HHS Public Access

Author manuscript

Med Anthropol Q. Author manuscript; available in PMC 2017 June 01.

Published in final edited form as:

Med Anthropol Q. 2016 December ; 30(4): 515–535. doi:10.1111/maq.12336.

Culture and Comorbidity: Intimate Partner Violence as a Common Risk Factor for Maternal Mental Illness and Reproductive Health Problems among Former Child Soldiers in Nepal

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Abstract

Our objective was to elucidate how culture influences internal (psychological), external (social), institutional (structural), and health care (medical) processes, which, taken together, create differential risk of comorbidity across contexts. To develop a conceptual model, we conducted qualitative research with 13 female child soldiers in Nepal. Participants gave open-ended responses to intimate partner violence (IPV) vignettes (marital rape, emotional abuse, violence during pregnancy). Twelve participants (92%) endorsed personal responses (remaining silent, enduring violence, forgiving the husband). Twelve participants endorsed communication with one's husband. Only four participants (31%) sought family support, and three contacted police. Ultimately, 12 participants left the relationship, but the majority (nine) only left after the final IPV experience, which was preceded by prolonged psychological suffering and pregnancy endangerment. In conclusion, comorbidity risks are increased in cultural context that rely on individual or couples-only behavior, lack external social engagement, have weak law and justice institutions, and have limited health services.

Keywords

reproductive health; mental health; intimate partner violence; trauma; war

Introduction

Comorbidity and multi-morbidity, the co-occurrence of multiple health conditions, have emerged as prominent themes in practice and research (de Groot et al. 2003; Mendenhall 2012; Singer 2009). Health care providers are more likely to treat patients with multiple health conditions rather than a single isolated disease (Gonzalez et al. 2008; Wang and Li 2003). Epidemiologists find that risk factors predispose populations to a range of health morbidities (Danese et al. 2009; Leon and Walt 2001). Present research on comorbidities includes exploration of etiological factors (e.g., economic disadvantage and adverse childhood experiences) (Danese et al. 2009; Leon and Walt 2001). Unfortunately, this research rarely receives sufficient attention about how cultural processes shape health

(Napier et al. 2014). The role of culture in comorbidities is absent from most empirical studies. These gaps in health research present challenges for anthropologists to elucidate how culture shapes comorbidities and the implications for research and practice. We address this challenge by exploring the role of culture in mental and reproductive health in the context of intimate partner violence (IPV) among former child soldiers in Nepal by first providing a framework for understanding culture and comorbidity.

Conceptual Framework for Culture and Comorbidity

In this special issue, Weaver, Barrett, and Nichter highlight that comorbidity traditionally has been viewed as a confound—a second disorder that complicates either treatment protocols or epidemiological studies for a primary condition of interest. They advocate moving beyond this traditional view to illuminate the complex relationships among disorders (Mendenhall 2012; Singer 2009; Weaver and Mendenhall 2014). We take up this challenge by proposing a heuristic for the role of culture in the pathway from risk factors to comorbidity (see Figure 1). We argue that decontextualized pathways contribute to incomplete and misleading models for prevention and treatment.

Influence of cultural context of risk factors and health comorbidities. Pathway *a* refers to the impact of reproductive health on mental health. Pathway *b* refers to the impact of mental health on reproductive health. r^a refers to the correlation of interpersonal violence with reproductive health problems. r^b refers to the correlation of interpersonal violence with mental health problems. The top of Figure 1 represents the observed associations between two health conditions: *a* and *b*. A risk factor (R) may cause health condition *a*, which, in turn, contributes to health condition *b*. Alternatively, risk factor *r* may contribute differently to both health conditions. Common risk factors contributing to multi-morbidities include poverty, child abuse, other forms of trauma and stress, pathogens, toxins, diet, and unhealthy behaviors such as substance abuse or lack of exercise. Studies investigating adverse childhood experiences (ACEs) demonstrate that ACEs increase risk for physical and mental health disorders (Brown et al. 2006; Danese et al. 2009; Felitti et al. 1998).

A shortcoming of most comorbidity models is the assumption that risk factors will have comparable contributions across cultures and context toward health problems (e.g., the assumption that poverty will contribute comparably to diabetes and depression in the United States, South Africa, or India). We operationalize culture according to Hruschka and Hadley's definition: "values, beliefs, knowledge, norms, and practices and the notion that that these are shared among a specific set of people" (Hruschka and Hadley 2008: 947). According to this framework, social stressors will transact with health based on values and practices that shape the local context.

As Mendenhall has described, this comorbidity and its association with common risk factors has important variation across cultural contexts, which can be attributed in part to the values and practices in those settings. Furthermore, cultural processes occur in transaction with environmental, social, and psychological processes, shaping access to resources and exposure to pathogens (Kohrt 2014; Worthman 2010). Cultural processes influence social processes such as discrimination, segregation, and availability of informal and institutional

social support, increasing risk for comorbidity. Cultural processes also influence psychological processes by enhancing or restricting personal and collective agency and determining social scripts about the acceptability and culpability for violence, such as IPV.

Therefore, in the bottom half of our heuristic model (Figure 1), we operationalize cultural influences through four categories: (1) internalized process (psychological); (2) externalized processes (social); (3) institutionalized processes (structural); and (4) health systems processes (medical). The framework demonstrates pathways by which a risk factor may lead to one, both, or none of the target health conditions based on cultural context. Employing diabetes, depression, and poverty as an example, internalized processes (psychological) include individual behavior and perception. Externalized processes (social) refer to expressed behavior within sociocultural groups. For institutionalized processes (structural level), local, national, and regional institutions influence social and individual behavior. At the level of health systems, the availability of health services (both mental and physical) mitigates the transformation of risk into health problems and the relationship among comorbidities.

To evaluate our four-component model of culture and comorbidity, we employ the case of former child soldiers in Nepal. Child soldiers are a population that has shown high risk of experiencing IPV in some populations (Betancourt et al. 2013). We use qualitative data from structured vignettes to explore how culture influences exposure to IPV and the relationship between IPV and comorbid sequelae of mental and reproductive health problems.

Methods

Setting

Nepal is a low development country, with a Human Development Index rank of 157 out of 186 countries, a life expectancy of 69.1 years, a mean of 3.2 years of education, and a gross national income per capita of US$1,137 (UNDP 2013). Nepal ranks 121st of 136 countries on the Global Gender Gap Index, a composite measure of female to male attainment (World Economic Forum 2013). Women experience a higher workload, lower literacy, and earlier average mortality than men, and 31% of women report experiencing IPV (Bennett et al. 2008). Recent legislation was designed to protect women by raising the legal age of marriage, improving inheritance rights, and prohibiting marital rape and sexual harassment, yet these laws are poorly understood and inconsistently enforced (Tuladhar et al. 2013). The Nepali population is also suffering economic, social, and health after-effects of a decade-long civil war (1996–2006) between the People's Army of the Communist Party of Nepal (Maoist) (CPN[M]) and the government of Nepal. One of the consequences of the war was the widespread recruitment of child soldiers (Human Rights Watch 2007), who experience high rates of PTSD, depression, and impairments in daily functioning (Kohrt et al. 2008).

Child soldiers are identified as CAAFAG (Children Associated with Armed Forces and Armed Groups), according to the Paris Principles (UNICEF 2007). We use child soldiers throughout because participants in Nepal regarded the term CAAFAG as stigmatizing because of its association with certain types of reintegration programs and lack of agency attributed to former youth combatants (Kohrt et al. 2010).

Sample and Recruitment

The data presented here come from 13 interviews conducted in 2012 with female former child soldiers, ages 18–23. Inclusion criteria included childhood association with the Communist Party of Nepal (Maoist) People's Army and female gender. The women in the current study were selected from a larger epidemiological sample (Kohrt et al. 2015b).

Ethical Considerations for IPV Research

Conducting research on IPV with young adult women raises a range of ethical questions regarding psychological and physical safety. Discussing IPV, whether disclosing personal experiences or discussing hypothetical scenarios, carries great risk of psychological distress and requires availability of appropriate psychological services. For this study, only female former child soldiers who lived in regions with ongoing psychosocial services (see Kohrt et al. 2015c) were recruited for participation. For most interviews, a trained community psychosocial worker (CPSW) facilitated the interaction between researchers and participants. This CPSW was a resident in the participant's community and thus able to assist with any debriefing or resources needed after the interview or in the future. All research staff had received ethical training and were members of Transcultural Psychosocial Organization (TPO) Nepal, a Nepali nongovernmental organization with extensive experience in mental health research that also includes a staff of supervising clinicians available for referral and internal data and a safety monitoring board to address any psychological and physical safety concerns in protocol design and implementation. No referrals for psychological distress or IPV were required during these interviews or in the months following.

We chose to employ hypothetical vignettes to qualitatively research IPV. This has the advantage of not requiring personal disclosure of IPV. Vignettes may contribute to lower levels of distress than personal disclosure; however, the severity of experiences in the vignettes may be more severe than personal experiences, and thus potentially more distressing. Therefore, full psychosocial services were available to all participants, which would have been comparable if the study had relied on personal disclosure. Vignettes were selected primarily due to physical safety and confidentiality concerns. Many of the participants lived with husbands and in-laws, therefore using hypothetical vignettes poses a lower risk of retaliatory violence for IPV disclosures. The World Health Organization (WHO) advocates using vignette-based approaches to IPV to reduce risks for participants (Ellsberg et al. 2005). The institutional review boards of Emory University (Atlanta, Georgia), George Washington University (Washington, DC), and the Nepal Health Research Council approved the study protocol and consent process.

Structured Vignette Interviews

Qualitative interviews incorporated structured vignettes that followed a WHO process comprising adaptation of an open-ended story format to study violence against women (Ellsberg et al. 2005). The Nepal vignette was developed based on programmatic and research experience in IPV in South Asia, findings from formative in-depth interviews and focus group discussions, and consultations with local service providers and researchers.

To conduct the structured vignette interview, a Nepali research assistant explained to the study participant that a story was going to be told about a young married woman who lived in a similar community. The participant was told that the young woman in the story was the same age, caste/ethnicity, religion, and education level. The participant was told that the woman also was a former child soldier. The interviewer asked the participant to name the woman in the story. The interviewer then presented participants a standardized narrative about the character, using the name the participant had chosen. The narrative included sequentially iterated experiences of IPV, presented in discrete sequences where each described one experience of violence. The sequential stages of violence were:

- Sequence 1: Husband forces sexual initiation of marriage on character
- Sequence 2: Husband is emotionally abusive and controlling (restricting outside social contact) of character
- Sequence 3: Husband commits a single episode of physical violence against character
- Sequence 4: Husband rapes character when she is pregnant
- Sequence 5: Husband commits severe physical violence against character

The interviewer sequentially prompted participants after each sequence (1) to suggest the character's somatic, emotional, and cognitive reactions; (2) to describe how the character would respond; and (3) to reflect on the efficacy of the response, alternative responses, and barriers and facilitators to response. The interviewer also elicited community and societal perceptions when the character involved others. For consistency, the narrative ended either after the fifth sequence or when the character left the relationship. The interviewer then invited the participant to reflect on how the narrative would differ if (1) the caste, religion, and community composition were different and (2) the character was not a former child soldier. Participants could share personal stories or experiences and make suggestions about needed supports for women in their communities. They were not required to share personal experiences of violence; if personal experiences were shared, the interviewer allowed the participant to determine the degree of disclosure.

The second author (CB) conducted all interviews with the assistance of a Nepali research assistant fluent in English and Nepali, who translated questions and responses during the interview to enable follow-up questions. Audio recordings were captured and subsequently translated and transcribed by the research assistant. The second author and research assistant reviewed interviews to clarify meaning and recorded pertinent observations in field notes.

Analytic Strategy

The second author (1) coded transcripts for narrative structure by marking each sequence of the structured vignette; (2) summarized responses for each participant and sequence; and (3) developed inductive thematic codes based on these summaries and line-by-line coding of a random sample of interviews. Inductive codes included participants' socio–demographic characteristics; participants' historical experiences before, during, and after association with the People's Army; and characters' emotional reactions, responses and rationale, relationship expectations, and community interactions. The second author applied these

codes, summarized and analyzed coded text within and across themes, and triangulated findings with summarized responses. Both authors then returned to the narratives to select case studies that illustrated these themes and their relationship to patterns of mental and reproductive health comorbidity.

Results

Participants were 18–23-years old, Hindu or Buddhist, with varied educational completion (grades 5–12) (Table 1). All were associated with the People's Army as minors, having joined when they were between 12 and 17 years old. Representative of former child soldiers in Nepal broadly, they differed on motivations for association (e.g., coercion, peer pressure, and attraction to Maoist ideology), length of association (mean: 9.3 months, range: four days to two years), and experiences of reintegration (e.g., limited felt-stigma, significant discrimination, and relocation to prevent coerced reentry into the People's Army). The case studies below present brief participant histories and in-depth examples of responses to the structured vignettes. The case studies are followed by a summary of patterns of vignette response among the entire sample.

Case Studies

Āshā—Āshā, a 22-year-old Dalit/Nepali woman, joined the People's Army at 12 years old. She participated in activities for six months, until she became tired of isolation from family and peers. When she returned home, her mother immediately married her to an older man in a distant village to avoid community stigma associated with her status as a former child soldier. In Āshā's marital home, her in-laws abused her until she attempted suicide by hanging. Her father-in-law found her during her attempt, cut her down, handed her the rope, and told her to return to her natal home to kill herself.

In her interview, her character, Sītā, expressed a mixture of frustration and self-blame. She recognized few options for response to escalating violence in the relationship, resorting to reciprocal violence before leaving the relationship.

> Sequence 1: Āshā's character, Sītā, consented to an arranged marriage and relocated to her husband's home where she experienced forced sexual initiation. As Āshā described, Sītā felt really sad because her husband "went against her wishes," forcing her to have sex when "there should have been consent between [her and her husband]." Despite wondering whether "the first night was just like this or life for her will be just like this from now," she did not act. She resigned herself to "accept whatever was happening."
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> Sequence 2: When Sītā 's request to visit friends was denied by her husband, she felt badly, initially thinking: "Why he is shouting and yelling at me when I haven't done anything wrong or bad?" Sītā asked her husband what she had done wrong and why he had become angry and yelled at her. Āshā explained that Sītā should assume blame for the experience, stating: "If she hadn't asked that she would like to go to her friend's house, then the problem wouldn't have started at all; the root cause of the problem is that she asked her husband for the permission to go to her friend's house." Prompted to suggest a course of

action following the violence, she contemplated leaving the relationship permanently. However, Āshā could not commit to action for Sītā, instead describing that she would have a heavy heart–mind ("heart–mind" refers to the Nepali ethnopsychological concept for the center of emotions and memories) and "might have also gotten sick or weak due to the stress of the incident."

Sequence 3: After the physical violence encounter, Sītā immediately became angry, thinking: "I haven't done anything bad or anything like that." She went to her room to sleep or "keep her mind busy on something." As she explained, "When two people talk or argue, things get worse or the argument gets bigger."

Sequence 4: After the rape-during-pregnancy sequence, Āshā narrated that Sītā "might have difficulties or a hard time, felt sad; I don't know." She described reciprocal violence, stating, "She might have fights, physical fights, maybe she might have hit him." However, she conceded that "she might get hurt … maybe she would get sick: headaches, fevers, and sickness [would] come." Although she did not commit to leaving the relationship, she discussed that Sītā's relatives and family, parents, and brothers might provide assistance, if she were to reach them.

Sequence 5: When the violence escalated to severe violence, Sītā felt sad. She "left [her] husband, walked out from the house" and returned to her natal home with her child. Her family had mixed reactions to her return, yelling and scolding her first, then admonishing her to "do whatever you can to raise your kid and take care of yourself," then accepting her as she brought "money home to her parents to support." Community members scolded her for leaving her husband. Āshā explained, "Her husband's house is her own house according to religion."

Pūjā—Pūjā, a 22-year-old Dalit/Nepali woman living in a predominantly upper-caste community, joined the Maoists when they threatened to take her entire family if she did not join. She joined and participated in cultural programs and extorted money from poor households. After a year, leaders discovered that her brother-in-law was a policeman. Suspecting her of being a spy, the leaders abused her verbally, punished her with six months of manual labor, and prevented her from leaving. She eventually escaped and returned home, yet she had to live separately from her family because leaders came to her village to reenlist her and threaten her family daily.

She returned to her natal home after the peace accord, where she experienced community stigma. Her stepmother chastised her publicly, "[She] had gone with the hope to earn money and be independent … but [she] came back empty-handed with disgrace." Friends commented about her future, suggesting, "The time when [she] was most suitable for marriage, [she] was hanging out with your group." Community members patronized her, claiming, "She went there and had illegal relationships, killed people, or did some immoral things."

Although she admitted “flashbacks to all those bad experiences” due to continued harassment from some community members, she also discussed how she had received post-conflict vocational support, which allowed her to open a small salon, and psychosocial counseling, which granted her skills to release negative comments from her heart–mind and respond openly to people who harass her. She expressed pride in the vocational skills that she had acquired, confidence in her ability to support herself financially, and “empowered to do things on her own.”

> Sequence 1: Pūjā’s character Mīra felt “depressed, unfulfilled, and saddened” when she experienced force sexual initiation early in her marriage. “Mīra was not ready when she got married” and “only married to fulfill her parents’ wishes,” Pūjā said. She saw two pathways for response, based on Mīra’s character: if Mīra were educated, experienced, extroverted, strong, and had options to be independent, she would “talk about not doing this and that … with her husband” or would separate from her husband. If Mīra were naïve and inexperienced, she would “think … now my life is in this house, stay quiet, and tolerate the abuses,” at least until her husband did “these kinds of forceful sex more often … again and again.” Because Mīra was naive and inexperienced, she “[thought] about separating, but [stayed] back.”
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> Sequence 2: When her husband demonstrated controlling behaviors and emotional violence, Mīra responded that she had a “bad husband.” She believed that her “husband should have understood her, because he also spends all day outside, to meet his friends; likewise, [she] also [needed] to go out to see her friends and work.” She further questioned, “[A] wife never questions where her husband was or for what reason he is leaving house, so why should he question her?” She ruminated that they were “not getting along well because of distrust.” She “[tried] to talk with her husband … [explaining] her errands outside and why she was leaving for that friend’s place.” She acknowledged, however, that the effectiveness of this conversation would depend of her husband’s character: “If he were understanding, he would not pick a fight … and would not ask where she was going or with whom. … If he were not understanding or had bad intentions of abusing her, then he [would] fight and yell.”
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> Sequence 3: After physical violence, Mira asked herself: “I have gone for a good purpose; why is my husband shouting and getting angry with me?” She wondered if he was having an extramarital affair and had picked a fight so that she would leave the relationship. She said: “What [could] she do? She [would] stay with him and cry a lot.” She added: “She [would] stay quietly; she [would] think about that if she [opened] her mouth, then her husband [would] get angrier.”
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> Sequence 4: Marital rape during pregnancy caused Mīra to comment again that her husband was “not good.” “When he wanted sex, then he was nice and sweet, and when he did not, he was mean and cruel.” Focused on cultural significance and prohibitions related to pregnancy, she noted, “that [community

members] will look at you with disgust that you haven't had kids." She decided to "talk with [her husband] and … make him understand about her condition and women's bodily changes during that time."

Sequence 5: Mīra did not tolerate severe physical violence. As "she also [needed] to think about the child and herself," she left her husband and moved out of the house. Her first desire was to move to her natal home, yet she acknowledged that this was contingent on her "parents and the family there [being] supportive and strong." She explained, "If not, they would ask her to go back to her husband; they would say: 'That is your home, you have to tolerate your husband, stay there with him whatever the cost, or maybe it is because of you that he was having these problems.'" This potential response, however, did not deter her: "If they had a bad condition, not enough money, or they were not supportive, then she would find her own apartment." Similarly, the community might not support her. As she described: "If the community [supported] her husband or [thought] that he [was] a good person, they [would] say: 'Oh, she came into his life to cause all these problems; she maybe caused the problems in that house; she might have had an affair with another guy.'"

When asked about how the narrative might have been different if Mīra had different socio–demographic status or was not a former child soldier, Pūjā described: "She might have been … discriminated in the community for being a girl already." As a Dalit/Nepali in a predominantly Bahun (high-caste) community, she also would face caste-based discrimination: "If there are certain majority castes in one community, then they will try to suppress the lower castes more and maybe other minority castes, too." Further, Mīra would experience discrimination because she was a former child soldier: "If she was known to be involved in the Maoist, then she will have harder times because of more discrimination; … some husbands or people would really hate or look with disgust if they come to know about the involvement with the group."

Pūjā distinguished herself from Mīra at the end of the narrative. Unprompted, she offered: "If I were that girl, I wouldn't stay." She elaborated: "I will try to find out about the person before marrying, and I will also tell everything about me frankly; if he accepts me, then I will be happy; if not, I will leave."

Kāmalā—Kāmalā, a 20-year-old Janajati woman living in a Janajati community, joined the People's Army when she was 16 years old, motivated by peer pressure, a desire to escape from daily work, and expectations that association with the People's Army might grant her the education or skills to improve her life. She worked for six–seven months, until she grew tired of the limited food and poor housing. Inventing a story that her mother was ill, she was allowed to return home, where she received support, love, and care from her family. Her neighbors and peers, however, would taunt her, saying she "had big dreams of coming back with some money or accomplishments, but returned with nothing." Although she thought about rejoining the People's Army, she decided to stay home and pursue her education after she received psychosocial counseling and community interventions began to change attitudes toward returning former child soldiers.

Sequence 1: When Kāmalā's character, Nīlām, experienced forced sexual initiation in her marriage, she thought: "I have made a big mistake by marrying this guy," and wanted to leave her marital home, but Nīlām remained in her marital home, believing she would slowly come to "understand about the intercourse and sex by herself." She explained:

> A girl in her lifetime will go to husband's house. After she leaves her parents' house, she should make a life there. In the village, people say that if the girl has problem in one house then she might have problem again in another house. … Most of the people have a saying that "fate of an earthen pot and the life of a girl is the same." Once it is broken, it won't be like the original: it cannot be put back together. (Kāmalā)

Sequence 2: After her husband's emotional violence and controlling behaviors, Nīlām thought: "I haven't spoken badly or said anything; why is he mad at me?" She continued: "He might beat me out of anger or due to his bad mood." She decided to talk with him because he "might have some feelings for her." She reached out to her family, who replied: "These are small things that happen between husband and wife; don't mind these things."

Sequence 3: After experiencing physical violence and hearing her husband apologize, she thought: "Even though my husband is mad at this moment, he still … cares for me deep inside." She decided: "Small fights or small discords in the marriage life are common … and she shouldn't make a big deal out of it." Seeking help from her family, she recounted that they would help correct "any deficiency in the running of the household."

Sequence 4: Marital rape during pregnancy brought forth regret. Nīlām "thought … in her heart–mind about the past incidents." She mentally reviewed her responsibility for the situation, thinking: "If I had left him back then and left this house, probably things like today wouldn't have happened." She remained silent: "Where would I go on this condition? If I [went] to my parents, I would be a burden to them too. Now whatever happens or whatever difficulties I have with him, I have to stay in this house."

Sequence 5: Nīlām was concerned with the safety of her child when severe violence occurred. She said: "Either I am going to die or he is going to die," if communication with her husband failed. She elaborated: "In self-defense or when she is really in rage," she might "throw stuff and hit with whatever is in the proximity … like knives." Otherwise, her "husband might try to kill them both." Despite this, she said that it was "her duty to stay with him." Kāmalā presumed that the husband was an alcoholic and believed her character needed to care for him: "Like when [he] drinks alcohol or has some kind of accidents, then who will take care of him and bring him home?" She also asserted that he loved her "deep inside."

In addition to believing "she could solve the problem herself slowly in time," Kāmalā described that discussing "household issues," such as domestic violence, with persons other

than close friends and family would affect the family adversely. “The issue will be totally different if it goes in the community; people will add more and more stories to the original problem as it goes from word of mouth from one person to another … like wild fire.” She added that her status as a former child soldier affected the situation. If she had not been associated with the People’s Army, “she might have continued her education and [have] more knowledge about life and future goals; … she would have a different perception on marriage and life, and this condition wouldn’t have come.” She also would have had a different relationship with the community, which would have allowed her to get help from the community.

Responses to IPV among Total Sample

The case studies above illustrate specific responses to the IPV narratives. When examined as a group, the 13 young women more often focused on individual behavior responses, followed by seeking support from family, and most infrequently pursuing community groups or police and legal assistance (see Table 2).

The most common responses to IPV, endorsed by 12 of 13 respondents, were personal behavior such as remaining silent and enduring, forgiving one’s husband, and changing one’s own behavior. Ultimately, 12 of the 13 women also decided to leave the relationship, either by returning to one’s natal home or by living independently. Nine of the 12 women who left the relationship did so only after the fifth sequence (severe violence). Engagement with one’s husband was the most frequently endorsed behavior, with 12 of 13 women endorsing communicating with one’s husband for at least one of the IPV experiences. Despite claims of suicidal behavior being a frequent response to IPV in Nepal, none of the 13 girls endorsed suicide as response to any of the IPV experiences. However, one Janajati woman said that her character would have attempted suicide if marital rape were repeated.

Social support in terms of family, friends, and community received limited endorsement from the young women. Only four out of 13 sought family support at any point in the narratives, specifically during Sequences 1, 2, 3, and 4. Similarly, only four young women reached out to friends and community members, for Sequences 2 (emotional abuse and control), 3 (physical violence), and 4 (forced sex during pregnancy).

Regarding institutionalized processes of response, only three of the 13 women sought support from police and legal organizations, and these were in response to forced sex (Sequence 1), physical violence (Sequence 3), and severe violence (Sequence 5). Similarly, only two women pursued community organizations, one in response to physical violence (Sequence 3) and one in response to severe violence (Sequence 5).

Internalized Processes (Psychological)

Coding of the narratives identified a number of internalized processes that influenced decision-making during the vignettes. All participants expressed negative emotional and somatic reactions to violence. They indicated that the narrative character would feel surprised or confused, unhappy or depressed (“heaviness in her heart–mind”), betrayed or unsafe (“like she fell from a cliff”), empty or hopeless, fearful, tortured, trapped, or angry. They also expressed feelings of physical pain and discomfort, illness, regret,

disempowerment ("He had the upper hand, and he had the authority."), self-blame, and resignation. Their responses to IPV included intrapersonal and interpersonal coping strategies (e.g., silence, communication, and reciprocal violence).

Externalized Processes (Social)

Perceived blame from the community resonated as a prominent theme. Particularly for one high-caste woman, whose responses largely focused on her "role in making a good home" to elicit reciprocal care and support from her husband, rigid gender roles were associated with significant self-blame. As she described:

> She is married, has a small child, and couldn't stay making her home, husband, and child happy. A woman should have stayed making them happy. … A girl becomes someone else's daughter, someone's daughter-in-law, and someone's wife. She might be a mother. She must fulfill all the responsibilities in every different role she has. … It wouldn't have happened if she had been able to make everyone happy. (Sarita)

Conversely, community blame arose from former child soldier status for many participants. As one participant described, former child soldiers had poorer marital prospects because they violated gender norms and were considered impure after spending a night away from their homes while associated with the People's Army.

Institutionalized Processes (Structural)

Three women indicated that their characters would engage formal community supports and would leave the relationship prior to life-threatening violence. These included a low-caste Hindu woman living in the southern plains of Nepal who had returned without experiencing stigma or discrimination. Her character sought assistance immediately following forced sexual initiation. Rather than ascribing forced sexual initiation to a personal failure, she believed forced intercourse was inappropriate. Expecting to receive support because she is below the legal age of marriage and experienced forced sex, she sought family and legal assistance immediately. As the participant described:

> First, she will try to find a solution within her family and, if that doesn't work, then she will go to the police. … Because she was married off underage … and was forcefully made to have sex, she will probably get legal aid. … At the police, she will tell her husband's misbehaviors and tell them what he did to her. Then she will decide: she won't have sex until she is old enough. She might tell [the police] her wishes, like the husband's house is not safe and [she] wants to go to her parents' house. (Ashmitā)

Her character left the relationship after experiencing physical violence, seeking assistance from her natal family, police, legal aid, and women's organizations. Although she acknowledged that some community members might react negatively, she explained her hope for at least some community support: "Whatever happens in my room, people just won't know. … [Only] when I tell others … they might be able to help me."

Discussion

This study employed a unique vignette-based approach to elicit responses to IPV. This was done to inform how IPV influences reproductive and mental health. Through the vignettes, we found that the majority of study participants (12 of 13 respondents) remained silent, endured IPV, forgave their husbands, or tried to change their own behavior. The majority of participants (12) tried to change the situation by communicating with their husbands. Eventually, 12 left the relationship. However, of those who left the relationship, nine only left after the fifth and final sequence of escalating violence. Family, friends, community organizations, and law enforcement/legal supports were sought only by four women. These findings and the narrative responses shed light on cultural contributions to pathways from IPV to types and severity of reproductive and mental health comorbidities. The values and practices related to gender in Nepal influence the risk and response to IPV. Below we summarize the internalized, externalized, institutionalized, and medicalized processes by which culture impacts comorbidities.

Internalized Processes (Psychological)

Experiencing IPV was seen as a personal failure and one that requires a personal change or endurance for resolution. Because of these internalized processes, there is limited agency to seek individual, social, and institutional solutions to escape IPV. Most of the young women stayed in the relationship until the final violence sequence. Thus, IPV is likely to be prolonged when it does occur, increasing the risk of health problems. For example, 10 women stayed in the violent relationship during pregnancy. The prolonged exposure sets the stage for mental health problems. As mental health problems escalate, feelings of hopelessness, worthlessness, and a foreshortened future impede appropriate care for reproductive health needs.

Externalized Processes (Social)

Most of the women expected that there would be limited support from the community and from their own family. Three women sought support from family or friends in the community. In one of the participant's (Āshā) personal experiences, she describes how her own family rejected her when she tried to escape IPV committed by her husband and in-laws.

Institutionalized Processes (Structural)

The structural conditions affect both opportunities and agency to leave and mitigate situations of IPV. The expectation that police will not do anything to help a woman experiencing IPV precludes contacting them (Tuladhar et al. 2013). Moreover, for these former child soldiers, the armed police and Nepal Army soldiers were seen more often as the perpetrators of sexual violence rather than as a resource to stop IPV. Women also suffer from economic disempowerment because of traditional practices and legal codes that historically have barred women from owning and inheriting property. Without institutional supports, women will be more likely to be in situations of prolonged IPV, thus increasing the risk that it has negative health consequences. Moreover, the lack of institutional resources

exacerbates feelings of helplessness, worthlessness, and self-blame, which increase risk and severity of common mental disorders.

Health Systems Processes (Medical)

Because of limited reproductive and mental health care, IPV health sequelae are more severe and lasting. Women have limited access to appropriate facilities for delivery and prenatal care; there is a lack of expertise in handling obstetric complications; and neonatal intensive services are limited to few urban centers in the country (Suvedi et al. 2009). Therefore, IPV is more likely to contribute to maternal and child mortality. Similarly, lack of psychological services precludes psychotherapeutic treatment for IPV survivors (Luitel et al. 2015).

One striking finding was the lack of centrality of identity as a former child soldier in the narratives of the young women. Other aspects of identity and expected cultural norms of women in general were more often invoked when describing risks and the behavioral responses toward IPV. As Pujā stated, the girl in the vignette experienced these problems first and foremost because she was a girl in a rural society. Being low-caste Dalit exacerbated this. Being a child soldier worsened the underlying vulnerability provided by these two facets of risk. For Kāmalā, being a child soldier impacted IPV risk only via the loss of educational opportunities, with lack of education seen as a risk factor for a poorer quality relationship. This has important implications for support programs that target female former child soldiers. For such individuals, other aspects of identity—notably gender, caste, and education—may be more salient in their perceived risk and response. Addressing these risk factors also has the potential to reduce vulnerability to recruitment of children into armed groups (Kohrt et al. 2015c).

Application of Findings

The framework we have proposed points toward multiple complimentary strategies to address IPV risk and negative health outcomes. Consistent with models we have used elsewhere, a multi-tiered approach can be employed to address psychological, social, institutional, and medical processes (Kohrt et al. 2015c). For psychological processes, individual and group psychotherapeutic interventions can reduce distress and empower women to pursue appropriate reproductive care and services to reduce IPV. This cannot be successful without appropriate pairing with interventions to reduce externalized social risk factors. By targeting opinion leaders in the community (teachers, political leaders, and health workers), social attitudes toward IPV can gradually be changed. Organizations in Nepal are currently engaged in these efforts. At the institutional level, changing practices within law enforcement and the legal community is crucial. In other LMIC settings, we have demonstrated the benefits of collaboration between law enforcement and mental health clinicians (Kohrt et al. 2015a). Through a combination of promoting psychological resilience and improving the social context for young women, there is potential to optimize long-term physical and mental health. Recent research with child soldiers in Nepal has shown that high resilience, including aspects of self-efficacy, is associated with down-regulation of genes associated with inflammation and up-regulation of genes associated with anti-viral activity (Kohrt et al. 2016). Finally, increasing availability of health services is crucial. In addition to improving the physical infrastructure for reproductive medicine, task-

sharing is an evidence-based practice shown to have benefits for both health outcomes (Fulton et al. 2011; van Ginneken et al. 2013). This final point highlights why thinking of comorbidities is so crucial. It is more advantageous to consider interventions and human resources that can tackle these co-occurring problems of common commodities than to treat reproductive and mental health as separate health problems requiring different health worker cadres. Therefore, the Pakistan model of using Lady Health Workers to provide both perinatal health services and mental health services (Rahman et al. 2008) would be appropriate for vulnerable populations in Nepal. Moreover, through a comorbidities approach the incorporation of mental health into perinatal services makes the mental health services more palatable. Comorbidities should be viewed as an opportunity to provide services for one health condition (that may be less prioritized or more stigmatized) within the context of more acceptable health services, such as maternal and child health care. In addition, we have demonstrated the high comorbidity of depression with hypertension and diabetes in Nepal (Neupane et al. 2015; Niraula et al. 2013). These would be other areas where mental health services could be incorporated into chronic non-communicable health services that are more acceptable and available.

Limitations

This study had some limitations. First, the study used a non-representative sample of former child soldiers, without a comparison group. Although this allows for preliminary documentation and analysis, the generalizability of findings is unknown, and further research is needed to explore variations among former child soldiers and other conflict-affected youth. Second, interpretation of the narrative assumes relative congruence between imagined responses for the characters, perceived responses for former child soldiers, and actual responses by IPV survivors. Limited data are available to evaluate congruence between the character and participant, although several participants suggested identification with the character by alternating between first- and third-person pronouns during the narrative, and elements of personal histories are visible within narratives (e.g., a participant whose character shared her somatic symptoms of psychological distress). Perceptions of IPV might not correlate with contextual realities due to response biases (e.g., social desirability bias may lead participants to report more culturally normative responses). Third, the study privileged relationship exit as an endpoint, potentially underestimating the effectiveness of negotiation strategies discussed by participants. IPV trajectories are poorly understood, and relationship dissolution should not be understood as a programmatic recommendation; this may not be a preferred endpoint in South Asia because single women frequently face economic hardship, stigma, and risk for exploitation (Haviland et al. 2014).

Conclusion

Our findings suggest that addressing mental and reproductive health intersections requires socio–ecological approaches that focus on psychosocial dimensions of mental health, including cultural norms and social support. Growing interest in mental and reproductive health for women in developing contexts demands thoughtful consideration of research methodologies that minimize potential stigma and psychological distress and generate rich data that account for cultural and contextual variations. Contextually specific and culturally

grounded evaluations of these intersections are essential, as social experiences play a central role for mental and reproductive health experiences. Simultaneously, innovative techniques, such as participant-directed narratives, should be evaluated systematically for the ability to capture both interpersonal and intrapersonal dimensions of health and well-being.

Acknowledgments

The authors gratefully acknowledge the support of staff at the Transcultural Psychosocial Organization (TPO) Nepal, psychosocial counselors Kamala Gahatraj and Maya Shrestha, and field research assistant Sushil Gurung. Carol Worthman provided invaluable supervision for the longitudinal biocultural child soldiers' study in which the current study was conducted. HopeLab (www.hopelab.org, San Francisco; Principal Investigators: Carol Worthman and Brandon Kohrt) and the Emory University Center for Ethics Noether Fellowship (Fellow: Christine Bourey) provided support for this work. Thanks for Anvita Bhardwaj for assistance with manuscript preparation. We thank the Nepal Health Research Council for ethical approval and monitoring of the study. Participants in the study were originally enrolled through research supported by the U.S. National Institutes of Health (F31 MH075584).

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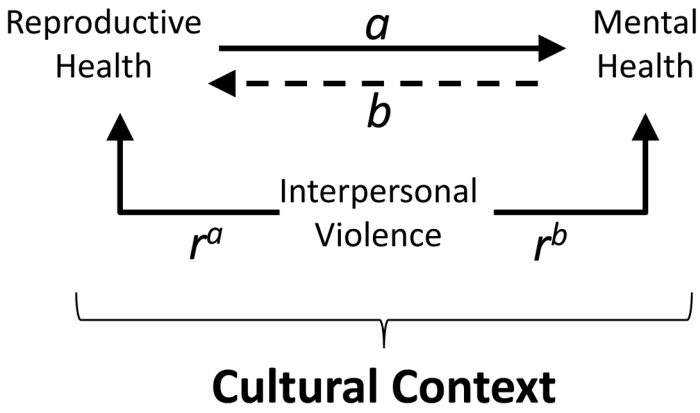

Cultural Context

- **Internalized processes (psychological)** – self-stigma, shame, perceived lack of autonomy, hopelessness
- **Externalized processes (social)** – caste- and gender-based social practices, micro-aggressions, verbal and behavioral practices, time allocation and social activities
- **Institutionalized processes (structural)** – marital practices (patrilocal, dowries), caste- and gender-based educational, economic, and employment practices; weak, male-biased law and justice system; lack of reproductive and mental health services
- **Health systems processes (medical)** – lack of reproductive and mental health services; high maternal and infant mortality; high burden of untreated common mental disorders (depression, anxiety, PTSD)

Figure 1.

Table 1

Characteristics of female former child soldiers in Nepal, 2012

Participant	Age*	Education (Grade)*	Religion	Caste	Marital status	Age at association*	Length of association (months)*	Reintegration experiences		
								Family support	Stigma	Leave
1	21–23	5–7	Hindu	High caste	Married	13–14	24+	Yes	None reported	5
2	18–20	10–12	Hindu	Dalit	Single	13–14	24+	Yes	None reported	1
3	21–23	8–9	Buddhist	Janajati	Married	15–16	1–6	Yes	Community	5
4	18–20	10–12	Buddhist	Janajati	Single	15–16	6–12	Yes	Community, classmates	Stay
5	21–23	10–12	Hindu	Dalit	Single	13–14	24+	No	Friends, community	5
6	21–23	8–9	Hindu	Janajati	Single	15–16	1–6	Yes	Community	5
7	18–20	10–12	Hindu	High caste	Single	10–12	1–6	Yes	None reported	5
8	21–23	5–7	Hindu	High caste	Single	10–12	24+	Yes	None reported, but left community for safety	3
9	21–23	10–12	Hindu	High caste	Married	17–18	12–23	Yes	Friend, school, community	3
10	18–20	10–12	Hindu	Janajati	Single	13–14	1–6	Yes	None reported	5
11	21–23	10–12	Hindu	Janajati	Married	15–16	1–6	Yes	Community	5
12	21–23	10–12	Hindu	Janajati	Single	not provided	not provided	not provided	not provided	5
13	21–23	5–7	Hindu	Dalit	Separated	13–14	1–6	No	Community	5

*Ranges provided to protect confidentiality.

Table 2

Number of Nepali female former child soldiers endorsing behavioral responses to interpersonal violence, 2012 (N=13)

	Sequence 1. Forced sexual initiation	**Sequence 2. Emotional violence and controlling behaviors**	**Sequence 3. Isolated physical violence**	**Sequence 4. Marital rape during pregnancy**	**Sequence 5. Severe violence**
Remain silent/endure	8	2	3	3	0
Forgive husband	0	0	3	0	0
Change behavior	1	1	2	0	0
Communicate with husband	2	10	8	7	2
Perpetrate reciprocal violence	0	0	0	1	0
Consult family	2	1	2	2	0
Consult friends or community members	0	2	1	1	0
Seek police or legal assistance	1	0	1	0	1
Seek community organization assistance	0	0	1	0	1
Leave (trajectory unspecified)	0	0	0	0	1
Leave and return to natal family	1	0	1	0	4
Leave and seek divorce	0	0	1	0	2
Leave and live independently	0	0	0	0	5
Suicide	0	0	0	0	0