancy loss.

Traumatic exposures may increase the risk of adverse reproductive outcomes not only directly, but also through an indirect pathway via mental health. Poor mental health resulting from traumatic experiences are thought to further increase women's risk of developing reproductive disorders and/or exacerbate pre-existing conditions [28,29,30]. Since reproductive disorders commonly provoke distress, mental and reproductive endpoints likely have synergistic, interactive and/or additive effects that serve to perpetuate the vicious cycle of exposure and disease [31,32,33].

Even in young women with a diagnosed illness undergoing treatment, the diagnosis is usually hidden and treatment is discontinued pre-marriage without advice from a psychiatrist. Misconceptions and cultural myths like positing of marriage as a panacea for all mental illness leads to early and incompatible marriages, inability to handle marital life and inadequate resources to handle the problems that occur thereafter.

Impact of Mental illnesses occurring in preconception period:

Both common and severe mental illnesses occurring in the preconception phase of a women's life can have serious consequences. One in four women of childbearing age are found to have some degree of mental disorders and are, therefore, prone to both pregnancy complications and adverse health outcomes in their offspring[34,35].Women are at their greatest lifetime risk for mood disorders during their childbearing years twice as much as men and this is the second leading cause of disability-adjusted life years (DALYs) for reproductive-age women.[36] Many social, psychological, and hormonal factors play a role in women experiencing depression during this window of vulnerability. Women who were suffering from depression in the preconception period are more prone to relapses during pregnancy, can have 40% higher risk of having pregnancy complications, and an increased risk of developing gestational diabetes[37]. Women with depressive and anxiety symptoms that persisted from adolescence into young adulthood developed maternal-infant bonding problems.[38] Further, women with serious mental illness (SMI) often have interrelated social, physical, and mental health needs, and experience stigmatizing attitudes about their desire for motherhood. Women with more severe symptoms before pregnancy were 1.48 times more likely to have a non-live birth and nearly twice as likely to give birth to a low-birthweight baby. Overall, pregnancy complications were identified in four out of ten women with SMI[39]. They can also have higher rates of unplanned pregnancy, domestic and sexual violence or abuse, and sexually transmitted infections as well as lower contraceptive usage compared to women without any psychiatric disorders.

Screening and interventions:

We have already discussed in detail about screening for traumas and interventions in chapter 1 and 3, and hence will touch upon important factors to be considered in the pre-conception period.

Majority of the approaches talk about trauma informed care for women in general or in perinatal period. The most important but unacknowledged area is pre-conception period. As already mentioned, care of woman in pre-conception period not only will take care of woman but it will take care the health of future generation too. Hence, the screening should start at the moment the reproductive age group woman comes in contact with health care system even if it is before her active sexual or marital life. Universal screening may be effective in many clinical settings[40], whereas universal education or the incorporation of information about trauma and its effects into programming and/or service provision may be effective if there are no clear benefits from individual disclosure of trauma [41]. Since, it may take at times months together to establish rapport and trust, consistent and continuous efforts are needed from the entry point onwards.

Apart from ACE (Adverse Childhood Experiences), Domestic or IPV, all other relevant aspects of pre-conception traumas needs to be elicited in a gentle manner without retraumatizing the individual. Flanagan et al. (2018) emphasized that prenatal screening is important for connecting patients to resources where appropriate, and ultimately breaking negative cycles of childhood trauma.[42]

After eliciting the details, appropriate referrals and interventions has to be planned and executed. The trauma may be at individual, family or societal level. Accordingly, the interventions need to be planned. Being able to provide immediate resources (e.g., educational handouts), referrals to other relevant trauma-informed and/or trauma-specific services, and trauma-specific interventions or modifications to reproductive care are very important during screening [43].

Another way that a trauma-informed approach can be applied in the prevention efforts is the incorporation of trauma-informed principles and trauma-related content into interventions aimed specifically towards populations with identified risk factors [44]. For example, Myers et al. (2018) developed a trauma-informed substance use and sexual risk reduction intervention for young women with past trauma and current substance use who were at risk of unintended pregnancy and other negative sexual health outcomes [45].

Apart from trauma informed approach, providing comprehensive mental health support, including therapy and counselling is needed to address both mental illnesses and stressors of the preconceptions period. Identifying healthy women at risk along with appropriate referral for social and psychological interventions during the preconception visits might prevent the emergence of symptoms later during pregnancy and postpartum. Enhancing social support systems by connecting women with resources and support groups to address issues such as isolation or domestic violence along with awareness about education and financial independence will help bring about the necessary change needed for better outcomes in future.

When trauma leads to psychiatric symptoms, interventions become necessary. In case of less severe symptoms nonpharmacologic interventions such as psychotherapy can suffice. In case of moderate to severe symptoms and a past history of psychiatric disorders, a combination of psychotherapy and medications is advised. For any intervention to be effective, it needs to adopt a gender and culture sensitive strategy along with a trauma informed approach.

Limitations and future Directions:

But country like India, still inadequate awareness towards the importance of mental health in women and its impact on future generations, significant stigma towards mental health disorders and its treatment, lot of misconceptions, myths and patriarchal approach. Also limited resources and trained personnel to provide comprehensive perinatal care including mental health screening.

Hence, Trauma screening and trauma focused approach and care are still at very much preliminary level and this chapter is one among the small, little initiative towards that goal.

Pre-conception Care needs lot more attention and awareness. We need Govt policies to incorporate this knowledge and promote care in this aspect not only among health professionals, among common public, family and at individual level for sensitization, identification and early interventions and more importantly in preventive aspects through societal change. Also by promoting resilience and resilience promoting therapies and life skill training, we should be able to make not only a strong current generation but also the future generation.

Finally, implementing a trauma-informed approach is a process of culture change, as it affects all aspects of an organization and its provision of services [46].

Key messages

1. Implementing a trauma-informed approach is a process of culture change. It includes *realization of* the widespread impact of trauma, *recognition* of the signs and symptoms of trauma and *responding* by fully integrating knowledge about trauma into policies, procedures, and practices, and to actively *resist* re traumatization.

2. Domestic violence, social stigma, and economic hardships exacerbate health issues for women of preconception age.

3. Anxiety, depression, PTSD and Severe mental illnesses can hinder women from engaging in healthy preconception behaviours.

4. Awareness about trauma along with a gender and culture sensitive tailored approach help women overcome barriers and improve preconception health. A proactive approach through preconception care, promoting healthy lifestyles, and addressing mental health needs can lead to not only a healthy pregnancy also will contribute significantly to the long-term health and resilience of both the mother and her future child.

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CHAPTER 7

Natal Trauma: Spanning Pregnancy to Childbirth

Abstract

Natal trauma can arise from various stressors and adverse experiences, ranging from complicated pregnancies and traumatic birth events to domestic violence. The impacts of psychological trauma during this time can manifest in conditions such as antenatal and postnatal anxiety and depression, post-traumatic stress disorder (PTSD) and mother-infant bonding disorders. Maternal trauma has far-reaching effects even across generations, influencing birth outcomes, brain development, and mental health. Trauma can be either directly related to pregnancy and its complications or traumatic events that are not directly related to pregnancy like Intimate partner violence. Negative childbirth experiences including disrespect and abuse during childbirth can also add to natal trauma. Addressing the psychological aspects of the natal period, healthcare providers can offer more holistic care, ensuring that mothers' emotional and mental well-being is prioritized alongside their physical health.

[**Keywords:** Natal trauma, Maternal mental health, PTSD, Anxiety, Depression]

Introduction

Reproduction is one of the most vital functionalities in a woman, forming a great part of her identity. While understanding psychological trauma through the gendered lens, it is paramount to understand the bearings of reproductive trauma as it is almost exclusively seen in women. Trauma during the natal period, comprising pregnancy and childbirth, is a critical yet often overlooked aspect of maternal health.

The natal period is a time of profound physical, emotional, and psychological transformation for expectant mothers. Though stressful experiences involving threats to one's physical or emotional integrity can occur any time in life, those occurring during the natal period would affect not only the woman but also her child and the entire family unit. Natal trauma can arise from various stressors and adverse experiences, ranging from complicated pregnancies and traumatic birth events to domestic violence. The impacts of psychological trauma during this time can manifest in conditions such as antenatal and postnatal anxiety and depression, post-traumatic stress

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disorder (PTSD), mother-infant bonding disorders, etc. The repercussions often lead to long-term mental health issues, difficulties in parent-child attachment, and strained family relationships. Maternal trauma has far-reaching effects even across generations, influencing birth outcomes, brain development, and mental health. It directly impacts infants' physiological regulation and indirectly affects both their behavioural and physiological regulation through increased maternal anxiety during pregnancy. Additionally, maternal trauma is linked to heightened infant reactivity, again mediated by elevated maternal anxiety during pregnancy[1].

The study done by Perera et al. on the impact of trauma on women revealed three main themes namely a) the effects of traumatic events on routine daily life during the perinatal period b) the psychological impact of these events on perinatal women like feelings of being overwhelmed, worried and having low mood and c) the pressure women feel to make the right decisions for their pregnancy and their baby including hypervigilance and helplessness[2].Thus, a deeper understanding of the causes and consequences of psychological trauma during the natal period is essential and helps in developing effective prevention and intervention strategies. In this chapter, we will try to elaborate on natal trauma constituting pregnancy and childbirth. For a better understanding, we would divide it into two sections – Trauma during the antenatal period and trauma during childbirth.

1. Trauma during pregnancy

Pregnant women with a history of childhood abuse face a twelve-fold higher risk of developing prenatal PTSD[3-5]. In a study involving 1,581 pregnant women from the community, pregnant women with histories of interpersonal trauma in the form of sexual abuse, physical or emotional abuse and foster placement were disproportionately found to have conditions like PTSD, major depression, generalized anxiety disorder, dissociation, somatization or affect dysregulation[3].

Traumatic experiences of women in the antenatal period are further elaborated under two main divisions –

Trauma directly related to pregnancy and its complications: perinatal loss including recurrent abortions and termination of pregnancy due to foetal anomalies, and other complications in pregnancy causing a threat to the life of the foetus or the woman.

Trauma not directly related to pregnancy: Intimate partner violence and domestic violence, pregnancies due to rape and sexual assault, natural disasters and pandemics, poor social support etc.

1.1 Pregnancy, loss and grief

A perinatal loss here refers to miscarriages, termination of pregnancy due to fetal anomaly (TOPFA) and the death of babies due to stillbirths. The death of a baby, whether during pregnancy, birth, or the neonatal period is profoundly devastating, often leading to feelings of guilt, disenfranchisement and betrayal by one's body. A meta-analysis of 144 studies highlights that bereaved parents face emotional isolation, compounded by a lack of mementoes and societal recognition of their loss. This grief is especially intense for mothers, who may also struggle with

a loss of self-esteem and a lingering physical connection to their deceased child. Themes that surfaced in prenatal grieving included conflicting emotions over choices made at the time of the baby's death, memory avoidance, worry about other children, fatigue and chronic pain and change in approach to using medical services[6,7].

Mothers face a sevenfold higher risk of PTSD after a perinatal death compared to those with a live birth. A review of 18 studies indicates that bereaved parents frequently experience self-blame, guilt and shame, which are linked to intensified grief. Following such loss, subsequent pregnancies can increase the risk of depression and anxiety in mothers. Grief can leave a profound existential impact, potentially leading to both post-traumatic growth and post-traumatic stress[8,9].

Those who opt for termination of pregnancy for foetal anomalies (TOPFA) often experience additional guilt and doubt. TOPFA is a traumatic event for mothers, as described in the article by Lafarge et al., wherein themes of trauma included a shattered world and losing and regaining control. Greater post-abortion sadness is substantially correlated with higher levels of self-judgment at the time of abortion[10,11].

Complicated grief is one of the major consequences of perinatal loss. Poor social support, lack of support from partners, nulliparous women, neurotic personality traits and ambivalent attitudes towards pregnancy are some of the risk factors contributing to complicated grief [12]. Effective communication with partners would be crucial, though many couples struggle to understand each other's grief. Improving support systems for bereaved women and the need for community advocacy to recognize perinatal grief is essential in this regard[13].

1.2 Pregnancy complications

Both short- and long-term psychological effects can result from early pregnancy difficulties such as miscarriage, ectopic pregnancies and hyperemesis gravidarum. It is more common for women who have previously experienced miscarriages to feel depressed and anxious during their next pregnancies. Ectopic pregnancy sufferers frequently struggle with mental health issues and low self-esteem, which can exacerbate anxiety and depression. Women's mental health may be negatively impacted by hyperemesis gravidarum, as seen by greater rates of severe depression and generalized anxiety disorder[14]. Late pregnancy complications like preterm birth are also known to act as traumatic factors. Women have reported reliving the trauma of their infant in the Neonatal Intensive Care Unit, hypervigilance and a lack of support when their infant transitioned home [15]. Thus, recognizing and addressing the psychological consequences of a woman going through pregnancy complications would be as important as addressing her physical health concerns.

1.3 Violence during the antenatal period – Intimate partner violence (IPV) and Domestic Violence (DV)

Any form of violence against a woman by her partner or close family is known to have hazardous effects not only on her physical and mental health but also on the entire family's integrity. Pregnancy becomes even more a vulnerable period for women to become victims of violence, with nearly

three out of ten pregnant women experiencing violence[16].The prevalence of IPV in pregnant women across the world ranges from 4 to 30%, as reported in various studies[17-19]. The rates of the same in adolescents in Africa ranged from 8.3% to 41% [20]. It is important to note that the actual rates may be much higher as IPV often goes unreported. With rates as high as 65%, domestic violence is far more common. In an Ethiopian study, physical violence was shown to be the most common type of violence (44.1%), followed by psychological (39.1%) and sexual (23.7%) violence[21,22]. In India, studies have reported IPV prevalence rates of 15-25% during pregnancy. In one of the Indian studies, 14% of women experienced physical assault, 15% reported psychological abuse, and 9% reported sexual coercion[23,24].

Pregnancy due to rape

Rape-related pregnancy is a leading cause of unintended pregnancies and is strongly linked to domestic and family violence. In their lives, 2.9 million American women (2.4%) had become pregnant because of rape; 77.3% of these cases included an intimate partner, either current or past. Those who were raped by an acquaintance (5.2%) or stranger (6.9%) were less likely to report rape-related pregnancy than intimate relationship rape victims (26.2%), and those who were subjected to reproductive coercion were more likely to become pregnant[25,26].

Risk factors

Several risk factors for IPV and DV in women during pregnancy have been identified in various studies. Partner risk factors include daily consumption of alcohol, aggressive and controlling behaviours, partners who used tobacco, occupation status (farmer and self employed), being illiterate, history of crime and arrests, history of violence in the family and spurious justification for violence[18,19, 21, 23, 24] .Risk factors in victims include younger age, poverty, foreign women, unemployed individuals, homemakers and university students, a substantial age difference (> ten years) in the couple, a history of abortions or adverse pregnancy outcomes, unwanted pregnancy, substance use , witnessing abuse as a child, adolescent pregnancy, low self-esteem, poor coping strategies and low social support[20,22,27,28].

Consequences

The impact of IPV/DV can be tremendous both on the pregnancy outcome and the well-being of the woman. Adverse birth outcomes include vaginal bleeding, premature rupture of membranes, low birth weight, preterm birth, stillbirth and less breastfeeding[28].Maternal health can be affected by violence in pregnancy as reflected by long-term physical disabilities, hospitalization or surgeries, chronic pain, higher odds of postpartum depression, antenatal anxiety and depression, higher rates of PTSD, reduced quality of life, risk of self-harm and suicide[29,30] Reproductive health complications such as sexually transmitted infections (STIs), unintended pregnancy and induced abortions can also be adverse outcomes of IPV/DV in pregnancy. IPV can also cause long-term social, emotional and cognitive problems in the child by negatively affecting the mother-infant relationship and the development of the baby[30-33]. Intimate partner violence during pregnancy significantly increases the risk of maternal morbidity and mortality due to severe injuries such as

fractures, internal bleeding and head trauma, as well as pregnancy-related complications. The World Health Organization (WHO) has reported IPV as a notable risk factor in pregnancy-related mortality in women. Hence, it becomes essential for healthcare providers to routinely screen for IPV during prenatal care to improve maternal and foetal health outcomes and reduce maternal mortality. Comprehensive IPV prevention programs, including public education, legal services, counselling and emergency shelters, can effectively reduce the occurrence of IPV during pregnancy through prevention, early intervention and long-term support.[34,35]

1.4 Natural disasters during pregnancy

The outcomes of disaster exposure are complex and may take years to resolve, with individuals often experiencing increased stress and forming beliefs about the event's causes and effects. Natural disasters significantly disturb social and psychological well-being, with women and children particularly affected, leading to issues like PTSD. Experiencing a natural disaster during pregnancy adds further complexity, disrupting routines and roles during a critical time and creating additional challenges due to limited mobility. The compounded stress from trauma during pregnancy is a form of double jeopardization and can have long-term, intergenerational impacts. Women may experience pregnancy complications due to heightened stress, such as IUGR and preterm delivery. Fears related to separation from family, losing homes and possessions, running out of fuel and concerns for their baby's well-being, which underscored their values of family connection, child safety and home protection amidst uncontrollable external circumstances, may be commonly seen in such women[36].A qualitative study done during Hurricane Maria described five significant themes that emerged from the pregnant women's lived experiences: the meaning of living through a disaster, fear of pregnancy loss, the burden of protecting themselves and their foetus, disruption in health care, and coping mechanisms[37].

COVID-19 pandemic and pregnancy

Pregnant women were one of the most impacted groups during the COVID-19 pandemic due to the drastic changes that occurred in maternity care pathways. COVID-19 was associated with adverse pregnancy outcomes like preeclampsia, preterm and stillbirth, gestational diabetes and low birth weight.[38] Implementing safety measures like lockdowns, quarantines, and travel bans due to the pandemic drastically altered daily life, increasing isolation and reduced access to maternity care services. Strict restrictions on antenatal, intrapartum and postnatal care, such as isolation, fewer appointments, and limited hospital access for birth partners, contributed to negative feelings. An online survey of Italian pregnant women revealed that while childbirth expectations pre-pandemic were marked by joy and safety, post-pandemic feelings were dominated by fear, loneliness, anxiety and worry[39,40]. Obstetricians from India had reported that the most common concerns that perinatal women had during the pandemic were about hospital visits, methods of protection, the safety of the child, anxieties related to social media messages and contracting the infection[41]. Thus, the trauma of going through the pandemic during their antenatal period resulted in significant physical and psychological complications in women, the aftermath of which continued.

2. Trauma during childbirth

Even though most women consider giving birth as a satisfying and rewarding experience, for others, it has been considered as a distressing negative experience or a traumatic event [42].

2.1 Fear of childbirth and tokophobia

'Fear of childbirth' (FOC) during pregnancy is something that any woman can have in anticipation of a difficult experience such as childbirth. However, extreme fear of childbirth or fear of death during parturition is termed 'Tokophobia'. Some even opine that tokophobia is not merely a phobic disorder but a kind of overvalued idea. [43] Tokophobia is often associated with anxiety, depression, PTSD, avoidance of pregnancy or, in severe cases, even termination of pregnancy[44].Tokophobia can be primary (pre-dating pregnancy) or secondary (after a traumatic childbirth). Findings from a study by Ibrahim et al. showed that substantial FOC was more common in nulliparous women (80%) than in multiparous women (67.8%). Key elements of fear of childbirth differed significantly between nulliparous and multiparous women, with higher levels of fear related to harming the infant, pain, the body's ability to give birth, clinical procedures, lack of involvement in decision-making, loneliness, loss of control and the fear of unknown observed in nulliparous participants. Unplanned pregnancy was one of the significant risk factors found in women who had FOC [45].A qualitative study done on women with a primary fear of childbirth revealed the following main themes – Expecting the worst and doubting one's abilities to cope with it; Trying to cope with fear and the risk of becoming pregnant; Missing and wishing for support from maternal health care services; and Negotiating with oneself by living with the consequence of either choice[46]. Hence, providing early support to such women can increase the likelihood of interrupting negative patterns and positively influencing a woman's reproductive life[46].

2.2 Traumatic Childbirth or Negative Childbirth Experience

Birth trauma is defined as *"an event occurring during the labour and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror".* This definition was later revised to also include *an event during labour and delivery where the woman perceives she is stripped of her dignity[47].* Childbirth as a traumatic event in some women can include things like excruciating pain that is out of control, a protracted state of extreme worry, uncertainty about the near future, losing control and being unable to keep an eye or in touch with the surroundings. Labour pain is one of the most intense forms of pain a human being can experience, explaining how a pleasurable milestone such as motherhood and childbearing could be traumatizing[48]. Research shows that nearly 30-50% of the prevalence of traumatic childbirth in various populations. Apart from acknowledging the presence of negative childbirth experiences, the impact of the same also needs to be studied with equal importance. There have been reports in the last two decades on how a traumatic experience of delivery could lead to psychological problems in the form of PTSD, anxiety and depression[49-52].

2.3 PTSD following negative childbirth experience

A review of literature across various studies indicates that the presence of PTSD symptoms can be up to 20%, and a diagnosis of complete PTSD can be made in 2-6% of the population [50,53,54]. Risk factors associated with childbirth-related PTSD include pre-natal, peri-partum and post-natal factors. A meta-analysis reported antenatal depression, fear of childbirth, complications in pregnancy, history of trauma or sexual abuse in the past and lack of counselling for problems associated with previous pregnancy or birth as significant pre-birth vulnerability factors. Risk factors associated at the time of birth included negative subjective birth experiences, operative birth, lack of support and dissociation. After birth, PTSD was associated with less social support and poor coping and was highly co-morbid with depression[55].Mothers with PTSD from childbirth face daily struggles, including nightmares, flashbacks, anger, anxiety, depression and isolation. This condition often leads to emotional detachment from partners and babies, fear of future pregnancies, avoidance of sex and preference for caesarean sections to avoid traumatic vaginal deliveries. PTSD after childbirth is associated with significant functional impairment, comorbidity, higher rates of suicidality, increased healthcare utilization and work absenteeism. Additionally, traumatic childbirth and PTSD negatively impact maternal-infant bonding and breastfeeding[47,54,56,57]. Primary prevention efforts, such as screening for antenatal risk factors and using trauma-informed care, aim to prevent traumatic childbirth experiences and related PTSD by mitigating risk factors. Secondary and tertiary prevention approaches including trauma-focused therapies and evidence-based psychological interventions like cognitive behavioural therapy are effective[58].

2.4 Disrespect and abuse during childbirth

"Disrespect and abuse during maternity care", "Obstetric violence", or "Mistreatment during childbirth" are various terminologies used to denote disruptions and violations of Respectful Maternal Care guidelines given by the WHO. Obstetric Violence is one of the major factors contributing to traumatic childbirth experiences of women. Mistreatment of women during childbirth is indicative of greater abuses of human rights, as well as a problem with the quality of care provided[59]. Violence committed by healthcare professionals impacts health service access, compliance, quality, and effectiveness in addition to the lack of resources[60]. The prevalence of such mistreatment during childbirth is reported up to 50-70% across studies[60-64].

Bowser and Hill conducted a landscape analysis in which they identified seven forms of abusive and disrespectful treatment that women receive after childbirth: physical abuse, discrimination, abandonment, non-consented clinical care, non-confidential care, non-dignified care and imprisonment in medical institutions[65]. Women from India described their bad experiences during delivery through unconsented interventions, unanaesthetised episiotomy, repairs and uterine exploration, verbal, physical and sexual abuse, extortion, detention and lack of privacy[66]. Another

study on women's narratives suggested determinants of care through the four themes: Influence of power, gender, status and structure and influence of culture on care during childbirth[67].Having understood the significant impact of negative childbirth experiences, it becomes very important to develop strategies to create positive birth experiences and provide respectful maternity care to all women. Supporting childbearing women, providing relaxation and pain relief, minimizing obstetric interventions and ensuring birth preparedness are helpful[68].

Implementing trauma-informed care in perinatal settings involves providing targeted interventions and specialized support for trauma survivors. Programs like To-CARE offer cognitive-behavioural therapy techniques and practical skills, such as relaxation and assertive communication, tailored for pregnant women with trauma histories. This program also trains obstetrical providers to support these skills and enhance patient control. Similarly, the Survivor Moms Companion (SMC) program provides psychoeducation through workbook modules and tutoring sessions, focusing on trauma symptom management and improving psychological and perinatal outcomes. Both programs have shown to improve women's sense of empowerment, communication with providers, and overall mental health, while enhancing their labour and postpartum experiences positively, along with bonding with their infants [69-71].

Conclusion

The often-untold side of motherhood and childbirth can be a traumatic experience. Therefore, it is crucial for us, as mental health professionals, to investigate and understand women's experiences during pregnancy and childbirth. By addressing the psychological aspects of the natal period, healthcare providers can offer more holistic care, ensuring that mothers' emotional and mental well-being is prioritized alongside their physical health. This comprehensive approach is vital for fostering healthier outcomes for mothers, infants and families and for breaking the cycle of trauma that can have intergenerational effects as well.

Key messages

- Natal trauma can arise from various stressors and adverse experiences directly related to pregnancy or traumatic events not associated with pregnancy, like domestic violence.
- The impact of trauma has a significant effect on maternal health such as depression, anxiety and post-traumatic stress disorders.
- The impact of the traumatic events is not limited to the mother alone but to the infants and the family.
- It is essential to recognise experiences of pregnancy and childbirth and its mental health sequelae.
- Comprehensive approach is vital for fostering healthier outcomes for mothers, infants and families and for breaking the cycle of trauma that can have intergenerational effects.

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CHAPTER 8

Postnatal Trauma: Postpartum And Motherhood

ABSTRACT

Postnatal trauma, encompassing both postpartum and broader motherhood experiences, presents significant challenges to maternal mental health. Trauma from childbirth experiences can significantly affect women's emotional well-being and bonding with their infants. Traumatic childbirth events can evoke distressing emotions, leading to short- and long-term adverse effects on health. Between 9% and 50% of women face traumatic childbirth, with some developing posttraumatic stress disorder (PTSD). The most substantial risk factors during birth were a negative subjective birth experience, having an operative birth (i.e. assisted vaginal or caesarean section), lack of support during birth, and dissociative experiences. PTSD was associated with poor coping and stress and is comorbid with depression. As a consequence, postnatal depression, anxiety disorders, and PTSD affect both mother and child. Assessment tools and prevention strategies like trauma-informed care and therapy can help manage trauma. Healthcare providers must recognise and support women to prevent long-lasting consequences for both mother and child.

[Keywords: Postnatal, postpartum, Trauma, PTSD, Maternal mental health**]**

INTRODUCTION

Childbirth is a deeply impactful experience that has physical, psychological, social, and existential effects in the short and long term, leaving enduring memories for women[1].The childbirth experience can be positive and empowering, but it also has the potential to be negative and traumatic, leading to stress and emotional well-being challenges.

The World Health Organization (WHO) cites a "positive childbirth experience" as the end point for all women undergoing labour. A" positive childbirth experience" being defined as one that fulfils or exceeds a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment with support from the family/partner and supportive healthcare system. Attachment and bonding are terms often used interchangeably to describe the relationship between mothers and infants. Bonding is understood

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to be more about a mother's feelings towards her baby whereas attachment relates to infants' relationship with the primary caregiver ie mother.

Traumatic childbirth can result in fear of future births, depression, increased requests for caesarean deliveries, reduced bonding and maybe reduced breastfeeding. Research indicates that psychological trauma during childbirth affecting maternal bonding and infant attachment can lead to long-term issues such as poor child development and sleep problems in infants[2].

Despite the high incidence and potential widespread and long-lasting effects, birth trauma is poorly recognised and insufficiently treated. Birth trauma can trigger ongoing psychosocial symptoms in women, including anxiety, tokophobia, bonding difficulties, relationship issues and PTSD. Additionally, women's future fertility choices can be inhibited by birth trauma [3].

Many people feel unprepared for their birth experience, and as many as one in three people report feeling traumatised after giving birth.Feeling upset or distressed by what happened when a woman was giving birth may mean she is experiencing birth trauma. Every person's experience is different, but both physical and emotional experiences can trigger trauma. It might be that her birth was long and intense, that she had an unplanned intervention, that she wasn't looked after or listened to in labour, or perhaps there were concerns about the safety of her or the baby[2].The trauma experienced by mothers after giving birth has a long-lasting impact on their well-being. This trauma is often worsened by gender bias, such as societal discrimination based on the sex of the newborn, inadequate maternity leave, and a lack of emotional support from partners and fathers. Middle-class women, in particular, need strong social support networks, especially from their mothers, to effectively deal with the challenges of the postpartum period.

In India, the family has a vital role during this time; daughters develop a strong dependence on their mothers beyond caregiving as they learn essential survival strategies. Significant transformation can occur if societies acknowledge and replicate the cultural dynamics and maternal interactions observed during the postpartum phase. It is crucial to recognise the pivotal role of a woman's mother in providing support during this phase[4] .Raising awareness and implementing best practices, including extended care for older, employed, or caesarean delivery mothers, is important. These findings emphasise the critical importance of familial support for the well-being of middle-class birth mothers, creating a safer and more nurturing environment for everyone involved. Rural Indian women experience postpartum depression, postpartum anxiety and/or both, which causes stress and impacts their functionality, bonding with the infant and relationship with their spouse and parents. Higher education, marital satisfaction and higher support from partners and in-laws reduce the risk of developing postpartum depression/anxiety and /or both[5].

A traumatic birth has been defined as "a woman's experience of interactions and events directly related to childbirth that caused overwhelming distressing emotions and reactions, leading to short- and/or long-term negative impacts on a woman's health and wellbeing." Alternatively, we can use DSM-5 criteria in which childbirth is deemed traumatic if there is a perceived threat to the life of the mother and/or the infant and/or if severe physical injury occurred[2].The expression of

birth trauma can extend beyond a solitary event. It can encompass a cumulative series of triggering events, such as distressing incidents during labour leading to interventions like vacuum extraction. Additionally, it can involve experiences that rekindle past trauma, such as routine maternity procedures like internal examinations during pregnancy or labour, particularly for survivors of sexual abuse. While birth trauma can stem from physical experiences, the subjective or psychological aspects of the trauma may hold greater significance.

As Beck articulated, trauma is often subjective, with its severity perceived through the individual's lens[6]. Research indicates that between 9% and 50% of women encounter traumatic experiences during childbirth[2].Between three to four per cent of pregnant women in community samples and 15% to 19% of women in high-risk samples, which include women with complications of pregnancy or birth, may develop post-traumatic stress disorder (PTSD) following traumatic childbirth experiences. This suggests that women who develop symptoms severe enough to meet the criteria for a diagnosis of PTSD after childbirth represent a subset of a larger group of women who perceive childbirth as traumatic. Yet, their symptoms do not reach the threshold for a formal PTSD diagnosis[2].

RISK FACTORS OF BIRTH TRAUMA

Risk factors that influence women's perceptions of their childbirth experiences as traumatic can be divided into the following categories.

1. PRENATAL FACTORS:

Prenatal anxiety, depression in pregnancy, poor health, complications of pregnancy (e.g., preeclampsia), prior traumatic deliveries, and child sexual abuse are among the common causes that fall under the prenatal causes of maternal post-traumatic stress disorder following childbirth (PTSD-FC).PTSD-FC is higher in mothers who have experienced a traumatic event compared to mothers who have not. A systematic review of risk factors for childbirth-induced PTSD showed that previous exposure to trauma is a significant risk factor for developing PTSD following childbirth.[7]

Experiencing multiple traumatic events, a history of sexual trauma,[8] traumatic experiences during childhood or childhood maltreatment could increase the likelihood of developing PTSD following childbirth. Partners who experienced past traumatic events also have significantly higher scores on the CBTS(City Birth Trauma Scale by Ayers et al) total scale compared to partners who did not experience past traumas. These results highlight the past traumatic events as a factor increasing the likelihood of possible PTSD following childbirth in partners. The mental health of both parents is crucial for a child's development. It is, therefore, important to be vigilant about the traumatic background of mothers and their partners while preparing for childbirth.[7]A higher number of lifetime traumatic events was associated with higher EPDS scores, and good social support was found to have a negative association between the predictor and the outcome of postpartum depressive symptoms in a study from south India. [9]

2. THE TYPE AND CIRCUMSTANCES OF THE DELIVERY.:

A high degree of medical intervention, particularly painful labour and delivery viz vaginal tears, haemorrhage, emergency hysterectomy and the type of delivery like vacuum/forceps and circumstances of the birth are among the factors that fall under this category. An emergency caesarean delivery, a preterm birth, or any event that puts the life of the mother or baby at risk can be deemed traumatic to the mother. Childbirth injuries, pelvic infections and pain, pelvic floor dysfunction would also be included in postnatal physical trauma. Also, neonate factors like the cord around the neck needed for NICU can be risk factors.[10]

Mothers of preterm neonates admitted to the NICU have significantly higher levels of stress, anxiety, and depression.[11]

3. SUBJECTIVE FACTORS EXPERIENCED DURING CHILDBIRTH:

Subjective risk factors during childbirth include the dread of dying, a sense of helplessness, and a lack of compassion and support from the labour and delivery team .Resilience or the ability to bounce back can be a factor in reducing/preventing PTSD. It was associated with greater positive emotion, optimism, active coping, cognitive reappraisal, altruism, mastery, social support, facing fears and having a sense of purpose or meaning. There are also genetic, epigenetic and environmental factors associated with resilience [13].When women evaluate their delivery, four factors predominate, viz. availability of support, quality of relationships, being involved in caregiving, expectations [15].A multivariate model showed that the presence of PP-PTSD was the strongest risk factor for PPD symptoms and vice versa. Other risk factors for PPD included low sleep quality, low social support and newborn incubator admission. In terms of PP-PTSD symptoms, risk factors included the presence of PPD symptoms and low social support, while having one child was a protective factor.

SYMPTOMS OF PSYCHOLOGICAL BIRTH TRAUMA

Birth trauma is often used interchangeably with the terms post-traumatic stress symptoms (PTSS) and post-traumatic stress disorder (PTSD). However, the perception of birth as traumatic does not necessarily mean women will experience PTSS or PTSD. Symptoms of PTSS include re-experiencing, avoidance, hyperarousal, and negative alterations in mood and thinking. PTSD acute symptoms are seen in 5-8% and posttraumatic stress symptoms in 9-27%.[16]Weariness, bewilderment, melancholy, worry, agitation, numbness, detachment, disorientation, bodily arousal, and muted affect are some of the initial reactions to trauma. The majority of reactions are self-limited and quite typical. More severe reactions are characterised by acute intrusive memories that persist even after returning to safety, significant dissociation symptoms, and constant anxiety without intervals of relative calm or relaxation. Prolonged exhaustion, sleep disturbances, nightmares, fear of recurrence, anxiety centred on flashbacks, sadness, and avoiding feelings, experiences, or activities even slightly connected to the trauma are examples of delayed reactions to trauma.[17]

PSYCHIATRIC MANIFESTATIONS OF BIRTH TRAUMA

The psychological issues resulting from childbirth take time to manifest. People often ignore some early symptoms without seeking medical attention until severe conditions like postnatal depression or PTSD cause significant distress in life[13].Postnatal depression, which affects 6% to 13% of women after giving birth, has received most of the attention in discussions regarding mental health problems after childbirth thus far. However, women who have recently given birth may face a variety of psychological issues. These issues include eating disorders like anorexia nervosa, schizophrenia, and bipolar disorder, as well as anxiety disorders like obsessive-compulsive disorder and PTSD (NICE 2007). The most significant severe psychological conditions linked to delivery are severe postnatal depression and puerperal psychosis.However, co-morbidity with other psychological trauma during the postnatal period may go unnoticed, or its connection to postnatal depression may be disregarded[14].

Four categories of symptoms are associated with PTSD: hyperarousal, poor mood and cognitive changes, avoiding reminders of the traumatic event, and reliving the traumatic event. The DSM-5 states that to be diagnosed with PTSD, a patient must exhibit at least one reexperiencing symptom, one avoidance symptom, at least two symptoms of negative mood and cognitive changes, and two symptoms of hyperarousal. According to the most current meta-analysis, 1.2% of fathers and 3% to 6% of mothers experience PTSD connected to childbirth[15].

IMPACT OF TRAUMATIC BIRTH:

Trauma related to childbirth has been linked to postpartum morbidity in mothers in terms of depression, suicidal ideation, anger and guilt, as well as signs of PTSD. Mother infant bonding, breast feeding can be impacted. Additionally, relationship issues with partners and children have an impact on subsequent pregnancies and deliveries and impact the child, too. They can have difficulty in emotion regulation, internalising and externalising problems, and PTSD[18].Due to their long-lasting effects on several biological systems, including the HPA axis, maternal PTSD during the perinatal period may even raise the risk of physical health issues in newborns[17].PTSD has also been linked to preterm birth, low birth weight, poor foetal growth, and a composite of eating and sleeping issues, according to a meta-analysis of 21 studies [19].

ASSESSMENT OF POSTNATAL TRAUMA

Traumatic birth experiences and childbirth-related PTSD remain largely unrecognised in maternity services and are not routinely screened for during pregnancy and the postpartum period. Those affected are, therefore, not routinely identified or treated for childbirth-related PTSD. A psychiatric diagnosis of childbirth-related PTSD is made using the diagnostic criteria shown in childbirth as the index trauma. Symptoms of PTSD must be experienced for at least 1 month to distinguish it from acute stress responses, such as acute stress disorder. The 1-month timeframe also allows for nontreatment-related remission, which occurs in approximately 44% of those with PTSD symptoms. Barriers to identification include a lack of awareness of childbirth-related PTSD among women and health professionals, a lack of consensus on the best way to screen for

childbirth-related PTSD, and a lack of clinical guidelines for the assessment and treatment of childbirth-related PTSD.

The Postnatal Risk Questionnaire (PNRQ), which addresses several risk factors for psychological birth trauma, may be used to determine a person's likelihood of enduring a traumatic birth experience.

There are diagnostic tools available, such as the City Birth Trauma Scale, Traumatic Events Scale, Impact of Events Scale, Davidson's Trauma Scale, Clinician administered PTSD scale, and Perinatal PTSD Questionnaire to evaluate clinical disorders and PTSD symptoms in women who have suffered trauma during childbirth.

The City Birth Trauma Scale (CBTS) is a self-reported questionnaire developed by Ayers et al. in response to the need for an instrument for assessing PTSD following childbirth. This scale includes 31 items, 29 of which correspond to the diagnostic criteria for PTSD according to the DSM-5 (including intrusion, avoidance, negative cognition and mood, and hyperarousal), as well as additional questions to assess the subjective criterion and symptoms of emotional insensitivity. Of the 31 items, 23 are based on a Likert-type scale (0 = not at all, to 3 = 5 or more times). The questionnaire has two subscales to evaluate general and birth-related symptoms (score range 0–69). The response scale for symptoms asks for the frequency of symptoms over the last week. The highest score reveals a higher risk for PTSD. An additional questionnaire for partners was also developed. It helps identify women and partners with PTSD-FC. The psychometric properties have been evaluated and validated by Ayers et al [20].

PREVENTION

It is critical to identify and assist women experiencing trauma due to childbirth as soon as possible. Healthcare professionals need to be alert to signs of psychological birth trauma, including dazed appearance, withdrawal, temporary amnesia, and detachment from the baby, during the postpartum hospital stay. A mother needs to be made aware of any psychological damage if she has undergone complicated childbirth, including problems for both her and her newborn. It is possible for past trauma to resurface during pregnancy and childbirth, causing women, partners, and delivery givers to relive the trauma. Therefore, to reduce re-traumatisation and/or avoid the occurrence of new trauma, physicians must identify patients who are at an elevated risk and execute care regimens accordingly. Therefore, postnatal care is beginning to pay attention to the idea of trauma-informed care .Healthcare providers should inquire proactively with women about whether they experienced previous childbirth as traumatic. Mothers may be reluctant to open up about their birth experience for fear of criticism of their parenting. It is advised that healthcare providers inquire about mothers' well-being and assess their delivery experiences at postnatal and well-baby check-ups and yearly physical examinations; paediatric practitioners may be in a unique position to recognise women who exhibit heightened symptoms of posttraumatic stress disorder and to make the necessary recommendations for mental health treatment [20].

First-time mothers' satisfaction with postnatal care and their confidence as new mothers were

primarily influenced not by the extent to which their expectations were met but by the varied extent to which their postnatal needs were met. Rapid and responsive assessment of needs both antenatally and postnatally, as well as appropriate adjustment of care, is key to supporting women effectively at this time[21].There is firm evidence to suggest that midwifery or clinician-led early psychological interventions administered within 72 hours following traumatic childbirth are more effective than usual care in reducing traumatic stress symptoms in women at 4–6 weeks. Further studies of high methodological quality that include longer follow-ups of 6–12 months are required to substantiate the evidence of the effectiveness of specific face-to-face and online early psychological intervention modalities in preventing the effects of stress symptoms and PTSD in women following a traumatic birth before introduction to routine care and practice[22].

Counselling has been reported to be an effective approach to the treatment of psychological birth trauma. In this regard, the counselling approach proposed by Gamble et al. is considered to be a highly contributing technique to the reduction of the psychological disorders associated with childbirth trauma. This counselling strategy allows women to talk about their experiences and emotions. At the same time, the counsellor increases their awareness so that they can have an insight into childbirth events and their correlations with their personal feelings and behaviours[23].Debriefing, promoting skin-to-skin contact with healthy babies immediately after delivery, structured psychological interventions, expressive writing, and seeing or holding the baby after stillbirth are some of the interventions that were examined in a recent systematic review to help prevent women who have recently experienced a traumatic birth from developing PTSD.[24] The findings demonstrated that the studied sample characteristics were highly heterogeneous and that the therapies' respective levels of efficacy varied. They found inadequate data to support the possibility of structured psychological therapies, expressive writing, and increasing skin-to-skin contact with healthy babies immediately postpartum as helpful interventions. The usefulness of counselling based on Gamble's approach in reducing psychological birth trauma in primiparas was recently supported by a study.[23] Integrating the counselling technique into healthcare programs may be beneficial because it is affordable, simple to use, and accessible to midwives. Improving the interveners' knowledge and skill sets is imperative to guarantee the intervention's effectiveness. In addition, the content, duration, frequency, and timing of intervention are significant elements that impact the effectiveness of the intervention, and further studies are needed to find the ideal programs.

MANAGEMENT

POSTNATAL DEBRIEFING

All health professionals need to be aware of the signs and symptoms of mental health problems postpartum, including psychosis, depression, anxiety and PTSD. It allows ventilation on the experience of childbirth and reflection on the same.

NON DIRECTIVE COUNSELLING

Non directive counselling, which can include supportive listening interventions, aims to provide

a safe space for women to narrate their experiences to a supportive other. It does not offer direct input to reprocess, challenge, or recall the delivery. While non directive counselling approaches may be utilised within a postnatal debriefing approach, they are more limited, with no planned focus on remembering and discussing specific aspects of childbirth.

TRAUMA-INFORMED CARE

The four fundamental tenets of trauma-informed care, or the "four Rs," are as follows:

(1) Realization of the pervasiveness of trauma.

(2) Recognising unresolved trauma.

(3) Responding by applying knowledge to practice; and

(4) Resisting re-traumatization.

When an institution adopts a trauma-informed approach to care, all of its employees must be aware of the pervasiveness of trauma, its repercussions, and how it affects not just people but also families and organisations. i.e. the first R The traumatic event or events may have happened recently, or they may have occurred in the past (for example, sexual abuse, domestic violence, or unfavourable childhood experiences).

The second R is designed to help staff recognise symptoms that indicate a trauma, including agitation, irritability, anxiety or depression, anger, sweating or palpitations, flashbacks, reliving the trauma, difficulty focusing or trusting others, numbness, and feelings of guilt or shame.

To support patients, families, and staff, it is imperative that the organisation as a whole respond (third R) by incorporating trauma knowledge into its structures, policies, and practices.

Lastly, by incorporating a trauma-informed approach into the care given, the organisation hopes to prevent the re-traumatisation of individuals (and groups) by assisting staff in identifying organisational practices that could bring up painful memories for those who have experienced trauma in the past. Organisational support is necessary for physicians to adopt a trauma-informed approach to care. Though trauma-informed methods seem sensible on the surface, not much study has been done to determine whether or not these methods lessen PTSD associated with childbirth.[25]

COGNITIVE BEHAVIOURAL THERAPY

Women who have experienced traumatic births may be provided cognitive behavioural therapy (CBT) therapies[26]. Although these are often very structured and provide women the chance to talk about their feelings and ideas surrounding the delivery, they are not the same as psychological debriefing because they don't follow the above-mentioned formal steps or concentrate on processing emotions. Instead, they focus on recognising maladaptive ideas and feelings that could be subject to reframing and questioning.

EYE MOVEMENT DESENSITISATION AND REPROCESSING

Eye Movement Desensitization and Reprocessing (TF-EMDR) is a standardised protocol used to reduce childbirth-related traumatic stress in postpartum women. It involves focusing on traumatic memories and receiving bilateral eye stimulation. Consecutive EMDR sessions have shown positive outcomes in affected women.[28] Identification of high-risk women for identification can help in the adequate and appropriate allocation of resources.

MEDICATIONS

Antidepressants and/or antianxiety medication can be instituted as support even as non-pharmacological interventions are planned after adequate counselling and psychoeducation.

CONCLUSION:

The exploration of postnatal trauma, encompassing both postpartum and motherhood experiences, underscores the critical need for comprehensive maternal mental health care. A significant proportion of new mothers endure trauma-related symptoms due to childbirth complications and the broader challenges of transitioning into motherhood. The impact of postnatal trauma extends beyond immediate postpartum distress, potentially leading to long-term psychological issues such as anxiety, depression, and difficulties in mother-infant bonding[29].By recognising and addressing postnatal trauma, healthcare providers can significantly improve the quality of life for mothers, promoting healthier outcomes for mothers, their infants and their partners. There is a need to explore tailored interventions and preventive measures to ensure that maternal mental health remains a priority in postnatal care. In the end, proactively addressing maternal mental health with empathy and compassion can strengthen moms and promote resilience and overall well-being during the critical early phases of parenthood.

Key Messages

Postnatal trauma refers to the physical trauma, psychological anxiety and distress experienced during a traumatic birthing process, and it can be avoided or reduced by preparing for birth to instil a sense of control..Postnatal depression, anxiety ,posttraumatic stress disorder or posttraumatic stress symptoms can present significantly impacting the mother meriting intensive intervention. Motherhood viz mother infant bonding, breastfeeding, relationships with the partner and others and parenting can be affected. The infant's development can also get affected as a consequence .So it's important to acknowledge distress and seek help and support when needed.Unlike other perinatal psychiatric disorders, there is an opportunity to prevent childbirth-related PTSD by identifying individuals at risk and implementing a care plan.Several interventions for postnatal trauma, such as expressive writing exercises immediately after giving birth and structured psychological interventions, could be effective in prevention and treatment.Trauma-informed care and Eye Movement Desensitization and Reprocessing (EMDR) can also help in specific cases when combined with psychiatric medication support after early identification and evaluation.

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KEY MESSAGE

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Postnatal depression, anxiety ,posttraumatic stress disorder or posttraumatic stress symptoms can present significantly impacting the mother meriting intensive intervention. Motherhood viz mother infant bonding, breastfeeding, relationships with the partner and others and parenting can be affected

The infant's development can also get affected as a consequence

It's important to acknowledge distress and seek help and support when needed.

Unlike other perinatal psychiatric disorders, there is an opportunity to prevent childbirth-related PTSD by identifying individuals at risk and implementing a care plan.

Several interventions for postnatal trauma, such as expressive writing exercises immediately after giving birth and structured psychological interventions, could be effective in prevention and treatment.

Trauma-informed care and Eye Movement Desensitization and Reprocessing (EMDR) can also help in specific cases when combined with psychiatric medication support after early identification and evaluation.

CHAPTER 9

Navigating Organizational Trauma: The Interplay of Women of Childbearing Age and Career Progression

Abstract

This chapter delves into the complex interplay between organizational trauma and women of childbearing age, examining the challenges they face in navigating their careers amidst systemic inequalities, biases, and societal expectations. Organizational trauma encompasses a range of adverse experiences within the workplace, including discrimination, harassment, and work-life conflict, which disproportionately impact women in the reproductive age group. Drawing on intersectional perspectives, this chapter explores the unique dynamics that shape women's experiences of organizational trauma, considering the intersections of gender, race, ethnicity, and socioeconomic status. Through an examination of structural, cultural, and interpersonal factors, we illuminate the ways in which organizational trauma undermines women's well-being, professional advancement, and sense of belonging within the workforce. The chapter also identifies strategies and interventions for addressing organizational trauma, including promoting diversity and inclusion, implementing supportive work-life policies, and fostering a culture of respect and empathy. By understanding the complex interplay between organizational trauma and women in childbearing age, we can work towards creating more equitable and supportive work environments where all individuals can thrive.

[**Keywords:** Organizational trauma, Women , Childbearing years , Career]

I: Introduction

In the modern workplace, the concept of organizational trauma has emerged as a significant area of concern, particularly for women navigating the delicate balance between their reproductive choices and professional aspirations. This chapter delves into the intricate intersectionality of organizational trauma, women of childbearing age, and career advancement, shedding light on the nuanced challenges they face.

Firstly, we will establish a comprehensive understanding of organizational trauma, illuminating its multifaceted nature and impact within the context of the workplace. Organizational trauma

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encompasses a range of experiences, from toxic work environments and harassment to systemic inequalities and discrimination, all of which can profoundly affect an individual's well-being and career trajectory.

Next, we will explore the demographic of women in the reproductive age group, delving into the unique dynamics and pressures they encounter. Women of childbearing age often find themselves at a critical juncture, grappling with the desire to pursue their professional ambitions while contending with the biological realities of fertility and family planning. This demographic is particularly vulnerable to the effects of organizational trauma, as they navigate the delicate balance between their personal and professional lives.

One of the central conflicts examined in this chapter revolves around the tension between the biological clock and career advancement. As women strive to progress in their careers, they are often confronted with societal expectations and systemic barriers that undermine their reproductive choices. The pressure to prioritize career advancement over family planning can exacerbate feelings of stress, anxiety, and disillusionment, contributing to a pervasive sense of organizational trauma.

By illuminating these interconnected dynamics, this chapter seeks to foster a deeper understanding of the challenges faced by women of childbearing age in the workplace. Through a nuanced exploration of organizational trauma and its intersection with career progression, we aim to inform strategies and interventions that promote a more inclusive and supportive work environment for all individuals, regardless of gender or reproductive status.

II. Understanding Organizational Trauma

A. Definition and Characteristics:

Organizational trauma refers to the collective distress experienced within a workplace environment due to various adverse events, systemic issues, or toxic cultures. It encompasses a range of negative experiences that can deeply impact the well-being and functioning of individuals within the organization. Characteristics of organizational trauma may include pervasive feelings of fear, distrust, powerlessness, and emotional distress among employees. It often manifests in dysfunctional dynamics, such as high turnover rates, low morale, and diminished productivity.

B. Types of Organizational Trauma:

1. Structural Trauma:

Structural trauma occurs as a result of systemic issues within the organization's policies, procedures, and power structures. This type of trauma is rooted in structural inequalities, such as discriminatory practices, lack of diversity and inclusion initiatives, and unequal access to opportunities (Table 1). Structural trauma can perpetuate disparities and injustices within the workplace, leading to feelings of marginalization and alienation among certain groups of employees.

2. Cultural Trauma:

Cultural trauma pertains to the prevailing norms, values, and attitudes within the organizational culture that contribute to distress and dysfunction. This may include a toxic work environment characterized by bullying, harassment, micromanagement, or a culture of silence where issues are ignored or dismissed. Cultural trauma erodes trust and psychological safety, creating a hostile atmosphere that undermines employee well-being and performance.

3. Interpersonal Trauma:

Interpersonal trauma involves harmful interactions between individuals within the workplace, such as harassment, bullying, discrimination, or abusive behavior. These interpersonal dynamics can inflict emotional harm, disrupt professional relationships, and create a climate of fear and insecurity. Interpersonal trauma often thrives in environments where power imbalances are prevalent, exacerbating feelings of vulnerability and powerlessness among targeted individuals.

Table 1: Types of Organizational Trauma Faced by Women of Childbearing Age

Types of Organizational Trauma for Women of Childbearing Age
1. Structural Trauma
- Systemic inequalities in policies and practices
- Discriminatory hiring or promotion practices
- Unequal access to opportunities and resources
2. Cultural Trauma
- Hostile work environment characterized by harassment
- Toxic organizational culture perpetuating discrimination
- Lack of support for work-life balance
3. Interpersonal Trauma
- Harassment, bullying, or microaggressions from coworkers
- Discriminatory treatment based on reproductive choices
- Lack of support or retaliation for reporting incidents

C. Impact on Individuals:

1. Psychological Effects:

Organizational trauma can have profound psychological effects on individuals, including increased stress, anxiety, depression, and post-traumatic stress disorder (PTSD). Employees

may experience feelings of helplessness, worthlessness, and disconnection from others, impacting their overall mental health and well-being. Psychological distress can also manifest in physical symptoms, such as headaches, insomnia, and gastrointestinal issues, further impairing employee functioning.

2. **Professional Consequences:**

The impact of organizational trauma extends beyond individuals' psychological well-being to affect their professional lives. Employees may experience diminished job satisfaction, decreased motivation, and impaired performance due to the toxic work environment. Additionally, organizational trauma can hinder career advancement opportunities, as individuals may struggle to thrive or excel in such challenging conditions.

3. **Intersectionality with Gender:**

Organizational trauma intersects with gender dynamics, particularly affecting women in unique ways. Women may be disproportionately impacted by structural inequalities, cultural biases, and interpersonal harassment or discrimination within the workplace. The intersection of organizational trauma and gender can exacerbate existing disparities in career advancement, leadership representation, and access to opportunities for women (The Canary Code – see Box). Additionally, the pressures of balancing family responsibilities with professional aspirations can compound the effects of organizational trauma for women of childbearing age, further highlighting the need for gender-sensitive approaches to addressing workplace trauma.[1]

Box: The Canary Code: Intersectionality with Gender in the Workplace

In the realm of workplace dynamics, the concept of the "Canary Code" serves as a metaphorical alert system, signaling the intersectional challenges faced by individuals, particularly women, in diverse settings. Much like the canary in a coal mine detects toxic gases, this code highlights the early indicators of systemic inequalities and biases that disproportionately affect marginalized groups, including women of different races, ethnicities, sexual orientations, and socioeconomic backgrounds.

Intersectionality with gender emphasizes the interconnected nature of identity and experience, recognizing that individuals navigate multiple layers of privilege and oppression based on intersecting social categories. In the workplace, this means acknowledging how gender intersects with other aspects of identity to shape individuals' experiences of discrimination, bias, and organizational trauma.

By embracing the Canary Code and centering intersectionality in our approach to gender equality, we can create more inclusive and supportive work environments where all individuals could thrive, regardless of their intersecting identities.

III. The Reproductive Age Group and Career Advancement

A. Biological Clock and Fertility:

1. **Overview of Reproductive Biology:**

   Women of childbearing age, typically defined as those between their late teens and early forties, experience a significant interplay between their reproductive biology and career aspirations. This period is characterized by the peak of reproductive potential, with fertility gradually declining as women age. Understanding the biological clock involves recognizing the finite window during which women can conceive and bear children, influenced by factors such as menstrual cycle regularity, hormonal fluctuations, and age-related changes in egg quality and quantity.[2]

2. **Social and Cultural Pressure on Women:**

   Women in the reproductive age group often face pervasive social and cultural pressure to conform to traditional gender roles, including expectations around marriage, motherhood, and caregiving responsibilities. Societal norms and expectations may reinforce the notion that women must prioritize family over career advancement, leading to feelings of guilt, inadequacy, and frustration for those who strive to pursue both.

B. Career Advancement Years[3]:

1. Establishment of Professional Identity:

The reproductive age group coincides with a critical period for establishing professional identity and career trajectories. During these formative years, individuals often embark on their educational and career journeys, acquiring skills, building networks, and defining their professional goals. For women, this stage may be influenced by considerations of family planning and fertility preservation, as they navigate the trade-offs between investing in their careers and starting a family.

2. Opportunities for Career Growth:

The reproductive age group presents numerous opportunities for career growth and advancement, as individuals seek to climb the corporate ladder, pursue entrepreneurial ventures, or engage in further education and skill development. However, women in this demographic may encounter barriers to advancement, including gender biases, limited access to mentorship and sponsorship, and workplace policies that fail to accommodate their reproductive needs.

3. Challenges Faced by Women in the Workforce:

Women in the reproductive age group confront a myriad of challenges in the workforce, ranging from overt discrimination and sexual harassment to subtler forms of bias and microaggressions (Table 2). Balancing career aspirations with family planning can be particularly daunting, as women may fear repercussions for taking maternity leave, requesting flexible work arrangements, or disclosing their intentions to start a family. The lack of supportive policies and workplace cultures that stigmatize caregiving responsibilities can exacerbate feelings of isolation and burnout among women striving to advance their careers while fulfilling their reproductive goals.

Table 2: Challenges faced by women in the workforce.

Challenges Faced by Women in the Workforce
Gender Pay Gap
Lack of Representation in Leadership Roles
Glass Ceiling
Workplace Discrimination
Sexual Harassment and Gender Bias
Work-Life Balance Issues
Limited Access to Opportunities
Unequal Access to Mentorship and Networks
Double Standards and Stereotypes
Maternal and Caregiving Penalties

Navigating the intersection of reproductive biology and career advancement requires addressing systemic barriers, challenging societal norms, and fostering inclusive environments that recognize and accommodate the diverse needs and aspirations of women in the workforce.

IV. The Intersection of Organizational Trauma and the Reproductive Age Group[4]

A. Discrimination and Bias[5]:

1. Gender Discrimination in the Workplace:

Women in the reproductive age group often face gender discrimination in the workplace, which can exacerbate feelings of organizational trauma. This discrimination may take various forms, including unequal pay, limited access to leadership positions, and exclusion from decision-making processes. Women may experience subtle biases, such as being overlooked for promotions or assignments, based on stereotypes about their competence or commitment due to their reproductive status.

2. Pregnancy Discrimination[6]:

Pregnancy discrimination is a pervasive issue for women of childbearing age, contributing to organizational trauma within the workforce. Pregnant employees may encounter bias, hostility, or even termination due to perceptions of diminished productivity or concerns about accommodations. Discriminatory practices related to pregnancy, such as being denied promotions or opportunities for advancement, can undermine women's career prospects, and perpetuate systemic inequalities.

3. Microaggressions and Stereotypes:

Microaggressions and stereotypes further compound the intersectional challenges faced by women in the reproductive age group. These subtle forms of discrimination, rooted in unconscious biases and societal norms, can erode confidence, belonging, and psychological safety in the

workplace. Women may experience microaggressions related to their reproductive status, such as assumptions about their commitment to work or competence based on their potential or actual motherhood.

B. Work-Life Conflict

1. Balancing Career and Family Responsibilities:

Women in the reproductive age group grapple with the ongoing challenge of balancing their career aspirations with family responsibilities, contributing to organizational trauma. The pressure to excel professionally while fulfilling caregiving roles can create significant stress and conflict. Women may face difficult decisions about delaying parenthood, navigating maternity leave, or returning to work while managing childcare responsibilities, all of which can impact their career trajectories and well-being.

2. Impact on Mental Health and Well-being:

The strain of navigating work-life conflict can take a toll on women's mental health and well-being, exacerbating feelings of organizational trauma. Women may experience heightened levels of stress, anxiety, and burnout as they juggle competing demands and societal expectations.

The study on higher-status occupations and breast cancer risk highlights the long-term impact of professional and managerial roles on women's elevated breast cancer risk, with estrogen-related and social stress factors contributing significantly. The research underscores the importance of considering occupational history in understanding health outcomes like breast cancer.

Precarious working conditions and psychosocial work stress, such as work-privacy conflict and effort-reward imbalance, acted as risk factors for postpartum depression symptoms. Domestic work stress, work-family conflicts, and lack of social support from families were negatively associated with women's psychological health, regardless of employment status.

3. Work-Life Policies and Support Systems:

The availability of supportive work-life policies and resources is crucial for mitigating the impact of organizational trauma on women in the reproductive age group. Flexible work arrangements, parental leave policies, and childcare assistance can help alleviate the burden of work-life conflict and promote employee retention and satisfaction. Cultivating a culture of support and inclusivity, where employees feel valued and respected regardless of their reproductive choices, is essential for fostering a healthy and productive work environment.

Addressing the intersection of organizational trauma and the reproductive age group requires a holistic approach that acknowledges and addresses systemic inequalities, biases, and barriers to inclusion in the workplace. By implementing supportive policies, challenging discriminatory practices, and promoting a culture of respect and empathy, organizations can create environments where all employees can thrive, regardless of their reproductive status.

4. Menstrual Cycle-Related Issues

Menstrual cycle symptoms significantly impact women's productivity at work, leading to both

absenteeism and presenteeism. Symptoms such as dysmenorrhea, premenstrual syndrome, and premenstrual dysphoric disorder reduce their productivity and overall quality of life. This burden affects not only daily life but also career progression and social functioning.[7]

V. Coping Mechanisms and Resilience

A. Individual Strategies:

1. Self-advocacy and Assertiveness:

Women in the reproductive age group can cultivate resilience by engaging in self-advocacy and assertiveness techniques. This involves advocating for their rights and needs in the workplace, such as requesting accommodations for pregnancy or childcare responsibilities, negotiating for fair treatment and opportunities, and speaking up against discrimination or bias. Developing assertiveness skills empowers women to assert their boundaries, assert their value, and navigate challenging situations with confidence and resilience.

2. Seeking Mentorship and Support Networks:

Connecting with peers, mentors, and role models who have navigated similar challenges can provide valuable guidance, encouragement, and perspective. Mentorship relationships offer opportunities for learning, skill development, and career advancement, while support networks offer emotional validation, solidarity, and practical advice for coping with stress and adversity.

3. Boundary Setting and Self-care:

Practicing boundary setting and self-care strategies is essential for maintaining resilience and well-being in the face of organizational trauma. Women can establish clear boundaries around work hours, responsibilities, and expectations to prevent burnout and maintain a healthy work-life balance. Engaging in self-care activities, such as exercise, mindfulness, hobbies, and socializing, helps replenish energy, reduce stress, and foster resilience.

B. Organizational Interventions:

1. Diversity and Inclusion Initiatives:

Organizations can promote resilience among women in the reproductive age group by implementing diversity and inclusion initiatives that address systemic inequalities and biases. This includes fostering a culture of belonging and respect, providing unconscious bias training for employees and leaders, and actively promoting gender diversity in recruitment, retention, and advancement practices. Creating inclusive policies and practices ensures that women feel valued, supported, and empowered to succeed within the organization.

2. Flexible Work Arrangements:

Offering flexible work arrangements is a key organizational intervention for supporting resilience among women balancing career and family responsibilities. Flexible options such as

telecommuting, flexible hours, compressed workweeks, and job sharing enable women to better manage their work-life balance and accommodate caregiving responsibilities without compromising their professional goals. Flexible work arrangements promote employee retention, productivity, and satisfaction, while also demonstrating organizational commitment to supporting diverse workforce needs.

3. Supportive Organizational Culture:

Cultivating a supportive organizational culture is paramount for fostering resilience and well-being among women in the reproductive age group. This involves promoting open communication, empathy, and mutual respect among employees and leaders, as well as providing resources and support for managing work-life challenges. Encouraging a culture of transparency, trust, and collaboration creates a sense of belonging and psychological safety, where women feel empowered to navigate organizational trauma and thrive in their careers.

VI. Policy Implications and Advocacy

A. Legal Protections and Rights:

1. Legislation on Workplace Discrimination:

Policy implications for addressing organizational trauma among women of childbearing age include strengthening legislation on workplace discrimination. Laws prohibiting gender-based discrimination, harassment, and retaliation serve as vital protections for women in the reproductive age group (Table 3). Advocating for robust enforcement of existing anti-discrimination laws and advocating for the expansion of legal protections to include reproductive health-related discrimination can help combat systemic inequities and promote a fair and inclusive work environment.

Table 3: The laws prohibiting gender-based discrimination, harassment, and retaliation in India

Law	Description
The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013	Mandates the establishment of Internal Complaints Committees (ICC) to address complaints of sexual harassment at the workplace.
The Equal Remuneration Act, 1976	Ensures equal pay for equal work for men and women in India.
The Maternity Benefit Act, 1961	Provides maternity leave and other benefits to women employees.
The Protection of Women from Domestic Violence Act, 2005	Addresses domestic violence against women and provides protection and support to victims.
The Prohibition of Child Marriage Act, 2006	Prohibits child marriage and protects the rights of underage girls.
The Dowry Prohibition Act, 1961	Prohibits the giving or receiving of dowry, which is often associated with gender-based violence.

2. Maternity and Paternity Leave Policies:

Maternity and paternity leave policies are critical policy interventions for supporting women and families during the reproductive years (Table 4). Advocating for comprehensive maternity and paternity leave policies, including paid leave and job protection, ensures that employees can take time off to care for newborns or adoptive children without jeopardizing their employment or financial security.

3. Advocacy for Gender Equality[8]:

Policy advocacy for gender equality encompasses a range of initiatives aimed at addressing systemic barriers and promoting equal opportunities for women in the workforce. This includes advocating for pay equity measures, promoting women's representation in leadership positions, and challenging gender stereotypes and biases that perpetuate inequality. By advocating for policies that dismantle structural inequalities and promote gender equity, advocates can create more inclusive and supportive workplaces for women of childbearing age.[9]

Table 4: The maternity and paternity leave policies in India

Policy	Description
Maternity Benefit Act, 1961	Provides for a minimum of 26 weeks of paid maternity leave for women working in establishments with 10 or more employees.
Paternity Leave	While there is no specific national law mandating paternity leave in India, some companies and organizations offer paternity leave ranging from 1 to 15 days.
Companies Act, 2013	Companies with 50 or more employees are required to provide crèche facilities and allow mothers to visit the crèche during working hours.
Labour Codes (Code on Wages), 2019	Proposed amendment to the Maternity Benefit Act, allowing women to avail up to 12 weeks of maternity leave before childbirth and 6 weeks after.
The Central Civil Services (Leave) Rules, 1972	Male government employees are entitled to paternity leave for 15 days, which can be availed within 6 months before or after the birth of the child.

B. Institutional Changes:

1. Role of Human Resources and Leadership:

Institutional changes within organizations are crucial for addressing organizational trauma and supporting women in the reproductive age group. Human resources departments play a pivotal role in implementing and enforcing policies related to diversity, inclusion, and anti-discrimination. By prioritizing diversity, equity, and inclusion in hiring, promotion, and decision-making processes, organizations can create a more equitable and supportive workplace for all employees.[10,11]

2. Training and Sensitization Programs:

Providing education on topics such as unconscious bias, harassment prevention, and inclusive leadership equips employees and leaders with the knowledge and skills to recognize and address discriminatory behaviors and create a more inclusive work environment. Regular training sessions and ongoing dialogue reinforce organizational values and promote accountability for upholding principles of equality and fairness.

3. Creating Family-friendly Work Environments:

Institutional changes to create family-friendly work environments are essential for supporting women in the reproductive age group. This includes offering flexible work arrangements, on-site childcare facilities, lactation rooms, and family leave policies to accommodate employees' caregiving responsibilities. Creating a supportive infrastructure for working parents not only promotes gender equality and work-life balance but also enhances employee retention, satisfaction, and productivity.

4. The National Creche Scheme for Children of Working Mothers, initiated by the Government of India, provides daycare facilities for children aged 6 months to 6 years, ensuring their nutrition, health, and early childhood education. The scheme aims to balance work and family responsibilities, promoting gender equality, and economic empowerment for working mothers.[12]

Policy implications and advocacy efforts aimed at addressing organizational trauma and supporting women in the reproductive age group require a multi-faceted approach that combines legal protections, institutional changes, and cultural shifts within organizations and society.

VII. Case Studies and Examples

Real-life Examples of Organizational Trauma

1. Uber Technologies Inc.:

Uber, the multinational ride-hailing company, faced significant organizational trauma due to allegations of systemic workplace harassment, discrimination, and a toxic corporate culture. In 2017, former engineer Susan Fowler published a blog post detailing her experiences of sexual harassment and the company's failure to address her complaints adequately. Fowler's account sparked a wave of internal and external scrutiny, leading to multiple investigations, leadership changes, and reforms within the company. Uber's organizational trauma not only damaged its reputation but also undermined employee morale and trust, resulting in significant turnover and legal challenges.

2. The Weinstein Company:

The Weinstein Company, a prominent film production company founded by Harvey Weinstein, experienced profound organizational trauma following revelations of Weinstein's decades-long

pattern of sexual misconduct and abuse of power. Numerous women, including actresses and employees, came forward with allegations of harassment, assault, and intimidation by Weinstein. The scandal ignited the ***#MeToo movement***, shedding light on pervasive sexual harassment and abuse in the entertainment industry and beyond. The Weinstein Company faced bankruptcy, lawsuits, and reputational damage, ultimately leading to its dissolution. The trauma inflicted on employees, particularly women, underscored the need for systemic changes to combat workplace harassment and foster a culture of accountability and respect.

Real-life Examples of Organizational Trauma in India

Shortening Reproductive Periods: A study by the International Institute for Population Studies revealed that Indian women are now finishing childbearing at an earlier age compared to three decades ago. The median age at birth has declined significantly, impacting women's reproductive choices and potentially leading to challenges in balancing work and family responsibilities.

Harassment and Microaggressions: A recent survey by Deloitte found that 44% of Indian working women reported experiencing harassment or microaggressions in the workplace over the past year. This highlights the prevalence of traumatic experiences women face in Indian organizations.

Occupational Hazards in Agriculture: Women make up a significant portion of the agricultural workforce in India, facing various occupational hazards like exposure to pesticides, musculoskeletal disorders, and poor working conditions.

B. Success Stories and Best Practices

1. Salesforce:

Salesforce, a leading cloud-based software company, has been recognized for its proactive approach to addressing organizational trauma and promoting employee well-being. The company prioritizes creating a supportive and inclusive workplace culture through initiatives such as its ***"Ohana Culture," which emphasizes the importance of treating employees like family***. Salesforce has implemented robust diversity and inclusion programs, including unconscious bias training, employee resource groups, and leadership development initiatives focused on promoting diversity and equity. By prioritizing employee well-being and fostering a culture of respect and inclusion, Salesforce has successfully mitigated organizational trauma and cultivated a positive work environment.

2. PwC (PricewaterhouseCoopers):

PwC, a multinational professional services firm, has implemented innovative strategies to address organizational trauma and promote mental health awareness among its employees. The company has prioritized destigmatizing mental health issues and encouraging open dialogue

through initiatives such as its ***"Green Light to Talk"*** campaign. PwC offers comprehensive mental health support services, including access to counseling, peer support networks, and mental health training for managers. By prioritizing mental health and well-being, PwC has created a supportive work environment that empowers employees to seek help when needed and thrive both personally and professionally.

3. Patagonia:

Outdoor apparel company Patagonia is renowned for its commitment to addressing organizational trauma and promoting sustainable business practices. The company prioritizes employee well-being and work-life balance through initiatives such as its ***"Let My People Go Surfing"*** philosophy, which encourages flexible work arrangements and autonomy. Patagonia offers generous benefits, including paid time off for volunteering, onsite childcare facilities, and comprehensive healthcare coverage. By fostering a culture of trust, transparency, and social responsibility, Patagonia has created a resilient and engaged workforce that is committed to the company's mission and values.

These success stories demonstrate that by investing in initiatives that promote mental health awareness, support work-life balance, and align with organizational values, companies can create positive and sustainable work environments where employees can thrive and contribute to long-term success.

C. Lessons Learned

1. **Recognize the Impact:** Organizational trauma has a significant impact on women of childbearing age, affecting their mental health, well-being, and career advancement opportunities. It is essential to acknowledge the unique challenges and vulnerabilities faced by this demographic and the intersectional dynamics that contribute to their experiences of trauma.
2. **Address Structural Inequities:** Organizational trauma often stems from systemic issues such as gender discrimination, bias, and unequal access to opportunities.

   The patriarchal family structure often forces women to choose between family, childcare, and career, resulting in greater parental responsibilities, increased family–job conflict, and higher physical and mental burdens compared to men.[13] Addressing structural inequities within the workplace is essential for mitigating trauma and promoting gender equality. This includes implementing policies and practices that support diversity, inclusion, and equity at all levels of the organization.
3. **Prioritize Support and Resources:** Providing comprehensive support and resources for women of childbearing age is crucial for managing organizational trauma. This includes access to mental health services, flexible work arrangements, parental leave policies, and supportive networks and mentorship programs.

Recommendations:

1. **Promote Diversity and Inclusion:** Organizations should prioritize diversity and inclusion initiatives that address systemic biases and promote equitable opportunities for women of childbearing age. This includes implementing unconscious bias training, creating diverse hiring and promotion practices, and fostering inclusive leadership behaviors. By creating a culture of belonging and respect, organizations can reduce the risk of trauma and create pathways for career advancement for all employees.
2. **Flexible Work Arrangements:** Offering flexible work arrangements, such as remote work options, flexible hours, and compressed workweeks, can help women balance their career aspirations with family responsibilities. Organizations should also ensure that flexible work arrangements are accessible and equitable for all employees, regardless of gender or parental status.
3. **Supportive Organizational Culture:** Cultivating a supportive organizational culture is essential for managing organizational trauma and promoting women's career advancement. Organizations should prioritize creating a culture of psychological safety, where employees feel comfortable speaking up about issues of harassment, discrimination, or work-life balance challenges. By prioritizing employee well-being and fostering a culture of support and inclusivity, organizations can mitigate the risk of trauma and create pathways for women to thrive in their careers.
4. **Leadership Commitment**: Leadership commitment is crucial for driving organizational change and addressing organizational trauma effectively. Leaders should prioritize gender equality, diversity, and inclusion in their strategic priorities and decision-making processes. This includes setting clear goals and metrics for diversity and inclusion, holding leaders and managers accountable for creating inclusive work environments, and fostering a culture of continuous learning and improvement. Leadership commitment sends a strong message to employees that the organization values their contributions and is committed to creating a supportive and equitable workplace for all.

VIII. Conclusion

Throughout this chapter, we have explored the intricate interplay between organizational trauma and women of childbearing age, highlighting the unique challenges and complexities they face in the workplace. The intersectional challenges faced by women of childbearing age underscore the importance of recognizing the multiple layers of identity and experience that influence their experiences in the workplace. Women navigate a complex web of gender dynamics, reproductive choices, cultural expectations, and systemic inequalities, all of which intersect to shape their experiences of organizational trauma. We must challenge systemic biases, promote diversity and inclusion, and prioritize employee well-being and work-life balance.

D. Future Directions and Research Needs

Future research should explore the long-term consequences of organizational trauma on

women's career trajectories, mental health, and overall well-being. Additionally, there is a need for greater attention to intersectional approaches to addressing organizational trauma, considering the unique experiences of women from diverse racial, ethnic, and socioeconomic backgrounds. Addressing organizational trauma requires a multifaceted approach that addresses systemic inequalities, challenges cultural norms, and prioritizes the well-being of women of childbearing age.

Key Messages

1. Organizational trauma impacts women of childbearing age.
2. Understanding the intersections of gender, race, ethnicity, and socioeconomic status is essential.
3. Implementing supportive work-life policies, promoting diversity and inclusion, and fostering a culture of respect and empathy are key strategies for addressing organizational trauma and creating more equitable work environments.
4. By recognizing the complex interplay between organizational trauma and women of childbearing age, we can work towards creating workplaces where all individuals can thrive, promoting a culture of respect, empathy, and inclusivity.

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CHAPTER 10

Traumas Related To Reproductive And Bodily Agency In Women

ABSTRACT:

Traumas related to reproductive and bodily agencies of women lead to physical and psychological consequences. Trauma related to reproductive agency leads to loss of autonomy over one's own reproductive choices. It can be in the form of legal and government policy restrictions on abortions and sterilization, reproductive coercion which involves coerced childbearing and coerced abortions, and trauma in medical setting related to medical procedures with or without proper informed consent. Such traumas could result in symptoms as evidenced in PTSD, anxiety and depression along with a feeling of being violated by agencies that ought to be protecting their autonomy. The trauma related to bodily agency on the other hand results in the disturbed sense of bodily agency leading to the perception of a body as an unsafe place. The resultant body image disturbances may act as a mediator between trauma and other conditions like eating disorders, body dysmorphic disorders, personality disorders (borderline, paranoid, anankastic) and sexual dysfunctions (like female orgasmic disorder, female sexual interest/ arousal disorder, genito-pelvic pain/penetration disorder, change in their sexual orientation). Any treatment focusing on alleviating symptoms associated with such traumas need to focus not only on the cognitions related to that trauma but also need to focus on the unique circumstances in which it occurred. This is essentially important for the victim(s), especially where the individual's bodily sensations are not addressed which are reminiscent of the somatosensory experiences that occurred during the trauma.

(**Keyword**s: Trauma, Reproductive agency, Bodily agency, Women)

TRAUMAS RELATED TO REPRODUCTIVE AGENCY OF WOMEN

Agency can be defined as one's ability to identify one's own goals and act upon them. Reproductive agency refers to the capability of a woman to set her own reproductive goals, take decisions accordingly and act independently. Trauma related to reproductive agency encompasses the psychological and emotional consequences including distress, following the loss of autonomy over one's own reproductive choices. While agency refers to the capability of a woman to identify her own goals and act upon them, reproductive autonomy refers to the rights of a woman to take

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decisions regarding their reproductive health freely and without any coercion[1, 2] A closely related term is reproductive coercion, where a woman's autonomy is interfered with coercive behaviours from intimate partner or family members in the form of physical, psychological, sexual, financial and/or other strategies [3].

Reproduction and reproductive choices come under the natural repertoire of a woman's developmental stages for most women. Based on her sense of self, family history, childhood trauma, generational trauma, cultural influences, influences of faith and family, a woman over her lifetime develops a story for herself unparalleled to any other [4]. Hence, a threat to autonomy not only threatens the woman's mental health, but also threatens the sense of self and her long-standing reproductive story. Negative reproductive events of any kind could lead to disturbances in existential, physical, emotional, psychological and interpersonal realms, which then go beyond an average woman's coping abilities[5].

Traumas related to reproductive agency can be grossly divided into the following subsections:

1. Legal and Policy restrictions related trauma:
    a. Abortion restrictions.
    b. Forced sterilization and contraceptive access.
    c. Legal rights of women regarding reproductive autonomy.
2. Reproductive coercion:
    a. Coerced childbearing.
    b. Coerced contraceptive sabotage.
    c. Coerced abortions.
3. Medical practices related trauma:
    a. Lack of proper informed consent.
    b. Non-consensual medical procedures and practices.

1. LEGAL AND POLICY RESTRICTIONS RELATED TRAUMA:

a. ABORTION RESTRICTIONS:

Abortion is criminalized in India, according to Section 312 of the Indian Penal Code(IPC), with the exception of Medical Termination of Pregnancy(MTP) Act. Though the primary objective of MTP act is to safeguard the health of the woman and to improve the health outcomes, MTP act does not take into consideration the autonomy of the woman regarding her reproductive choices. There is considerable psychological distress when abortion is denied, especially in special populations like rape survivors, women suffering with mental illnesses, victims of violence and/or abuse (physical and emotional) and survivors of other traumatic life events[6]. In all such special situations, the trauma of being denied abortion

leading to unwanted pregnancy leads to further distress in addition to the distress of the original trauma. Though the MTP act and IPC Section 312 aim to safeguard the health outcomes of women, a study done to assess the mental health outcomes of women five years after receiving abortion, showed that women were found to be happier five years after abortion when compared to those who wanted an abortion but were denied one [7] The negative consequences of unintended pregnancy seem to be often underestimated. This was shown in a study, where children born through an unintended pregnancy showed cognitive developmental delays, behavioural problems and a greater likelihood of substance abuse problems compared to children born through intended pregnancy [8]. In a woman's lifetime, pregnancy is considered as a stressful period physically and psychologically. The overall risk of psychiatric disorders increases during pregnancy. The risk of death following childbirth was found to be 50-130 times greater than the risk of death following abortion, making denial of abortion a mortal, physical and psychological hazard.

b. FORCED STERILIZATION AND CONTRACEPTIVE ACCESS:

The modern contraceptive methods available in India include oral contraceptive pills, intrauterine devices, injectable (depot) contraception, male condoms, subdermal implants, diaphragms, lactational amenorrhoea, emergency contraceptive pills and sterilization. But, as a very common practice, sterilization is the only contraceptive method that is offered to the patient [9]. Both overt and covert forces are used by health workers at health centres in order to achieve their necessary sterilization targets that the government has set for them [10]. Forced sterilization practices are seen more commonly in women from poor socioeconomic backgrounds, rural population, disabled women and women with HIV [11]. A genuinely informed consent after duly providing comprehensive information is rarely obtained in these populations, highlighting the denial of autonomy of women in assisting her to reach her desired contraceptive choice. Further, the family planning programs and contraceptive education in India targets women who have completed their family size. Inherent in this process, is a denial of the need for contraception to women for other reasons. Many women, especially living in rural India, have no access to contraception when they want to delay pregnancy in the beginning of marriage or to space out two subsequent pregnancies, or delay pregnancy in situations where they are not ready. Contraceptive access in such situations is grossly undermined by the legislation and the family planning services to such an extent that the woman develops a sense of being denied and judged for contraceptive access for choices other than to complete their family size.

c. LEGALS RIGHTS OF WOMEN REGARDING REPRODUCTIVE AUTONOMY:

India's laws about abortion and contraceptive access were considered rather progressive as compared to other countries. However, even with the legislation and policies in place, there are still significant barriers to a full autonomy. MTP Act of 1971, Law penalizing marriages of girls under 18 years of age, IPC Section 313 to Section 316, aim to protect

and safeguard the reproductive health of women. But these legislations are often met with opposition with government policies on population which focus on numbers-based sterilization or have a biased view on maternal mental health issues after unintended pregnancy. This has led to a deep chasm between what was aimed and what is being practised. Even today the glaring defect in Indian legislation and policies on reproductive decisions of women remains the lack of a rights-based approach.

2. REPRODUCTIVE COERCION:

Reproductive coercion can be in the form of either coercion into pregnancy, coercion in sabotaging contraceptives or coercing into abortions. The methods employed could be financial, physical, psychological or other forms. All these are closely linked and share some of the common risk factors for their prevalence. The risk factors for reproductive coercion in common includes intimate partner violence, emotional and physical abuse by in-laws, cultural factors, child sex preferences, illiteracy, financial dependency of the woman on the intimate partner, and lack of proper legislations for preventing reproductive coercion among others [12]. In a study conducted in Uttar Pradesh, 1 in 8 women had admitted that they have faced some form of reproductive coercion [13]. Two other studies from India have reported distress faced by women who are surrounded by decision-makers, who using coercion and abuse, try to take control over the woman's basic reproductive choices[14,15]. Studies have consistently found a strong relationship between reproductive coercion (which can be measured with the help of RC scale) and intimate partner violence [16, 17].

A. COERCED CHILDBEARING:

Coerced childbearing is often found in Indian families, where either the husband or the in-laws take over the reproductive autonomy of women as a form of control over their lives [18]. Pronatalist attitudes that are found in many Indian families compound the coercion, forcing women to think that the purpose of their lives is child bearing and that she would be committing a sin if she is not willing to bear a child. In other words, coerced childbearing is abuse that extends and spills over the woman's reproductive autonomy.

B. COERCION IN SABOTAGING CONTRACEPTIVES:

One of the methods of reproductive coercion is sabotaging contraceptives, either by damaging the contraceptive physically by puncturing holes in them, denying visits to health centres, withholding money to buy contraceptives, and throwing away the contraceptives that women have. In such situations, the women resort to covert contraceptive access leading to increased anxiety, distress and guilt. In a multicentric study done in Rajasthan, it was found that the most common form of reproductive coercion was to obstruct the receival of family planning services [19].

C. COERCED ABORTIONS:

Coerced abortions in India commonly occurs because of the preference of male offspring. Though gender determination is legally punishable, it has not completely eradicated the attempted female genocide that happens in many states especially in rural India[20].

3. MEDICAL PRACTICES RELATED TRAUMA:

A. LACK OF PROPER INFORMED CONSENT:

A proper informed consent is where a health care provider educates a patient about the risks, benefits and alternatives of a given procedure so that the patient can make a voluntary well-informed decision about getting or declining a proposed investigation, intervention or procedure[21]. But in majority of hospitals, the consent is taken without explaining the contents of the consent form, thus obtaining an ill-informed consent rather than a well-informed one. This results in those women undergoing painful and sometimes invasive procedures without being prepared for it, thus sabotaging their decision-making autonomy. The woman feels violated and confused as it happens in a medical setting, usually by a doctor. The woman would attach a significance of abuse and trauma to the obstetric procedures because of the loss of autonomy in these settings [22].

B. NON-CONSENSUAL PRACTICES:

In more situations than can be ignored, reproductive procedures like labour, episiotomy repair, C-Section and others are done without obtaining a well-informed consent or with only the consent of the husband. A closely related term, “Obstetric Violence” refers to the denial of proper standard of care for women in the reproductive health care settings due to factors like lack of respect, existing stigma, paternalistic attitude, contempt and others. This is one of the types of trauma that many women face but not much is done about. The responsibilities towards a woman’s autonomy by the health care professionals in rural settings are grossly neglected especially in places like labour room and procedure rooms[22].

THE EFFECTS OF TRAUMA ON REPRODUCTIVE AGENCY:

1. Women who were forced to have an abortion have reported higher intensity of severe trauma, distress and depression[23].
2. Following forced sterilization, women often feel isolated, experience a deep sense of loss and feel as if their reproductive autonomy has been abruptly robbed in a simple visit to the hospital.
3. Most of the women who have faced reproductive coercion have shown increased mental health issues like anxiety, depression and emotional disturbances.
4. Most often in many of the situations described above, women develop PTSD symptoms with repeated flashbacks anxiety and mistrust.

5. In coerced childbearing, women suffer from the consequences of unintended pregnancy. Pregnancy in itself is a challenging period for many women, but coercion in the process deepens the distress and leads to worsening of mental health issues or gives rise to new mental health problems. Postpartum depression and other post-partum onset mental illnesses have been found at a greater frequency in women with unintended pregnancy [24].
6. Common to all kinds of trauma to reproductive agency, women feel a sense of loss, feeling violated and develop a general sense of mistrust to partners as well as health workers.

STEPS TO BE TAKEN TO ADDRESS THE TRAUMA TO REPRODUCITVE AGENCY:

1. Adopting a rights-based approach in any of the aspects of a woman's reproductive choices is the first and foremost step to reduce the trauma. Planning and implementing well-being programs, legislation, policies and emphasizing / promoting a woman's autonomy in decision-making of what happens to her own body.
2. Understanding through research and interviews about the mental health effects that are the consequences of such traumatic experiences.
3. Defining with more accuracy terms like reproductive coercion and reproductive autonomy. Striving to develop stringent laws on reproductive coercion, on par with physical and sexual abuse.
4. Legislative changes to MTP Act, the need for a new amendment that accommodates the need of women to abort an unintended pregnancy.
5. Provision in all health centres, a specialised team to provide counselling services related to contraceptive services, trauma to reproductive agency, actively screening / identifying potential / ongoing cases of reproductive coercion.
6. Developing a dedicated and specific psychological module to address the unique aspects limited to trauma to reproductive agency.
7. Taking a rights-based approach to sterilization only after obtaining a thorough and well-informed consent. Removing sterilization targets for health care workers to further promote the rights-based approach.
8. All health care workers should be trained in screening, identifying, reporting, promoting and guiding women to seek the right help in any potential / on-going partner coercion and intimate partner violence in a reproductive setting.
9. Health professionals in contact with reproductive age women should be up-to-date in various abortion care services, regular contraceptive services and emergency contraceptive services.
10. Involving and including women in their labour process and other obstetric procedures and establishing a grievance redressal committee to address the irregularities in the standard of

care in hospitals.

11. Encouraging women in situations, where necessary covert contraceptive services need to be accessed and minimizing visits to health centre of the woman to avoid reproductive coercion.
12. An active role of community in restoring the autonomy of the woman.
13. Reproductive and sexual health decisions should ideally be free from discrimination, coercion, violence and avoid being traumatic situations for women.

TRAUMAS RELATED TO BODILY AGENCY IN WOMEN

Traumas related to bodily agencies in women refers to the psychological and physical responses to trauma that impact a woman's sense of control and ownership over her body.

The sense of bodily agency creates a sense of ownership over one's body and their peri-personal space[25].

This includes the following:

1) Boundaries of the body differentiating one from the world.
2) Bodily self-consciousness, which includes location of self within the body and gives one a first-person perspective.
3) Interoceptive body awareness which is an awareness of body's internal state.

This sense of bodily agency comes when the various somatosensory experiences of the body are modulated by emotions and cognitions. Indeed, all individuals process all experiences and environment throughout their life span which in turn alter their health and functioning, a phenomenon known as biological embedding [26]. Trauma is one such experience that impacts the sense of self at both cognitive and bodily levels. This leads to an alteration on how an individual perceives self and interacts with the environment.

NEUROBIOLOGICAL BASIS OF SENSE OF SELF

The sense of self is a complex process known to be mediated through the temporoparietal junction and the medial prefrontal cortex following integration of the various sensory inputs via the somatosensory system and the reticular activating system of the brain stem (which regulates consciousness, behavioral arousal and motivation). These inputs are in turn regulated by the higher cortical centers (cognitive and affective centers).

During a trauma, the sensory inputs, which are perceived as negative, overwhelm the lower-level processing regions within the brainstem. This then disrupts the subcortical-cortical communication alongside disruptions in the vertical integration, especially involving the midline structures of the brain which are implicated in generating the sense of self. Thus, the sense of bodily agency is disrupted during trauma and creates a feeling of not being in control of the body,

a feeling of being unsafe and helpless to meet survival needs.

Trauma-related disorders arise when these perceptions persist post-trauma in the form of ingrained traumatic memories. Such traumatic memories include both explicit (conscious recall) and implicit memories (does not require conscious recollection necessarily but is usually expressed in behavior). Implicit memories of the somatosensory experiences that occurred during trauma are assumed to be stored and experienced via the same sensory modalities through which they were originally perceived. The body's natural fight, flight or fright response pathways are hypothesized to be variably triggered even after the cessation of the trauma, thus maintaining the traumatic response ranging from hypo- to hyper-arousal states.

The result is that, much after the original trauma, the sense of comfort one should derive in bodily experiences is replaced by bodily perception associated with implicit memory of trauma, which are then amplified and fearfully perceived, accompanied by a feeling of helplessness. Consequentially the body vigilance is also high, in order to monitor the interoceptive bodily signals in search of signs of illness. This tendency increases psychosomatic symptoms and body shame.

One such example is the Post-traumatic stress disorder (PTSD) in which there is either a hypo- or a hyper- responsivity to internal or external sensory inputs. In sensory hyper-responsivity there is a lower threshold for incoming sensory information resulting in detecting innocuous stimuli as threatening. Whereas in sensory hypo-responsivity there is increased threshold to sensory inputs leading to dissociative symptoms and analgesia/anesthesia. Depersonalization corresponds with somatic sensory hypo-responsivity, while derealization corresponds to exteroceptive sensory hypo-responsivity. These altered thresholds may be linked to the under or over modulation of the somatosensory input by higher cortical centers.

CLINICAL MANIFESTATIONS

PTSD: A person may develop PTSD after exposure to trauma related to reproductive and bodily agency. The traumatic event maybe persistently re-experienced, the stimuli associated with it avoided, and both internalizing symptoms like negative thoughts and decreased interest in activities and externalizing symptoms like risky behaviour may arise. The trauma is encoded in the body as traumatic body memory which is defined as the sum of all past body experiences stored in the body and influencing behavior as seen in PTSD.The disturbance of bodily agency is seen very prominently in the Dissociative type of PTSD which occurs in 44 % of all PTSD presentations. It presents with a diminished sense of agency (depersonalization and derealization), altered sense of time and social difficulties and isolation. The dissociative type occurs as an adaptive response to inescapable stress. So, the reaction to trauma per se is consequential for the sense of self, rather than trauma per se[27].

BODY IMAGE DISTURBANCES: Following trauma there could be both physical and psychological damage. Physical damage may include injuries like abrasions, contusions, lacerations and fractures among others, while psychological injuries might result in body image disturbances. Body image issues develop due to maltreatment especially during vulnerable periods

of identity development. It may partially mediate the association of maltreatment and development of psychopathology like self-harm, eating disorders, borderline personality disorders and poor sexual functioning later in life. Body image distress following such trauma acts as a predictor of depression[28].

PERI-PERSONAL SPACE DISTURBANCES: Peri-Personal Space (PPS) is the space around the body where one can reach and can be reached by external agencies. It is an essential component of bodily agency that allows us to perform actions in the world and protect our body while interacting with the environment. Trauma related to agency leads to disruption of the peri-personal space. In PTSD the PPS tends to be larger, rigid and less malleable to sensory input for defensive purposes, whereas in dissociative form of PTSD, the individual has a highly unstable PPS thereby preventing the formation of a stable defensive boundary around the body[29].

MANAGEMENT

Cognitive behavioral therapy has a response rate of 50% in PTSD. This poor response may be attributed to the fact that it does not consider the reawakening of the traumatic somatosensory experiences that occurred during time of trauma. However, when traumatic memories are made to recall during specialized psychological therapies like Trauma-focused therapy, Intensive Short-Term Dynamic Psychotherapy (ISTDP), the painful somatosensory experiences can be relieved. These painful flashbacks when recalled in a safe and controlled environment helps to mobilize and release the repressed emotions. Thus, gradually assisting the individual to challenge the avoidance and empower them to face the fear, which would help in progression rather than just interfering with the cognitive process and impeding the therapy. Therapies based on somatosensory reintegration will therefore help in building back the brain body connect.

1. **Sensorimotor psychotherapy** – Here, the bodily experience is the entry point of therapy. It emphasizes the mindful attention to touch, posture and movement. The basic premise of such therapy is to shift the attention away from threatening sensations of body and to experience bodily sensations without judgement. This uncouples the unpleasant experiences and thoughts and reduces hyperarousal.

2. **Audio-visual Entrainment (AVE) Therapy** – This is a sophisticated form of neurofeedback / biofeedback treatment using two sensory (audio and vision) modalities of simultaneous activation. The aim of the treatment is to target the necessary brain wave frequency which is disordered. Providing regular AVE therapy would promote entrainment of the brain which would have long-lasting benefits (even after the therapy is discontinued). This targeted approach would promote relaxation, improve the quality of sleep, aid in dissociating from the traumatic events (thereby reducing the fear response), improving the mood, regulating important neurotransmitters like serotonin and boost the optimism [30].

3. **Deep brain reorientation** – This targets brainstem and midbrain integration centers by focusing on orientation and posture. It facilitates the awareness of somatic sensations in the present moment of safety as compared to past trauma.

4. **Eye movement desensitization and reprocessing** – The oculomotor muscles are connected to the brain regions responsible for multisensory integration like the reticular formation and the vestibular nucleus. The saccadic eye movements are used to elicit an innate relaxation response which helps in reintegrating maladaptive stored trauma.
5. **Play therapy** – Play based approaches include vestibular and somatosensory feedback/ integration, which in turn restores the urge to seek relational connection through somatosensory connection
6. **Yoga** – This involves mindful movements which allow proprioceptive feedback to ground the body and attune to its needs. It enhances top-down regulation of the somatosensory arousal.
7. **Equine/Pets-assisted therapy** -Traumatic experiences may make feeling safe with any human difficult. Grooming of horses or other pets helps establish trust through somatosensory processes.
8. **Expressive arts therapy** – Art, music, dance engages body in purposeful activity and helps in forming and reforming sensory feedback loops. This creates a sense of agency and helps in positive interaction with the environment.

CONCLUSION:

Trauma not only leaves in its wake visible physical injuries and explicit memories, but implicit memories encoded in the somatosensory system, implicated in generating a sense of self. In victims of trauma, this sense of bodily agency is disrupted. Neutral bodily sensations are misinterpreted as a source of danger on the background of the implicit memories. The body is no longer perceived as a place of safety but as a place of vulnerability. Therapy for trauma should address these issues as well.

KEY MESSAGES

1. Legislations, policies, family dynamics, and standards of health care have focused more on achieving targets and fulfilling abstract aims of better physical health at the cost of loss of agency and autonomy of women over their reproductive choices.
2. Including women's rights in the policies will lead to better mental and physical health outcomes over a longer period.
3. Trauma disturbs the sense of bodily agency, by disrupting the vertical integration of the subcortical–cortical structures responsible for generating the sense of self.
4. Trauma-focused therapy should address the reawakening of the painful somatosensory experiences associated with trauma related to reproductive and bodily agency.

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CHAPTER 11

Menopausal Trauma: Women Beyond Reproductive Years

Abstract:

Menopause is a natural process in a woman's life marked by significant biological, psychological and social changes. This phase is characterized by an increase in her vulnerability to various psychological issues, with resurfacing of her traumatic experiences at times. Symptomatic perimenopause and menopause can impact overall psychological well-being and quality of life. The exacerbation or emergence of psychological ill-health in menopausal women depends not only on the frequency and severity of menopausal symptoms but also on the trauma faced, and individual attitudes towards the process of aging and loss of fertility. Cultural beliefs regarding menopause and the ability to cope with oncoming somatic and social changes play an important role in pathogenesis of the psychological issues arising during menopause. Holistic management involving hormone replacement, anti-depressant medications, lifestyle modification, and psychotherapy is essential to reduce psychological distress and improve the quality of life in a woman undergoing menopause.

[Keywords: Menopause, Oestrogen deficiency, Post-traumatic stress disorder, Trauma.]

Introduction:

Menopause is a normal physiological condition marked by permanent end of menstrual cycles in a woman's life due to the cessation of the production of reproductive hormones from the ovaries for at least a year.[1] It occurs due to physiological deficiency in the female reproductive hormones, especially oestrogen. Worldwide, the mean age of menopause is 45 to 56 years. In Indian women, the mean age is lower and ranged from 44.69 years to 48.95 years.[2]

Menopause is characterized by cessation of ovulation and loss of reproductive ability in women. The woman is born with a fixed number of follicular cells in ovary. With increasing age and with every ovulatory cycle, there is a decrease in the number of follicular cells and granulosa cells in the ovary. As these cells produce oestrogen, inhibin A, and anti-mullerian hormones, the levels of these hormones in the blood decrease with attrition of these cells. This disturbs the Hypothalamic-Pituitary-Gonadal axis, leading to a rise in levels of Follicular Stimulating Hormone (FSH) and

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Luteinizing Hormone (LH) in the body. This impairs endometrial growth leading to irregular menstruation initially and causes complete cessation of menstrual cycles finally. Menopause can be a natural process or can result from surgical removal of ovaries or uterus or following cancer treatment like radiation, chemotherapy, or certain medications.

'Perimenopause' or 'Climacteric' refers to the period from when signs of impending menopause such as irregular menstrual cycles are first observed and ends one year after the final menstrual period. The duration of this phase can be variable, lasting from 1 year to maximum of 10 years.[3] Various physical as well as psychological issues associated with menopause are reported in the perimenopausal period rather than after the complete cessation of menstrual periods.[4] Reduced levels of circulating oestradiol in blood and body tissues is primarily responsible for menopausal symptoms which can be divided into three types namely, Vasomotor, Genito-urinary, and Psychological.

Menopause and Trauma

The experience of trauma can affect physical health by disrupting biological processes that lead to prolonged stress, changing hormone levels, and speeding up cellular aging.[5] These effects are mediated through dysregulation of biological systems.[5] Menopause and psychological trauma can intersect in various complex ways and can influence a woman's physical and mental health to a large extent. The trauma can remarkably interfere with menopausal process in two ways:

A. Past trauma influencing menopausal symptoms.

B. Menopausal symptoms affecting the psychology of a woman.

A: Past trauma influencing menopausal symptoms: The impact of trauma on the process of menopause transition is multifaceted. Trauma can significantly impact both the experience of menopause and also the overall psychological and physical health of women undergoing this transition. Psychological trauma can transact with the menopausal process in following ways:

- **Emotional Impact:** Trauma processing and response to menopausal symptoms can be correlated through the following themes:

a. Heightened Stress Response - Trauma survivors are often observed to have a heightened stress response. In these women, the usual physiological and emotional symptoms of menopause can be magnified and perceived as more distressing, making it difficult to cope.

b. Increased Anxiety and Depression: Women with a history of psychological trauma are more susceptible to exacerbation or development of symptoms of anxiety and depression, especially post-traumatic stress disorder (PTSD). Those in peri-menopausal period report higher PTSD symptom severity than premenopausal and postmenopausal women.[6]

- **Impact on physical and cognitive health:**

a. Sleep Disturbances: Both menopause and trauma are associated with sleep disturbances. Women with a history of trauma in past may experience severe insomnia, night sweats causing disturbed sleep and nightmares, which can lead to impairment of their overall quality of life in menopause. Reported incidence of sleep problems ranges from 16% to 47% during peri-menopause and 35%–60% in postmenopausal period. History of associated anxiety, depression, mood disorder along with restless leg syndrome are the most common manifestations associated with insomnia.[7]

b. Cognitive and Behavioural Impact: The reports of cognitive decline in menopause are more of a subjective feeling of 'brain fog' rather than objective poor performance on cognitive screening tests. Examples of such symptoms are deficits in attention, information processing speed and working memory, which manifest as a lack of focus, slowed thinking and forgetfulness.[8] In women who are trauma survivors, these cognitive difficulties can be more noticeable and distressing. Behaviour-wise, trauma can lead to maladaptive coping styles, such as denial, substance abuse or social withdrawal. These behavioural patterns can further worsen menopausal symptoms and create hindrance in effective management strategies.

c. Chronic Health Morbidities: It is known that the menopause increases the risk of osteoporosis and cardiovascular diseases, whereas trauma, particularly when experienced early in life, can lead to chronic health issues like diabetes mellitus, cardiovascular disease, and chronic pain conditions. The overlap of these two scenarios can complicate overall management of menopause.[9,10]

- **Biological impact:**

Here chronic stress due to trauma and that of menopause is mediated through the hormonal interactions and inflammation. Hypo-estrogenic phase in bodies of women, is supposed to be the key factor in causation of various psychological symptoms associated with menopause. Reduction of circulating Oestrogen levels leads to decreased Oestrogen receptor-beta (ER-â), which usually keeps neuroinflammation in check. As a result, reactive oxygen species (ROS) activate the inflammation, leading to the activation of cellular inflammatory markers and the spread of the inflammatory response to nearby neuronal cells.11 During the menopausal transition, the development of anxiety and depressive disorders might be linked to the diminishing neuroprotective and neurotrophic effect of Oestrogen on the brain. Trauma additionally affects the HPA axis, causing dysregulation of stress hormone cortisol. These biological mechanisms can sum up to precipitate psychological health issues in a susceptible woman undergoing menopause.

Case vignette: Re-experiencing of past trauma during menopause

Mrs. A, 48 years old, 2nd-year degree course drop-out (the family got her married to her boyfriend immediately as soon as they came to know about the relationship, which brought a break in her studies), came with complaints of increased feelings of rage, guilt and crying spells since 3months. She had been in peri-menopause for a year with irregular menstrual cycles, fatigue and weight gain. However, she reported that these symptoms were tolerable.

Since 4 months, her mother-in-law had took to staying with her following the demise of her father-in-law. Mrs A reports that during the last 3 months, she has been bothered by traumatic memories of the past ,where in she was not accepted by her in-laws for a long time after marriage, was compared with others and taunted for being dependent financially. Mrs A suddenly got into rage and had anger outbursts, with a concern that her daughter may have to go through the same trajectory as her. She also reported of persistent feelings of resentment about so many compromises she had to make for sustaining the marriage. On one side, she could acknowledge that all the misgivings were in the past and currently she wasn't troubled in any way; Yet, on the other side, she couldn't bring herself to forgive her mother-in-law which she had done successfully and effortlessly a long time back!

Menopause and childhood adverse experiences:

Inquiring childhood neglect and trauma is a crucial step in evaluating a woman in perimenopause. Research studies indicates that adverse childhood experiences may be linked to various negative health outcomes in middle age. One such example is vasomotor symptoms. It has been observed that childhood abuse is linked to higher reporting of vasomotor symptoms in adulthood[12-14]. The way women perceive and deal with menopausal symptoms can be affected by their psychological mindset and coping strategies. Women who have low levels of hostility and stress, along with high levels of optimism and a strong sense of coherence, are more likely to handle their menopausal symptoms effectively without needing outside interventions[21]. Few research articles also aimed to evaluate the existence of any association between adverse childhood experiences and age at menopause. Stressful life experiences may negatively influence overall physical and psychological health for a midlife woman. However, the study observed that the age at natural menopause did not get influenced by the same.[15]

Intimate partner violence and Menopause:

There might be a potential association between experiencing intimate partner violence throughout one's life and the presence of clinical insomnia in midlife. The significance of screening women in midlife going through menopause with clinical insomnia for intimate partner violence is emphasized to acknowledge the potential impact of this traumatic experience on her health.[16]

B. Menopausal symptoms affecting psychology of women:

The peri-menopausal period is said to be associated with an increased predisposition to develop psychiatric disorders of which, mood disorders have an especially strong correlation.

Other disorders too appear during this period, the most common being depressive disorders, followed by anxiety disorders, sleep disturbances and cognitive decline. These disorders can develop for the first time in a woman without any prior history of psychiatric disorders. However, during the peri-menopausal period, there may be a worsening in the symptoms of pre-existing psychiatric conditions like schizophrenia, depression, bipolar disorder, and anxiety disorder. Various menopausal symptoms are also observed to interplay and make women susceptible to develop the psychological distress more. Women experiencing symptomatic menopausal transition have been noted to have associations between vasomotor symptoms, fatigue, weight gain, sexual dysfunction and sleep disturbances on one hand, with the onset of depressive and anxiety disorders on the other hand[17,18].

The symptoms of menopause, such as fatigue and mood swings, are considered to be interconnected conditions that may be linked to mood and anxiety disorders through common neurological pathways associated with inflammation, oxidative stress, and disruption of the HPA axis[19].

In Taiwan, a study covering the entire nation found that experiencing symptoms during menopausal transition could elevate the likelihood of developing newly occurring bipolar disorders, depressive disorders, anxiety disorders and sleep disorders[20].

As mentioned before, psychological behaviour patterns could impact the way women experience menopausal symptoms and deal with them. Women in their mid-life often face various psychosocial stressors. These may include dealing with marital problems, adjusting to changes in caregiving responsibilities such as children leaving home or aging parents, coping with issues related to aging and managing career demands alongside a limited social network. These factors have been associated with depressive and anxiety disorders in women going through the menopausal transition[22-24].

Depressive disorder: During the transition into menopause, women face a significantly higher risk, approximately two to four times more, of experiencing major depressive disorder as compared to women who have not yet reached menopause[25].The onset of major depression during menopause can include symptoms such as reduced energy levels, feelings of irritability or hostility, lower self-esteem, withdrawal from social interactions, increased anxiety, physical symptoms, disrupted sleep patterns, weight increase, decreased interest in sexual activities and difficulties with memory and focus[26]. The prevalence of depressive disorders in perimenopausal and postmenopausal women in India is estimated to be around 42.47% according to a study done in 202127.As reported by Bromberger et al, 15.8% women developed a new major depressive episode during the perimenopausal period, without any prior history of MDD. The risk factors identified included limitations in physical health, difficulties in social functioning, a history of anxiety and negative life events. In menopausal symptoms, experiencing weight gain, fatigue and memory problems can predict the presence of both depressive and anxiety symptoms as well as psychological distress. Women in menopause who have previously experienced pre-menstrual dysphoric disorder may find that their symptoms worsen during this phase[28].

Bipolar Affective Disorder: Bipolar disorder has been said to display two distinct peaks in onset (bimodal age of onset), namely occurring in early adulthood and during later years (ages 45–54). This later phase aligns with the typical age for perimenopause in women[29]. Each phase of hormonal disturbances such as menarche, pregnancy, delivery and menopause can pre-dispose towards relapse of an episode of bipolar disorder- depressive or manic episode. Depressive and mixed episodes are in general more common in women than manic episodes, with 77% of women reporting worsening of mood at any of these times[30].

Anxiety Disorder: Symptoms of anxiety disorder can co-exist and overlap with symptoms of perimenopause. Anxiety symptoms are frequently co-occurring with depressive symptoms also. Palpitations, tremors, dry mouth, panic attacks and feelings of nausea are a few observed anxiety symptoms here.

Cognitive decline: The phase of hypoestrogenism during menopause is speculated to lead to cognitive aging symptoms and increased susceptibility to Alzheimer's disease in genetically predisposed individuals[31].

Management:

Management of perimenopausal symptoms goes in concordance with the bio-psycho-social model in etiopathogenesis of the same. Various treatment modalities are as follows:

- Hormone Replacement Therapy (HRT)
- Non-Hormonal Medications
- Lifestyle modification and Sleep hygiene
- Psychotherapy

Hormone Replacement Therapy:

The HRT options available are Oestrogen or Combined hormone replacement therapy.

HRT is indicated for menopausal symptoms especially vasomotor, fatigue and genitourinary symptoms. However, active unexplained vaginal bleeding, previous idiopathic or current venous thromboembolism, active or recent arterial thromboembolic disease and active liver disease with abnormal liver function tests are contraindications to HRT. It is also contraindicated for individuals with breast cancer (suspected, current or past or with family history), known or suspected Oestrogen-dependent cancers (including endometrial cancer), thrombophilic disorders and untreated endometrial hyperplasia[32].

Non hormonal prescription medications:

SSRIs, SNRIs, and anticonvulsant medications are being more commonly utilized beyond their approved uses(off-label) for controlling vasomotor and psychological symptoms of perimenopausal period without hormonal treatments. Low-dose Paroxetine Mesylate (up to 10mg per day) and Venlafaxine (up to 75mg per day) are the non-hormonal medications which are FDA-approved for the treatment of vasomotor symptoms. Specific medications found effective in

treatment of vasomotor symptoms are Escitalopram (5-20mg per day), Citalopram (10-20mg per day), Desvenlafaxine (100-150mg per day), Gabapentin (900–2400 mg in three divided doses) and Pregabalin (75mg twice daily). Armodafinil is studied for its benefit in treating fatigue33.For treatment of genito-urinary and sexual dysfunction symptoms, water-based or silicone-based vaginal lubricants can be used. Regular use of long-acting vaginal moisturizers can also be advised. Dyspareunia shall be managed using vaginal lubricants, vaginal dilators and relaxation techniques.

Lifestyle modification and sleep hygiene: Lifestyle measures like attention to nutrition (with eating balanced meals with good fibre content to take care of digestion and weight gain), engaging in hobbies, relaxation exercises, deep breathing exercises, yoga or regular physical exercise, sleep hygiene and developing a good support system around oneself are effective in reducing menopausal symptoms. Focusing on coping strategies, one's living situation and how one perceives their health is crucial. Role of family is of utmost importance in extending support and care to help the women overcome the menopausal trauma and resume her new life.

Psychotherapy: Cognitive-behavioural therapy (CBT) for trauma and trauma-focused therapies can be beneficial in managing the psychological and emotional challenges accompanying menopause, especially in women with history of trauma. Obstetrician-gynaecologists and other health-care workers should have a good understanding of the trauma-informed care model, which emphasizes universal trauma screening, avoidance of stigmatization and the prioritization of resilience.34

CBT for Trauma: CBT helps individuals understand and modify negative thought patterns and behaviours. In a menopausal woman with a history of trauma, CBT can help address symptoms of anxiety, depression and overall stress management.

Various trauma-focused therapies in menopause which can be beneficial in dealing with overlapping symptoms of trauma and menopause are:

1. Eye Movement Desensitization and Reprocessing (EMDR): EMDR is designed to reduce the distress associated with PTSD and the traumatic memories. It can help women manage unresolved trauma that may be exacerbating their menopausal symptoms.
2. Mindfulness-Based Stress Reduction (MBSR): MBSR incorporates meditation techniques centered on mindfulness to assist people in directing their attention to the current moment and alleviating stress.
3. Somatic Experiencing: This type of therapy specially focuses on the body's perceived sensations and aims to release trauma symptoms stored in the body. It can be useful for women experiencing vasomotor symptoms like hot flashes and physical symptoms like fatigue and pain, which may be linked to trauma.
4. Narrative Exposure Therapy (NET): NET comprises of creating a detailed narrative of the traumatic experience, which can help an individual to contextualize and process the trauma. This process can provide a healthy vent out and a sense of control for women dealing with past trauma during menopause.

5. Integrated Care Approach: Combining physiological health care with psychological health support can address the complex needs of a woman in her menopause with a history of trauma. This involves collaboration between gynaecologists, mental health professionals and endocrinologists.
6. Self-care and Support groups: Encouraging self-help with healthy lifestyle, seeking support for physical and psychological needs, understanding the interplay of past trauma in women dealing with menopause is essential. They can be guided to participate in support groups for menopausal women or trauma survivors. Personal experience sharing and sense of belongingness can reduce distress and reduce feelings of isolation in such women.

Conclusion:

Past or current psychological trauma can precipitate or exacerbate mental health issues in women transiting through menopause. The interplay between menopause and psychological trauma highlights the need for a comprehensive approach to women's health that considers both physical and mental well-being. Pharmacotherapy combined with an integrated and trauma-informed approach can importantly provide holistic management in such transition. Individualized care plans that address the unique experiences and needs of each woman can significantly improve quality of life beyond their reproductive years.

KEY MESSEGES

- Menopause marks a very important transition in a woman's reproductive life.
- While it has biological, psychological and social determinants, this phase carries possibilities of resurfacing trauma in life of women.
- Various factors which determine the psychological health in perimenopausal period shall be considered while managing the symptomatic menopause.

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CHAPTER 12

The Mental Health Impact of Sexual Violence

Abstract

Sexual violence remains a pervasive and deeply entrenched issue in India, affecting countless women across diverse socio-economic backgrounds. This type of violence is not only a severe violation of human rights but also has profound implications for the mental health of survivors. In India, the incidence of sexual violence has been alarmingly high, as reported by the National Crime Records Bureau (NCRB), which documented around 32,000 cases of rape in 2022 alone, indicating a critical public health crisis that demands urgent attention.

[Key words: Sexual violence, NCRB, Mental health, women.]

1. Introduction

Sexual violence in India is an insidious and deeply troubling issue that affects women across all strata of society. The National Crime Records Bureau (NCRB) reported a significant number of crimes against women in the year 2022 with 4,45,256 reported cases. This is almost a 4 percent increase from the previous year 2021. In terms of sexual violence cases, 31,982 incidents of rape were recorded in 2022 alone, indicating a critical and persistent problem[1]. These figures, however, are widely believed to be underreported due to the stigma and social repercussions faced by survivors, leading to a significant number of cases that go unrecorded [2]. Sexual violence in India manifests in various forms, including but not limited to rape, sexual assault, child sexual abuse, marital rape and sexual harassment. Rape, being one of the most severe forms, often captures public and media attention, and is just one aspect of the broader spectrum of sexual violence. Sexual harassment, particularly in workplaces and public spaces, is another prevalent issue, with a significant percentage of women reporting experiences of unwanted advances and inappropriate behaviour [3].

The cultural and social context in India, further plays a crucial role in the prevalence and reporting of sexual violence. Patriarchal norms and traditional gender roles contribute to the marginalization and victimization of women, perpetuating an environment where sexual violence

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can occur with relative impunity[4]. Additionally, the legal framework, despite having stringent laws against sexual violence, often fails in effective implementation, leading to prolonged legal battles for many survivors.[5]

Child sexual abuse is another critical area of concern, with alarming rates reported by various studies. A study by the Ministry of Women and Child Development revealed that over 53% of children surveyed had faced some form of sexual abuse, highlighting the vulnerability of minors to such atrocities[6]. Marital rape, although recognized globally as a serious offense, remains a contentious issue in India, with no specific laws criminalizing non-consensual sex within marriage[7].

The mental health impact on survivors of sexual violence is profound, leading to issues such as post-traumatic stress disorder (PTSD), depression, anxiety and long-term psychological trauma. The social stigma associated with sexual violence often exacerbates these mental health challenges, leaving survivors isolated and without adequate support[8].

2. Sexual Violence against Women

According to United Nations, "Sexual violence is a form of gender-based violence and encompasses any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. Sexual violence takes multiple forms and includes rape, sexual abuse, forced pregnancy, forced sterilization, forced abortion, forced prostitution, trafficking, sexual enslavement, forced circumcision, castration and forced nudity". This definition ascertains that sexual violence is a serious violation of human rights and a pervasive public health issue that encompasses a range of coercive behaviors and acts. World Health Organization (WHO) also defines sexual violence similarly and these broad definitions highlight the various ways sexual violence can manifest, impacting individuals across different contexts and relationships[9,10].

3. Forms of Sexual Violence

There are various forms of sexual violence faced by women. These forms of sexual violence have far-reaching consequences, including severe physical, psychological and emotional impact on survivors. The complexity of addressing sexual violence in India is compounded by cultural, legal and societal barriers, making it imperative to have a nuanced understanding and multi-faceted approach to prevention and support.

3.1. Rape: Rape is one of the most extreme forms of sexual violence, involving non-consensual sexual intercourse. It often includes physical force, threats or coercion, and can occur in various contexts, including within intimate relationships or by strangers[11].

3.2. Child Sexual Abuse: Child sexual abuse involves engaging a child in sexual activities that they cannot comprehend, are developmentally unprepared for, and cannot give informed consent to. This includes molestation, exploitation and exposure to inappropriate sexual content[12].

3.3. **Marital Rape:** Marital rape refers to non-consensual sex forced upon a spouse. Despite being recognized as a serious offense in many countries, marital rape is not explicitly criminalized in India, reflecting deep-seated societal and legal challenges[13] .

3.4. **Sexual Harassment:** Sexual harassment includes unwanted sexual advances, requests for sexual favours and other verbal or physical conduct of a sexual nature that creates a hostile or offensive environment. It is particularly prevalent in workplaces and public spaces[14].

3.5. Sexual Assault: Sexual assault is a broader category encompassing any non-consensual sexual act. It includes groping, forced kissing and other forms of sexual coercion that do not meet the legal definition of rape[15].

3.6. Incest: Incest involves sexual activities between family members or close relatives, which is not only a form of sexual violence but also carries significant social stigma and psychological harm[16].

3.7. Sexual Exploitation and Trafficking: Sexual exploitation and trafficking involve coercing individuals into sexual activities for financial gain, often through force, fraud or coercion. This form of violence is prevalent in both local and international contexts and is a major human rights concern[17].

It is important to acknowledge that globally, 6 per cent of women report that they have been subjected to sexual violence from someone other than their husband or partner. However, the true prevalence of non-partner sexual violence is likely to be much higher, considering the stigma related to this form of violence.

3.8 Cyber enabled forms of sexual violence and abuse against women : In recent years, the rise of digital technologies and internet access has led to the emergence of cyber-enabled sexual violence, adding a new dimension to the existing forms of violence and abuse. This category of violence encompasses various acts of sexual harassment, exploitation and abuse facilitated through digital platforms, social media and other online means. Some of the major forms of Cyber-Enabled Sexual Violences are as follows**:**

3.8.1.Cyberstalking: Cyberstalking involves the repeated use of electronic communications to harass or frighten someone. This can include sending threatening emails, monitoring online activity and hacking into social media accounts[18]. Cyberstalking often intersects with offline stalking and can lead to severe psychological distress for the victim.

3.8.2. Revenge Porn: Revenge porn or non-consensual pornography involves the distribution of sexually explicit images or videos without the consent of the individual depicted. These images are often shared by former partners to humiliate or blackmail the victim. In India, this form of abuse has garnered significant attention, leading to legal amendments aimed at addressing it[19].

3.8.3. Online Grooming: Online grooming refers to the process by which an adult uses the internet to manipulate and exploit a minor for sexual purposes. This often involves building an emotional connection with the child to gain their trust before exploiting them sexually. The anonymity of the internet makes it easier for perpetrators to target vulnerable children[20].

3.8.4. Sextortion: Sextortion is a form of blackmail where someone threatens to distribute the victim's private and sensitive material if they do not comply with certain demands, which are sexual in nature. Perpetrators typically gain access to these materials through hacking or deceitful methods[21].

3.8.5. Doctored Images and Deepfakes: The misuse of technology to create doctored images or deep fake videos, which are realistic looking but digitally altered, is a growing concern. These materials are used to defame or harass individuals, often without their knowledge or consent, causing significant emotional and reputational damage[22].

4. Impact of sexual violence on Mental Health of the victims

Sexual violence has profound and long-lasting impact on the mental health of survivors. The trauma associated with such experiences can manifest as various psychological and emotional disorders, affecting well-being, functioning and quality of life of survivors.

4.1 Psychological Effects

4.1.1. Post-Traumatic Stress Disorder (PTSD): One of the most common mental health conditions resulting from sexual violence is PTSD. Symptoms include intrusive memories, flashbacks, severe anxiety and nightmares. Survivors may also experience hyperarousal and avoidance behaviors, significantly impacting their daily lives [23].

4.1.2. Depression: Survivors of sexual violence are at a higher risk of developing depression. This can be characterized by persistent sadness, loss of interest in activities, changes in appetite and sleep patterns and feelings of worthlessness or hopelessness. Depression can severely affect a survivor's ability to function and maintain relationships [24].

4.1.3. Anxiety disorders: Sexual violence can lead to various anxiety disorders, including generalized anxiety disorder, panic disorder and social anxiety disorder. Survivors often experience heightened levels of fear, worry and panic attacks, which can interfere with their ability to engage in normal activities [25].

4.1.4 .Substance Abuse: To cope with the psychological pain, some survivors may turn to substance abuse. The use of alcohol or drugs as a coping mechanism can lead to dependency and further complicate mental health issues, creating a cycle of abuse and mental health decline [26].

4.1.5 .Suicidal tendencies: The severe emotional distress resulting from sexual violence

can increase the risk of suicidal ideation and attempts. Survivors may feel overwhelmed by their experiences and see suicide as a way to escape their pain [27].

4.2 Behavioral Effects

4.2.1. Shame and Guilt: Survivors often experience intense feelings of shame and guilt. They may blame themselves for the violence, leading to deep-seated feelings of self-hatred and unworthiness. This emotional burden can hinder their recovery process and prevent them from seeking help [28].

4.2.2.Dissociation and self-neglect: As a coping mechanism, some survivors may dissociate, experiencing a disconnection from reality, themselves or their surroundings. This can manifest as feeling detached from their bodies or emotions, impacting their ability to engage fully in life[29].

4.2.3. Interpersonal Difficulties: The trauma of sexual violence can affect a survivor's ability to form and maintain relationships. Trust issues, fear of intimacy and social withdrawal are common, which can lead to isolation and loneliness [30].

4.2.4 Aggression and Self-Destructive Behavior: Some survivors may exhibit aggressive behavior or self-destructive tendencies, including self-harm. These behaviors can be expressions of internalized anger or attempts to regain a sense of control [31].

4.3 Long-Term Consequences

4.3.1. Chronic Mental Health Issues: The mental health impact of sexual violence can be long-term, with some survivors experiencing chronic mental health conditions that require ongoing treatment and support. This includes persistent depression, anxiety and PTSD that can last for years after the initial trauma[32].

4.3.2. Impact on Daily Functioning: The cumulative effects of mental health issues can impair a survivor's ability to function in daily life, affecting their educational, professional and social outcomes. This can lead to difficulties in maintaining employment, achieving academic success and engaging in social activities[33].

4.3.3. Physical Health Correlations: There is also a significant correlation between mental health issues and physical health problems. Survivors of sexual violence are more likely to experience chronic pain, gastrointestinal issues and other stress-related physical conditions, further impacting their overall health and well-being [34].

5. Barriers in Recognition and Treatment of Mental Health Effects of Sexual Violence

In India, various social, cultural and systemic factors contribute to the under-recognition and inade2quate treatment of the mental health effects of sexual violence. Deeply ingrained prejudices and biases in society play a significant role in shaping attitudes towards mental health of survivors of sexual violence. These attitudes create substantial barriers to seeking and receiving appropriate mental health care. One of the primary obstacles is the pervasive stigma associated with both mental health issues and sexual violence. Mental health

disorders are often viewed with suspicion and shame, leading to the marginalization of individuals who seek help. This stigma is compounded when the mental health issues are a consequence of sexual violence, as survivors are frequently blamed or doubted. The prevailing societal norms often dictate that survivors remain silent to avoid bringing dishonor to their families, which inhibits open discussions about their mental health needs and discourages them from seeking psychological support [35].Gender biases further exacerbate the problem. In a patriarchal society like India, women and girls are often seen as the custodians of family honor and their victimization through sexual violence is viewed as a personal and familial disgrace. This attitude not only silences survivors but also fosters an environment where their mental health struggles are trivialized or ignored. The belief that women should endure suffering silently, coupled with the fear of societal retribution, prevents many from accessing mental health services [36].The lack of awareness and education about mental health among the general population and even among healthcare providers is another critical barrier. Many people, including survivors themselves, may not recognize the symptoms of mental health disorders such as PTSD, depression or anxiety as legitimate health issues that require professional intervention. This ignorance extends to healthcare providers who may lack the training to identify and appropriately treat the psychological effects of sexual violence, leading to misdiagnosis or inadequate care [37].Economic barriers also play a significant role. Access to mental health care in India is often limited by financial constraints, especially in rural areas where resources are scarce. Public mental health services are underfunded and understaffed, and private care can be prohibitively expensive for many survivors. This economic disparity means that even when survivors recognize the need for mental health care, they may be unable to afford it or access it due to geographical and logistical challenges [38].Social support systems, which are crucial for the recovery of survivors, are often weak or non-existent. Survivors may face isolation and rejection from their families and communities, which can lead to further psychological distress. The lack of supportive networks undermines the healing process and reinforces the stigma and silence surrounding both sexual violence and mental health issues [39].Additionally, the legal and justice systems in India often fail to provide the necessary support for survivors of sexual violence. The process of reporting sexual violence and pursuing justice can be re-traumatizing and may not always lead to a conviction. The perceived or real ineffectiveness of the legal system deters many survivors from coming forward and seeking the help they need, including mental health care [40].

6. Mind of the perpetrator

" *The more you try to figure out why he does it, the more you become enmeshed in his justification, rationalizations and distortions. The more you grasp the full meaning of his abuse, the more you understand that his problem is not his feelings, but his lack of respect***"**
- Lundy Bancroft[41].

The mind of the perpetrator of sexual violence against women is often characterized by a combination of distorted beliefs, psychological factors and social influences.

6.1. **Distorted beliefs and attitudes:** Perpetrators often believe in traditional gender roles that devalue women. They might see women as objects or property rather than individuals with autonomy and rights. This dehumanization facilitates the justification of their actions. Belief that a woman is inferior and treating them as objects of gratification is held by few[42].

6.2. **Entitlement:** Some men think that they have a right to control and use women's bodies. This sense of entitlement can stem from societal messages which show male dominance. These beliefs further can be reinforced by surrounding patriarchy.

6.3. **Desire for power and control:** More than sexual desire many perpetrators have a desire to exert power and have control over their victims. It goes beyond sexual gratification [43].

6.4. **Lack of empathy:** Perpetrators may be unable to or unwilling to recognize the suffering they cause, viewing their actions as justified. They could be having narcissistic or antisocial personality disorder. This can also have a base from previous violent behavior that they faced as a child [44].

6.5. **Psychological factors:** Some of them are having underlying psychiatric issues like personality disorder, substance abuse disorder or post-traumatic stress disorder. When one has such illnesses, it can increase impulsivity and reduce judgment [45].

6.6. **Social and cultural influence:** Environments that normalize or trivialize sexual violence, promote hyper masculinity can contribute to the perpetuation of sexual violence.

6.7. **Cognitive distortions:** People can have distortions of thought wherein they try to rationalize their behavior. They may blame the victim, deny the seriousness of the assault or convince themselves that their actions were consensual or not harmful [46].

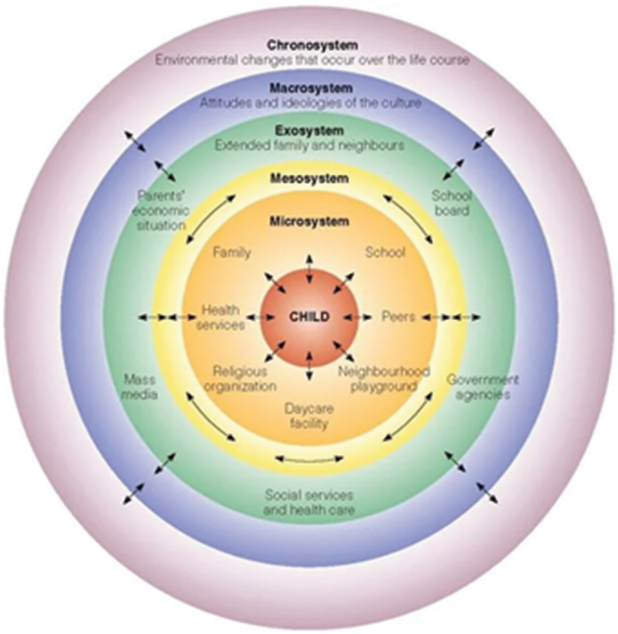
6.8. **Emotional and situational factors:** Perpetrators can take advantage of the situation where they can exert control such as where the victim is vulnerable, isolated or incapacitated. Sometimes when the person is under influence of substances, their impulsivity can increase leading to violence.

Understanding these factors can help in developing interventions and prevention strategies aimed at reducing the incidence of sexual violence and addressing the root cause of such behavior.

7. Prevention

This chapter perhaps cannot be concluded meaningfully without a discussion on effective prevention of such traumatizing acts. Having discussed the impact of sexual violence on victims and what contributes to the mind of a perpetrator, we probably can attempt to imagine an ideal preventive strategies

Figure: 1



7.1 . Urie Bronfenbrenner's ecological theory of human development needs a mention here, as impact of sexual violence seems to be affected by all the system factors that he mentioned (see Figure:1). Hence, *primordial and primary prevention* could be to create awareness to change the meta constructs that stem from all levels of this ecological model, that are responsible for self- blaming of victims, revictimization by society and flawed perception of perpetrators [47].

7.2. *Secondary prevention* can be achieved by carrying out awareness programs on various social platforms for wider outreach .

7.3 .Setting up 'sexual violence crisis centers', by the state to sensitively provide multidisciplinary support, such as legal, social and health support to victims can be *tertiary prevention.*

7.4. Government and non-government organizations working towards destigmatizing the victim and facilitating their smooth reintegration into society, could be deemed *quaternary preventive* strategies.

8. Conclusion

The mental health impact of sexual violence in India is profound and multifaceted, encompassing psychological, emotional and behavioral disorders that significantly impair well-being of survivors. Cultural and social norms, such as patriarchy, victim-blaming and pervasive misconceptions about sexual violence, perpetuate these issues and hinder effective responses. The stigma surrounding

mental health and sexual violence, coupled with gender biases and economic barriers, prevents many survivors from seeking or receiving the care they need. Furthermore, systemic shortcomings in healthcare, legal and social support systems exacerbate the challenges faced by survivors. Addressing these issues requires comprehensive measures, including raising awareness, reducing stigma, improving access to mental health services and ensuring supportive and effective legal frameworks. By transforming societal attitudes and strengthening support systems, India can create a more just and empathetic environment for survivors, helping them heal and reclaim their lives. This multi-pronged approach is crucial for mitigating the mental health impacts of sexual violence and fostering a society that respects and upholds the rights and dignity of all individuals.

Key Messages

- Despite being grossly underreported, number of sexual violence cases reported by NCRB is staggering.
- Mental health impact of sexual violence is more profound than other kinds of trauma due to constant re-traumatization by the legal and socio-cultural constructs currently in place, that act as multiplying agents.
- Socio-cultural factors also act as barriers for adequate support and rehabilitation of victims.
- Understanding the psychosocial aspects around this violence, 'Mind' of the perpetrator as well as the victim, can help us in envisaging effective preventive strategies.
- Prevention at present is mostly at a preliminary stage, most of it being at quaternary level, as rehabilitation provided by non-government organizations.

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CHAPTER 13

Intimate Partner Violence: Mental Health Impact

Abstract:

Violence against women is a major concern, especially Intimate Partner Violence (IPV) and sexual violence. It may cause a number of physical, reproductive and mental health related problems and more importantly, violate a person's human rights. Very few women victims of IPV seek help, especially in India and still fewer seek help for mental health issues related to IPV. The most common mental health disorders associated with IPV are depression, post traumatic stress disorder (PTSD), anxiety disorders and substance use. IPV is faced more by women having lesser education and being financially dependent. This chapter aims to highlight key issues of IPV which includes its definition, epidemiology , perpetuating factors , mental health outcomes, screening and interventions.

[Keywords: IPV, Women, Typologies, Intervention, Mental Health Outcomes, Screening]

"*It is not the bruises on the body that hurt. It is the wounds of the heart and the scars on the mind." — Aisha Mirza*

Introduction:

Intimate partner violence (IPV) can be defined as any conduct inside an intimate relationship that causes physical, psychological or sexual hurt to those in the relationship . It is one of the most imperative causes of morbidity and mortality among women of reproductive age groups worldwide. IPV is different from domestic violence (DV) but may be a part of it because DV encompasses physical, psychological or sexual trauma caused by any member of a family to another. Intimate partner can include both current or past partner or spouse. It is recognized as a gender based violence, with a higher proportion of women being affected than men. Females have a higher chance of being hurt in case of IPV, hence most studies focus on male to female partner violence[4,5]. IPV may be bi-directional and a few studies have shown a more or equal rate of female to male partner violence but overall rates of male to female violence is more[6-10]. Up to 60% of married women have reported of domestic violence[7]. WHO estimates that one third of all women

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have faced physical and sexual violence at the hands of an intimate partner or sexual violence from another person and 27% of women in the world, in the age group of 15-49 years, who are in a relationship have faced IPV in their lifetime[1].

Prevalence:

National Family Health Survey(NFHS) of all Indian states done in 2020–2021 showed that 29.3% of ever-married women of the age group of 18–49 years experienced spousal violence, 3.1% experienced physical violence during any pregnancy, and 1.5% experienced sexual violence. 22% of participants experienced physical abuse, 6% sexual abuse, and 10% emotional abuse by their partner in the past year[11]. In this survey , surprisingly women with relatively advanced education, employment or earning status more than their spouses faced more repeated violence than women with lower educational levels. This could be due to under reporting of IPV in lesser educated women cohort along with other factors like fear of perpetrator, economic dependence on the spouse, a hope that IPV will stop, humiliation and loss of prestige.

Type Of Violence:

CDC (Centre for Disease Control and Prevention) has included any of the following behaviours as IPV[12,13].

a) **Physical violence**-This is when a person hurts a partner by physical force that can cause death, injury, disability or harm. It includes scratching, pushing, biting, throwing, choking, shaking, hair pulling, hitting , burning, use of a weapon or use of restrain on another person. Physical violence also includes coercing other people to commit any of the above acts. Physical violence was the most common form of IPV (29.2%) experienced and was reported from the highest age groups, uneducated, poorest respondents from Eastern part of India, who were mostly multiparous, married at a young age and were economically empowered. Economic empowerment in this study , however meant that women owned or co-owned some property or were earning some income, without that significantly contributing towards any substantial change in overall family's financial status or her status within the family . There was a high prevalence of controlling behaviour and alcohol dependence in their spouses[14]. A study found that among women with young children living in rural tribal communities of Rajasthan , more than one-third experienced psychological abuse or physical abuse in the past year and the majority of women reported controlling partner behaviour. Women reporting physical abuse had higher levels of mental distress than women reporting no abuse with a linear relationship being observed between the number of physical abuse acts and mental distress in women experiencing up to five physical abuse acts[15].

b) **Sexual violence**- This includes forcing a partner to take part in a sexual act, touching or a non physical sexual event (sexting, taking or showing pictures / videos), when a partner does not want to or cannot consent (incapacitated, unconscious or unaware). Prevalence was reported to be 9.6% in round 3 NFHS (2005-6) and 6.7% in round 4 (2015-16). Higher prevalence was seen in 25–34 years age group, uneducated, poorest respondents from

Eastern part of the country who were married at a younger age, were multiparous, and economically empowered. Their spouses again had a high rate of controlling behaviour and alcohol dependence[14].

c) **Stalking**- This is when there is repeated unwanted attention (calling, messaging, leaving cards or gifts) or contact by a partner that causes fear or concern for one's safety or safety of someone close to the victim . It includes watching or following, sneaking into someone's property and cyberstalking.

d) **Psychological aggression**- This encompasses verbal or non verbal communication with a partner with an intention to cause emotional harm or exert control over a partner (humiliating, threatening, controlling access to money, friends, healthcare). National prevalence was reported to be 13%. The weighted prevalence was nearly similar in all age groups but highest in uneducated, and poorest respondents belonging to the eastern India, who were multiparous and economically empowered Spouse characteristics remained the same as above two[14]. Controlling behaviour is common in India[16], and some women in this context may not consider it abuse. There is also some debate in the literature regarding if controlling behaviour should be considered a part of or as separate from IPV[17,18]. Controlling behaviour, however, may have negative implications for women's mental health.

Different forms of violence:

a) Male to female aggression – This is also called as intimate or patriarchal terrorism where the perpetrator is male who tries mainly to exercise control or instil fear in his female partner.

b) Female to male aggression : Here the perpetrator of violence is female and victims male. This goes to show that IPV may be bi-directional .While few studies have shown a more or equal rate of female to male partner violence[6-10], overall rates of male to female violence is more.

c) Violent resistance- Here, a partner tries to defend oneself and in that process gets more injured.

d) Common or situational couple violence- This occurs as a consequence of situations that lead to conflict, resulting in a low intensity aggression from both the sides[19,20].

Severity of Abuse[21]:

a) Level I abuse- This includes pushing, grabbing, throwing objects to instil fear or damage to property or pets.

b) Level II abuse-This involves a higher level of hurting like slapping, kicking or biting.

c) Level III abuse- This escalation includes more grievous or dangerous acts like attempting strangulation, choking or using a weapon.

Types of male batters[21]:

a) Family only batterers- These are men who usually cause less severe violence, only inside the

family and are not likely to cause sexual or psychological abuse. They may not have any significant psychopathology, except for a passive dependant personality.

b) Dysphoric or Borderline batterers- Here, they are likely to cause physical, psychological or sexual abuse of a moderate to severe nature. They could be dysphoric or having borderline or schizoid traits in personality and may have substance use or dependence too.

C) Violent or Antisocial batterers- These are men who may cause violence of moderate to severe form both inside and outside the family as well. They exhibit dissocial traits in personality.

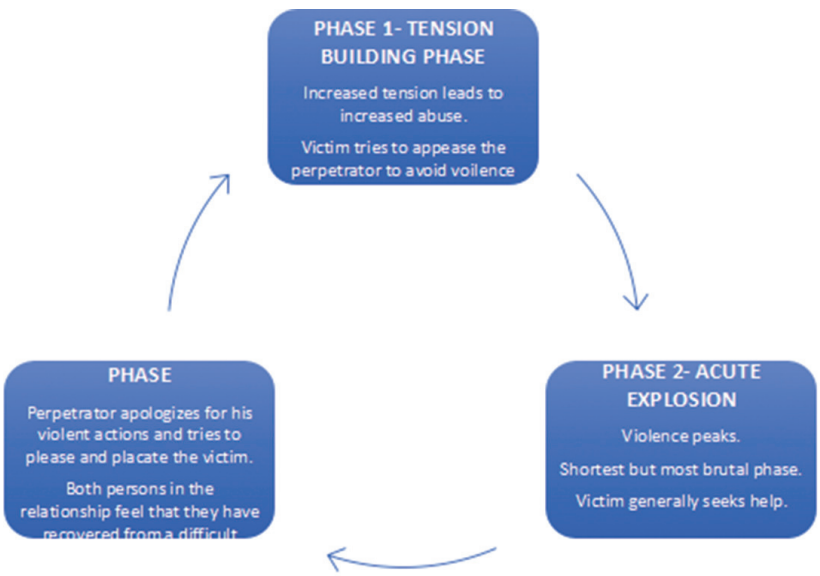
Cycle of Violence:

The cycle of violence theory was developed by Dr Lenore Walker in 1979 and it describes the phases of a violent relationship and how it leads on to violence[12,13].

Phase 1- Tension building phase- Tension increases in a relationship that causes an increase in verbal, emotional and financial abuse. The victim tries to appease the perpetrator by doing things that she considers to be 'right' to avoid the violence.

Phase 2- Acute explosion- Violence peaks in this stage and the perpetrator experiences a release of tension. This is the cycle's shortest but most brutal phase in which the victim faces severe violence. Help seeking generally takes place during this time because the victim is scared for her life.

Phase 3- Honeymoon phase- In this phase, the perpetrator apologizes for his violent actions and tries to please and placate the victim by being extremely nice to her. He buys her gifts and is very attentive of her needs. Both persons in the relationship feel that they have recovered from a difficult phase but sometime later, the cycle repeats.



Social constructs behind IPV in India:

India is a patriarchal society, with preference to male child. It has been observed that in Indian states with anisometric sex-ratios of first births favouring males, women with first born sons are less likely to experience IPV than those with first born daughters and those who have experienced IPV once are more likely to experience it again[22]. The likelihood of IPV is higher in women who are dependent on their partners financially[21]. Due to the risk of violence, they are less likely to seek jobs and are caught up further in an abusive relationship. However, a study done in India[14] although observed that IPV was common in the poorer strata, went on to show that economic empowerment of women paradoxically increased the probability of violent episodes. The most common risk factors for IPV are young age, illiteracy in the victim; substance use, personality disorders in the perpetrator; history of abusive environment in childhood, acceptance of violence and sexual abuse as children in both partners[23,24]. Economic empowerment, that was considered to be protective for the victim globally, exposed her to a higher chance of IPV according to studies done in India[14]. This could be due to the perpetrator feeling threatened by his partner's empowerment and hence trying to supress her. Pattojoshi et al. found a prevalence of domestic violence of up to 18.2% during the lockdown in an online survey period[16]. This study brought into the limelight the disastrous implications of a work-from-home culture where affected spouses were exposed to new violence owing to all family members residing together during the lockdown period. This could again be superimposed by consequences generated due to frustration arising from forced abstinence from alcohol and other substances in the spouses during the suddenly imposed lockdowns[25]

Children in IPV household:

Children who have been brought up in a violent atmosphere accept violence as a way of dealing with conflicts and react in aggressive ways more than others[26,27]. This is a concern because there is evidence that exposure to IPV in children leads to increased risk of perpetration of IPV among boys and of IPV victimization among girls, through what is commonly referred to as the 'intergenerational transmission of violence'[28]. Children who are exposed to violence at home are often traumatized themselves and exhibit PTSD like symptoms[29]. Overall, these children are more likely to use violence at school or community(in response to perceived threats), to attempt suicide, use drugs, commit crimes(especially sexual assault), use violence to enhance their reputation and self esteem and become abusers in later life[30].

Long term impact of IPV

Physical Health:

IPV may result in injuries ranging from bruises and fractures to chronic disabilities, such as partial or total loss of hearing or vision, or burns leading to disfigurement[21]. Intimate partner violence with sexual violence is associated with high risk of pregnancy, problems associated with illegal abortions, sexually transmitted diseases (STDs) and HIV infection[31]. Studies in Uttar Pradesh have shown that unplanned pregnancies are significantly more common among wives of abusive

men[32]. Battered women have twice the risk of miscarriage and four times the risk of having a baby that is below average weight. Violence also accounts for a sizeable portion of maternal deaths[33]. A review on homicides in women shows that around 38% were committed by a current or former intimate partner[34].

IPV and Mental Health:

PTSD, depression and substance abuse are both the cause and risk factors for experiencing IPV. PTSD has been identified in 31–84.4% of women with IPV[35]. Substance abuse, depression, anxiety, sleep problems and suicidality are commonly seen comorbid conditions with PTSD. Hence, effective treatment for same , may help reduce the victim's distress and risk for future IPV.

Psychological IPV is not visibly evident and hence , it becomes difficult to quantify and assess, leading to minimization by both clients and clinicians. Psychological IPV contributes to poorer mental health, sometimes even beyond the effects of physical and sexual IPV. Clients often report that psychological IPV, (which includes social isolation, belittling, intimidation, and gaslighting, for example., "I'm not lying, you are imagining things") is the worst part of their IPV experience. These episodes reduce self-efficacy and a sense of control, reduce internal and external resources and exacerbate psychological distress. The crippling effect of IPV and associated internalizing feelings (of hopelessness, self-doubt, and fear) may enable the individual to stay in or re-engage in abusive relationships again and again[36,37].

In an Indian survey, 40% of IPV survivors had poor mental health[38]. In a study of female psychiatric outpatients with history of intimate partner violence, 14% had PTSD[39]. In another study on urban women, 22.3% of them had suicidal thoughts and 3.4% had attempted suicide[40]. Women presenting with physical symptoms may have somatoform disorders, that manifest as headache, back pain, neck pain, joint pains or stomach cramps.

Depression:

In a review done by Dilon[31], most studies reported a strong association between IPV and depressive symptoms. Also, the severity, chronicity and subjective perception of IPV was seen to be correlated with more severe depressive symptoms. 34.7% of the total IPV disease burden was attributed to depression. Being exposed to more than one type of violence increases the risk of depression and its severity. Women who were depressed in an abusive relationship, continued to be depressed even after leaving that relationship. Helfrich[41] has reported an incidence of major depression to be 51.4% in one year in women in violence shelter homes.

PTSD:

In the same review by Dilon[31], PTSD was seen to be more likely (up to 2.3 times more) in women who had faced IPV and was higher in those who gave history of more types of IPV and in those where violence was more severe and more sustained. In most cases, PTSD co occurred with depressive symptoms which could also be due to overlapping symptoms like anhedonia, insomnia and reduced concentration. Women with PTSD were ten times more likely to report of

depression. The prevalence of PTSD has been varied in different studies, depending on where the sample was taken; 14% among female psychiatry outpatients who had faced IPV[39], to 16.2% - 92.4% in crisis shelters, to 30.9% in health maintenance organization.

ANXIETY:

Anxiety has very commonly been associated with IPV and Dilon's review[31] has reported of up to 77% of women suffering from anxiety in a women's shelter. 27.3% of disease burden in IPV was reported to be due to anxiety. A higher severity of anxiety symptoms have been found to be comorbid with depression in IPV and more so , when the abuse was more frequent, severe and intense.

SUICIDE AND SELF HARM:

All the studies related to self harm in this review[31] reported of an association between the lifetime experience of abuse and increased suicidal ideation and suicide attempts in women. Ellsberg ,cited in the review, reported that women who had experienced physical or sexual violence, or both, were three times more likely to have thought about suicide and almost four times more likely to have attempted suicide. In an urban Indian study[40] on women who had faced partner violence, 12% reported suicidal thoughts in the past month and 3.4% of them had tried to commit suicide. Suicidal tendencies were more common in women with a history of partner violence. Increase in the number of types of violence was closely seen to be related to suicidal ideation, as was physical and sexual violence in the past twelve months. Sexual violence that occurred more than 12 months before, was still closely related to ideas of suicide probably because it was perceived to be a more severe form of violence. Victims consider self- harm to be a method for airing painful emotions, or as a last resort to escape by dying when they see no other option or , when they are no longer able to endure the violence.

SELF PERCIEVED PSYCHOLOGICAL DISTRESS:

In the review by Dilon[31], a number of instruments like SF 36, SF 12, SRQ 20 and GHQ 12 were used in various studies to assess the psychological distress. Women who had experienced IPV in any form had lower mental health and social functioning scores than women who had not experienced IPV. The degree of serious psychological distress experienced was highest among women who reported experiencing both physical and sexual violence (15.4% v/s 2.1% in women who had never experienced any form of violence).

POOR QUALITY OF SLEEP:

Among the articles reviewed[31], IPV was seen to be affecting both the quality and quantity of sleep, the main mediating pathway being depression and PTSD. Women reported of being afraid of sleeping while the perpetrator was awake, for fear of an attack. In other cases, keeping the victim awake was the perpetrator's way of exercising control over her. Living in a constant anticipation of violence, these women had sleep disturbance even when they had separated from their partners.

SCREENING METHODS:

All patients who come with history of IPV, should be screened for mental health problems like Depression, Anxiety, PTSD and Suicidal ideation. Screening for IPV can be interview or questionnaire based, depending on the time available, preference of the woman and training of the medical staff. Some studies have indicated that women prefer questionnaires[42,43], which could be because of privacy issues. Women working as ASHA or Anganwadi workers could be trained in educating and screening for IPV.

SCREENING TOOLS

The HITS screen[44] has a Likert scoring system (1-5) for four items, Hurt, Insult, Threaten, Scream. The score ranges from 4 to 20 and a score of 10 or more is considered to be positive for abuse. STaT screen[45], which stands for Slapped, Threatened and Thrown has a high sensitivity and a score of 1 or more is considered positive for a lifetime IPV. Other instruments[46] used to detect IPV are, Woman Abuse Screening Tool, Women's Experience with Battering Scale, The Abuse Assessment Scale and Conflicts Tactics Scale.

INTERVENTIONS

WHO has done randomised controlled trials in low and middle-income settings of several interventions to reduce symptoms of common mental health disorders that can be delivered by trained and supervised non-specialists for victims of IPV. Prominent among these needs a mention here.

Problem Management Plus[47] is a brief psychological intervention comprising problem management and few behavioural strategies that can be delivered individually or in groups. It does not diagnose but may help several psychological and practical problems. It has been tested and effectively used in communities that face extremely difficult circumstances (including women with a history of domestic violence) in Kenya and Pakistan[48].PM+ effectively reduced depression and anxiety symptoms and improved daily functioning which included ability to communicate, get around, care for oneself, complete work or household chores, and participate in society.

Self-Help Plus[49] is an innovative, facilitator-guided, group-based, transdiagnostic stress-management course for adults that uses pre-recorded audio and an illustrated self-help guide to communicate stress-management techniques to groups of up to 30 people. It is used in persons facing adversities like violence, disease and lack of economic opportunities. Self Help+ prevented the onset of mental disorders and resulted in meaningful reductions in psychological distress at 3 months compared with enhanced usual care among South Sudanese female refugees, including those who had experienced IPV[50].

RESPECT Women[51], a framework for preventing violence against women, was developed by WHO and UN Women in 2019 and has been endorsed by 12 other UN agencies and bilateral partners. It aims to mitigate the risk factors and amplify the protective factors for violence against women by influencing policy makers. RESPECT is an acronym for the seven strategies used in this program: Relationship skills strengthened, Empowerment of women (economically, socially

and psychologically), Services ensured (including health, legal or judicial and social welfare services), Poverty reduced, Environments made safe (including schools, workplaces and public spaces), Child and adolescent abuse prevented and Transformed attitudes, beliefs and norms. The evidence for each of these seven strategies is summarised in the framework and specific programmatic examples are provided, with a focus on low-income and middle-income countries[52]. An important strategy in RESPECT Women is the transformation of gender attitudes, beliefs and norms.

A buddy system (Survivor's network) needs to be developed, in which the survivor is assisted by a recovered survivor for re-integration into society[53]. There is an urgent need to train the health personnel, police department, judiciary, women and child welfare department and all other people involved in providing care. Survivors and providers alike have called for urgent reforms to enable pathways to safety through production of trauma-informed approaches to care. Political will needs to shape all this to bring about a positive change. India may require culturally acceptable and specific strategies for IPV[54].

Practitioners and authorities , along with public ,should be informed about males being victims of IPV too. Psychologically threatening events can have negative mental health consequences for male victims as well[55]. Prevention and treatment should also be devised and made available for male victims and IPV among LGBTQ partners need to be addressed specifically too.

CONCLUSION:

Intimate partner violence is one of the most common forms of violence worldwide and contributes substantially to the global burden of mental health problems. Violence from a partner could be physical, sexual or psychological, with all three types causing significant psychological distress in the victim. The severity and duration of IPV are determinants of mental health disorders in women. Very few women seek help for sequelae of IPV. Disorders like Depression, PTSD, Anxiety and Substance use could cause significant problems in the short and long term, causing disability and sometimes even death by suicide. These disorders can be the cause and risk for IPV. So health or community personnel who are the point of first contact should be sensitized and trained to pick up IPV and its consequent mental health disorders, and implement interventions in these victims. The Police, judiciary and policy makers should all be sensitized about IPV so that culture or region specific interventions can be designed to help these individuals lead a life of dignity, without fear.

Key Messages

1. Mental health impact of IPV is significant and tends to continue even after the violence is over.
2. Majority of IPV goes unreported.
3. Health personnel should be sensitised about IPV so they can screen women for it and provide necessary information to help them.
4. Community awareness should be increased to reduce tolerance and normalization of IPV.

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CHAPTER 14

Marital Rape : Socio-cultural And Legal Scenario In India

Abstract

Marital rape refers to rape committed when the perpetrator is the victim's spouse. In India, the Bharatiya Nyaya Sanhita(BNS) and the erstwhile Indian Penal Code(IPC) do not consider marital sexual act without the woman's consent as rape, except when the couple are separated. In the latter situation, the rape does not fall under definition of rape in section 63 of BNS and the punishment is less severe. Cultural and social sanctions for marital rape in our patriarchal society are under the presumption that the marriage is a sacred union and the wife is 'subservient' in position. This causes trauma and adverse health outcomes to women. There are opposing court judgements regarding criminalization of marital rape, though there is a progressive move to validate marital rape, with the JS Verma committee report being the landmark one. The reality needs to be acknowledged and victims of marital rape be treated with dignity, empathy and with recourse to law, which should be rooted in truth and justice for all genders.

[Key words : Marital rape, Socio-cultural, Legal scenario , BNS , IPC]

Introduction:

"A murderer kills the body but a rapist kills the soul" -Justice Krishna Ayer

Sexual intercourse with one's spouse, when non-consensual, takes on the contours of marital rape. All forms of non-consensual sexual acts with a woman by her husband constitutes marital rape. Adding to the dismal legal outlook on marital rape in India, is the much more disparaging and deeply entrenched, socio-cultural stances prevalent in the largely patriarchal Indian society. Though this makes research in this area further difficult, the existing research does point to the magnitude of the problem currently present within the institutions of marriage spread across a religiously and culturally diverse India. According to a systemic review done as recently as in 2022, sexual coercion by an intimate partner, was quite varied and prevalent, ranging anywhere between 9-80% [1]. Among these, around 56% cases amounted to marital rape too. Studies also demonstrated statistically significant associations between spousal sexual violence and adverse

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mental health outcomes. Prominent among these were depression, PTSD and sleep disorders. Adding to the existing problems, were shame and guilt induced by the surrounding socio-cultural milieu, thus negatively affecting the victim's ability to speak about the abuse and seek help for the same. These further exacerbate the anger, stress, anxiety, and depressive symptoms leading to deliberate self-harm and suicidal feelings. In spite of glaring evidence pointing towards grave and adverse mental health consequences due to marital rape, the selective inattention of the society towards it, has compelled it to remain largely unaddressed or inadequately addressed in most settings, including clinical practice, research areas or public health surveillance domains[2,3].

The socio-cultural paradox surrounding marital rape in India:

Marriage is considered a 'sacred' institution by India's largely patriarchal society, wherein a culture of tolerance and compromise is mostly expected of the women in the equation. Often, the popular propaganda revolves around saving and respecting honour, pride and values of the Indian family system, where maintaining a 'status quo' in marriage assumes grave importance. That this maintenance of a 'married culture' is expected to happen, often at the cost of women and their sufferings is something that the Indian society fails to take full cognizance of. Our society while superficially ready to place its women on a divine pedestal, expects the women to be docile, subservient and compliant, especially within the conjugal spheres of a marital relationship. Hence any violence and trauma, be it be physical, emotional or sexual, arising within the 'sanctified' territory of marriage , is often ignored or condoned, rendering women all the more vulnerable and powerless in the event of marital rape. The current socio-cultural stance even indirectly vilify those women who dare to complain about the abuse they experience in their conjugal lives as being essentially 'anti-family 'and as those who are breaking the sacred bonds while converting their bedrooms into unnecessary battlefields. The largely misogynistic view is further bolstered by several law commission opinions, which state that criminalizing marital rape would amount to excessive interference of the state in the private sanctum of marriages. These socio-cultural assumptions are noxious and stand on the presumption, that all marriages imply lifelong blanket consent to sexual acts , thus making the concept of 'rape' within the sphere of ' marriage' a redundant concept to begin with. Religious traditional beliefs too hover on the idea of an 'ideal' wife being sexually compliant and thus overlooks fundamental principles of bodily integrity and agency of women in the process. This idea borders on irrationality, failing to address the inherent structural inequalities in the system and ends up indoctrinating violence against women as 'normal'. Also, the role of the society and the state appears diminished and misplaced, when its logic tends towards safeguarding the marital institution, rather than protecting the rights of women within it [4,5].

The influence of socio-cultural stance on the legality of marital rape

Socio-cultural customs and values in India significantly differ from that of the western world and also serves as justification against criminalization of marital rape in the Indian judicial system. Religious beliefs and customs endorse the idea of a marriage being sacrosanct, private and

decided by the Gods in heaven, thus nudging mere mortals and their earthly courts to stay out of it. Criminalization of spousal rape is viewed as ruinous to the purity of the marriage institution, which has huge cultural, religious and societal significance attached to it. Religious sacred scriptures further endorse the socio-cultural stance, wherein, sexually satisfying the spouse is considered to be one of the marital responsibilities of the wife, irrespective of her sexual desires or lack of it. Men are considered to have higher sexual needs, and thus, they using force to sate such needs becomes culturally accepted inside the orbit of a marriage. The socio-cultural and religious convictions conceive marriage as a sacrament in India. These convictions coupled with alarmingly high rates of illiteracy and poverty, have successfully created a climate, where criminalizing marital rape, appears highly unsuitable .The lack of education and economic security in Indian women also make their chances of survival outside marriage dismal, thus discouraging the criminalization of spousal rape by the Indian judiciary [6-8].

Research findings on socio-cultural aspects of marital rape:

A critical review of literature in this area, though done almost two decades back, highlights the endemic nature of marital rape where it is found to be as prevalent as other rapes, especially being more prevalent in women who were battered. The victims of such spousal rape were often found to endure multiple traumas and thus were at higher risk of experiencing severe post traumatic distress, resulting in grave emotional, medical and mental health consequences. Further, the invalidation of the traumatic experiences of the victims of marital rape was bolstered by the widespread cultural belief which deemed marital rape as not 'real 'rape. Also numerous studies highlighted a cultural pattern, where, as the relationship between victim and perpetrator became more intimate, the chances of the incident to be described as rape decreased, thereby decreasing the levels of perceived harm and increasing attribution of blame onto the victims. Cultural beliefs also strengthened the idea that men inside the marriage sphere, with overpowering sexual needs, had forced sex on their partners, as wives were withholding sex on purpose. These beliefs again tend to minimalize the traumatic experiences and maximize victim blaming in the context of marital rape. These widespread socio-cultural biases and beliefs tend to cause legal and professional invalidation of marital rape, thus severely limiting identification and treatment of its victims. This in turn limits the research in this area, which otherwise might have helped to improve services towards them [9-11].

Legal scenario in India

According to the World Health Organisation (WHO), globally one in three women suffer physical or sexual violence during their lifetime (WHO, 2021) .As per the National Family Health Survey (NFHS) conducted in 2021, 29% of married women experienced physical or sexual abuse from their husbands. One in five women aged 15-49 years have been victims of intimate partner violence in the previous 12 months. Nevertheless there are still 36 countries in the world, including India where marital rape is not criminalized[12-14].Therefore there are no authentic statistics regarding marital rape in India.

How is rape defined?

According to the WHO, "Rape is defined as physically forced or otherwise coerced penetration - even if slight - of the vulva or anus, using a penis, other body parts or an object[15]."

Definition of rape as per IPC (Indian Penal Code) and BNS (Bharatiya Nyaya Sanhita, 2023)[16,17] are as follows-

As per IPC, section 375, rape is a crime. The wording of article 375 of the IPC after the Criminal Law (Amendment) Act, 2013 are:

A man is said to commit "rape" if he penetrates his penis, to any extent, into the vagina, mouth, urethra or anus of a woman or makes her to do so with him or any other person; or inserts, to any extent, any object or a part of the body, not being the penis, into the vagina, the urethra or anus of a woman or makes her to do so with him or any other person; or manipulates any part of the body of a woman so as to cause penetration into the vagina, urethra, anus or any part of body of such woman or makes her to do so with him or any other person; or applies his mouth to the vagina, anus, urethra of a woman or makes her to do so with him or any other person, under the circumstances falling under any of the following seven descriptions:

First.—against her will.

Secondly.—without her consent.

Thirdly.—with her consent, when her consent has been obtained by putting her or any person in whom she is interested, in fear of death or of hurt.

Fourthly.—with her consent, when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married.

Fifthly.—with her consent when, at the time of giving such consent, by reason of unsoundness of mind or intoxication or the administration by him personally or through another of any stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she gives consent.

Sixthly.—with or without her consent, when she is under eighteen years of age.

Seventhly.—when she is unable to communicate consent.

There are two exceptions to this clause.

Exception 2 reads as, *sexual intercourse or sexual acts by a man with his own wife, the wife not being under eighteen years of age, is not rape".*

As per BNS 2023 which has come into effect on July 1,2024, repealing and replacing the IPC(1860), the definition of rape and exception 2 have not changed. Chapter V, section 63 of BNS dealing with 'rape' remains the same, as in IPC in letter and in spirit.

Is marital rape a crime in India?

The erstwhile IPC and the current BNS as per the exception 2 clause have not completely criminalized marital rape. Sexual intercourse without consent, with wife who is separated from the husband is considered a crime, although the punishment for rape of such a kind is less than that of non-spousal rape.

When rape occurs within the confines of marriage, what are the legal recourses available to women at present?

1. Non consensual sex between couple who do not live together-Section 67 of BNS / (Section 376 B of IPC)

   Whoever has sexual intercourse with his own wife, who is living separately, whether under a decree of separation or otherwise, without her consent, shall be punished with imprisonment of either description for a term which shall not be less than two years but which may extend to seven years, and shall also be liable to fine.

2. Grounds of cruelty-Section 84 of BNS / (Section 498 A of IPC)

   Whoever, being the husband or the relative of the husband of a woman, subjects such woman to cruelty shall be punished with imprisonment for a term which may extend to three years and shall also be liable to fine.

   For the purposes of this section, "cruelty" means—

   (a) any wilful conduct which is of such a nature as is likely to drive the woman to commit suicide or to cause grave injury or danger to life, limb or health (whether mental or physical) of the woman; or

   (b) harassment of the woman where such harassment is with a view to coercing her or any person related to her to meet any unlawful demand for any property or valuable security or is on account of failure by her or any person related to her to meet such demand.

3. **Marital rape as part of domestic violence**

   The Protection of women from domestic violence act, (PWDVA) 2005, was enacted by the Indian Government in 2005[18] .Physical, sexual and emotional abuses are covered by this act. Though this act does not consider marital rape as a crime, it considers it as a form of domestic violence.

4. **The POCSO act**

   Sexual act with wife, if the wife is less than 18 years of age constitutes rape[19]. (The legal age of marriage in India is 18 years).

The rationale behind the non-criminalization of rape and the obstacles therewith

Implied consent theory and possible false allegations- The purported reason of non-criminalization of marital rape is that, consent to marry encompasses a consent to engage in

sexual activity. The essential ingredient of committing a crime of rape is lack of consent. When marriage is a contract in which consent for sexual intercourse is implied, the idea of marital rape is considered antithetical [20]. When lack of consent is the defining feature of rape and the victim's testimony is of paramount importance in proving rape, the possibility of filing fraudulent cases against husbands could not be ignored.

Non-interference of the criminal law- That the criminal law must not penetrate into the private spheres of the marital relationship was one of the reasons upheld for not criminalizing marital rape.

Wife as subservient to her husband - At the time the IPC was drafted in the 1860s, a married woman was not considered an independent legal entity and her identity was considered to be merged with that of her husband. She was then regarded as the "chattel" of her husband. But with the passage of time and consequent social reforms, this concept does not hold true anymore. Women are recognised as equal citizens as men[20].

Restitution of conjugal rights (RCR)-It is a mechanism through which a court may pass order compelling a married couple to live together, a restitution of a spouse's conjugal right[10]. Though this originated in the English law it is no longer valid there. Paradoxically, in India, this is found in section 9 of The Hindu Marriage act, 1956 [21].

To protect the institution of marriage and for the larger good and stability of the society, incorporating the socio-cultural undercurrents were also other reasons for courts in India to resume condoning marital rape.

The move towards criminalization

Aligning with International Covenants : Most of the countries in the world are moving towards criminalisation of marital rape, in keeping with the international laws like Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),Universal Declaration of Human Rights, The International Covenant on Civil and Political Rights (ICCPR) and Declaration on Elimination of Discrimination against Women (DEDAW)[22].

In tune with the Fundamental Rights of the Indian constitution: Marital rape violates the right to equality enshrined in Article 14 of the Indian Constitution by the differential treatment of married and unmarried women. By the mere status that she is married to the perpetrator, the act of rape within marriage is not considered as crime. By the act of implied consent in marriage, not every act of sexual intercourse can be considered as a consensual act. In fact when rape and sexual violence occur in marriage and the victim has to continue to live thereafter with the perpetrator, with the socio- cultural and legal presumption, that she has to consent to acts of spousal sexual violence with no adequate laws to protect her, it may be more traumatic, psychologically and sexually than rape by stranger. 'Does the exception 2 clause of rape confer a silent sanction to men for marital rape?' would be the valid query on the psyche of any conscientious nation therewith. According to wider interpretation by the Supreme Court, rights

enshrined in Article 21 include the rights to health, privacy, dignity, safe living conditions and safe environment, among others. So rape within marriage violates article 21of the Indian Constitution as well.

Indian Judiciary : Some court verdicts have struck down the constitutionality of RCR, because it violates Article 14, 19 and 21 of the Indian Constitution. Nevertheless it exists and some courts have upheld the constitutionality of RCR too. Judgements, both reaffirming decriminalisation and asserting criminalisation by various courts, though unable to reach a consensus now, may ultimately provide more clarity in the future.

Collectivism vs Individualism: In the pretext of protecting the larger good of society, should the woman's individual right to live with dignity, privacy and safety be sacrificed? This question should weigh heavily on the conscience of a progressive nation which claims to bestow equal rights to all its citizens , irrespective of their gender.

Current scenario

- **Justice J S Verma Committee Report (2013):** This committee, following the Delhi gang rape case of 2012, recommended criminalizing marital rape, but the proposal of criminalizing marital rape has not been implemented. Nevertheless, this was a landmark report towards a progressive stance[23].
- **Split verdict of Delhi High Court***:* In May 2022, the Delhi High Court delivered a split verdict on the issue of marital rape with one judge favouring criminalization and the other opposing it.
- **Awaiting the verdict of the Supreme court**: Several petitions challenging exception 2 of section 63 of BNS are pending before the Supreme Court and the apex court is yet to deliver its judgment on these. The legal battle for criminalizing marital rape continues.

Future implications:

It is imperative that future research in this area needs to educate professionals regarding prevalence, socio-cultural and legal aspects and consequences of marital rape, so that identification and education of victims can be bettered. Crisis centres and shelters for rape and domestic violence victims need to include marital rape in their mission and vision statements, so as to include and serve victims of spousal rape in a better and sensitized way. This unique issue of marital rape also needs more research, to evaluate assessment and treatment strategies and to study the possible effects of legal reforms on the perception of this intimate violence [8]. The future needs to consolidate its efforts in understanding, educating and validating the trauma of marital rape victims and research needs to focus on better identification, prevention and treatment of the same. Let not the possibility of false rape allegations in marriage deter the genuine victims from getting redressal of their grievances. A compassionate, non-judgmental approach preserving the dignity of women and striving towards egalitarian solutions, upholding truth and justice should be the way forward. "Rape accusations are easy to make, hard to be proved, and harder to be

defended against" opined Mathew Hale, the 17the century English Judge.

Conclusion:

Marital rape is to be considered as yet another heinous crime along with other coercive sexual violences, instead of invalidating and silencing the traumas of its helpless victims. Professionals from varied related fields like mental health , social services, legal , medical and religious forums need to first validate and acknowledge the reality of marital rape, thus changing the surrounding noxious and negative socio-cultural aura to a more compassionate and positive one, towards this under-served community. According to the United Nations, "taking legal steps to protect women's human rights are just as important as educating boys and men to view women as valuable partners in life, in the development of society, and in the attainment of peace", because it may not be possible for the law to penetrate into the delicate confines of the dynamics of the home, in its true spirit, and therefore may render itself to errors of omission and commission. Progressive change in attitude and approach to marital rape is very much needed, not just because the spousal rape victims deserve their dignity, and justice, but because, we as a society deserve to live in a culture which is kind to its vulnerable cohort as well!

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Disclaimer:

All the legal wordings(depicted in italics mostly) had to be copied verbatim from the law texts available and already published to give out the exact information as per the demands of this chapter and hence plagiarism regulations will not apply in this particular context.

Key messages

1. Rape within marriage, in India is currently not recognised as a crime
2. The social and cultural invalidation of the marital rape traumatises the sufferer with adverse consequences
3. Grounds of cruelty within marriage and the domestic violence act, 2005 are the legal recourses mainly available to women who are subjected to marital rape
4. Court judgements are divided in the matter of marital rape and decision from the apex court is awaited, as of today

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CHAPTER 15

Legal and Social Constructs of Sexual trauma in Women

Abstract:

Social constructs influence laws of any land, invariably influencing perception and experience of sexual trauma and violence. Gender too appears to be inextricably linked to sexual trauma and how it comes to be defined. Sexual trauma with its layered socio-cultural underpinnings is often mired with controversies, gender-laced stereotypes, complex socio- cultural and health consequences. Prevalence of sexual violence is found to occur more commonly in cultures that fosters unhealthy gender biases. Analyzing the history of social constructions, varied definitions, controversies, legal constructions, prevalence of sexual violence and the role of gender and stereotyping in its manifestations, is essential for a holistic comprehension of this intricate issue. This chapter attempts to shed light on these areas, while also examining the socio-cultural consequences and socio-sexual processes underlying sexual trauma.

[Keywords: Sexual trauma, Socio-cultural constructs, Legal constructs, Gender, Violence]

Introduction:

Certain behaviors come to be regarded as violent, forms news reports, calls for legislative action, and scholarly inquiry, whereas others come to be regarded as nonviolent and miss our attention completely. This happens because, what accounts as violence is socially constructed and has varied over time reflecting power relationships. Social constructionism involves "elucidating the process by which people come to describe, explain, or otherwise account for the world in which they live" (Gergen, 1985).Sexual violence is likely to occur more commonly in cultures that foster beliefs of perceived male superiority and thereby socio-cultural inferiority of women. .It often gives rise to a wide range of negative emotions. Fear of sexual violence in women has restricted their freedom and occupational opportunities and affect their long-term psychological well-being due to associated social stigma and shame for the victim and those related to them.

History of Social and legal Construction of Sexual violence:

English common law considered rape as territorial crime against men, as women were deemed as men's property (Brownmiller, 1975). During17th century , Chief Justice Sir Matthew Hale

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clearly declared that a husband cannot be guilty of raping his wife as she has given her sexual consent in marriage and she cannot take it back (Bergen, 1998; Estrich, 1987)[1] This has influenced the Indian marriage acts too, which say marriage is a lifelong consent.In1960s and 1970s, psychologists and sociologists like Muehlenhard, Harney, and Jones, often blamed women and Abrahamsen in 1960,went as far as to research on wives of rapists to see how they had motivated their husbands to rape other women[2,9].

In 1971, research by Amir and MacDonald amounted to clear victim-blaming wherein it was reported that 19% of the forcible rapes in Philadelphia in 1958 and 1960 had been "victim precipitated." as they were caused by women who had deviated from gender roles. It explicitly stated that women would invite rape if they talked with strangers or worked in the garden with bathing suits. These social scientists' assumed that women provoked sexual violence, and they conducted research to 'prove' that "fact!" such researches served to facilitate social control of women's behavior. Important research by Koss and Russell in 1980s showed that rape was much more common than had been reported and most of it were committed by acquaintances, with only few of these ever coming to the attention of the criminal justice system[2,3].

Currently, research on sexual violence has proliferated in the west, and researchers seldom blame women for the traumatic experience. Explanations have fortunately moved from pointing the faults of victim to examining the perpetrator and society. Unfortunately, this is still not the case with the socio-cultural scene in countries like India , where people in power ask women not to be adventurous, as a reaction to heinous crimes like gang rapes. Thus culture plays an important role in how certain societies perceive and process sexual violence.

Indian history regarding the same has a different story. Women enjoyed equal status and important positions in Indus valley civilization with early Vedic periods celebrating poetesses like Avviyar, and philosophers like Gargi .There were no much restrictions on women as they could choose their partners(Swayamvar). Marriage was not a compulsion either. Late Vedic period, however saw the rise of patriarchal society with rising violence against women giving birth to rituals like 'Sati'. Medieval times too turned out to be more horrible for women. Fortunately ,later societies started recognizing these atrocities and started making amends to bring in more gender parity. Quite a few inequities however remained and Indian society continued to have different opinions and standards regarding women and gender equality.

Controversies:

Sometimes, women whose experiences meet legal definitions of rape do not regard themselves as victims. Koss, Dinero, Seibel, and Cox (1988) identified women who had been raped, based on Ohio's legal definition of rape out of which only 27% labeled their experiences as "rape." They also found that victims of Acquaintance rape were less likely than victims of Stranger rape (as Koss et al., 1988, defined it) to label their experiences as rape (23% vs. 55%, respectively)[3].On the other hand, Gilbert and Gutmann argued for an extremely narrow definition of rape. Gilbert (1991) stated that feminist researchers' definitions of rape were too broad, resulting in a "phantom epidemic

of sexual assault" . Gutmann argued that men should not be considered guilty of rape unless they actually intended to commit rape, as she advocated excusing men who interpreted women's refusals as foreplay[4,5].In a highly apartheid South Africa, only the rape of white women was prosecuted, while sexual violence against black women was accepted as a part of their lives[6].Childhood marriages prevalent in certain parts of India involve marriage and sexual relationship with a girl who is not an adult. It amounts to sexual coercion

less free to refuse or consent to sex. Gavey (1992) wrote about the negative labeling of women who refuse sex , and ' inferred 'normality', which dictates how often and under what circumstances a "normal" woman should have sex. Morgan's (1974/1992) definition of rape even included sex initiated by the female victim, if she initiated it out of 'fear of losing the person, fear of being called a prude, fear of hurting his fragile feelings,. MacKinnon (1987) wrote, ",I call it rape every time a woman has sex and and is considered illegal as per POCSO act now, but certain religious personal laws do approve such marriages[7]. Hyper-local semi-democratic governing bodies like *Khap Panchayats* decide on marriage partners in certain parts of North India and some inhuman sexual offenses have been reported against women who dared to go against such marriages. Northeastern states have similar horrifying stories of sexual assaults which tend to reinstate patriarchal superiority.

Definitions:

The World Health Organization (WHO) defines sexual violence as "any sexual act or an attempt to obtain a sexual act, unwanted sexual comments, or advances, acts to traffic or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim in any setting, including but not limited to home and work[8].Some earlier definitions that limited sexual violence to situations involving extreme physical force are not acceptable, as it was found that the most common strategy men used to have sexual intercourse with unwilling women is ignoring their refusals without using physical force .In these contexts, women may not resist because of fear, confusion, or embarrassment thereby making use of force unnecessary. Such situations would not fit definitions that required extreme physical force[9,10].A group known as 'Women Against Sex 'argued that, in this cultural context, women were never really free to give or deny sexual consent because sex is considered to be a part of a "package deal—with love, security, emotional support," and rejecting sex would likely result in losing the entire package. (A Southern Women's Writing Collective [ASWWC], 1990).

Some writers have suggested subtle yet powerful social pressures that make individuals feels violated" and she was not suggesting that men should be arrested as rapists based on this definition, but instead, she proposed this definition to encourage people to reevaluate and change their perspectives on sexual agencies[11,12].

The Role of Gender in Defining Sexual violence

Currie suggested that gender stereotypes were inextricably linked to violent behaviors and how it comes to be defined. Women tend to normalize male violence as "understandable", a

response that supports the notion of men being innately aggressive. On the other hand, because women are traditionally typified as passive, violent behavior on their part becomes notable or remarkable. In short, the way gender plays itself out in heterosexual violence is far more complex than what meets the eye[13].Several case studies of married couples with significant difference of opinion between them showed that, in the process of them trying to make the marriage work , the men in the marriage often resorted to domestic violence regularly , justifying it as a remedial measure to mend the ways of the disobedient wife. Such marriages would also end up in abandonment of the wives if and when they would hit back. Few studies have revealed even men reporting of having to engage in "unwanted" sex ,owing to varying contexts like peer pressure, to gain experience, to be popular, or to avoid appearing shy, afraid, inexperienced, or homosexual. However in these self-reports, sex did not seem to be wholly unwanted, but appeared to be wanted by men for some other ulterior purpose[14]. Also, men who reported of experiencing coercive sex reported of experiencing less serious consequences when compared to women. Significantly more women (58%) than men (26%) reported of deciding to go along with the sexual act , even in situations, where it was not initiated by them and was without their consent in the first place. In their subsequent reactions to such events, women reported more confusion ,anger, self-blame, and depression and men reported feeling the incident as either inconsequential or even fun. With both women and men spanning the entire range of responses on most scales, just few men reporting more trauma than women, should be considered cautiously before generalization of that experience[15,16].

Prevalence of sexual violence

Higher rates of sexual violence are expected to be more in cultures that, make women appear inferior to men. Also cases of sexual violence going unreported may be as high as 67%-84% , due to the stigmatization of the issue, thereby making it difficult to gather exact figures. Unreported sexual offences are higher in some Asian cultures where virginity is highly valued and a woman's modesty is of utmost importance to the status and respect of her family in society. It has been suggested that skewed sex ratios may contribute to increased prevalence of sexual violence with the male-female sex ratio, in India being skewed in an "*always negative*" way. But in spite of decrease in gender gap over the past decades, incidence of sexual violence has risen according to National Crime Records Bureau data. This could be due to increased reporting in recent years .In addition to violence, sexual assaults also involve elements of control, power, domination, and humiliation. Paradoxically, it has also been hypothesized that gender equality may increase sexual violence due to male backlash, especially in societies presently witnessing a shift from male-dominated to gender equal society, as in India. It is also postulated that increased media attention may attract some individuals to perform these acts so that they gain a degree of notoriety, which they would consider to be better than mundane anonymity[17-23]. Sanday studied 156 societal structures and found that rape is a vital part of a sociocultural configuration that revolved around male dominance and weakness in women[24].This work was taken forward by Briere and Malamuth to explore sexuality variables and attitudes that encouraged violence toward women and their

association with self-reported likelihood of using sexual coercion. This showed that personality traits too seem to have an important role in what constitutes rape[25].Though Jaffee and Straus found no relationship between sexually liberal attitudes and incidence of sexual violences, they did posit a significant association between urbanization, poverty, high percentage of divorced men, and increased prevalence of reported sexual violences[26].

Role of stereotypy in sexual violence

Rape has also been described as the psychological extension of a dominant-submissive sex-role stereotyped culture. Socio-culturally transmitted attitudes toward women, rape, and rapists can even predict sexual violence. Such stereotypes are often internalized from the male dominated society. Sexual violence can result from a misogynist attitude prevalent in a patriarchal culture, where in at times cattle are meted out better treatment than women. In rural India, for example, girls have no independent control of their sexuality. They are expected to get married, give consent to the man chosen by the family and bear children, thus shifting the control from one man (the father) to the other (the husband)in their lives. Men tend to play the most important role in a woman's life in India as they do in many other cultures which may have similar traditional patriarchal social constructs[27-29]. Woman resisting sexual intercourse, may be perceived as a direct threat to a man's masculinity, leading to identity crisis and contributing to control through sexual violence, as it is seen as a way of resolving this crisis. It has been reported that victims who attempt resistance or escape from the situation are more likely to be brutalized by the offender, giving an inflated sense of power, however transitory, to the abuser as was seen in the New Delhi gang rape case of *Nirbhaya* in December 2012[30].

A largely prevalent stereotyped belief is that sexual violence is often provoked by an attractive and seductively dressed woman who is out alone at night and hence is literally asking for trouble. This belief puts the complete onus of the act on the victim, further victimizing her in the process .However the fact that acquaintance rape is more common than stranger rape with even young children being victims of sexual crimes, debunks the myth that only the young, attractive, and seductively dressed women are raped. Perceived or real vulnerability of the victim is a far more important factor compared to attire or attractiveness. This statement is consistent with the NCRB report showing greater percentage of sexual assaults being reported in extremes of ages. The young and attractive are mostly protected by families and societies alike. Thus we have little doubt that perpetrators are looking for vulnerability, as it increases the possibility of assault[31, 32].

Socio-cultural consequences of sexual violence:

In sociocentric cultures, the dignity of the family (*izzat*) becomes important than the individual trauma, with the notion of harm being shared more by the family members. This is well reflected in the fiery statement of social activist Kamala Bhasin , who once rightly questioned as to who put the pride of a family, a village or sometimes entire community in a woman's vagina?! Instead of letting her deal with her trauma, she is burdened to have lost 'the pride' of the family too. On the contrary, in ego-centric cultures, this harm from sexual violence is much concentrated around the

dignity and identity of the individual member. Victims of sexual violence often suffer negative reactions upon disclosing their trauma, the most traumatizing of which is being blamed for the assault. The social stigma around sexual abuse is higher in Asian cultures compared to the more sexually liberal western societies[33, 34].

Understanding of underlying socio-sexual processes:

Several studies have concluded that men are more likely to misinterpret leading to erroneous decoding of women's platonic interests as sexual signals. This could be due to higher likelihood of men to perceive the world in sexualized terms or it could be men's bias to perceive sexual interest. This possibility is more likely to occur in men from sexually conservative cultures[36,37].

Biology versus culture

Sexuality, though, like other biological processes is controlled by genetics, sexual attitudes and practices are influenced by culture. The biological or evolutionary theory of sexual violence suggests that sexual violence is a result of a man's natural sexual urge, which is different from that of a woman. This theory, proposes that, the act of sexual violence resulting from a man's aggression is a natural thing but has been widely challenged. Another theory claims that sexual violence is socio-culturally constructed. Based on these, Sanday divided cultures into two types,1) Rape-free and 2)rape-prone cultures which are molded by sociocultural values; the former are more balanced in gender equality and have low rates of rape. The latter have high rates of rape and women here are kept away from positions of power while restricting their freedom and objectifying them. He also pointed out the widespread existence of rape-prone societies. Similarly, Otterbein observed 17 cultures and reported that cultures with rigid sex-role systems showed higher incidence of sexual violence. Thornhill and Palmer clubbed these two hypotheses, stating, that the socially learned behaviors known as culture are largely biological too. Thus overlap of biological and cultural factors are involved in sexual violence[38-42].Cultural sanction of violence seem to encourage sexual violence. For example, higher rates of rape were observed by Le Vine in the Gusii or Kisii tribe of Kenya. In Gusii marriages, sexual aggression is a socially approved behavior, where men are encouraged by the society to be sexually aggressive on their wives during sexual intercourse .It is argued that the higher rates of rape among the Gusii occur when marital sexual aggression overflows into the premarital or extramarital area. Some south African societies too face similar conditions where female circumcision is followed, sometimes bleeding girls to death. Further, negative social reactions lead to higher levels of mental health issues in the victims, like depression, social isolation ,phobias, and post traumatic stress[43, 44].

The bi-directional pathway between legal And social constructs in sexual trauma:

Social problems and their impact on people leads to framing of laws that then govern social order. On the other hand some laws framed back in time seem antiquated as societies change over time, making contemporary social constructs demand amendment of older laws in order to keep up with the changes of time. Bhartiya Nyaya Samhita(BNS, 2023)[45] has been an attempt to

update laws in India. There have been some interesting changes in laws pertaining to sexual crimes. A few noteworthy changes are as follows-

1. Introduction of e- FIR's for swift reporting.
2. Age limit for consensual rape cases raised from 15 to 18 years.
3. Sexual offenses/ assaults are made gender neutral for both victim and perpetrator.
4. Section 69 considers consent obtained by deceitful means as sexual offense.
5. Section 70 removed age based parameters for gang rape and more stringent punishment for offenders.
6. New provisions have been made to discourage bigamy, child exploitation and pornography.

Conclusion:

Violence and trauma, when sexual, are heterogenous in its manifestations, depending in which societies, cultures and genders they occur. The socio-sexual processes underlying sexual trauma point towards both - innate biological factors and sexual attitudes and practices, which are influenced by culture. Socio-cultural understanding of crime, undoubtedly

influences the legal processes and punishments and laws of the land have a definitive impact on the socio-cultural milieu suggesting a bi-directional pathway between social and legal constructs of sexual trauma . While higher rates of sexual violence and subsequent trauma are found to be more in cultures that foster male superiority and unhealthy gender biases, it becomes imperative to study the surrounding socio-cultural constructs, varying definitions , controversies, role of gender and its accompanying stereotypes and the negative consequences of sexual trauma in a world that is witnessing significant psycho-socio-sexual changes. Understanding the many social and cultural layers of this sexual trauma could help clinicians relate and respond better to the pain and agony of the victims borne out of an unjust and inequitable society.

Key Messages

- Higher rates of sexual violence and subsequent trauma are found to be more in patriarchal cultures (including India) that foster male superiority and unhealthy gender biases.
- Gender is inextricably linked to sexual trauma and violence, which vary across cultures and need to be conceptualized as socio-cultural constructs too.
- Socio-cultural understanding of sexual crimes undoubtedly influences the legal processes and punishments and laws of the land have a definitive impact on the socio-cultural milieu suggesting a bi-directional pathway between social and legal constructs of sexual trauma
- The socio-sexual processes underlying sexual trauma point towards both - innate biological factors and sexual attitudes and practices, which are influenced by society and culture
- Study of the prevailing socio-cultural constructs, definitions, controversies, prevalence, negative consequences of sexual violence and the role of gender and stereotyping in its manifestations, is essential for a holistic comprehension of this intricate issue

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CHAPTER 16

Trauma In Sexual Minorities

Abstract

The LGBTQIA+ community, representing diverse sexual orientations and gender identities, faces unique challenges that often result in significant trauma. Discrimination, stigma, and violence against sexual minorities can lead to profound emotional distress and psychological issues such as anxiety, depression and PTSD. The sociopolitical landscape in India has historically marginalized these communities with only recent legal advances, such as the decriminalization of Section 377, providing some protection. However, the need for trauma-informed care is critical. Mental health professionals must employ culturally competent, inclusive and empathetic strategies to address the specific needs of sexual minorities. These strategies include creating safe spaces, understanding minority stress and providing personalized, intersectional care. The implementation of these approaches can significantly improve the mental health and well-being of sexual minorities, ensuring that they receive the support and affirmation necessary to thrive in society

[**Keywords** : LGBTQIA+, Sexual minorities, Sexual stigma, Trauma, Trauma informed care]

Introduction

The LGBTQ community, which stands for lesbian, gay, bisexual, transgender, and queer/ questioning individuals, encompasses a diverse coalition of people who identify with non-heteronormative sexual orientations and gender identities. Sexual minorities refer to individuals whose sexual orientation or gender identity differs from the majoritarian societal norm. These diverse identities are an integral part of the rich tapestry of human sexuality and experiences associated with it .Sexual minorities often face unique challenges and barriers to acceptance and inclusion. Discrimination, prejudice, and violence directed towards individuals based on their sexual orientation or gender identity can have profound negative impacts on their mental health and well-being.

Sexuality and gender identity are two concepts that beggars better comprehension. Sexuality or sexual orientation refers to the way one experiences attraction (romantic or sexual) towards another person. Gender identity, on the other hand is how an individual conceptualizes or identifies with one's own gender. Gender differs from sex ,as sex is essentially based on biological and

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physiological characteristics whereas gender refers to a personal sense of self, which is also based on socially constructs. Gender identity also encompasses some subdivisions of gender expression/presentation which is how one expresses their gender identity , be it be through clothing, behaviour, or gestures. It is important to note that expression of gender may not always align with gender identity. Another nuance to keep in mind is the use of pronouns as a means of self-reference, used by all individuals, irrespective of their gender identity.

Before we delve into the topic of trauma and that faced by sexual minorities, let us first briefly discuss the acronyms used to describe various sexual identities-

- L (Lesbian) - Woman attracted to another woman
- G (Gay) - Man attracted to another man
- B (Bisexual) - A person attracted to two or more genders

Lesbians, gay men, and bisexual individuals (LGB) are categorized based on their sexual orientation, which is commonly understood in relation to sexual attraction, behaviour, identity, or a combination of these factors. What they have in common is that their sexual orientation is not solely heterosexual[1].

- T (Transgender or transsexual) - A person who identifies as a member of a gender other than the sex assigned to them at birth. Transgender people can be heterosexual, homosexual, or bisexual in their sexual orientation.
- Q (Queer) -A term used by people whose sexual orientation is not exclusively heterosexual.
- Q (Questioning) - Describes a person who is still discovering and exploring their sexual orientation, gender identity, gender expression or some combination thereof.
- I (Intersex) - A general term used for a variety of situations in which a person is born with reproductive or sexual anatomy that doesn't fit the boxes of clear cut "female" or "male." These may show up as differences or abnormalities in reproductive organs, their functions, or even hormonal productions in the body, and may be due to chromosomal changes.
- A (Asexual/Aromantic) - A term wherein people do not have sexual or romantic feelings towards people of any gender. This is also a spectrum where grey/ demi sexual/romantic people also fall under, where they might have sexual/romantic feelings in very rare situations or only with people with whom they have extreme emotional connections with.

Other common identities include-

- Hijras - A social group which is defined as neither men, nor women.
- Non-Binary - A person who does not identify as exclusively male or exclusively female.
- Gender Fluid - A person whose gender expression or gender identity or both changes over time.
- Gender Queer - People who see themselves as being both male and female, neither male nor female or as falling completely outside these categories.

- Pansexual - A person that is attracted to any person regardless of their gender identity.
- Androgynous - People identifying and/or presenting as neither distinguishably masculine nor feminine.
- Bigender - A person with two genders.
- Demigender (boy/girl/enby/trans) - This includes nonbinary gender identities and uses the prefix "demi-" to indicate the experience of having a partial identification or connection to a particular gender.
- Omnisexual – This is similar to pansexual, where there is attraction to all genders with gender here playing a role in the amount one is attracted to that gender.
- Butch - A term used to describe the nonconforming gender expression of someone who has some traditionally masculine traits.

Trauma and sexual minorities

Janet's French psychodynamic school defines psychological trauma as one or more events that, due to their characteristics, can alter the subject's psychic system, threatening to fragment mental cohesion[2]. It is an experience that is subjectively perceived as painful or distressing that leads to acute or chronic physical and mental dysfunction. The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5), defines a traumatic event as the exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. The word trauma is derived from the Greek word 'Trauma' or 'Traumatikos' which means wound , hurt , to damage or to harm. This term was initially used in the medical and surgical disciplines but was later used in psychiatry and clinical psychology to explain the overwhelming impact that a noxious stimulus has on an individual's ability to cope with it. Trauma can be described across multiple dimensions and can be classified in many ways. Trauma can be acute or chronic with acute trauma often manifesting as Acute Stress Reaction, which is usually a short lasting sympathetic response to a real or perceived threat that typically leads to a fight or flight response. If this response persists, it may then progress to a Chronic Trauma Response[3].

Sexual minorities often face various forms of trauma that can have significant social and psychological implications. Discrimination, harassment, and violence based on sexual orientation or gender identity can lead to profound emotional distress and trauma. This type of trauma can manifest in symptoms such as anxiety, depression, post-traumatic stress disorder (PTSD), and substance abuse. Family rejection, stigma, homelessness, adverse experiences in school and other social settings, interpersonal violence are some of socially traumatic challenges that people of the LGBTQ+ community are subjected to. This can lead to feelings of isolation, alienation and a sense of not belonging, which may cause difficulties in forming and maintaining relationships, both within the LGBTQ community and in the broader society. Discrimination and stigma can also impact access to healthcare, employment, housing and other essential services, further exacerbating social inequalities and marginalization[4].

The types of trauma encountered by this community include verbal, physical, psychological, financial, social, sexual, health care related and institutional. Sexual minorities often face various forms of trauma that can have significant social and psychological implications. Discrimination, harassment, and violence based on sexual orientation or gender identity can lead to profound emotional distress and trauma. This type of trauma can manifest in symptoms such as anxiety, depression, post-traumatic stress disorder (PTSD) and substance abuse as well as chronic physical illnesses[5-8](see Table 1[9,10])

Table 1 **: Types of trauma**

Active	Passive
Threats, restrains, house arrest, abandonment / thrown out of the house, kidnappings, forced sexual activities, forced marriages	Neglect, withdrawal of funds & support, cutting communication

The LGBTQIA+ community is more likely to encounter adverse childhood experiences compared to their cis gender heterosexual peers. Gender identity and sexual orientation are essential components of an individual's overall identity. Any divergence from heterosexual norms can lead to stigmatisation, marginalisation and discrimination. Socially, family rejection, stigma, homelessness, adverse experiences in school and other social settings, interpersonal violence are some among many challenges that adolescents of the LGBTQ+ community are subjected to. This can lead to feelings of isolation, alienation, and a sense of not belonging which may cause difficulties in forming and maintaining relationships, both within the LGBTQ community and in broader society(See Table 2[10-12,14]).

Table 2**: Trauma in Adolescents of sexual minority groups**

Social settings	Type of Trauma	Psychiatric impact
School	Bullying, lack of support	Depression, Anxiety, Suicidality
Home	Bullying, rejection, stopping education, deprivations	Depression, mood disorders, substance use
Public spaces	Harassment, assault	Depression, PTSD, Anxiety Disorders, Suicidality
Communities	Shaming, teasing, conversion camps, isolation, discrimination	Depression, Anxiety, PTSD, sexual stigma, substance use, suicidality

Discrimination and stigma can also impact access to healthcare, employment, housing, and other essential services, further exacerbating social inequalities and marginalization, when these adolescents become adults . Psychologically, trauma can have long-lasting effects on mental health and well-being. LGBTQ individuals who have experienced trauma may struggle with self-esteem, self-acceptance and identity formation. They may also face challenges in coping with stress, managing emotions and developing healthy coping mechanisms. The cumulative impact of trauma can contribute to higher rates of mental health disorders among sexual minorities compared to the general population[6-8](See Table 3[11-14]).

Table 3: **Trauma in Adults of sexual minority groups**

Social settings	Types of trauma	Psychiatric impact
Home	Restricting access to information, finances, health care, movement. Abuse. Forced treatment	Depression, Mood Disorders, Anxiety disorders. Suicidality
Workplace	Discrimination, harassment, employment challenges	Depression, Substance Use
Public spaces	Harassment, assault, lack of facilities (toilets)	PTSD, Mood Disorders
Communities	Ostracization, discrimination, shaming, conversion camps	Depression, anxiety, PTSD, substance use, suicidality, sexual stigma

Socio-religious underpinnings in the trauma of sexual minorities:

The LGBTQ+ community has represented a source of conflict to some within orthodox religious communities, many of which view same-sex behaviour and cross-gender

identification as immoral and a deviation from their core religious values. There exists a cycle of abuse seen in religious settings that may even include adverse events leading to traumatic experiences. A strong correlation has been found to exist between the level of religiosity and attitude towards homosexuality. LGBTQ+ persons who are brought up in religious communities tend to experience higher levels of discrimination and internalised homophobia.

Conversion camps, often rooted in certain religious beliefs, aim to change an individual's sexual orientation or gender identity through various methods, including psychological manipulation and physical coercion. These camps perpetuate the harmful notion that being LGBTQ+ is a

disorder that can be "cured" leading to significant emotional and psychological trauma for those who undergo such experiences, including increased chances of psychiatric diagnoses including suicidality and substance use .Many individuals from the LGBTQ+ community face intense struggles with their faith, as they navigate the conflict between their identity and the teachings of certain religious institutions that condemn nonheteronormative orientations. This internal and external conflict can result in feelings of isolation, shame and rejection, further exacerbating the challenges they face in seeking acceptance and understanding within both their communities and families[6-8, 14].

Socio-political and legal landscape of the trauma of sexual minorities:

The community of sexual minorities have long been at the forefront of sociopolitical movements advocating for equality, rights, and acceptance. They have faced systemic discrimination, marginalization and violence, leading to significant social and political impacts. The fight for LGBTQ rights has sparked important conversations around issues such as marriage, equality, anti-discrimination laws, healthcare access and representation in media and politics.

History dating back to 1861 shows that the British considered sexual activities of all sexual minorities ,including all homosexual activities as "against the order of nature" and deemed them to be criminalised under Section 377 of the Indian Penal Code. In independent India , transgenders were recognised as a third category of gender in 2014.It wasn't until 2017 when the Supreme Court gave the country's LGBTQIA+ community the freedom to safely express their sexual orientation. An individual's sexual orientation was protected by the Right to Privacy act . On 6th September 2018, the Supreme Court legally decriminalised Section 377.In 2019, parliament enacted Transgender Persons (Protection of Rights) Act with an objective to provide for protection of rights of transgender people, their welfare, and other related matters. The prevailing sociopolitical landscape has also been found to have a profound impact on the LGBTQ community and sexual minorities. Policies and legislation, both supportive and discriminatory, have shaped the lived experiences of these individuals. The struggle for equal rights and recognition has led to significant progress in some regions, while in others, LGBTQ individuals continue to face legal barriers and social stigma.

New policies and laws are now essential to ensure equal rights and protections for all individuals, regardless of their sexual orientation or gender identity. Existing laws may not adequately address the unique challenges and discrimination faced by LGBTQ individuals, making it crucial to implement more inclusive policies that reflect the diverse needs of this community. Inclusive laws and policies are necessary to safeguard the rights and well-being of LGBTQ individuals and to promote a more equitable society. By enacting legislation that prohibits discrimination based on sexual orientation and gender identity, we can create a more inclusive environment where all individuals are treated with dignity and respect. Additionally, inclusive policies can help address disparities in healthcare, employment, housing, and other areas that disproportionately affect LGBTQ individuals. Furthermore, this inclusivity sends a powerful message of acceptance and

support to the LGBTQ community, fostering a culture of diversity and inclusion in the mainstream society . By recognizing and affirming the rights of LGBTQ individuals, we can create a more just and compassionate society where everyone has the opportunity to thrive and live authentically. It is imperative that we continue to advocate for new policies and laws that protect and empower the LGBTQ community, ensuring that all individuals are able to live free from discrimination and prejudice. By advocating for change, challenging discriminatory practices, and promoting diversity and understanding, these communities are reshaping societal norms and paving the way for a more equitable and inclusive future. Regardless of the laws of the land ,sexual minority groups continue to experience trauma in varied forms requiring mental health professionals to play a critical role in providing trauma-informed care to these individuals across their lifespan[15].

Trauma-Informed Care for sexual minorities

Trauma-informed care[16,17] involves understanding, recognizing, and responding to the effects of trauma. Some key strategies and considerations for effective trauma-informed care for sexual minorities in India can be outlined as follows:

1. **Safety**: Creating a safe physical and emotional environment where clients feel secure.
2. **Trustworthiness and Transparency**: Building trust through clear communication and setting appropriate boundaries.
3. **Peer Support**: Encouraging connections with supportive peer groups and communities.
4. **Collaboration and Mutuality**: Valuing the client's expertise in their own life and working together in the therapeutic process.
5. **Empowerment**: Supporting clients in regaining control over their lives and fostering resilience.
6. **Cultural, Historical, and Gender Issues**: Recognizing and addressing the unique cultural and societal factors affecting sexual minorities.

Strategies for Mental Health Professionals to provide trauma -informed care to sexual minorities

1. Culturally Competent Care[18]

Mental health professionals must be culturally competent, understanding the unique challenges faced by sexual minorities in India. This includes:

- **Educating Themselves**: Staying informed about LGBTQ+ issues, including the historical and socio-political context in India.
- **Using Inclusive Language**: Avoiding heteronormative assumptions and using clients' preferred pronouns and identities.
- **Challenging Biases**: Reflecting on and addressing personal biases that may affect therapeutic practice.

2. Creating Safe Spaces[19]

- **Confidentiality**: Ensuring that client information is kept confidential to protect them from potential harm.
- **Non-judgmental Attitude**: Providing a space where clients can express themselves without fear of judgment.
- **Accessibility**: Making services accessible to all, including those with limited financial resources or those in rural areas.

3. Addressing Intersectionality[17]

Sexual minorities often face intersecting forms of oppression, such as caste, religion, and socioeconomic status . This requires that mental health professionals should aim for a holistic assessment along with tailored interventions:

- **Holistic Assessment**: Consider all aspects of a client's identity and how they intersect to impact their experience of trauma.
- **Tailored Interventions**: Develop interventions that are responsive to the unique needs of each individual.

4. Peer Support and Community Resources[20]

Connecting clients with peer support groups and LGBTQ+ organizations can provide the much needed support. In India, organizations such as the Humsafar Trust, Naz Foundation, and Sangama offer valuable resources and community connections .

5. Advocacy[21]

Mental health professionals should advocate for the rights and well-being of sexual minorities. This can involve:

- **Policy Advocacy**: Supporting policies that protect LGBTQ+ rights and improve access to mental health services.
- **Education and Training**: Providing training for other healthcare providers to improve the overall standard of care for sexual minorities.

Trauma-informed care for sexual minorities in India requires a nuanced and empathetic approach, taking into account the unique challenges faced by this population. By adhering to the principles of trauma-informed care and implementing culturally competent strategies, mental health professionals can significantly improve the mental health and well-being of sexual minorities across their lifespan[22].

Qualities of LGBTQ Affirmative Mental Health Professionals for trauma informed care of sexual minorities

- **Develop cultural competency and humility -** Mental health professionals must develop an understanding of the specific challenges faced by LGBTQIA+ individuals, including stigma, discrimination, and the impact of minority stress. Practitioners should adopt an attitude of

cultural humility, recognizing their own biases and continuously learning about LGBTQIA+ identities and experiences[17,18].

- **Create an affirmative environment -** Create a welcome, safe space where LGBTQIA+ clients feel accepted and validated. This includes using correct pronouns, affirming diverse sexual orientations and gender identities, and avoiding heteronormative assumptions. The support staff at the care facility must also be trained and sensitised similarly [23].
- **Understand minority stress -** Recognize that LGBTQIA+ individuals are at a higher risk for trauma, including hate crimes, family rejection, and societal discrimination. These experiences contribute to minority stress, which can exacerbate psychiatric conditions like depression, anxiety, and PTSD. A trauma-informed approach requires acknowledging the role of past trauma in present psychiatric symptoms and working to avoid re-traumatization in treatment [24].
- **Embrace Inclusivity & Intersectionality -** Consider the intersecting identities of LGBTQIA+ clients, such as race, ethnicity, socioeconomic status, and disability, which may compound their experiences of discrimination and trauma. Treatment should therefore be personalized, taking into account these intersecting factors to provide better and comprehensive care [25].
- **Empower & Collaborate -** Encourage client empowerment by involving them in their treatment planning and decision-making processes. Collaborative care involves working with other healthcare providers, community organizations, and support networks to address the holistic needs of LGBTQIA+ clients [26].

Therapeutic Approaches

1. **Cognitive-Behavioural Therapy (CBT):**
   - Adapt CBT[27] to address the specific thought patterns related to internalized stigma and minority stress in LGBTQIA+ clients .
   - Techniques might include challenging negative beliefs about one's identity and developing healthier ways of coping with stressors.
2. **Narrative Therapy:**
   - Allow clients to reframe their experiences by telling their stories, highlighting their resilience, and redefining their identities in a positive light.
   - This approach can help counteract the negative narratives imposed by a heteronormative society.
3. **Mindfulness-Based Therapies:**
   - Mindfulness practices[27,28] can be beneficial in managing the effects of trauma and stress, helping clients stay grounded and present.
   - These therapies can also support clients in dealing with dysphoria or distress related to gender identity.

4. Family and Community Support[28]:

- Engage family members, when appropriate, in therapy to improve understanding and acceptance of LGBTQIA+ identities.
- Connect clients with LGBTQIA+ support groups and community resources to reduce isolation and build supportive networks.

Conclusion:

In conclusion, addressing the mental health needs of sexual minorities requires a knowledge based, nuanced and empathetic approach that acknowledges the unique challenges faced by them. Discrimination, trauma, societal stigma and violence can have profound effects on the mental well-being of LGBTQIA+ individuals, necessitating trauma-informed care and support systems that are culturally sensitive and inclusive. Mental health professionals must strive to create safe, non-judgmental spaces and employ therapeutic strategies that respect and affirm the diverse , fluid and dynamic identities of this minority group. The legal advancements and socio-political shifts in India, while significant, must be accompanied by continued advocacy for more inclusive policies and practices. By fostering resilience, empowering clients, and integrating support from family and communities, mental health care can play a crucial role in improving the quality of life for sexual minorities. This holistic and culturally sensitive approach is essential for promoting healing and well-being across the lifespan of LGBTQIA+ individuals.

Key Messages

People belonging to sexual minority groups represent diverse sexual orientations and gender identities face unique challenges that often result in significant trauma.

Trauma arising out of discrimination, stigma, and violence against sexual minorities can lead to profound emotional distress and psychological issues such as anxiety, depression and PTSD.

The sociopolitical and religious landscape in India has historically marginalized these communities with only recent legal advances providing only some protection, if any.

This necessitates a more nuanced and empathetic trauma-informed care and approach along with advocacy for support systems that are culturally sensitive and inclusive to create safe, non-judgmental spaces and employ therapeutic strategies that respect and affirm the diverse , fluid and dynamic identities of this minority group.

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