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ARTICLE THÉMATIQUE

## ***Nature of domestic/family violence and barriers to using services among Indian immigrant women***

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### **Abstract / Résumé**

Domestic/family violence is a widespread major public health and human rights violation issue that runs across ethno-cultural affiliations and economic status. Relative to the actual incidence of family violence, use of services is low, and delayed for years after onset, within the broader Victorian and Australian community. Utilization is even lower for women from immigrant and refugee communities. It has been noted that family violence service utilization by Indian women immigrants in particular was especially low, relative to the size of the Indian population in Victoria. With the Indian culture understood to be traditionally a strongly male-dominated culture, it was deemed important to explore the nature of family violence experience of Indian women living in Australia, and culturally determined barriers to use of services. A partnership was formed to explore this issue through a participatory community theatre approach.

Forum Theatre is a powerful tool that uses theatre for generating community understanding around hard to address issues such as domestic violence. Using such theatre-based ethnography, we aimed to identify the key issues, challenges and needs of Indian immigrant families when accessing and using services that could assist in situations of domestic/family violence.

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## Introduction

Violence against women (VAW) is now widely recognized as a significant global problem, a major public health concern and one of the most widespread violations of human rights (Colucci & Heredia Montesinos, 2013; Eng, Li, Mulsow, & Fischer, 2010; VicHealth, 2008). The perpetrators of the violence are often well known to their victims (WHO, 2005). Domestic violence (DV), which occurs within the context of families, can encompass a wide range of behaviors including verbal abuse, threats, coercion, harassment, intimidation, manipulation, physical and sexual abuse, criminal damage, rape, and homicide (Wilcox, 2006). Although women represent the overwhelming majority of victims of violence occurring in the home, men are sometimes victims too (VicHealth, 2011).

The landmark report published by the World Health Organization a decade ago (WHO, 2002) gave global relevance to the epidemic rates and serious and long-term impacts of violence by positioning it as a leading worldwide public health concern. In 2005, WHO set the prevention of violence against women as a high priority (WHO, 2005). Violence against women is not only a serious breach of human rights, but has major health, social and economic consequences for women, their families and communities. Several studies have highlighted the impact of violence against women, particularly domestic/family violence, on physical and mental health (e.g.: Coker, Smith, Bethea, King, & McKeown, 2000; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; VicHealth, 2008; WHO, 2005), including suicidal behavior (Chowdhary & Patel, 2008; Colucci & Heredia Montesinos, 2013; Davar, 2003; Devries et al., 2011; Ellsberg, et al., 2008; WHO, 2005).

Violence against women, including DV, is a universal phenomenon that persists in all countries and societies of the world (WHO, 2005), affecting all communities irrespective of race, gender, class, religion, cultural background or ethnicity (Bannenberg, & Rossner, 2003). Nevertheless, there are cross-national and cultural variations. For instance, a review of 134 studies in different countries and ethnic communities showed that the prevalence of lifetime domestic violence varied from 1.9% to 70% (Alhabib, Nur, & Jones, 2010). Higher risk of VAW is found in societies with traditional gender norms and roles, unequal distribution of power and resources between men and women, a normative use of violence to resolve conflicts, and cultural approval of (or weak sanctions against) violence against women (VicHealth, 2011; WHO, 2011). In Australia, from the age of 15 years, well over one-third of women (40%) had experienced physical and/or sexual violence (VicHealth, 2011). In particular, in the state of Victoria (capital, Melbourne) intimate partner violence was found to be the leading contributor to illness, disability and premature death among women aged 15 to 44 years. Furthermore, there is evidence that domestic/family violence in this state is on the increase (Victoria Police, 2011).

As observed by Poljski (2011), only a few studies have been conducted in Australia that determine the prevalence and dynamics of violence against women across and within ethnic communities. Researchers and service providers have, however, brought attention to the higher levels of violence experienced by women from immigrant and refugee backgrounds (Bonar, & Roberts, 2006; Erez, 2000; O'Donnell, Smith, & Madison, 2002). For instance, a recent study in Hong Kong confirmed existing evidence that female marriage migrants are more vulnerable to spousal violence compared with local women (Choi, Cheung, & Cheung, 2012).

Women experiencing violence have been reported as being often emotionally involved with, and economically dependent on, those who victimize them, making it difficult to disclose their experiences, let alone to seek support (VicHealth, 2011; Lewis, Dobash, Dobash, & Cavanagh, 2000). A recent study in Melbourne showed that women from immigrant and refugee backgrounds face barriers in addition to those for the broader community, to seeking help (Intouch, 2010). In particular, immigrant women often feel trapped because of immigration laws and fear of deportation, language barriers, social isolation, and lack of financial resources (Orloff & Little, 1999; Raj & Silverman, 2002). A similar study carried out in the U.S. with nine migrant communities showed that "for these women, domestic violence occurs against the backdrop of social and economic marginalization that is similar to and extremely different from women who are mainstream" (Bhuyan & Senturia, 2005, p. 896).

As indicated previously, although violence against women and domestic/family violence affects every community, some groups are at higher risk. Indian women are among them. As observed by Satish, Gupta, and Abraham (2002), “domestic violence is prevalent and [a] largely accepted part of family life in India” (p. 12). There is also some evidence of an increase over time of violence against Indian women (Enayatullah & Zeba, 2003), partially attributed to increasingly “modern” attitudes among women (Simister & Mehta, 2010). In spite of the greater acceptability and presence of domestic/family violence (DV)<sup>1</sup> among Indian women, and higher risk of violence among immigrant women, Indian immigrant women seem to make particularly low use of the services available in Melbourne for victims of domestic/family violence. No official data is available in this regard, despite Indians being a growing and emerging community in Australia (Poljski, 2011).

The 5-yearly Australian Census conducted in 2011 (Australian Bureau of Statistics, 2011) indicated that within Australia, India is the fourth most prevalent country of birth (after Australia, England and China) and in Victoria, the third most prevalent (after Australia and England), comprising 2.3% of the Victorian population, with 47% of these being recent arrivals and 80% being first generation migrants. Despite being the largest migrant group (after the English who would be expected to access culturally mainstream services), of the 641 women who accessed the Immigrant Women's Domestic Violence Service in 2008-2009 in Melbourne, only 54 (8%) were of Indian background (IWDVS, 2010). In the same period, the Federation of Indian Association of Victoria (an association that provides support specifically to Indian victims of domestic violence) supported a total of 16 Indian males and females (AISV Taskforce, 2009). Meetings with other Melbourne-based stakeholders and service providers have also confirmed that Indian women barely access domestic/family violence services (e.g.: AISV Taskforce, 2009) relative to their proportion within the Victorian community.

Together with unequal power relations between men and women and the way gender roles, identities and relationships are constructed and defined within communities and societies, a lack of access to resources and systems of support has been identified as a key determinant of violence (VicHealth, 2009). However, a gap in the literature has been widely acknowledged among researchers and practitioners with regard to appropriate service delivery for ethnic minority people/migrant populations (see Sawrikar & Katz, 2008). There is growing recognition that understanding how various communities perceive and respond to domestic violence is essential for designing effective, culturally competent interventions (Bhuyan & Senturia, 2005). Thus, as also argued by Sawrikar and Katz (2008), examining how to improve access to and delivery of services for specific immigrant and refugee backgrounds communities is an important line of critical inquiry in multicultural countries such as Australia. No previous study of this kind had been carried out in Australia; the few studies carried out in other countries (such as Bhuyan & Senturia, 2005) have not focused on Indian migrants.

For this reason, a partnership<sup>2</sup> was established in Melbourne to explore Indian immigrant women's perceptions of “domestic/family violence” in their community and knowledge about the specific barriers that prevent disclosure and help-seeking. Through this, we aimed to deepen our understanding of the nature and dynamics of DV in the Indian community and provide suggestions to improve access to and delivery of DV and family relationship services to Indian immigrant women.

## **Methodology**

DV is a sensitive area of research, which requires careful planning and consideration of the specific ethno-cultural context (Ellsberg & Heise, 2005). Bhuyan and Senturia (2005) highlighted the importance of in-depth, culturally competent research as a means to allow women's voices to be heard and integrated into our understanding of DV. Previous research has also indicated that community members wanted to see tangible benefits from participating in research beyond simply documenting problems in their communities (Bhuyan & Senturia, 2005). WHO emphasized the importance of action-oriented research to increase our understanding of DV and what to do about

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<sup>1</sup> For brevity, hereafter the acronym “DV” will be used to refer to domestic/family violence.

<sup>2</sup> This project is a collaboration between an Indian community organization (Australia India society of Victoria), a University research Centre (Centre for International Mental Health, The University of Melbourne) and a service provider (Drummond Street Services). Assistance for the theatre workshops and performances was provided by the cultural collective Third Way Theatre.

it (WHO, 2005). Thus, in the same spirit of community-based participatory research we implemented an approach to research called *participatory community theatre*.

Practices of “theatre by the people and theatre for the people,” such as street theatre, have a long tradition in the Indian culture (see Capila & Bhalla, 2010), thus this method can be regarded as a powerful means to engage the Indian community and to promote change through increasing awareness and agency.

### *Theatre and performance as ethnographic research methods*

Over the past two decades, the use of theatre and performance within social science research has gained both popularity and critical attention (Rossiter & Godderis, 2011). There is a growing scholarship that uses theatre as research (Dennis, 2009), including a handful of research-based theatre projects that have addressed a variety of health-related issues (Rossiter & Godderis, 2011).

As observed by Dennis (2009), an analysis of the literature indicates that drama is currently involved in research on several levels (often using drama in multiple ways): as a data collection technique; to reflect data and analysis to a broader audience; to bring participants and others into dialogues that data collection has inspired; as disciplinary critique; and as a participatory form of analysis. Drama has also been used to complement and transfer knowledge gained through statistics (Mieniczakowski, 2001) and as a participatory technique to address social concerns and explore potential social transformation (Conrad, 2004; Prentki & Selman, 2000).

Denzin (2003) defined *performance ethnography* (also described as ethnodrama or ethnotheatre) as a form of social science methodology in which performers and audience are engaged reciprocally and democratically in performing common text. In a previous work, Denzin called ethnodrama “the single most powerful way for ethnography to recover yet interrogate the meaning of lived experience” (1997, p. 94, cited in Conrad, 2004).

Mieniczakowski (2001) defined performance ethnography as co-constructed with research participants, a process that gives participants a forum they may not have in more traditional research.

In their research, performance ethnographers find or create opportunities to perform their cultural understandings by observing, participating in performances, and/or representing their findings to others through performance (Conrad, 2004).

Over the past century, new developments of the concept of “theatre” have allowed the definition of varied tools and intervention methods (Dragone, 2000, p.61). In such theatre forms, the main result is not so much connected with a final aesthetic production (as in the traditional theatre) as with the possibility for a community to explore collectively their issues and avenues of potential action (Prentki & Selman, 2000).

Most of the interactive work genre draws on the *Theatre of the Oppressed* developed by the Brazilian theatre practitioner Augusto Boal (1985), under the influence of Paulo Freire’s *Pedagogy of the Oppressed* (1977/2000). Theatre of the Oppressed is “a system of physical exercises, aesthetic games, image techniques and special improvisations whose goal is to safeguard, develop and reshape this human vocation, by turning the practice of theatre into an effective tool for the comprehension of social and personal problems and the search for their solutions” (Boal, 1995, p.14-15).

Between the specific set of theatrical techniques encompassing the Theatre of the Oppressed, his techniques of Imagine Theatre and Forum Theatre give the audience a part in the dramatic action. In Forum Theatre, the community of participants creates and acts out a symbolic representation in which they witness their struggle and highlight the forms of oppressive conflicts within society. The scenario runs once and is subsequently enacted again, encouraging the audience to stop the action and change the dramatic action replacing a character on the stage. Discussion is promoted by the facilitator, with the aim to create a deeper understanding of the scenario and gain a critical awareness about cultural assumptions, beliefs and values.

### *Theatre and domestic violence*

Boal's theatre techniques have been applied in a few studies that investigated and worked with communities on domestic violence issues, such as Lev-Aladgem (2003) in Israel, Mitchell, and Freitag (2011) in the U.S., Sliep, Weingarten, and Gilbert (2004) in Uganda and Wang (2010) in Taiwan. As Sliep and collaborators pointed out, working between individuals and society is crucial to improve strategies to address issues of social health, moving the locus of control from external agencies to the people who are directly experiencing it. By bringing the stories of marginalized people on stage, Forum Theatre offers a rare opportunity to people on the fringe to be in the center (Chilton, 2000 cited in Lev-Aladgem, 2003) where, being the experts of their own lives, they can be engaged in a dialogue with the audience to discover and explore collectively how to deal with their own problems.



**Photo 1 Performance in a Sikh Temple, by E. Colucci, 2011**

In conclusion, the Boalian techniques (including Forum Theatre and its adaptation such as the techniques used in this project) seemed an adequate and powerful tool to achieve the aims of this project. These aims were to increase our understanding of the nature of DV within Indian immigrant communities of Melbourne, and barriers to help-seeking among Indian immigrant women while, at the same time:

- breaking the silence around DV
- reducing isolation of victims of violence who volunteered in the project
- promoting social change through increasing awareness and agency.

## Method

### *Sample and procedure*

The participants in the project consisted of community members, key stakeholders and service workers<sup>3</sup> who lived in Australia (temporarily or permanently) and were of Indian origins<sup>4</sup>. Based on Wang's (2010, p. 426) experience of women tending to remain silent and voiceless in the public arena when men were present, the study included only Indian women. However, one of the final performances was opened also to male audience members, in order to enable the exploration of possible concepts not expressed by the women-only groups.

Participants were recruited by project partner organizations through flyers distributed at key venues and events for the Indian community (e.g.: International Women's Day, Indian Consulate) and by snowball sampling. During the recruitment, we aimed to have a mixture of recently-arrived and more established migrants, younger and older women.

This performance ethnography comprised three stages: information/focus group sessions, theatre workshops, and community theatre performances.

### *Stage 1: Info/focus group sessions*

The information/focus group sessions had duplicate aims: collect views about what women in the Indian migrant community identify as domestic/family violence and what might be some of the obstacles encountered by those women to seek help in case of violence, and introduce some of the forum theatre games and exercises to recruit participants for the theatre workshops and performances. More specifically, at the start of the session participants were asked to describe first what makes an Indian family a "happy family, a family that lives in harmony" and later an "unhappy family," that lives in disharmony<sup>5</sup>. When the issue of domestic/family violence was brought up by participants, they were asked to describe what they meant by these terms and to provide examples. The sessions were semi-structured and only a limited number of questions were pre-defined by the researcher to prompt discussion (e.g.: "What does it look like when there is domestic violence, abuse?"). At the end of the session, participants were invited to provide their contact information if they wished to continue their participation in the project.

Four focus groups were held in four different locations over three weeks, with a total of 72 Indian women attending. Each Focus Group went for four hours, including dinner. First languages of participants included Hindi, Punjabi and English. Ages of participants ranged from 22-82 years of age. Participants had a range of timelines for their migration, from recently arrived to many years lived in Australia.

### *Stage 2: Theatre workshops*

The participants who accepted to take part in the workshop were engaged in trust-building exercises and several theatre games as metaphors to initiate dialogue. These techniques were used as a means to get deeper understanding of the topic under investigation. Fourteen volunteers participated in six full-day (8-hours) workshops over a four-week period.

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<sup>3</sup> Mainly from legal, social/family, immigration or mental health services.

<sup>4</sup> As mentioned before, victims of violence may have fears connected to disclosure of violence, including fear of isolation and re-victimization. Thus, in accordance also with what emerged from community consultations, the project was opened to Indian women, independently from having direct or indirect experience of DV. In this way, it was not possible for the community and the audience at the performances to identify the volunteer actors as victims of violence.

<sup>5</sup> Previous community consultations pointed out that talking about DV at the start of the session could be too confronting for some participants and suggested to start from the concept of "family harmony/disharmony," which would most likely led to the topic of DV.



The principal investigator (EC) and the research assistant (AB), rather than just “observing,” actively took part in the games.

From the “theatrical investigation” and focus group discussions, a script was devised that aimed at supporting an interactive dialogue with community audiences. To protect the privacy of participants, the script did not represent specifically the personal experiences of the participants. In the last workshop, participants discussed the name of their performance and agreed for *Ghungat*, a Hindi word that means ‘veil’ or, symbolically, ‘hidden’. A flyer was then prepared to invite community member to attend the performances.

### *Stage 3: Community theatre performances*

As for the info/focus group sessions, the interactive theatre performances were based on a community outreach model, i.e. they took place where the community was located. All performances were held in spaces open to the (invited) public. In this way, the play was performed to the women who were involved in the initial sessions (Stage 1), as well as others new to the project.

The primary task of the performances was to share understanding and perceptions of DV in the Indian community and to identify the key issues, challenges and needs of Indian families when accessing and using services.

One hundred and fourteen participated as audience. The majority (92%) were women, with one male at the Tarneit Temple, and mixed men and women at the University of Melbourne performance. All were Indians except for the University of Melbourne forum when academics and professionals from diverse cultural backgrounds, several from Indian diaspora, were invited.

The table 1 below shows the total number of participants in the project across locations.

**Table 1 Number of participants in the project**

<b>Locations</b>	<b>Focus/info group participants</b>	<b>Audience members at performances</b>
Indian consulate (rehearsal)	–	2
Balwyn	20	25
Sunshine	20	–
St Albans	12	–
Glen Waverley	20	12
Melbourne University	–	50
Tarneit Temple	–	35
Total	72	114

### *Data collection and analysis*

The info/focus group sessions and the performances were audio-recorded and transcribed verbatim. In three instances, the researcher interviewed individually participants who appeared to have had no opportunity to share their thoughts. These interviews were also transcribed. These sets of data, together with the field-notes taken by the principal investigator and the assistant during these sessions and the theatre workshops, formed the basis for the qualitative data analysis.

Transcriptions and field-notes were analyzed using the principles of Interpretative Phenomenological Analysis (see Colucci, 2012).

Pre- and post-workshop and performance interviews with audience participants were also conducted and evaluation surveys were completed by the participants and audience members. These data provided the basis for an evaluation of the project (Pryor, Colucci, Reardon, O'Connor, Field, & Baroni under submission).<sup>6</sup>

### *Ethics*

Ethical clearance was approved by the University of Melbourne Ethics Committee. Consultations were carried out with community members in order to prevent potential negative effects of participation in this project. Furthermore, during the information/focus groups, workshops and performances, all care was taken to ensure that a suitably trained support person was in the room and that women were able to access culturally-sensitive advocates and services if the need arose.

### **Results**

Participants indicated the presence of several forms of DV in their community, discussed attitudes that sustain such practices, and barriers to receiving help and accessing services. The following section presents the key findings divided into the two main areas of investigation<sup>7</sup>: the nature of DV and barriers to help-seeking.

#### *Nature of domestic violence*

Participants identified several kinds of DV towards women that were present in the Indian migrant communities, which can be summarized as:

- Emotional/Psychological
- Financial
- Social
- Physical
- Sexual
- Spiritual/Religious

Emotional violence/abuse (defined in some cases also as “psychological”) was one of the most common forms of DV, as indicated by participants. Emotional violence was described as taking different forms, such as lack of control and being dominated. As it will be further discussed in the next section, often participants expressed a generally accepted and reinforced inequality between Indian men and women, and lack of freedom in decision-making for women. This lack of control, or an excessive control, was seen as a form of DV by some of the participants. Emotional abuse was also expressed as verbal abuse, either as use of abusive language towards the woman or as verbal threats, including threats of deportation and cancellation of immigration visas. Also the silence that many women depicted as being expected to be maintained (see later) was identified by some participants as a form of violence, e.g.: *“The silence kills. I used to listen to my husband, then my mother in law and now even my son. I’m listening since 3 generations”* (fg1).

Being blamed for everything that happens, being humiliated and “put down in her self-esteem” were also forms of violence described and, for few participants, seen as “the ‘best’ way of controlling.” Participants provided several instances when they or women they knew had not been treated with dignity and equality and felt humiliated. In several instances the women referred to household chores (e.g.: *“He said that is why he married, so that he can have a hot chapatti cooker,”* perf4) and the kinds of expectations placed on Indian women. In an example, these expectations were described as a form of abuse: *“[Expectations] are a form of abuse because get to a point where*

<sup>6</sup> In the surveys, participants were also given the possibility to provide opinions that they might have been unable or unwilling to share during the performances. No substantial new data was produced through these surveys with regard to the questions dealt with in this article.

<sup>7</sup> Quotations from participants will be used to exemplify the concepts described. The letters and numbers indicate the source of such quotations (e.g.: “fg1” stands for “focus group 1,” “wrk” for workshop, “ind” for individual interview and “perf” for performance).



*they are unrealistic and when these expectations became unrealistic they became social abuse, emotional abuse” (ind1).*

Emotional/psychological abuse was not only one of the most mentioned forms of abuse, but was also described as *“the worst one” (fg1)* and the one that *“takes longer to heal” (fg3)*.

Also a form of social abuse was identified by participants, e.g.: *“Society abuse is the biggest abuse in India community. The fear of society never makes you change the things that are happening in your life” (ind1)*. Different kinds of controlling behaviors such as not being allowed to talk to anybody or having phone and e-mail use ‘tapped’/controlled were described as forms of social abuse.

Control was expressed also at an economic level. This included control of the money the woman earns and other possessions, and non-acceptance of a woman’s financial independency. Dowry (referred also as “contract marriages”) and other economic pressures placed on the woman and her family were also described both as forms of financial abuse and cause of other kinds of violence, for instance: *“There are contract marriages: my son is in Australia, he has a PR, drives a BMW, you pay this much money to get your daughter there in Australia and your daughter will have to do this for my son” (fg2)*.

Sometimes the financial expectations both on the woman and man imposed by their families, for example sending money to families in India, was seen as causing or contributing to conflicts and DV.

In some instances, participants spoke about physical (e.g.: beating, hitting, punching) and sexual violence (e.g.: non-consensual sex, being forced into sex during their period, when pregnant or unwell). While physical abuse was described by a few women as easier to identify, sexual abuse was seen as particularly difficult to identify as abuse (*“It’s my husband, he can do it,” fg3*) and disclose (*“The girl cannot go and tell that to her parents like my husband is demanding me to do oral sex,” ind2*). Sexual abuse was represented by a few as being due to migration and the exposure of men to new forms of sexuality.

Although mentioned by only a few participants, spiritual/religious forms of violence were also described, where the woman is not allowed to go to the temple, pray, or cook food to offer to God.

In summary, participants were familiar with the different forms DV may take. In a few instances, however, they appeared to be uncertain about what in fact represented violence. For examples, in the focus groups some participants asked if what they described was a case of DV.

The “perpetrators” of violence were usually identified as the husband, however, at other times it was the brother- or father-in-law or they used the more generic terms of “the men/man” and the “in-laws.” Also mothers-in-law and sisters-in-law were described as also being perpetrators. Participants pointed out that the family members do not necessarily live in Australia and violence and abuse can be caused by *“family and friends back in India” (ind2)*.

From the participants’ descriptions, it was clear that DV was perceived as a problem that cuts across the spectrum of education, class and age. On the other side, a few women argued that in upper classes it can be more hidden, more subtle, and more at the psychological level. Furthermore, differences were also expressed in regards to generations. A few participants felt that older women were at greater risk of DV and had greater expectations placed on them compared to the younger generation. This was confirmed by younger participants who felt more involved in decisions about their own life and saw themselves as having more freedom compared to previous generations. Nevertheless, younger people and new families were also represented as being exposed to DV (e.g.: *“I think that lots of abuse will come out in our generation as well,” ind1*). In a few instances, in fact, participants pointed out issues that might make the conditions for the new generation of immigrants even worse, for example, while the woman is still expected to look after household chores, she is also expected to work and earn well, and pressured by the family to have children. Generational gaps and clashes of values and costumes between younger and older generations were often mentioned as a source of conflict and possibly of violence.

Finally, in several instances participants brought attention to “migration” as an important contributing factor to violence against women, including the threats of deportation, cancellation of visas and control of passport. In particular, participants discussed young couples who migrate to Australia “to seek a better life” (fg2) but end up not finding the job they aspire to (e.g.: going from being an engineer to a taxi driver) or earning less than expected (by themselves and by the families back in India), becoming a source of stress and frustration that could trigger the violence. This was seen as even more so if the wife was more successful than the husband. Some examples of this follow:

*“(…) these Bollywood movies are adding to everything. Like Salaam Namaste, it was shot in Melbourne (...), in the movie it is shown that a chef is driving a Mercedes, everyone thought that. I thought that too, that the standard of living is so high that I can just go there, start working and buy a BMW. Well, when I came here, it was different.” (ind2)*

*“[these] frustrations come out in the form of vocal or physical abuse.” (perf1)*

The lack of social support due to migration was also indicated to contribute to violence, either because it can generate conflict and then violence or because it makes the man less accountable and the woman more vulnerable to being a victim of violence. For example: *“I know so many men here who never hit their wives back in India but here they do it because they know there is nobody to protect them.” (perf1)* Shifts in attitudes and behavior in the woman as a result of migration may not be accepted by the man, and he might react with violence against the woman. A few participants also observed that some behavior/attitudes towards women that were accepted in India can become a source of conflict or be acknowledged as a form of abuse once the couple migrates, such as: *“it was normal there [in India] and you tend to accept it but here it is not acceptable.” (perf4)*

### *Barriers to help-seeking*

Throughout the project it became evident that barriers to an Indian immigrant woman receiving help were at two levels: one related to more generic barriers to disclosing DV and accessing informal social support, and the second related to barriers specific to accessing professional help. In the following section, we outline both levels of barriers, with the former seen as important impediments, which may “come even before” the second typology of barriers.

**Generic barriers.** Across groups and throughout the different stages of the study, participants often reported Indian community acceptance of inequality and violence against women and the expectation that a woman will maintain silence in such situations. For example:

*“Even when she is growing up and when she gets married, her parents always tell her that she must listen to her in-laws, her husband and even if something wrong is happening with her, she must have the patience to bear it because she is a woman (perf3).”*

*“Women can’t even talk about it because they are expected to keep it together and lead a happy life. With all this it makes it even harder for them to approach anyone and discuss it with someone. It is considered not right to tell people that you’re having violence in the house” (fg1).*

In particular, once married, women are expected to accept violence “like their mothers,” and thus might not receive social support from their family and friends to get out of the situation of violence.

Because this was seen as an important (and for some the biggest) barrier to asking for help, empowering the community to “break the silence” and to assist the woman in seeking help, and providing “good role models in Indian women” able to challenge the expectation of silence and submission, were proposed as strategies to overcome this barrier.

Participants also disclosed the presence of social stigma towards a woman who is a victim of violence (*"people don't want to be associate with a woman who has put herself in that situation,"* fg3), who is seen by some members of society as responsible for the violence (*"there must be something wrong with her,"* perf4) and *"the one to blame."* This attitude toward the "victim" of violence (which, in fact, re-victimizes the woman) generates fear for the possible consequences of the disclosure, above all fear of being isolated from the rest of the community, which stops a woman from disclosing the violence and seeking help.

Lack of freedom and dependency, especially financial dependence, was often raised as a main factor why an Indian woman remains in a situation of DV. Participants observed that *"abusive men can be controlling so even if she would like to ask for help, he might have control on who she calls, her emails, where she goes, so she might not be able to access help"* (wrk1). Others noted that some Indian women are financially dependent on their husband or their lifestyle relies on him and accept the situation of violence as result of this. For example: *"Girls think twice before leaving their husband because they are worried where they go, they don't have enough money and parents to look after them"* (fg1).

In a few instances, lack of evidence and fear of not being believed (because there is no physical evidence, or because the perpetrator hides proof or holds a position of high prestige and status) were indicated as potential barriers.

In addition to the above barriers, which were sometimes referred to as *cultural barriers*, participants also indicated the important barrier created by the lack of information. More specifically, they mentioned the lack of violence awareness and the lack of knowledge about laws and rights. Talking about the former, participants expressed difficulties in identifying a behavior as DV. In this regards, a service provider commented: *"The new generation which is coming from India, I have to explain to every single client what domestic violence means, most of them think it is just slapping, pushing. Sexual abuse, they say, no but we are married, he is my husband, he can do that, isn't it?"* (ind2).

In regard to lack of knowledge, participants highlighted the importance of giving immigrant women, especially on arrival, the correct information about their rights and laws available in the host country.

**Barriers specific to services.** First of all, it is important to note that services were rarely part of participants "discourse" around DV and, when discussing help-seeking, this seemed to be about immediate family and the broader community rather than seeking professional help.

In addition to obstacles to reaching out for any kind of help, participants indicated a number of specific barriers when prompted to reflect on professional help. One of the main barriers discussed was the cultural background of the professional. Generally participants felt a counsellor or other professional from Indian background would be better equipped to deal with a case of DV in the Indian community compared to an "Australian" professional, because of the shared understanding of the culture, ease of establishing a relationship and knowledge of the language. As one participant put it, *"If it took me 5 minutes to explain my name, how long is this person [talking about professionals] going to take even with my first problem"* (wrk3). However, some advantages were also pointed out (although rarely) in connection with workers who do not belong to the same cultural communities. These opposite views were expressed in particular when talking about the key role of GPs in violence prevention, something that was recommended by some participants but questioned by others.

One of the issues raised in accessing (non-culturally sensitive) services was the kind of intervention provided by services. In a group, participants felt that services *"go too fast, expect them to do too big steps"* whereas the woman *"might need to go baby steps"* (wrk 5). In particular, while *"leaving the husband"* was presented as a typical answer to a situation of DV, this *"is not the Indian way"* (wrk 4) and divorce was described in several instances as not an option for Indian women. For example: *"For a woman it is like even if this man is physically abusing me, I can't divorce him because what would people think of me, I'm going to lose friends, my place at work,"* or *"Divorced women are considered less respectful and are isolated"* (fg1). Other types of help were seen positively, such as

violence prevention and outreach programs, activities aimed at empowering women, helplines and community groups such as self-help groups. Some concerns about access were also raised in regard to these strategies.

Another main barrier to professional/service use was the lack of knowledge about services (including what and where they are) and how to access such services: *"The biggest barrier to seeking help is that people don't know who to tell"* (perf4). This can be greater for women with a spouse or student visa who might be even unaware that they can access certain services (*"some services are very strict"* perf4).

In addition to this, participants often described bureaucratic barriers that might stop the person from accessing or returning to the service. In a few instances, they complained about the presence of lengthy waiting lists. But the main concern was about assessment and consent forms, which were regarded with great skepticism and mistrust: *"they freeze when they see that"* (wrk2). This, in their opinion, is exacerbated in newly migrated women who fear that disclosure of such information might have consequences on their visa status. Thus, to address these barriers, participants suggested explaining the use of the information collected and the circumstances in which confidentiality might be broken, and to ask for identifying information only when the person had established some engagement with the worker.

Confidentiality and privacy were described as important issues, as was the trust in the professional and service. Due to bad experiences in home countries, Indians may lack trust in the service system, particularly the police force. Building trust and meeting client's expectations were therefore seen as facilitating access to services.

Social stigma was also occasionally mentioned as being a barrier to seeking formal help from services. The view expressed was that people who engage with a mental health service may be seen as "mad" by the community. One participant had this to say on the subject: *"This perception within the Indian community is the biggest barrier. The problem is not with the system, the barriers are within the Indian community"* (perf1).

Lastly, migration-related issues were also represented as creating difficulties in service access. In particular, a migrant woman might lack support and be isolated, thus more dependent on her husband and less able to reach out for help: *"When people come to Australia they are so isolated so they keep in everything until it blows up. Then they can look for extreme solutions, like killing themselves"* (wrk2). Furthermore, the pressure to keep silent was presented as greater among migrant communities in order to avoid being stigmatized by the host countries and avoid problems with their visa.

## Discussion

Participants seemed to have an understanding of the different forms of DV that have been identified in the literature (e.g.: WHO, 2005; Wilcox, 2006): emotional/psychological (including verbal abuse), financial, social, physical and sexual, and spiritual/religious abuse. Participants also expressed uncertainty, however, about what represents culturally "normal" and acceptable behavior and practice in the Indian community and what may, in fact, be classified as a form of DV.

Participants reflected on the social drivers behind such violence and explored dynamics of DV within their community. Indians often live in an extended family when they migrate to Australia as they often do in their homeland, thus violence may be perpetrated not only by partners/husbands but also by members of the extended family such as mother, father, brother/sister in law. This finding has been confirmed by other studies, such as Simister and Mehta's (2010). Thus, services must be aware of and capable to address the complex dynamics of DV in Indian families.

Immigration issues were often described as contributing to DV at different levels, from its causes (directly or indirectly) and forms, to accessing help and getting out of the situation of violence. The relationship between visa status, vulnerability to violence and service utilization was also observed by Bhuyan and Senturia (2005) and Poljski (2011) and highlights the need for system level changes and education for new migrants. These findings underline

that DV might take different shapes and forms within different socio-cultural contexts and, thus, the need to seek to understand DV in its complexity and multiple layers.

The same is true about barriers to accessing services. The reasons for underutilization of current services span from the lack of knowledge and awareness on the part of the community to the lack of appropriate culturally-sensitive practices in the providers. Lack of knowledge or understanding of services that are available, reflecting insufficient or inadequate dissemination of information about the range of services available, was also one of the barriers to uptake of services by an ethnic minority identified by Sawrikar and Katz (2008)<sup>8</sup>. However, as those authors argued, offering linguistically and culturally appropriate information is only a partial solution because potential clients from ethnic minorities need to believe that the service itself will be delivered in a culturally and linguistically appropriate fashion. Language and cultural barriers have been emphasized by other authors (e.g.: Bhuyan & Senturia, 2005; Intouch, 2010; Poljski, 2011; Sawrikar & Katz, 2008). The latter also found that confidentiality and trust issues may be heightened for families from immigrant and refugee backgrounds because of their concern that the community may find out; this was certainly true for our sample. To help overcome this, the authors suggested being honest and comprehensive in the protocols and boundaries on sharing information. Cross-service and sector partnerships are also key factors to improve both violence reporting and service utilization (see also Bhuyan & Senturia, 2005; Intouch, 2010; Sawrikar & Katz, 2008).

These findings point out that, in order to improve utilization of services, changes are required at the system and service level, as also argued by Bhuyan and Senturia (2005) and Sawrikar and Katz (2008). However, key obstacles to seeking help and escaping the violence (the most significant barriers, in some participants' opinion) were at the community level. A study on Indian women who migrated to Canada also confirmed that the pressures of social, cultural and family ties prevent these women from getting help for domestic violence (Shirwadkar, 2004).

As previously noted by WHO (2002), persisting societal and/or cultural "silence" on the problem, together with fears of not being believed, ostracized or re-victimized by people around them, can determine or intensify women's reluctance to take help-seeking steps. Similar studies in Pakistan and Bangladesh (Andersson, 2010; Naved, Azim, Bhuiya, & Persson, 2006) showed that women who report violence risk their reputation and are seen as bringing dishonor to the family. Gendered discourses about self-sacrifice and the virtue of silence and acceptance, which have also been observed among other ethnic groups (Bhuyan & Senturia, 2005; Lichtenstein & Johnson, 2009) were dominant in participants' discourse about DV and barriers. The review by Flood and Pease (2009) also showed that attitudes towards violence against women play an important role not only in the perpetration of the violence, but also in the individual, community and institutional responses to violence and women's own responses. Lichtenstein and Johnson (2009) observed that "socio-cultural factors affect how victimization is perceived or managed, in turn affecting victims' willingness to seek help for domestic violence" (p. 286-287). For instance, an ethnography of the lived experiences of DV victims in rural areas of Kentucky by Websdale (1997) highlighted that DV victims were further marginalized through isolation from victim services and that abused women feared the consequences of reporting violence because of systemic protection, including by police, of male abusers (the "old boys' network"). Similar fears were found also among Indian women in this study.

The findings from previous studies (see Bhuyan & Senturia, 2005) and the outcomes of this study emphasize the key role of the community in preventing violence and in supporting help-seeking (see Colucci & Pryor, 2014, for a discussion of DV prevention strategies).

The Indian community and community leaders have a key role to play in changing certain norms and attitudes, such as traditional gender role attitudes (Flood & Pease, 2009) that condone, normalize and justify DV as well as norms and attitudes that render violence "invisible" and silence the victims of this violence. As argued by Poljski (2011), "immigrant and refugee women and their representative groups and organizations should be at the forefront of violence prevention efforts, whilst collaborating with other identified community leaders in these efforts" (p.12). Future research should aim at understanding how to change such attitudes while, using an action-research

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<sup>8</sup> However, even prior to this, lack of information about their rights and how to access them was also identified by participants in this study and by previous authors (Bhuyan & Senturia, 2005; Intouch, 2010).

approach as in this study, being in itself a small step towards such change. Empowering women and strengthening communities, including setting up self-help groups, are fundamental to the change of attitudes towards violence, silence and help-seeking (Andersson, 2010; Bhuyan & Senturia, 2005; Poljski, 2011).

### Limitations

There were limitations in our study design that should inform future studies. First of all, although we had a small number of men in the last performance, we aimed to understand DV from the perspective of women. Future studies should explore men's perspectives, including the less prevalent but nevertheless important circumstances where the man is the victim of violence. Participants in our study expressed a preference to keep the group a women-only group. However, although this was mentioned by only a few participants, some community members, including their own husbands, expressed fears that taking part in this project would "*put wrong ideas in their mind*" (perf1). It might be worth investigating if bringing some trusted males into the project would help to reduce such fears for men and women, while maintaining women's comfort and safety.

Although the project has some limitations, it is important to note that during the workshops and performances, as well as in the pre/post-performance surveys and the pre/post-workshops interviews (Pryor et al., under submission) participants made positive comments about the use of the theatre for research as well as increasing awareness and promoting social change. For instance, a one participant observed, "*theatre is an exploring experience, it brings reality closer to us and it opens up the space for communication. The reason I am here is in India, theatre is a very powerful medium*" (perf4). However, further studies are also required to build evidence in relation to the use of community theatre both as an education/social change tool and as a research method.

### Conclusions

In the Australian context, violence against women occurs among all cultural, religious and socio-economic groups. However, women marginalized by age, culture, ethnicity, sexual identity and visa status are more vulnerable to violence and are less likely to have the resources to act upon it (Poljski, 2011). Indian immigrant women appear to be among those. Through this study, we aimed to improve our understanding of the nature of DV among Indian women who have migrated in Melbourne and barriers to accessing services, by using a theatre-based ethnography, in order to inform more culturally appropriate help for this population. This study uncovered several cultural and social factors that are acting as barriers to accessing services. Although several of these barriers are shared by the general population (e.g.: Rose, Trevillion, Woodall, Morgan, Feder, & Howard, 2011), cultural differences and migration issues seem to further complicate the issue. Initial indications have been highlighted and further research is needed in order to develop strategies that address those factors that might put an Indian woman in a situation of violence in the first place and keep her in such situation.

In addition to building our understanding of the nature of DV and culturally specific barriers to help-seeking, the evaluation of this project (Pryor, et al., under submission) indicates that the performances also played a role in shifting Indian community attitudes towards women and violence against women, and to open a conversation about an issue often maintained under *Ghunghat*.

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