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MBBS FRANZCP MMed DPM

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SUBMISISON TO THE ROYAL COMMISION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Suicide , mental health, the practice of dowry and family violence in Victoria among Indian and the South Asian communities.

I am grateful to the Royal Commission for this opportunity to present my views as a Psychiatrist and a community advocate with expertise in mental health, family violence, suicidality in diverse communities and dowry abuse

About the Author

Professional work- I am a Psychiatrist with 4 decades of clinical experience , an applied researcher, a published author and a reviewer for National and International Journals. My primary area of interest for past 15 years has been mental health , suicidality and family violence in immigrant communities from the Indian Subcontinent . My private practice in Psychiatry is focussed on migrant mental health suicidality and treatment of victims of family violence, and perpetrators mental health . I identified pattern of dowry abuse in Indian immigrants in clinical and research work.

I hold an academic position of Hon Senior Fellow at the department of Psychiatry at the University of Melbourne . And conduct regular research projects and use research evidence to support my professional and voluntary work in migrant communities . I am a Research Affiliate of the Gender Violence Research Network, UNSW.

I am regularly invited to speak at local and international conferences and have presented papers in UK , Germany , Australia , Dublin.

I Chair Bi—National Family Violence Psychiatry Network at the Royal Australian NZ college of Psychiatrist.

Community Volunteering –As a co-founder the Australasian Centre for Human Rights and Health in 2012, and as a person of Indian heritage I am heavily engaged with the Australian -Indian community . I identified dowry abuse in my research and clinical practice . I advocate against family violence in immigrant communities and part of advocacy work I led the public dowry abuse campaign in Australia and that led to the inclusion of laws against dowry abuse in the

Victorian Family Violence Protection Act in 2019 . The campaign helped to trigger the Federal Senate Enquiry into dowry abuse in Australia in 2018 . I have been the lead Project developer for prevention programs such Mutual Cultural Respect, Mutual Relational Respect, *Natak Vihar* – community participatory theatre and United We Stand video resource . All programs can be accessed via www.achrh.org

I am a Council Member of Harmony Alliance , peak body representing Immigrant Women of Australia.

Method and prevalence of suicide

I will describe international , Australian and my research with a focus on the Australian Indian and broadly South Asian Community in family violence, dowry abuse and suicidality . I have heard of approximately 8 cases of female suicide since 2016 . I will describe one case of suicide in detail showcasing the association with family violence and dowry abuse -a common pattern in the Indian Subcontinent.

I will describe the deeper cultural meaning of arranged marriage and dowry abuse , mental health and association with suicide, and recommendations to stop suicide

Introduction

Australia is highly multicultural and hosts migrants from every country of the world. Indians in Australia form a sizable minority with 592,000 they constitute about 2.4% of the population(ABS2017) . With the migrant population increasing and more diverse than ever before, migrant suicides need to be examined.

Suicide in immigrants, stressors, Family Violence

Incidence- Among Australian men the rate of successful suicide is 19.1 per 100,000 persons, while the rate of suicide among women is 6.2 per 100,000 persons[1]. The average rate is 12.6/100,000. It is estimated that for each person who dies by suicide, more than 20 others attempt suicide. In fact, suicide attempts are an important risk factor for subsequent suicide[2]. Suicide attempts are far more common in women as is depressive illness[2] .

Suicide rates are rising – the last annual national toll increased by 300 suicides. A significant proportion of the increase was made up of migrants. Nearly 3,000 Australians took their lives in 2014, and persons born outside Australia accounted for 25.1% of deaths (ABS 2014). According to Gerry Georgatos (2016) a suicide *researcher "We know of the humanitarian crisis with Aboriginal and*

[1] Causes of death, ABS 2017 .
[2](WHO, 2014).

Torres Strait Islander suicides but little is known about the high suicide rates of many migrant groups[3]"
Second generation children born in Australia , whose parents were born overseas are at elevated levels of risk to clinical depression and suicide. On average, each year more than 800 suicides are of persons born overseas.

Suicide is highly prevalent in already marginalized and discriminated groups of society. Social, psychological, cultural and many other factors can interact to increase the risk of suicidal behaviour, but the stigma attached to suicide means that many people who are in need of help feel unable to seek it. Risk factors for suicide include previous suicide attempts, mental health problems, harmful use of alcohol, drug use, job or financial loss, relationship breakdown, trauma or abuse, violence, conflict or disaster, and chronic pain or illness (WHO, 2014).

Role of Immigration related factors – Why Immigration increases suicide risk.

A review of research evidence from UK demonstrates that although there is some contradictory evidence, overall the data suggest that immigration increases suicide risk. Specific migrant populations and ethnic minorities presented a higher risk of suicidal behaviour than native populations, as well as a higher risk of death by suicide. Non-European immigrant women in the study were young women of South Asian and black African origin[4]. Risk factors among migrants and ethnic minorities were found to be: language barriers, worrying about family back home, and separation from family. The lack of information on health care system, loss of status, loss of social network, and acculturation were identified as possible triggers for suicidal behaviour.

Recommendation 1- Education on mental health systems and support should be provided as part of settlement services .

The Australasian Centre for Human Rights and Health has developed an award winning program called Mutual Cultural Respect or MCR (see www.achrh.org). MCR received Victorian Governments Multi-cultural Certificate of Innovation and is cited in 'A Platform for Change' [5] (DSS 2016,P23) as culturally suitable education program . MCR uses case based scenarios. Interactive group discussion using adult learning principles help migrants explore various aspects of life and culture in Australia vis a vis their country of birth, provides deep understanding of cultural issues around mental health and family violence and provides sources of systemic help in mental health and family violence. Further information on evaluation of the program is attached as Attachment 1.

[3] (Gerry Georgatos (2016. Ref: Migrant suicides – more than 1 in 4 Australian suicides are of migrants but discussion is lost in translation. The Stringer).
[4] . Forte A, Trobia F, Gualtieri F, et al. Suicide Risk among Immigrants and Ethnic Minorities: A Literature Overview. Int J Environ Res Public Health. 2018;15(7):1438. Published 2018 Jul 8. doi:10.3390/ijerph150714380 .
[5] A platform for change . DSS 2016. Page 23 . https://plan4womenssafety.dss.gov.au/wp-content/uploads/2015/04/final_online_accessible_a_platform_for_action_report_1_april_2016.pdf

Recommendation 2- Programs such as Mutual Cultural Respect should be mandatory for new and settled migrants

A US study found that stressors that accompany migration such as disrupted social networks, devalued identity, unemployment and legal uncertainties may account for poor psychological well-being and increased risk of psychiatric disorders among certain immigrant groups, particularly those who become racial/ethnic "minorities".[6] In general, the study notes that previous research has found the risk for suicidality is lower among immigrants before migration , possibly due to selection of healthy migrants compared to native born, but this risk equalizes to that of the native population over time after migration. This is said to be related to acculturation stress or goal striving hypothesis . Whether acculturation acts as a risk or protective factor likely depends on characteristics of both the host country and the individual migrating, including social and cultural characteristics of their country of origin.

Stressors that accompany migration such as disrupted social networks, devalued identity, unemployment and legal uncertainties may account for poor psychological well-being and increased risk of psychiatric disorders among certain immigrant groups, particularly those who become racial/ethnic "minorities" refers to a study on Somali migrants in US.

Immigration visa status e.g., refugees, students, permanent residents), a variable is an important risk factor for acculturative stress according to Brown et al (2015).

Marital Status - Immigrant divorced persons were over 2 times more likely to commit suicide than native Americans.[7] Single immigrants were nearly 2.6 times more likely to kill themselves than the native born. Shorter duration of residence was associated with higher suicide risk. Integration of immigrants in receiving societies is important for decreasing suicide. Policies aimed at reducing suicide should target more recent immigrants .

Family , Violence and suicide in communities from Indian subcontinent

In an early study P. W. Burvill demonstrated that migrant suicide rates in Australia had significant co-relation with the country of birth.[8] Research evidence suggests that migrant males tend to have

[6] (Brown MJ, Cohen SA, Mezuk B. Duration of U.S. residence and suicidality among racial/ethnic minority immigrants. Soc Psychiatry Psychiatr Epidemiol. 2015;50(2):257–267. doi:10.1007/s00127-014-0947-4).
[7] (Kposowa AJ1, McElvain JP, Breault KD. Arch Suicide Res. 2008;12(1):82-92. doi: 10.1080/13811110701801044.
[8] DOI: https://doi.org/10.1017/S0033291797005850Published online: 01 January 1998).

lower suicide rates than the Australian born male, whereas the rate is higher for females born overseas.[9]

The high anecdotal evidence of successful suicides in women of Indian subcontinent, and high rates of suicidal ideation and attempts noted in my clinical practice deserves attention . The association between Family violence and suicide is well known. Studies internationally and nationally show that FV increases the risk of suicide by 2 times, FV increased the risk of mental illness eg PTSD 7 times, depression and anxiety 4 times[10]. In a clinical audit of 88 women who had been subjected to FV , the Middle Eastern women (32) who were not able to leave their marriage , continued to live with their perpetrator, and remained suicidal in 100% of cases. They did not respond well to treatment . Whereas the south Asian young women (56) rejected by husbands, suffered FV , full of fear for their life at the hands of husband and his family 75% had suicidal thoughts , 17 % had attempted suicide , while two women nearly died due to very serious attempts . The dowry demands, extortion and humiliation was present in 50% of women[11](Attachment 2). The significant majority of women improved after treatment lasting 1-3 years . Key factors were they felt safe with IVO , got control of their life and income , started working or studying. After one year follow up those who had received their visa for permanent residency did much better than those who had not .
Clinically I have observed that victims of family violence who have no path to permanent residency are on temporary visas , or dependents of international students are at great risk of on-going mental illness and suicidality.

Recommendation 3-. Self-empowerment and control over their life and income needs to be facilitated by Governmental supports

Potential Issues in Marriage

Indian, and broadly South Asian women have the highest rates of suicide in the world. In some parts of South India the rate of suicide among women is more than 100/100,000, in the age groups 15–24 years. The rates of suicide in females compared to males –the ratio can be equal or higher, whereas in the western world men's rate of suicide is 3 times that of women . Research shows that unlike western countries ,in India, marital status is not protective to the mental health and suicidality in women [12]

[9] Morrell, S., Taylor, R., Slaytor, E. & Ford, P. (1999). Urban and rural suicide differentials in migrants and the Australian-born, New South Wales, Australia 1985-1994. Social Science and Medicine, 49, 81-91.
[10] Rees S, Silove D, Chey T, et al. Lifetime Prevalence of Gender-Based Violence in Women and the Relationship With Mental Disorders and Psychosocial Function. JAMA. 2011;306(5):513–521. doi:10.1001/jama.2011.1098)
[11] O'Connor Manjula & Ibrahim Samir. 2018. Suicidality and family violence in Australian immigrant women presenting to out-patient settings. Australasian Psychiatry)
[12] Mythri SV, Ebenezer JA. Suicide in India: Distinct Epidemiological Patterns and Implications. Indian J Psychol Med. 2016;38(6):493–498. doi:10.4103/0253-7176.194917).

Our research (Attachment 3) with Indian community in Australia shows that the pattern of family configuration and family violence in Australian-Indian communities is highly analogous to that of Indian family in India. The level of social distress is based on number of family related matters. Our study explored the cultural dynamics of FV and associated social distress in 165 participants (largely women) from the Australian Indian migrant community [13]
The study examined in depth the key themes associated with FV, such as the intersection of cultural contexts (e.g., gender inequality, patriarchal attitudes); societal behavioural norms for women (e.g. self-silencing, submissiveness, and subordination); societal issues (e.g., migration stress, isolation from one's own family); and individual factors (e.g., lowered self-belief, feelings of worthlessness, humiliation, entrapment and threats of visa status inconsistency). Our results indicate that these factors contribute to deep social distress, which may adversely affect the emotional and mental health of Indian migrant women, and contribute to suicidality .

In another published paper on dowry related Post Traumatic Stress Disorder , I demonstrated suicidal behaviour and severe PTSD , shame humiliation are caused by persistent dowry demands. Husband unsatisfactory reaction to dowry, demands, extortion with threats of violence , withdrawal of visa sponsorship lead to extreme fear, anxiety, hopelessness and suicidality[14] (Attachment 4)

I will briefly describe the case of one woman who committed suicide in Melbourne. Her family live in ███ India .I conducted detailed interview of her extended family in ███ in ███ and following summary is based on that interview.

Ms █ was married in an arranged marriage to her husband Mr █ – an Australian resident on ███. It took 8 months for her spousal visa to come through and she left for Australia in ███.

At the wedding her parents gave her gold jewellery weighing about 1 kg (850 gms to be exact) costing about $65,000. Her husband demanded dowry cash and Ms █ 's father gave him about $90,000 in cash at the time of the wedding.

Ms █ ' s husband pressured her father to transfer one of their family properties in Ms █ 's name at the time of the marriage. With some hesitancy he transferred the property in Ms █ 's name. The rent of that property was used by husband's family in ███.

Life in Australia

Her husband a mechanical engineer arrived in Australia as an international post- graduate student. Sometime later he got married in an arranged marriage to Ms █ . Soon after her arrival he told her he wanted to start a pizza franchise. He asked Ms █ to ask her father to send $50,000 approx. Her father said they complied with his demands to support their daughter's marriage. Her father told me that he later returned the money
He bought a house in ███ at the same time. He did not ask for money to buy the house, which was in joint names. But the loan was only in Ms █ 's name.
Her mother-in-law and father-in-law came to stay with them in 2016 for a couple of months, mother-in-law was in Australia until just a month before Ms █ 's suicide.

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[13] O'Connor, M. Colluci E. 2016. Exploring Social distress, domestic violence in Australian Indian migrants. Journal Transcultural Psychiatry 53 (1) 20-44).
[14] (M O'Connor. March 27, 2017. Dowry related Complex Post Traumatic Stress Disorder. Australasian Psychiatry)

Ms █ told her parents that she was working full time at a restaurant at the airport, but was pressured to cook and clean for the extended family. She was being criticized and harassed by her husband and mother-in-law frequently to ask for more money while her own income was being used to for household expenses. Her mother-in-law said to her that her father was wasting his money on welfare work- educating poor girls of █████ , instead he should give that money to Ms █ and her husband to help them. Ms █ mentioned this in a phone call to her parents and was quite upset, her father said.
Her father said that in 2015, Ms █ visited █████ for 3 weeks for a wedding. During that visit she complained to her parents that all her gold, nearly 1 kg of it and silver 2.5 kg was forcibly taken by her mother-in-law in ███. Ms █ was very upset and cried but her father told her 'not to worry, we will get you some more gold jewellery'.

She did not tell them that she was seeing a mental health professional near home.

Ms █'s brother and cousin brother both visited her in Melbourne for 6 months at a time. Both told me they saw evidence of physical violence by her husband against her. They were not sure what the exact circumstances were but she pressured them not to tell her parents. Both felt it was a passing phase and often occurs in arranged marriages. They both deeply regret not telling their parents about the domestic violence she was enduring

She wanted a child but she was not falling pregnant. Her husband and mother-in-law started blaming her and called her infertile.

In summary, Ms █ was married in arranged marriage and arrived to live with husband in ██3 in █████ Suburbs. She committed suicide in ███ after persistent FV, dowry demands and humiliation by mother-in-law (MIL) and financial abuse dowry demands, physical violence by husband . Husband 's lack of support to protect her from MIL s verbal abuse and dowry demands would be crucial . She possibly felt unable to share her full trauma with her parents because they had given extensive dowry and for her there was no going back. Not being able to have a child is a known factor for humiliation and suicide

Victorian Royal Commission into Family Violence report 2016 in its most comprehensive report acknowledged the work of Australasian Centre for Human Rights and Health (ACHRH) and its anti-dowry petition. Recommendation 156 of the RCFV included the petition and that was turned into Law on 29/3/19 by the Government of Victoria . Dowry demands are now an example of financial abuse in the Family violence Protection Act of Victoria- a first in Australia and the Western world. The ACHRH campaign also led to Senate Inquiry into Dowry Abuse in Australia. The Report of this Enquiry recommends inclusion of dowry demands and extortion as example of financial abuse in the Family Law Act of Australia . The 2nd National Plan to reduce violence against women and children did not mention dowry abuse .

Recommendation 4- Include dowry demands and extortion as example of financial abuse in the Family Law Act of Australia . The 3rd National Plan to reduce violence against women and children needs to recognise dowry abuse a san example of FV
.

Recommendation 5. To assist migrants and refugees improve resettlement outcomes and post-migration stressors focus on psychological aspects such as helping the person in regaining control over their lives and developing a sense of stability, safety and trust are paramount.

Recommendation 6- Resilience enhances coping abilities and reduces suicidality. Social networking and support systems are protective to mental health . Women of Indian subcontinent should have a drop in hub where they can meet other women for coffee and chat. They can be located in North , Northwest and South -Areas for new migrant settlement

Recommendation 7. To understand the ways forward we need to disaggregate population groups and understand the deeper cultural factors among diverse communities to better provide for prevention and service programs

Recommendation 8. A speedy pathway to allow permanent residency for FV victims on temporary visas , and those who are on dependent visa of international student needs to be established.

Attachment

1. Evaluation . Mutual Cultural Respect. Pilot Training . 2015. Clare Keating , Effective Change
2. O'Connor, M. Colluci E. 2016. Exploring Social distress, domestic violence in Australian Indian migrants. Journal Transcultural Psychiatry 53 (1) 20-44).

If you would like me to discuss this Report further I would be pleased to attend in person .

Kind Regads

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Consultant Psyhciatrist

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Suicidality and family violence in Australian immigrant women presenting to out-patient mental health settings

Dear Sir

Family violence, noted in one in three women globally, is commonly associated with mental health disorders such as Post-Traumatic Stress Disorder (PTSD), Major Depressive Illness, anxiety disorders and suicidal behaviours.[1] Suicide is seven times more likely in family violence victims.[2] Australia is a highly multicultural country, yet there is paucity of culturally nuanced studies to understand suicidality in ethnic patients, and especially victims of family violence. We report a de-identified clinical audit of 84 immigrant victims of family violence presenting at two private psychiatric clinics (City and Bundoora, Victoria) with a focus on suicidality, its association with mental conditions and outcome after treatment. Patient permission to use de-identified data for research and teaching purposes was obtained. Two ethnic groups – South Asian victims (n = 56; one male) and Middle Eastern victims (n = 28; all females) – were provided treatments as usual for mental health conditions and followed up for nine months. Clear differences emerged between the two groups. South Asian women were younger (median age 27 years), single, had fewer children and sought treatment after severe violence. Middle Eastern women were older (median age 40), married with children (n = 24) and suffered mild to moderate but not severe violence and sought treatment for unresponsive depression. PTSD was found primarily in South Asian women who suffered greater threats to life, serious physical violence, fear and dowry extortion. Suicidal ideation was present in 100% Middle Eastern women, and 43% attempted suicide. In comparison 75% of South Asian women were suicidal and 17% attempted suicide. After nine month follow-up, disconnection between mental health outcomes and suicidal ideation emerged. A greater number of Middle Eastern women (43%) showed clinical improvement (HAM D GAS), but a greater number (82%) remained suicidal (one suicide attempt). In contrast only 27% of the South Asian group improved but the suicidal ideation stopped in the majority – 67% (one suicide attempt). Further analysis revealed key differences in social factors – the majority of South Asian women had greater education, returned to work/study, found financial independence and felt a degree of control over their life. Whereas the majority of Middle Eastern women (84%) returned back to live with the perpetrator in a dependent marital situation, had limited education and little prospect of work outside the marriage.

This clinical observational study reflects the reality of everyday life. Complex clinical phenomena intersected with multiple social factors such as female gender, immigrant status, suicidality, psycho-social factors, for example family violence, relationship with perpetrator, autonomy and degree of control over one's life and finances. When treating suicidal immigrant women family violence should be kept in mind.

Acknowledgement

A detailed version of the study was presented at RANZCP International Congress, Hong Kong, 2016.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.[AQ: 1]

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Dowry-related domestic violence and complex -post-traumatic stress disorder: a case report

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Abstract

Objectives: This paper draws attention to the mental health impact of coercive practice of dowry demands, associated with domestic violence (DV) in an immigrant woman.

Methods: This study was based on a case report and selective literature review.

Results: This case history illustrates the serious mental health impacts of repeated emotional and physical trauma inflicted by a husband who was dissatisfied with his wife's dowry. Bio-psycho-social / cultural aspects of mental health treatments needed to be augmented with attention to safety, advocacy, and access to support networks.

Conclusions: Cultural factors are important determinants of mental illness. Psychiatrists need to be aware of DV and dowry when treating immigrant women.

Keywords: domestic violence, immigrant woman, dowry, mental illness

Globally 1 in 3 women suffer domestic violence.[1] Australia is no exception.[2] Domestic violence (DV) is increasingly being recognized for its serious mental health consequences[1, 3] and is found to be responsible for 8% of burden of health, predominantly mental health, for women aged 15–44 years, greater than smoking or hypertension.[4] DV is a complex issue. The ecological model of Heiss et al.[5] illustrates the interactions between societal, cultural, family and individual factors that can give men the position of power, dominance and control over women and children. The social model of women's mental health posits that women's social positions make them more prone and vulnerable to poor mental health outcomes.[6] South Asian cultures predominantly practice patriarchy, a practice that disadvantages women at multiple levels: societal, familial and individual.[7] Dowry is a South Asian cultural practice where harassment by in-laws on issues related to dowry is reported to be a major factor associated with poor mental health and suicides in women[8] and is also a determinant of DV.[8] Notably, the husband's unsatisfactory reaction to dowry is said to be strongly associated with common mental disorders in Indian literature.[9]

Australia is a highly multicultural country.[10] The intermingling of many different cultures and ethnicities results in hybrid identities and hybridization of cultural practices.[11] In this rapidly changing trans-migratory world, studying the lives of individuals is crucial to the study of cultural factors, which are increasingly recognized as important determinants of mental health.[11]

This paper presents a case report of a South Asian migrant woman, victimized by the social practice of dowry in Australia, associated with DV and its serious impact on her mental health

Case report

Ms A is a 25-year-old, recently separated woman referred by her general practitioner for the treatment of mental health impacts of DV. She was married in an arranged marriage in India to an Australian-Indian resident. A day after the marriage he stopped talking to her, he seemed annoyed and his mother repeatedly complained about dowry gifts being insufficient and of poor quality. Over the next week Ms A increasingly became anxious and sad. Over three ceremonies her parents had given extravagant gifts comprising gold and cash, expenses totalling over AUS$70,000. Indian culture is virilocal (i.e. the son stays with the family and his bride moves in).[4] Accordingly, Ms A moved in with her in-laws. Her personal gold jewellery was taken by her mother-in-law ostensibly for 'safe guarding' (but never returned). Ms A anxiously realized she was in a hostile environment from which escape was difficult. Divorce was not an

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option, a sign of shame and failure. The following week her father visited Ms A. She was traumatized by her mother-in-law exploding at him, she was dishonoured by insufficient dowry gifts and threatened to send Ms A home. Her father cried and pleaded, that would dishonour his family. He said he had spent all his life savings. Ms A felt deeply sad, helpless and humiliated. The mother-in-law relented.

Some months later, Ms A arrived in Melbourne. Her husband started making escalating demands for money. She told him he had to follow the tacit culturally accepted agreement (where the father gives a dowry, and the husband takes care of the new wife). Her 'backchat' angered him, he hit her, and slept in a separate room. She asked why he was rejecting her, he yelled abuse and hit her again saying she was costing him too much. She was given little food to eat, no access to money, and lost weight. She was often kicked out of the house on cold nights and not allowed back for hours. She would go and sit in the park nearby, alone, fearful, tearful, sad, and becoming suicidal. His sister and mother-in-law arrived from interstate, and both made threats to her life on a number of occasions. She recognized the ominous threats were dowry-related. She reported that she knew that dowry demands can lead to murders in her culture. She felt acutely fearful and ran out of the house and went to the police station obtaining an intervention order against him and his family.

Mental health examination revealed a sad, anxious, and fearful young woman who was suffering daily panic attacks. Sleep was disturbed with nightmares. She had poor concertation, low appetite and low energy. She reported intrusive thoughts and flashbacks of physical violence, threats to her life, and criticisms of her on the basis of insufficient dowry with frequent periods of disassociation and panic attacks. She felt suicidal but did not attempt suicide. Her self-score on the post-traumatic stress disorder (PTSD) checklist PCL-5[12] was 80 out of a possible 80. The Clinical Global Impression (CGI) score was assessed as 3/10. The core symptoms of PTSD were hyperarousal, intrusion, and depersonalisation. There was no previous history of mental illness.

Her treatment comprised bio-psycho-social approaches. She was commenced on escitalopram 20 mg daily and diazepam 5 mg nocte. Culturally sensitive trauma-based cognitive behavioural therapy (CBT) was commenced on a weekly basis. She was referred to specialist domestic violence services for safety provision. Her husband withdrew his support for her spousal visa, an application for permanent residence on grounds of DV was made. She was not eligible to receive unemployment benefits and unable to look for a job. She was provided pro bono psychiatric reports to support the intervention order against her husband, and for the immigration department, supporting her application for residency.

Progress

She received weekly trauma-focussed CBT, and crisis support. For example, she telephoned in a panicked state that her Australian residency visa was in doubt. She was advised to do slow rhythmic breathing and take clonazepam 0.5 mg. An urgent consultation with an immigration agent was arranged. Another time she reported seeing her ex-husband standing within 50 meters. She suffered an acute attack of de-personalisation needing telephone support. She suffered nightmares, panic attacks and fear. Sometimes she felt he was standing right behind her looking over her shoulders. She knew that to be not real. At other times she had to confront him in court hearings, each contact with him led to panic attacks and depersonalisation.

Escitalopram was changed over to des-venlafaxine 50 mg, due to severe insomnia and extreme anxiety, mirtazapine 30 mg nocte was added. Due to the ever-present fear of being stalked, quetiapine 100 mg nocte was prescribed. She took clonazepam on a prn basis. This combination gave her partial relief from fear, anxiety and insomnia. The PCL-5 score dropped to 55–60. Her mental state fluctuated and concentration remained low. She started applying for jobs. She was introduced to a non-governmental organization with a social network of young women with similar issues. She noted difficulty in trusting people. Her CGI score hovered at around 5–6/10

Discussion

This case report shows a previously demonstrated complex association between dowry demands, DV and mental illness.[8,13] The husband's dissatisfaction with the dowry appeared to be the major driver of rejection, abuse, violence and threats. Demands for dowry are shown to be an independent risk factor for common mental disorders and suicidal ideation.[9] In this longitudinal study dowry demands turned out to be a stronger predicator of mental illness in women than DV and husband's alcoholism. To our knowledge this is the first case report that draws attention to the association between dowry-related DV and complex PTSD. This case reveals how bullying behaviour, abuse of power and control, escalating coercive dowry demands leads to 'intimate terrorism'[14] with increasing fear and threats to life and PTSD.[3] Despite its illegality, dowry-related murders in India have steadily increased in the past decade.[15,16] They are attributed to a toxic mix of patriarchy, greed and materialism.[15,16] The exact prevalence of dowry-related DV is unknown in Australia but dowry-related DV is documented in a previous qualitative Australian research study,[13] two dowry-related murders are reported in Victoria[17] and the problem is considered substantial.[18]

As the result of repetitive stress from which there is limited escape, associated with feelings of shame, worthlessness, and defeat, some have identified a variant of PTSD, termed 'complex PTSD',[19] a diagnostic category suggested for ICD 11 but not present in DSM-5.[20]

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Research is needed to determine prevalence of dowry-related DV in Australia, its impact on mental health and optimal treatments.

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