


Research Article

Coping Strategies and Help-Seeking Behaviors among Survivors of Intimate Partner Violence: A Qualitative Study of Spouses of Men with Heavy Drinking in India

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Background. Despite the high prevalence of intimate partner violence (IPV) against women in India (33%), there are persistently low rates of disclosure and help-seeking amongst survivors. The aim of this study was to explore both coping strategies employed by survivors and the perceived barriers and facilitators to seeking support from informal and formal resource networks. **Methods.** We conducted semistructured, in-depth qualitative interviews with thirty-five women survivors of IPV in Goa, India, in secure, private locations, utilizing flipcharts and vignettes to elicit deeper insights into efficacies of support resources. The data were transcribed, translated, and analyzed utilizing qualitative content analysis. **Results.** The most common coping mechanisms cited by survivors involved passive resistance, such as self-distraction, keeping quiet during violent outbursts, and leaving the home temporarily. Generally, survivors sought support from informal support networks (the natal family, in-laws, neighbors/community members, and close friends) before approaching formal support structures (medical/legal professionals, professors, police, and nongovernment organizations). In fact, informal structures were often facilitators of formal help-seeking. Survivors sought help at various stages of their marital relationship. Primary deterrents to help-seeking included the normalization of IPV by survivors and providers alike, resulting in the stigmatization of disclosing experiences of IPV and ostracism of survivors and close relatives; another barrier was a general lack of awareness of existing support resources. **Conclusion.** Our findings reveal that there are numerous barriers to help-seeking and shortcomings of support resources. Survivors' evaluations of support resources reveal that robust, community-level, and meso-level structural changes are required to promote help-seeking behaviors, including the destigmatization of IPV amongst providers and broader society and raising awareness of available support resources.

1. Introduction

Violence against women is a significant public health concern that affects millions of women globally through practices including sex-selective abortion, female infanticide, female genital mutilation, sexual violence, and elder abuse [1]. One of the most widespread forms is intimate partner violence (IPV), defined as “behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors” [2]. There are innumerable physical, reproductive, and mental health sequelae of IPV, including physical injuries (e.g., lacerations, burns, traumatic organ injuries), chronic pain, appetite changes, sleep disruption [3]; exacerbated risk of sexually transmitted infections (STIs) and diseases (STDs), unintended pregnancies, and other gynecological problems [4, 5]; and exacerbated anxiety and chronic distress, eroded self-esteem, suicidal ideation, and self-harm [6].

Despite global commitments to preventing IPV, approximately three of every ten women globally endure at least one of the forms of IPV [7, 8]. The global average lifetime prevalence of IPV among ever-partnered women ranges from 23% to 28% across varying age groups, with the highest prevalence estimates in Oceania (49%) and sub-Saharan Africa (44%) [9]. The lifetime IPV prevalence in South Asia for women aged 15–49 years is 35%, higher than global averages [9]. In India, the prevalence of lifetime IPV amongst ever-married women is 33%, ranging from 6% to 44% across states [10]. Such high occurrence has been ascribed to heteropatriarchal gender power asymmetries and stringent gender roles, both of which cement women in subordinate positions [11–15]. Such patriarchal structures permeate both the community and institutional levels, normalizing spousal violence and stigmatizing women survivors who disclose such “private” matters in public spheres. Women survivors are compelled to reach out to informal support sources such as family, friends, and neighbors only after individual coping strategies have been exhausted [16, 17]. Formal support networks, including police, social and legal services, and medical aid, are rarely sought out due to fear of reputational damage, perceived and lived experiences of ineffective support, and women being socialized to manage quotidian degradation and abuse silently [18, 19]. Recent findings reveal that only one in seven survivors of IPV in India seek any help at all, with less than 1% seeking support from formal institutions [20].

Some of the more frequently used coping strategies by survivors of IPV include religious and spiritual strategies, self-care, attempts to increase independence and empowerment, emotional expression, problem-solving, moving to an undisclosed location or a shelter, and relying on social support [21]. Broadly, the themes that inform these strategies include engaging informal networks, avoidance of stressors, distraction, minimizing the damage to self and family, and building personal resources [22]. When help-seeking for IPV happens, it is

strongly influenced by several individual, interpersonal, and sociocultural factors. Survivors of IPV seek help for reasons as varied as escalation of severity and frequency of the violence, fear for their lives and safety of their children, and when their informal support systems are no longer adequate [23–26]. However, even after deciding to access help, the survivors experience several barriers such as those created by the perpetrator (e.g., intimidation and threats), fears about negative response from family members and stigma associated with disclosure, accessibility issues (e.g., disability), and structural barriers (e.g., childcare, location of services) [27–31]. Additional barriers to help-seeking in developing countries include traditional gender roles, unequal gender and power relations, acceptance of violence as a means of solving conflict, perception in female IPV victims that violence is justified and engagement in self-blaming behavior, lower levels of women empowerment, poor access to education and employment, and lower female autonomy and decision-making powers [32–36].

Only a small proportion of women who experience domestic violence in India seek help [37]. If they do seek help, it is usually from other family members or close friends, as they believe it is a problem to be resolved privately to avoid distressing their family and to maintain family coherence [38, 39]. Help-seeking from formal authorities is rare, as the police are perceived to be “less useful or useless,” healthcare staff lack training on care for victims of domestic violence, and legal counsel often does not take them seriously [40–42]. This reflects cultural norms that encourage acceptance of violent behaviors, avoidance of situations that confront the violence, emphasise the submissiveness of the wife to her husband, and dictate a lower status for women [43–45].

Addressing factors that influence IPV and help-seeking behaviors is therefore imperative. Several studies conducted across South Asian countries have identified IPV survivors’ individual coping mechanisms and patterns of informal and formal help-seeking behaviors [12, 20, 39, 46, 47]. Most of these studies employed quantitative methods, and the only qualitative study conducted in India explored the perspectives of community members and IPV experts rather than survivors themselves. Furthermore, the only existing study of IPV survivors’ disclosure and help-seeking behaviors in Goa, India, was cross-sectional [39]. The nuances of the specific factors that both promote and discourage help-seeking behaviors are critical to discern and can be best understood through qualitative research.

The relationship between alcohol use and IPV, and subsequent coping strategies, and help-seeking behaviors are governed by several theoretical frameworks, and we summarise the ones which are the most relevant to our study. The impact of alcohol on IPV differs according to the balance of instigating (e.g., anger management issues) and inhibiting forces (e.g., empathy). In individuals with high levels of instigating characteristics and low levels of inhibition, episodes of excessive drinking are likely to lead to aggression even in the absence of provocation. IPV will

occur when an individual's aggression threshold (strength of the aggressive motivations against the strength of the inhibitions) is exceeded, and alcohol has its greatest impact on those whose baseline (i.e., when sober) is just below an aggression threshold [48].

Liang's help-seeking framework has three stages in the IPV context. The first stage involves "defining the problem," and this is influenced by individual factors (e.g., readiness for change), interpersonal factors (e.g., shock and disbelief expressed by family and friends), and sociocultural factors (e.g., social, religious, and cultural institutions that reinforce power inequities between men and women). The second stage involves "deciding to seek help," and this is triggered by recognizing the problem (i.e., IPV) as undesirable, and accepting that it is unlikely to go away without help from others. The final step involves selecting a source of support and this involves multiple, interacting cognitive and affective processes such as considering the relative costs of loss of privacy and stigmatization [49].

Our study sought to address a gap in existing research and is the first solely qualitative study exploring IPV disclosure and help-seeking behaviors in Goa, India. We aimed to illuminate the specific microlevel interactions and meso-level factors that inform women survivors' help-seeking behaviors. More specifically, this involved ascertaining the coping strategies employed by survivors, understanding existing informal and formal support structures and their perceived efficacies, discerning deterrents, and barriers to seeking and accessing help, and determining survivors' preferred sources of support.

2. Methods

2.1. Setting. Goa, one of the smallest states in India with a population of approximately 1.6 million, has a sex ratio of 1,020 females per 1,000 males [10]. Compared to the average national literacy rate of 74%, Goa has a rate of 89%, with female literacy being slightly lower at 85% [50]. Cross-sectional studies and census data report varying prevalence of physical, emotional, and/or sexual IPV in Goa among ever-married women between the ages of 15 and 49, ranging from 10% to 27% [10, 39]. Usual quantity of alcohol consumed by 14.8% of current drinkers in Goa is at high-risk level [51]. About 28.6% and 33.7% of current drinkers in Goa report monthly or more frequent heavy episodic drinking and drunkenness, respectively [51]. Research from Goa has demonstrated a strong relationship between alcohol use, especially risky use, and IPV [51–54].

The following services are available in Goa to respond to different needs of DV survivors: (a) One Stop Centre (governed by the Ministry of Women and Child Development) in each of the two districts in Goa, (b) statewide women's emergency helpline service, (c) free support services through public health and legal institutions, (d) nongovernmental organizations engaging in rights-based activism and supporting women against violence and trafficking, and (e) counselors who provide emotional support over the course of help-seeking, in addition to other forms of social and legal support.

2.2. Study Design and Sample. Our qualitative study was nested in a larger study that aimed to deliver psychosocial care to affected family members (age ≥ 18 years) of heavy drinkers in Goa [55]. We recruited a purposive sample, i.e., women from the parent study who had self-reported experiencing IPV at any time in the past 12 months.

2.3. Data Collection. Data collection was performed through semistructured, in-depth interviews (IDIs) which lasted between 45 and 60 minutes. The interview guide explored help-seeking behaviors, perceptions and evaluation of support resources, and priorities and preferred outcomes (Appendix). Interim analysis of the initial round of 14 interviews led to the refining of the interview guide. Flip cards were utilized to better inform participants of available support resources; and a vignette about an IPV survivor was utilized to elicit participants' perceptions of informal and formal support networks [56, 57]. The flip cards had pictures of a range of specific formal or informal sources of support (e.g., the police), and the participant was asked questions on seeking help from them, particularly focusing on understanding their perceptions and/or experiences of challenges/facilitators. In the vignette, we presented a fictional story of "Laxmi," about help-seeking after experiencing violence in the home. The vignette focused on understanding preferred individual/social/financial and other support options. Both these tools allowed for a more nuanced understanding of help-seeking behaviors, particularly ideal help-seeking pathways for survivors of violence.

Interviews were conducted in local languages by PK, DG, and LK, field researchers trained in sensitive interviewing and probing techniques. All interviews were conducted in person at a private venue chosen by the participant, such as their home or a local Church, with field notes taken postinterview noting key observations. In case a participant felt overwhelmed or emotional during the interview, the researcher paused the recording and interview, allowed space for the participant to sit with their feelings, and offered to postpone or terminate the interview. After each interview, the participants were informed about different services available in the state for women who are seeking help for IPV, including shelter, legal services, medical help, and services for children and their own mental health. A handout outlining steps for creating a safety plan was also discussed with the participants. All interviews were conducted in the vernacular, audio recorded, and subsequently transcribed and translated into English.

2.4. Data Analysis. We used the framework analysis method to thematically analyze the collected data, which involved the following stages: familiarization with data, open-coding, development of an analytical framework, application of the framework, and interpretation of data [58, 59]. The framework analysis method belongs to a broad family of analysis methods often termed thematic analysis or qualitative content analysis. It involves organising and analyzing

data using a predefined analytical framework based on a set of predetermined themes or categories that are derived from the research objectives.

Data immersion entailed reading interview transcripts and listening to the audio recordings to discern participants' expressions of effect. After entering the data into NVivo 12, AC and AS used an inductive approach to independently open-code the first five transcripts and identify emerging themes. Following this process and the comparing of codes, AC and AS developed two coding indices to hierarchically organize agreed-upon codes, one examining experiences of violence and the second exploring the support needs of survivors. Discrepancies were reconciled by UB, who also provided oversight during the entire data analysis process. As new themes emerged, existing codes were redefined or merged, and additional codes and subcodes were generated iteratively until data saturation was reached. All transcripts were recoded to reflect the most updated version of the respective codebooks, and all 35 transcripts were coded, analyzed, and interpreted in NVivo 12.

2.5. Ethical Considerations. This study was approved by the Institutional Review Board at the implementing organization (reference numbers UB_2016_022 and AN_2018_46). All participants provided written informed consent.

3. Results

In-depth interviews were conducted with 35 women, six of whom were currently separated from their partners. The mean age of survivors was 39.2 years (range 24–60 years). Further sociodemographic data are detailed in Table 1. All 35 were survivors of IPV, and nearly half also described violence perpetrated by in-laws. Six broad themes emerged from qualitative analysis: effective coping strategies; informal help-seeking behavior; formal help-seeking behavior; support resource evaluation; barriers to help-seeking; and ideal support resources (Figure 1).

3.1. Coping Strategies. Survivors described a range of coping strategies to deal with the violence, and all employed at least one of the following strategies.

3.1.1. Leaving the Home. The coping mechanism employed by most survivors ($n = 29$) was leaving the marital home for temporary respite after episodes of violence. Survivors and their children found refuge in places of worship and the homes of their neighbors or relatives, though most returned to their natal homes. While some stayed for only a short time, others remained permanently. In some instances, this coping mechanism had adverse effects since the survivor's husband would follow her or become more aggressive when he was uncertain of her whereabouts.

I took my son, immediately I stayed at [my] mother's place and I did not go back. I stayed at my mother's place when my son was six months old, and until now I am at [my] mother's place, not even once [has] he came to ask

TABLE 1: Sociodemographic characteristics of survivors of intimate partner violence ($n = 35$).

Age, n (%)	
<25 years	2 (1.2)
25–35 years	12 (49.3)
36–45 years	15 (28.5)
46–55 years	3 (15.7)
56–65 years	3 (5.3)
Marital status, n (%)	
Married	29 (82.9)
Separated	6 (17.1)
Marital relationship duration, n (%)	
<5 years	2 (5.7)
5–10 years	17 (48.6)
11–15 years	5 (14.3)
16–20 years	4 (11.4)
21–25 years	3 (8.6)
>25 years	4 (11.4)
Education level, n (%)	
None	1 (2.9)
Primary and middle school (until 8 th grade)	5 (14.3)
High school (9–10 th grade)	20 (57.1)
Higher secondary (11 th –12 th grade)	8 (22.9)
Other	1 (2.9)
Employment, n (%)	
Part-time employment	7 (20.0)
Full-time or self-employment	9 (25.7)
Homemaker	15 (42.9)
Unemployed	3 (8.6)
Other	1 (2.9)

about my wellbeing or my son's well-being. For six years I have looked after my son by myself. (32Y, 10 years in relationship)

3.1.2. Conciliatory Behavior. More than two-thirds of survivors ($n = 24$) discussed "keeping quiet," remaining patient, or avoiding their husband to cope with emotional and physical violence. Numerous survivors mentioned that fighting back would exacerbate violence, citing avoidance and compliance as a more effective response. Other reasons that survivors endured silently included their wish to remain deferential towards their husband or their resignation to violence as a marital norm.

I would not respond to him. Even now if he gets irritated, if he keeps on talking, swears or does something, I do not respond to him. I quietly do my [own] things and stay aside. I keep quiet. I don't mix with him, I don't talk to him. I never back answer him. [this] Means, I don't tell him to do or not to do anything. I never tell him anything, I do not increase the fight. Means . . . let him be there. Then he cools down on his own. (59Y, 30 years in relationship)

3.1.3. Self-Distraction. Approximately two-thirds of survivors ($n = 23$) reported occupying themselves with activities to divert their attention from the abuse. These included

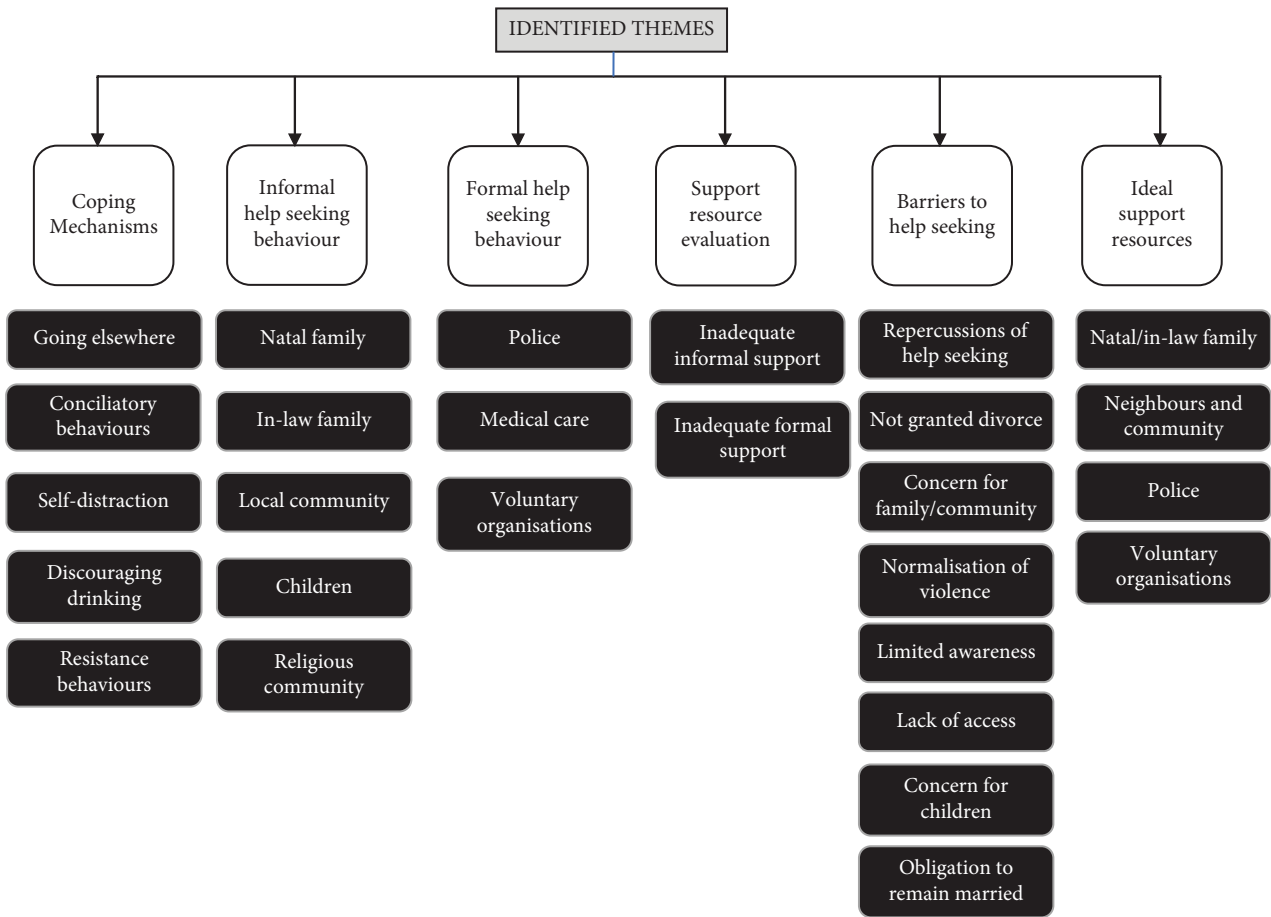


FIGURE 1: Identified themes.

working, performing household chores, doing craftwork, decorating the home, spending time with children, and socializing with others. Nearly one-third of women ($n = 12$) described chanting prayers, reading religious scriptures, or visiting places of worship to relax.

3.1.4. Discouraging Husbands from Drinking. More than half of survivors ($n = 22$) said they had confronted their husbands about their alcohol consumption since that was often a catalyst for IPV. Because discouraging their husband's drinking could be futile, some survivors would hide the alcohol from their husbands or threaten ultimatums. While most women expressed a desire for their husband to renounce alcohol consumption to prevent IPV perpetration, one said that her main motivation in curbing her husband's alcohol use was so that her son would not emulate his father's drinking behaviors and violent tendencies.

3.1.5. Resistance Behaviors. While passive resistance was a more common strategy, a handful of women ($n = 7$) retaliated against their husbands physically or verbally.

Only arguments with [the] mouth. He does not beat more that way. Means if he gets angry and holds my hand . . . my hand is held—And the hands of men are a bit stronger. If I

tell him that it hurts, then he would not let go. He would twist the hand for sure. Then I would lift my hand on him (hit him). Then the other hand is there to hit, isn't it? When I would hit then he would also hit me. When I hit, after that he will hit. (35Y, 10 years in relationship)

Of the two survivors who reported slapping and beating perpetrators, one said that she did so out of self-defense. A few survivors cautioned against physically attacking their husbands since it would result in more severe beatings and instead advocated "fighting back" verbally.

3.2. Informal Help-Seeking. All survivors ($n = 35$) mentioned seeking help from informal sources, including their natal families, marital families, friends, neighbors, and/or spiritual leaders. These informal social networks offered a range of options for both short and long durations and were commonly sought for support before formal sources. Survivors revealed seeking informal support at various points during victimization and at different points in their marriages.

3.2.1. Support from Natal Family. Most survivors ($n = 30$) relied on their natal families for support. In addition to providing necessities such as food and secure shelter, immediate and extended family members offered financial

support, childcare, and logistical support (e.g., accompanying the survivor to the police station or doctor's office). Some families provided emotional strength by condemning the abuse, discouraging the survivor from suicidal ideation and self-harm attempts, and encouraging her to leave her husband and return to the natal home. In some instances, the natal family emboldened survivors to confront their husbands about their abusive behavior and seek formal support. In contrast, some survivors said that family members believed that matters of spousal violence should be kept within the family and not shared with others. One mentioned her reluctance to disclose intimacy issues with anyone other than her mother.

How [do] I bear [it]? With someone . . . with my sister or somebody I call up and talk to them. Those people explain to me, let it be, you don't do anything . . . If you do anything with your life (die by suicide) then your children are there. Looking at their faces you have to live (for the sake of your children you have to live). By saying so my sisters explain to me. So, then I forget about all this. (24 years old, 7 years in relationship)

Unique to natal family support was its permanence. Survivors reported escaping to the maternal home with an intent to stay for a few days but ultimately remaining for months and years in their own and their children's best interest. In a few instances, a survivor sent her children to reside with her natal family because of her husband's abuse and neglect.

3.2.2. Support from Perpetrator's Family. Though fewer survivors sought support from their husband's family than from their natal family, more than half ($n = 23$) disclosed receiving emotional, financial, and childcare support from their in-laws. A few survivors also mentioned a preference for confiding in their in-laws rather than nonfamily or formal support networks. Since most survivors lived with their in-laws, support and involvement from the perpetrator's family were prompt. For example, numerous survivors said that their brothers-in-law would come promptly to rescue them. A few said that their in-laws would physically attack or berate their husband about his abusive behaviors, and in some instances would even call the police on him. Interestingly, although approximately half of the survivors ($n = 15$) endured violence from in-laws, which was frequently instigated by the mother-in-law, six reported their mother-in-law providing various forms of help, including taking them to buy clothing, physically stopping their husband from beating them, encouraging them to attend women's groups and file formal complaints, and advocating on their behalf.

Earlier, they (in-laws) would not care about me. But when they understood about it (IPV), they started caring for me-[my] brother-in-law, his wife, all of them. Then they supported me a lot. His brother filed a police complaint one day. The police came and took him [husband] away. (38Y, 9 years in relationship)

3.2.3. Support from the Local Community. Almost three-fourths of survivors ($n = 25$) disclosed seeking and receiving support from their friends, neighbors, and community members. Though reluctant to divulge intimate aspects of abuse to nonrelatives out of fear of being ostracized or gossiped about, women would seek nonfamily support to mitigate the emotional, psychological, and physical effects of abuse.

I had gone to some neighbor to ask for help. My neighbors who are close to me . . . they did not provide any help. But the ones who are a little far away, they helped . . . 2-3 houses [down the street]. But how it is? I cannot shut the mouths [gossip] of people. (35 Y, 10 years in relationship)

While neighbors provided a haven for survivors and offered them food, clothing, shelter, and, in some instances, medical and financial support, friends became empathetic confidants and extended advice on seeking formal help. Occasionally, members of the local community would attempt to dissuade the perpetrator from the abusive behavior.

3.2.4. Support from Children. Another form of familial support sought by roughly half of the survivors ($n = 19$) was offered by their children. The extent of support varied according to their age. Younger children tended to provide more emotional and physical support, such as attempting to stop their father from beating their mother, whereas adult children were more able to provide financial and logistical support, in addition to advocating for their mother.

3.2.5. Support from Religious Communities. In addition to finding refuge in a place of worship, a few survivors ($n = 7$) sought and received support through their religious communities, particularly in the forms of monetary aid for children, relationship counseling, and blessings for an improvement in the marriage.

3.3. Formal Help-Seeking. Most women ($n = 26$) sought help from formal sources, including the police, medical professionals, and voluntary and nongovernmental organizations. Formal help was commonly sought after informal networks were exhausted and the experiences of violence intensified, becoming unbearable or life-threatening.

3.3.1. Police Support. Roughly one-third of survivors ($n = 11$) said they had sought assistance from the police, either by directly calling them or by filing a formal police complaint. Examples of supportive measures enacted by police officers included verbally reprimanding the husband for perpetration and arresting him for a few hours at a time. Women cited varying motives for calling the police, including taking advantage of police detainment of their husbands so that they could safely pack their belongings and return to their natal home, managing an extreme escalation of violence, and bringing momentary peace within the home. In a few instances, women were referred to the police by

NGOs and filed police reports with the support of their or their husband's relatives. However, many women said they were unwilling to take police support again in the future (described further in Section 3.4).

I actually had no intentions of filing [a] police complaint against him or even getting him arrested. Because I knew that there is no use arresting. I only wanted police protection to move out from the house and to come here at my mother's place. I just wanted to get rid of him. That was my only intention to file a police complaint. Because he wasn't allowing me to move out from the house. So many times, I packed my bag and I told him that I am going. But he would blackmail me by saying, "leave the children and go." By doing this, he wouldn't allow me to go. So, because he will not allow me to move out, I filed a police complaint. (39Y, 15 years in relationship)

3.3.2. Medical Support. Acute physical and psychological injuries resulting from intimate partner violence, ranging from abrasions and lacerations to multiorgan trauma, resulted in approximately one-third ($n=12$) of survivors seeking professional medical treatment. Survivors traveled to public tertiary care hospitals, often accompanied by their relatives. Examples of medical support include the prescription of medicines to alleviate stress, completion of full physical examinations, and care for wounds and injuries, such as sutures, dressings, and injections. Some women confided in their doctors about enduring abuse and other physicians suspected injuries as being caused by IPV. Two survivors admitted to actively obscuring the source of their symptoms and injuries from their physicians.

3.3.3. Organizational Support. Nearly one-third of survivors ($n=11$) reported seeking help from voluntary and non-governmental organizations. Survivors most commonly sought support from organizations that work directly with victims of IPV, though several approached Women's Cell, a special unit of police dedicated to assisting women. Collectively, these organizations provided financial, medical, and therapeutic assistance and offered an array of services, including microloans, medical attention, and self-help groups. Two organizations specifically offered religious and legal services, referring women survivors to court-appointed advocates who would assist with filing formal complaints and seeking alimony and child support. Several survivors described organizational support being a primary, and often *sole*, source of support networks, introducing women to other survivors of IPV and facilitating a sense of belonging and collective empowerment. Survivors were referred to such organizations by relatives, friends, and community members, many of whom accompanied the survivor.

3.4. Perceptions and Evaluations of Available Support Resources. Despite the available informal and formal support structures, all but three survivors ($n=32$) disclosed

encountering inadequate or even arrant lack of support. Ineffective support structures and mechanisms frequently resulted in women's despondency, reinforcing their resignation to their circumstances as help-seeking seemed fruitless.

3.4.1. Inadequate Informal Support. Among survivors who perceived support as inadequate, the deficiency was most often attributed to in-laws and neighbors. Survivors said that their in-laws were apprehensive about taking a position against the perpetrator, who was either their son or brother, out of fear of retaliation. Neighbors and community members exhibited similar apprehension about providing help.

Our neighbours do not come [to support] that way. He is [the] devil they say. Means what if he beats them or does this . . . that is the reason they do not come . . . They don't come. Now . . . day before yesterday also he gave me so much of beating but nobody comes close. That way they do not interfere. (59Y, 30 years in relationship)

Other survivors experienced their in-laws explicitly taking the side of the perpetrator, accusing women of infidelity, and blaming them for the perpetrator's alcohol consumption. In some instances, neighbors and community members would support the perpetrator and his family or spread gossip about the women's predicaments. Though less common, in certain cases, even a survivor's natal family would doubt the veracity of her experiences and refuse to help.

3.4.2. Inadequate Formal Support. Survivors said that the police and voluntary organizations, specifically those that provided legal aid, were the two most ineffective formal support structures. Numerous survivors said that counselors, legal advocates, and even judges advised and encouraged them to overlook the abuse for the sake of keeping the family unit intact. In one instance, denial of a husband's request for a divorce resulted in the perpetration of severe violence against the survivor and her child. Some voluntary organizations were particularly notorious for upholding and espousing patriarchal cultural values that held marriage sacrosanct, even above individual rights, and spreading gossip about survivors' private and confidential concerns.

They (NGO staff) told me to go home or to give the child to them [perpetrator's family]; I said "I am not giving my child, because for nine months I carried him in my womb." Then I told them, "I will stay here only [at natal home]." They [in-laws] were asking for him [my son] so I was scared of all three of them (mother-in-law, sister-in-law, husband) . . . They [NGO staff] said, "You go to your house (at husband's place) and you stay there." I said, "I am not going there because they beat me; I myself know what torture I have experienced no one else knows." They said, "We can't help you." (29Y, 5 years in relationship)

One frustration that survivors shared regarding both organizational and police support was their perceived inertia. Police ineffectiveness was a dominant theme and was mentioned by more than half of the survivors ($n=20$). Survivors expressed numerous grievances about seeking police support, including police releasing the perpetrator the same day as an arrest without any punishment, requiring bribes to achieve small outcomes, blaming the survivor and siding with the perpetrator, ineffectively “threatening” perpetrators, and claiming that marital conflicts should be dealt with privately. Collectively, these negative encounters with formal support systems triggered intense distrust in authorities and reluctance to file formal reports.

3.5. Barriers to Help-Seeking. All but one of the survivors ($n=34$) recounted experiencing barriers to help-seeking beyond the inadequacy of informal and formal support resources.

3.5.1. Repercussions of Help-Seeking. Most survivors ($n=30$) feared the negative repercussions of their help-seeking behavior, especially when seeking police support. One common consequence included victim-blaming and shaming by relatives and community members. Numerous survivors said that their natal and marital families had treated them differently after they filed a formal police complaint against the perpetrator. A few women even internalized the guilt and disclosed not filing a report to spare their husbands the possibility of defamation and unemployment.

In my initial days at work, I would talk about my household trouble with others. However, they often went back to my husband to tell him the things that I had mentioned to them. After I would go back home, he would ask me if I said any of those things and he would hit me right away. Since then, I stopped interacting with others. Because if I talked to them, then it would be misinterpreted and wrongly narrated to him. So, I stopped telling anyone, anything. (45Y, 28 years in relationship).

Another consequence was an increase in taunting and physical violence by perpetrators who were angered by women’s endeavors to seek support. These repercussions collectively deterred women from obtaining medical care for physical injuries and effects since they feared the need to file formal complaints.

3.5.2. Not Granted a Divorce. Roughly half of the survivors ($n=17$) either considered or sought divorce to mitigate the consequences of intimate partner and marital family violence. Most survivors who sought divorce were met with discouragement by others, likely a result of stigma and the upholding of marriage as a sacrosanct institution. Some perpetrators refused to grant a divorce to evade paying alimony, employing emotional manipulation to pressure the survivor into remaining in the marriage.

3.5.3. Concern for Family and Community. More than a third of survivors ($n=13$) reported not disclosing their experiences of IPV to their natal family and others in the community out of concern for others’ safety. Most commonly, survivors said they did not want their natal family members to endure psychological distress from worrying about them, although in one case a survivor was apprehensive about informing her brother since he would beat up her husband. One survivor noted concern about disclosing her abuse since she did not want to tarnish her parents’ reputation. Another did not wish to disclose to her mother the abuse she was enduring since her mother had suffered violence at the hands of her father, an incident that demonstrated how women often endured multigenerational trauma. Survivors were also apprehensive about seeking community support since their husbands would frequently insult, threaten, and sometimes even physically harm those who supported them.

3.5.4. Normalization of Violence as a Private Problem. In addition to expressing shame about returning to the natal home permanently, survivors described experiencing humiliation in disclosing personal matters outside the home, fearing the spread of gossip. Instead, most had a strong preference for dealing with IPV informally and privately, even if that meant strengthening their own resolve and tolerating the abuse. In some instances, survivors were encouraged by family members and neighbors to resolve marital disputes privately. Numerous women said that it would be futile to seek support since spousal violence was perceived as an expected and normal aspect of marriage.

3.5.5. Limited Awareness. Over a quarter of survivors ($n=10$) cited a lack of awareness regarding available informal and formal support mechanisms as their primary reason for not seeking help. A few said that if they had knowledge about available resources, they might have sought help rather than suffered silently.

And again and again, the same thing comes to my mind that how should I handle this [IPV] . . . this thing. How can this thing be finished off, whom should I talk to, whom should I ask for support, who is the person who will support us fully so that I can finish this thing off? (44Y, 22 years in relationship)

3.5.6. Lack of Access and Perceived Inability. Nearly half of survivors ($n=18$) said that violence from husbands and in-laws and practical challenges precluded them from accessing help. Financial limitations, including restrictions on working outside the home imposed by perpetrators and a lack of financial independence, prevented survivors from obtaining medical care.

Difficulties she can . . . there can be financial difficulties, traveling, and transport. For example, now if suppose in my case and I think of going to IPHB [local psychiatric

institution], I will have to take an appointment, I will not get a leave. When to take the leave? Then I will require money from transport, I will get my salary on the 5th, how will I adjust it within 7000? All this I will have to think [about]? I have to think about the leave, transport also I have to think. There are such problems; like you have to take psychiatric treatment, but you can't take. Financial problems plus your working difficulties. (39Y, 15 years in relationship)

Similarly, survivors were often unable to confide in family and friends due to the curtailment of social freedoms through mechanisms such as forbidding family visits, confiscating their SIM cards, and being physically followed by perpetrators. Though less common, a few survivors disclosed that the physical and psychological effects of abuse, including emotional distress and lethargy, prevented them from seeking help. Practical challenges that hindered help-seeking included lack of transport, geographical distance from support resources, language barriers, and the absence of an alternate shelter.

3.5.7. Concern for Children. Most survivors interviewed were mothers, with over one-fourth ($n=10$) citing their maternal responsibilities as obstacles to help-seeking. Concern for their children was a significant factor, with many survivors apprehensive about seeking assistance from children, fearing that they would either be victims of their father's abuse or that children would be forced to choose sides, resulting in the estrangement of children from their father. Survivors also disclosed not wanting to burden their adult children who were leading independent lives. Multiple survivors had to refuse hospitalization and surgery for injuries or decline participation in self-help groups due to anxiety about a lack of secure childcare in their absence. Lastly, survivors did not want to draw community judgment upon their children by deciding to return to the natal home, claiming that tolerating abuse within the marital home was the better alternative to damaging her children's reputation by living elsewhere.

Now the children—I tolerated because of my children. Otherwise, I would have never stayed with this one . . . this is what I think. I would have not stayed with him for a single day. Because the children are there I have tolerated [the abuse] so much. Otherwise, I would have not tolerated [it]. I would have said, set him on fire and I would have gone . . . Because the husband is harassing [me], if I go and stay at my mother's place or something else then the life of the children will be spoiled. What will the people say to the children? Just for the sake of the children till today I am with this husband. (59Y, 30 years in relationship)

3.5.8. Obligation to Remain in the Marriage. Approximately one-fourth of survivors ($n=8$) said they were unable to leave their marital home. Most commonly, they expressed shame in returning to the natal home for extended periods, especially if they had married of their own volition and against the advice of

their natal family. A few unequivocally said that leaving their husband was not an option, revealing the deep-rooted cultural belief in the sanctity of marriage. A few survivors cited the dangers of living alone as a female. One even mentioned the harmful impact that separation would have on the broader community.

I had to tolerate, right? Otherwise see, one thing is that there is [a feeling of] shame as I got married by my wish. Now if I go and tell my family, then what will they say? And it comes out also, "you got married with your wish, right? Now who will look at this?" . . . So, thinking of all that, I keep quiet. Because this was my choice and if that was a mistake, then it will be like I am making a fool out of my own self. So that is why I do not go to tell anyone . . . I had to live with him. Where would I go? That is the main problem with women. They cannot live alone . . . If they live alone, then there are many people having bad eyes on them [people look at them with bad intentions]. That is why you feel staying there is better. (41 years old, 16 years in relationship)

3.6. Ideal Support Resources. Analysis of the vignette data yielded ten support resources that survivors identified as ideal for themselves and other survivors of intimate partner violence. They most frequently cited four support systems from whom the vignette character should ideally seek support: natal and marital family, neighbors and broader community, police, and voluntary organizations. Women described the advantages of each. Numerous survivors maintained that the natal family should be the first resource that women utilize to maintain privacy and discretion, followed by neighbors and community members. They said that if these two support networks proved insufficient, the natal family and community members could act as facilitators in seeking external intervention and formal support. Survivors said that police officers could instill fear in their husband by verbally and physically threatening them before sending them home. Organizations, conversely, could help women achieve economic independence through micro-loans and self-help groups, enabling them to support themselves and their children. One common factor amongst all suggested support networks, including medical support, was the preference for someone to speak to the husband on the survivor's behalf in the hopes that if someone else pointed out the error of his ways, he might be persuaded to reduce his abusive behavior.

Survivors commonly recommended that the vignette character seek various informal and formal support systems from which they themselves experienced repercussions or which they themselves did not utilize. A salient example is a survivor who mentioned that the character should seek counseling support, despite her own negative experience with a counselor who recommended reconciliation. Though not a support structure, roughly one-fourth of survivors suggested that the character should leave her husband, either informally by living separately, or through a divorce. Although numerous survivors had described the stigmas and challenges associated with divorce, they nonetheless

advocated for the character to lead an independent life along with her children, free from violence.

4. Discussion

In addition to being one of the few existing studies employing in-depth interviews to explore the help-seeking behaviors of survivors of IPV in India, our study revealed the intricate processes by which survivors decided to seek help or not. Before seeking external help through the disclosure of violence, participants opted to manage their circumstances through an array of coping strategies. The thirty-five women interviewed in our study used coping mechanisms that included *denial of the victimizer* (placing blame on external forces, such as perpetrators' alcoholism), *denial of victimization* (self-blame for reacting aggressively against IPV), *denial of options* (lack of income, alternative housing, or emotional support), and *an appeal to higher loyalties* (remaining in marriage out of spiritual and religious commitment). The latter two, in conjunction with the aggravated IPV resulting from physical and verbal retaliation, cultivated learned helplessness since survivors felt unable to separate from their husbands because of economic dependence, socioreligious stigmas of being divorced or living independently, and cultural obligations. Such rationalization was expressed through avoidant coping strategies of keeping quiet, self-distraction, and leaving the home for momentary respite. While these findings echoed prior research that describes survivors normalizing their experiences [12, 15, 60], we found that few survivors in our sample minimized the severity of IPV, and they instead openly discussed its painful consequences, including suicidal ideation and attempts.

Numerous individual, interpersonal, and community-level factors influenced both help-seeking behavior and support-network responses to survivors, confirming the findings of prior research [11, 20, 61, 62]. While the temporality of help-seeking was not always made explicit, a pattern emerged of survivors seeking informal support after violent outbursts intensified or coping mechanisms became ineffective in mitigating perpetration. Corroborating existing literature, informal support from natal relatives, in-laws, and community members was critical as it allowed survivors to disclose violence confidentially with minimal fear of reputational damage [19, 20, 63, 64]. Our findings substantiated existing data by suggesting that most survivors would delay seeking formal support through police, medical, and legal institutions, often only after enduring violence for extended periods or experiencing a life-threatening encounter [19, 38, 40, 65]. Whereas informal support sources were used for emotional and occasionally financial support, formal help was sought for either logistical support or in efforts to reform the perpetrator's behavior. Formal support was oftentimes only accessible if relatives or community members were able to accompany the survivor.

Our findings on survivors' evaluations of available resources are consistent with previous research, which reveals that, while informal support is more accessible than formal resources, typically both tacitly, and sometimes explicitly,

condone IPV as an ordinary aspect of marital relations [16, 66–70]. Data from our interviews revealed a testimonial injustice against survivors: their natal and marital relatives dismissed narratives of IPV unless concrete evidence was provided [71]. While little evidence is available for emotional, economic, and sexual violence, even injuries and scars from physical violence were often denied as legitimate proof of IPV. Such victim-blaming and victim-shaming attitudes permeated formal institutions, reinforcing nondisclosure amongst survivors. Survivors who sought help from police and legal organizations were turned away if there was insufficient evidence of abuse, noting that it was implausible that formal complaints against their husbands would result in arrests. Formal institutions habitually showed ambivalence by saying that IPV was a private issue and should be dealt with within the home, advocating for reconciliation, delaying the provision of services, or offering inadequate redressal mechanisms. Consistent with other studies, formal and informal support networks espoused patriarchal cultural values, placing the onus of maintaining family integrity and harmony on survivors, deterring women from seeking external support, and resulting in their alienation from society [12, 72]. While our findings confirmed existing evidence, our study also revealed that challenges in accessing informal and formal support, including a lack of transportation, financial means, childcare, and general awareness, were eclipsed by the entrenched fear of disclosure resulting in reputational damage for survivors and their natal family and children or in exacerbating perpetration.

An original aspect of our study involved the examination of survivors' preferred and ideal support resources through the vignette. This vignette offered them an opportunity to make meaning from their own experiences of IPV by answering questions about how a character, a fictional survivor of IPV, should approach informal and formal support systems. Perhaps surprisingly, even though many survivors rationalized their own experiences of violence, they offered encouraging advice for the character. For example, though numerous women described the challenges of separating from their husbands, they encouraged the character to leverage informal and formal support networks to leave her husband. Although nearly all of the survivors who sought help from police faced unintended negative consequences, several still emphasized the utility of police in the character's case. One of the most common recommendations was asking an arbiter such as a relative, neighbor, *panchayat* (village governance system) member, *anganwadi* worker (cadre of community health workers), police officer, or legal advocate to speak with and admonish the perpetrator on the survivor's behalf. Our findings support the hypotheses of psychological studies that suggest that help-seeking is an outcome of a confluence of factors, starting with women's recognition of the problem [73]. Survivors who indicated that violence should not be a customary aspect of marriage were more likely to identify support resources for the character to utilize, compared to their counterparts who considered IPV a prerogative of their husbands.

While the focus of our study was to understand help-seeking amongst survivors of IPV, it is important to note

that this is within the context of heavy alcohol consumption by the spouse. This further complicates coping behaviors and help-seeking through overlapping and sometimes competing mechanisms related to being the spouse of a person with drinking problems. These include stigma related to husband's drinking, previous negative help-seeking experiences, hopelessness, and feeling undervalued [74].

Policy initiatives need to focus on increasing access to social, health, and economic resources, especially in circumstances where separation from the perpetrator is unlikely. Access to IPV services can be improved by integrating with other programs aimed at improving women's health. Service providers should be appropriately trained to provide care in a sensitive, supportive, and nonjudgemental manner. In summary, a multipronged approach is required which includes strengthening the existing informal support systems, screening, and support in healthcare settings, creating a nonstigmatising environment that encourages disclosure of abuse, and public awareness efforts.

A limitation of the study was that no data on the temporal nature of help-seeking were explored with the participants, making it a challenge to determine the precise point in time when women sought informal and formal help. A more comprehensive understanding of when women choose to seek help could enhance the potential uptake of certain interventions. A second limitation involves the generalizability of our study as qualitative studies do not have representative samples and are focused on exploring phenomenological depth.

5. Conclusion

The IPV survivors' first-person narratives revealed that barriers to help-seeking are insidiously and systematically arranged to obstruct survivors at the individual, interpersonal, and institutional levels from help-seeking. Informal and formal support networks are perceived to be sorely inadequate, especially since many resources advocate for marital reconciliation instead of survivors' ideal preference for marital separation or divorce. These insights must be used to initiate sustainable local and systematic changes that increase women survivors' access to higher quality informal and formal service provisions, which are contextually relevant, culturally sensitive, and cater to the needs of individual survivors. Concurrent with structural changes should be a raised awareness of IPV in the community and local structures for survivors to seek help without being stigmatized.

Appendix

Interview Guide

Part A: Experiences

1. Mapping of family structure and environment

(The purpose of this section is to briefly gather information on the participant's home environment, including information about immediate family members, close relatives, and close friends, etc.)

1.1. Could you tell me about the family you live with and any other residents in your house?

Probe for

- (a) Number of residents
- (b) Relationship to the participant
- (c) Current employment status/education status

2. Experience in the relationship

(The purpose of this section is to understand the participant's experience in the relationship with the person with drinking problems, in detail)

2.1. Can you tell me about your relationship with your husband?

Probe for

- (a) How would you describe your relationship with him?
- (b) Have there been times in your relationship where he has got angry with you? What does he do when he gets angry with you?
- (c) Have there been times in your relationship when you have felt that he was trying to control you? (your relationship, your behaviors and interests, your assets, e.g., money)
- (d) Have there been times in your relationship when he has forced you to do something? (at home or elsewhere)

2.2. Can you tell me more about these experiences (episodes) that you have had?

(Probe for each type of episode)

- (a) Beginning: When did these episodes begin? At what point of the time in the relationship did it begin?
- (b) Reason: How do these episodes usually arise? What triggers these episodes? In what context do they occur?

- (c) Examples: Can you describe recent episodes?
- (d) Feelings: How did you feel?
- (e) Frequency: How often do these episodes occur?
- (f) Meaning: What do you understand/think of these episodes? What does your partner understand/think of these episodes? What do others understand/think of these episodes?
- (g) Others: Is there anyone else that contributes to these episodes? What does the family do when you experience these episodes?
- (h) Context: Are there situations when these episodes do not occur? Are there situations where these episodes get worse?

2.2. Do you think violence is common in your community? Why yes or why not?

Probe for

- (a) Do you know/think other in your community who may experience something similar? Can you tell more about it?

Probe for

Same probes as above: b–h

2.3. Could you tell me about the impact the violence has had in your life? OR How has the violence affected your life? OR What has changed in your life after the violence started?

Probe for impact

- (a) Self (physical, mental, and sexual health, wellbeing, sense of self, interest, involvement or engagement with others/things, and daily routine)
- (b) Family relationships (relationship with partner, children, parents, and other relatives)
- (c) Social functioning (relationship with friends, neighbors, and community)
- (d) Occupational functioning (work related difficulties, performance at work)

3. Relationship between violence and drinking

(The purpose of this section is to understand whether the participant thinks that the alcohol consumption and experience of violence are related)

3.1. We have earlier discussed that your husband drinks alcohol. Can you tell me more about your husband's drinking?

Probe for

- (a) How often does he drink?
- (b) At what point of time when he drinks alcohol, does the violence arise?
- (c) Can you describe any recent episode like this?

3.2. What role do you think alcohol plays in your experience of violence?

Probe for

- (a) How does your partner's behavior change when he does not drink alcohol?

4. Coping with violence

(The purpose of this section is to understand how the participant copes with the violence. We want to know whether she actively responds to the episodes or passively responds or a combination of both. We also want to know the role others in her life play in her response to the episodes)

4.1. How do you respond when you experience the episodes? OR What do you do to manage/cope with the episodes? OR Can you describe what you do to make yourself feel better?

Probe for

- (a) What are each of the ways in which you respond to violence?
- (b) What do exactly do you do?
- (c) What happens after you respond that way?
- (d) For how long have they tried responding that way?

4.2. How helpful do you find your response?

4.3. Have you considered any other ways of responding which you may not have tried?

4.4. How does your partner respond after the episode?

4.5. How do others respond after the episode?

5. Seeking help

(The purpose of this section is to understand whether the participant seeks help or not when she experiences violence. We want to know what kind of help has she sought, and whether the help she received is useful or not. We need to distinguish between help that she has sought for herself versus help she has sought for others. Use the social support diagram to guide you through this section.)

5.1. Do you think you have needed or need help when you experience violence?

5.2. What kind of help have you sought in the past?

5.3. When/at what point in the situation did you think it was important to get help?

5.4. Was there anyone else involved when you sought help?

5.5. How did you find the help?

Probe for

- (a) Positive consequences of getting help
- (b) Negative consequences of getting help

5.5. What has helped you to reach out for support?

5.6. What has stopped you from reaching out for support?

Part B: Future help-seeking

1. Present story: "What should she do next?"

Probe for

- (a) What do you think happens to x?

- (b) What should x do next?
- (c) In which areas of impact (e.g. self, family, financial, and social) do you think she needs most help and support?
- (d) What kind of services do you think will be most helpful for her?
- (e) What are difficulties she will face if she chooses to go to x service/s?
- (f) Should others in the family be involved? Who? What should be their role? How can they help or change his/their behavior?
- (g) Should anyone in the community be involved? Who? What should their role be?

2. Explore coping and support options: “Cards’ selection”

2.1. These are some options that x could explore, what are your thoughts about it? (show the cards to the participant and ask her for each of the card, “Should x go here,” “Will she receive help?” and “What are the challenges she will face”?)

Data Availability

The data used to support the findings of this study are available on request from the corresponding author.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors’ Contributions

AS conducted conceptualization, formal analysis, methodology, and writing of the original draft; AC conducted conceptualization, formal analysis, methodology, and writing, review, and editing; UB conducted conceptualization, investigation, methodology, project administration, validation, and writing, —review, and editing; DG conducted conceptualization, investigation, methodology, project administration, and writing, review, and editing; ND performed funding acquisition, writing, review, and editing; DO performed funding acquisition, writing, review, and editing; AN performed conceptualization, funding acquisition, investigation, supervision, validation, writing, review, and editing.

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