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Physical Intimate Partner Violence in Northern India

Maya I. Ragavan[1], Kirti Iyengar[2], and Rebecca M. Wurtz[3]

Abstract

In this article, we examine perceptions about the definition of physical intimate partner violence (IPV) in northern India utilizing feminist perspectives as a framework. We interviewed 56 women and 52 men affiliated with a health services nongovernmental organization in the Udaipur district of Rajasthan. We transcribed, coded, and analyzed the interviews utilizing grounded theory. We found that perceptions regarding physical IPV were associated with both structural and ideological patriarchal beliefs and microlevel constructs such as alcohol use. We discovered multiple types of physical IPV in the study region, including rationalized violence (socially condoned violence perpetrated by a husband against his wife), unjustified violence (socially prohibited violence perpetrated by a husband against his wife), and *majboori* violence (violence perpetrated by a wife against her husband). Our results add to the breadth of research available about IPV in India and create a framework for future research and IPV prevention initiatives.

Keywords

abuse, physical; Asia, South / Southeast; gender; interviews, semistructured; violence, domestic

Intimate partner violence (IPV) is recognized as a serious medical and public health concern for women (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). The World Health Organization (WHO) has defined IPV as behavior within an intimate relationship that causes physical, psychological, or sexual harm such as acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors (Heise & Garcia-Moreno, 2002). Although men can be victims of this type of violence, the majority of IPV globally is perpetrated by men against women (Heise, Ellsberg, & Gottemoeller, 1999). Trauma is a common consequence of IPV, but numerous studies also have shown that victims of IPV are at a higher risk for physical and mental health morbidities. These include unwanted pregnancies, pregnancy loss, and sexually transmitted infections, as well as depression, posttraumatic stress disorder, and anxiety (Campbell, 2002; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008). Preventing IPV worldwide is critical for the safety, health, and well-being of women.

IPV is a problem of epidemic proportions in India. Kishor and Gupta (2009) used data from the 2005–2006 National Family Health Survey 3 (NFHS 3), a countrywide survey conducted by the Government of India, to show that the prevalence of physical IPV ranged from 5.3% (in the state of Himachal Pradesh) to 56% (in the state of Bihar), with a national average of 30.4%. Although researchers have found that IPV in India resembles IPV worldwide, some factors are specific to India. Indian culture is generally regarded as patriarchal and hierarchical, where women are expected to be obedient and men are viewed as the disciplinarians in the family. These traditions are changing over time; however, socially dictated gender roles are pervasive and relate to how IPV is manifested in India (Dalal, Lee, & Gifford, 2012; Martin et al., 2002; Tichy, Becker, & Sisco, 2009). Alcohol consumption by the husband is a risk factor affiliated with IPV, whereas higher educational levels and upper socioeconomic status (SES) have been shown to protect against IPV (Jeyaseelan et al., 2007; Kishor & Gupta; Pandey, Dutt, & Banerjee, 2009; Stanley, 2008).

IPV in India is a complex phenomenon and there are several associated predictive and protective factors; however, only a few researchers have examined Indian men's and women's attitudes toward IPV, and the majority who did so used quantitative analyses. In these previous studies, researchers found that 54% to 57% of women and 51% of men in India thought it was acceptable for a

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husband to hit his wife in certain circumstances (Dalal et al., 2012; Kishor & Gupta, 2009; Rani & Bonu, 2009). Indian women in one study had difficulty labeling violent acts perpetrated by a husband against his wife as abuse (Tichy et al., 2009). Additionally, previous investigators studying men's attitudes about physical IPV in India found that men considered it their right to discipline and dominate their wives (Dalal et al.; Zhu & Dalal, 2010).

Further in-depth exploration in India is necessary to better understand attitudes toward IPV, frame policies, and design IPV prevention initiatives. Researchers utilizing qualitative methodologies gain a rich perspective that enables them to develop new theories and understand multifaceted ideas (Malterud, 2001; Ulin, Robinson, & Tolley, 2005); however, qualitative research about attitudes toward IPV in India has been limited. Go et al. (2003) used interviews and focus groups in urban south India to show that both women and men justified violence in certain circumstances, but beyond a particular threshold, they considered spousal abuse objectionable. Through ethnographic work in the southern state of Karnataka, Krishnan (2005) found that structural inequities such as SES and gender shaped women's attitudes toward IPV. Finally, Kaur and Garg (2010) conducted focus groups and interviews of women in rural north India and discovered that even though physical IPV was a pervasive problem, victims felt socially isolated and lacked support from their communities.

Although these perspectives are relevant and important, we see several gaps in the current data. To the best of our knowledge, no scholars as of yet have applied qualitative research using individuals' perceptions and opinions as a mechanism by which to define IPV in India. Few researchers have sought to understand the social appropriateness of IPV in India, perceptions regarding a woman perpetrating violence against her husband, or opinions as to why victims of IPV stay in abusive marriages. The majority of researchers have only ascertained the views of Indian women (Kaur & Garg, 2010; Krishnan, 2005; Tichy et al., 2009) or men (Dalal et al., 2012; Zhu & Dalal, 2010), without comparing perspectives. Additionally, only a few qualitative studies have been conducted in northern India and no studies have been done in the state of Rajasthan on this topic. Rajasthan not only has a high percentage of women affected by IPV (above India's national average), but also maintains a different culture and language from other states in India (Government of India, 2011; Kishor & Gupta, 2009).

In this study, we employed qualitative methodologies to conceptualize the meaning of physical IPV in India, both how it was defined and how it was understood.[1] IPV is a multidimensional phenomenon, so to focus our study we chose to explore only physical spousal abuse rather than other types of IPV, such as emotional or sexual. We approached this goal by examining men's and women's perceptions regarding how and why physical IPV was manifested in communities, with a special emphasis on when physical IPV was considered justified. Data used in this article were collected from a large qualitative examination of attitudes toward physical IPV in Rajasthan. We explored opinions on three main topics: physical IPV in the marital relationship, options available for victims of physical IPV, and abuse perpetrated by a mother-in-law against her daughter-in-law. In this article, we focus specifically on perceptions regarding physical IPV in the marital relationship. Information about additional components of the full study can be found in other documents (Ragavan, Iyengar, & Wurtz, 2012, in press).

Conceptual Framework

To conceptualize participants' definitions of physical IPV, we used feminist perspectives as a framework. Feminism is not a monolithic theory but rather a broad, dynamic, and multidimensional way of viewing and experiencing the world. In fact, DeKeseredy (2011) wrote that there are at least 12 variants of feminist theory. We drew the majority of our framework from Jasinski (2001), who stated that feminist analyses of IPV center on patriarchal attitudes, socialization practices emphasizing traditional gender roles, and structural forces that limit women's access to resources. Patriarchy itself is a complex term; however, we chose to view it as described by Dobash and Dobash (1979), who defined patriarchy as comprising two key elements: structure (men have more power and privilege than women) and ideology (the belief that men are naturally superior to women; see also DeKeseredy, 2011). We also drew from later feminist perspectives that attribute IPV not only to macrolevel constructs such as gender inequity and patriarchal attitudes but also to microlevel factors such as unemployment, SES, substance use, and stressful life events (DeKeseredy; DeKeseredy & Dragiewicz, 2007).

A feminist perspective, focused on gender, patriarchy, and microlevel factors, was an appropriate lens through which to view our data. Statistically, a large number of women in India are affected by physical IPV, making it a macro, societal-level problem (Kishor & Gupta, 2009). Additionally, researchers have repeatedly found a relationship between patriarchal attitudes, traditional gender norms, and IPV in India (Ahmed-Ghosh, 2004; Jeyaseelan et al., 2007; Krishnan, 2005; Martin et al., 2002; Tichy et al., 2009). Using a multidimensional approach, we also examined how microlevel factors (especially a husband's alcohol use) affected perceptions about physical IPV. Feminists do not presuppose that IPV is a gender-unidirectional phenomenon in which men are always the perpetrators and women always the victims (DeKeseredy,

2011; DeKeseredy & Dragiewicz, 2007; Johnson, 2011). Therefore, to better understand the phenomenon of physical IPV as a whole in India, we also sought to understand perceptions regarding a wife perpetrating physical violence against her husband.

Study Setting

We conducted this study in the Udaipur district located in the northwestern state of Rajasthan. In Rajasthan, 75% of the population lives in villages or towns and 25% in cities.[2] The Udaipur district (which includes the city of Udaipur as well as multiple surrounding villages and towns) is in the southern portion of the state, with a population of approximately 3.1 million (Government of India, 2011). The main languages spoken in the Udaipur district are *Hindi* and a dialect of Hindi called *Mewari* (Action Research and Training for Health, 2010). This district is an important area in which to conduct research related to IPV considering that women's low status in Rajasthan was reflected in both the 2011 Census of India and the NFHS 3. Literacy rates in the Udaipur district were 49% for women compared to 75% for men (Government of India, 2011). Sixty-three percent of women in Rajasthan were married on or before their 18th birthday (average in India = 39.5%).[3] Additionally, the percentage of women who have experienced physical IPV in Rajasthan is 40.1% (India's average = 30.4%; Kishor & Gupta, 2009).

Per the 2011 Census of India, 90% of people in the Udaipur district identify as Hindu, 9% as Muslim, and 1% as another religion (Government of India, 2011). The caste system, a component of the Hindu religion in India, is practiced in the Udaipur district as well as many other parts of India. Castes can be defined as ways that Hindus are "grouped" historically based on family name and trade. According to the Indian government, castes are divided into the following four categories: scheduled castes (SC), scheduled tribes (ST), other backward castes (OBC), and other castes (Government of India, 2011). Members of scheduled castes and scheduled tribes, who were traditionally laborers, tend to be socioeconomically disadvantaged and have long histories of being oppressed (Charsley & Karanth, 1998; Krishnan, 2005).

We conducted this study in affiliation with Action Research and Training for Health (ARTH), a nongovernmental organization (NGO) in the Udaipur district of Rajasthan. ARTH has a field area that encompasses 49 villages and the city of Udaipur. These villages are located in two regions: one 25 kilometers from Udaipur and the other 52 kilometers from Udaipur. ARTH focuses on improving reproductive and child health and provides services to more than 60,000 people. ARTH employs men and women from the communities as fieldworkers who provide health education in the villages and collect data about the health of the villagers. The organization operates three rural health centers and one urban health center, as well as village-based centers where ARTH health care providers and fieldworkers offer education and outreach services (ARTH, 2010). ARTH does not provide IPV-specific services, but ARTH health care providers can make referrals to other IPV-focused NGOs in the district.

Methods

We utilized a methodology for this study that consisted of in-depth interviews with 56 women and 52 men from communities affiliated with ARTH. Using qualitative interviews, we encouraged participants to talk freely about their opinions regarding the complex and sensitive issue of physical IPV. We specifically utilized a semi-structured interview approach in which we had an interview guide but allowed ourselves the flexibility to ask new or follow-up questions as needed. By using this approach, we were able to develop and implement a systematic yet iterative data collection and analysis process (Ulin et al., 2005). We paid close attention to ethics during the entirety of our study in accordance with the WHO's ethical and safety recommendations for conducting IPV research (WHO, 2001). Specifically, we held training sessions for the interpreters, maintained confidentiality, did not ask about personal histories of IPV, and conducted interviews in private settings. Northwestern University's Institutional Review Board (IRB) and ARTH's ethics committee approved all components of this study.

We conducted 10 interviews at a time, usually conducting 3 to 4 interviews in one day. All participants in each set of 10 were of the same gender and we alternated our data collection between groups of men and women, except for the first 20 interviews, which were of women (as described below). All interviews were carried out in one of three places: (a) one of the three rural health centers; (b) the urban health center; and (c) villages during times when ARTH employees were providing outreach services. After each set of 10 interviews, we transcribed and analyzed the data, developed and refined themes related to our study, devised new and follow-up questions based on our analysis, and then started another round of data collection (see Figure 1). This process is described in detail in the ensuing sections.

Preparation for Data Collection

The authors designed the interview guide in a collaborative effort based on past literature (Go et al., 2003; Kaur & Garg, 2010; Tichy et al., 2009). We reviewed the interview

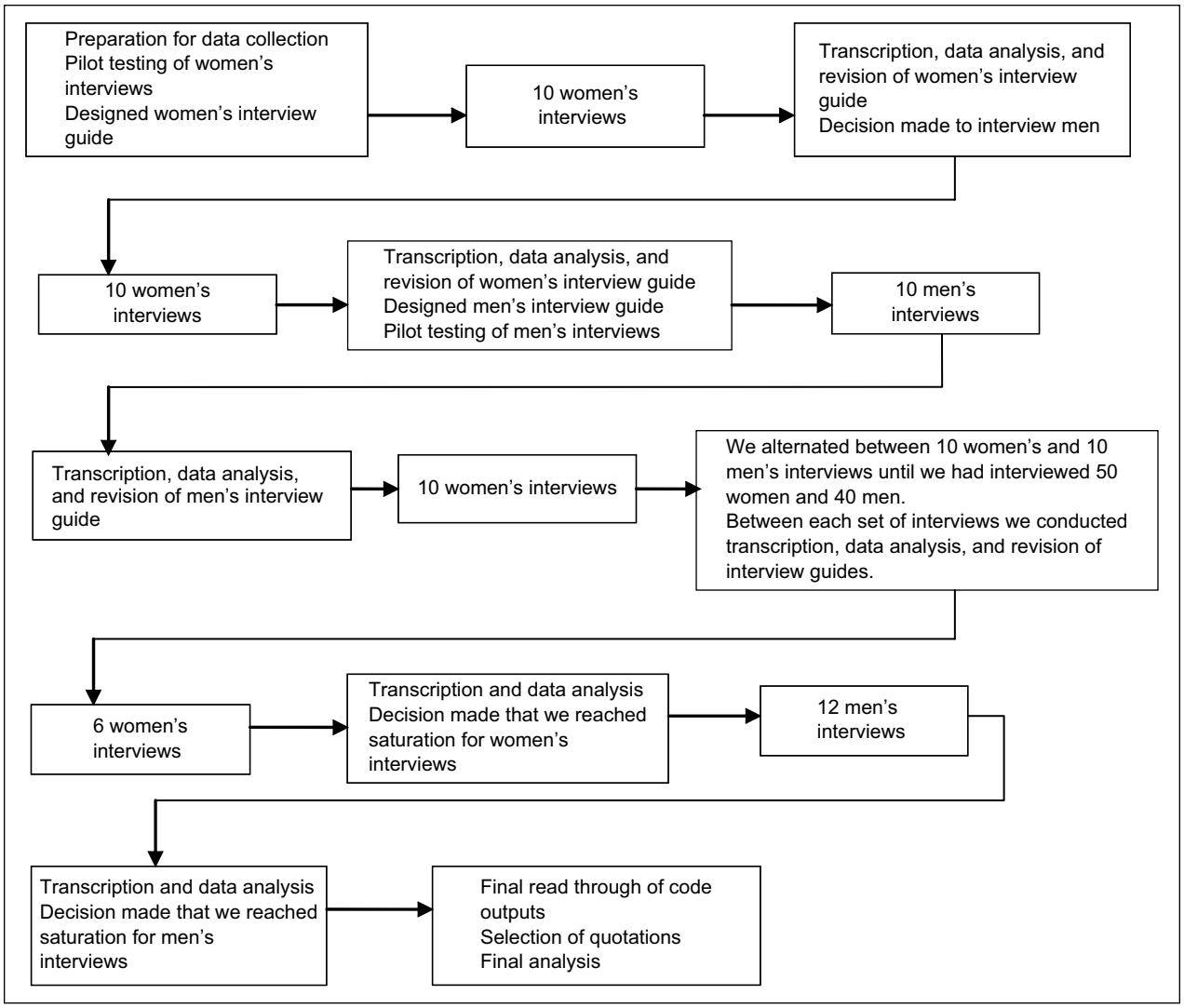

Figure 1. Overview of the data collection and analysis process.
Note. At several points during the data analysis process, we also held meetings with interpreters and Action Research and Training for Health field workers to ascertain their perspectives on our emerging theories.

guide with ARTH fieldworkers, then pilot tested it with four women (three rural, one urban) to ensure that the questions were easily understood and culturally sensitive. The study was initially designed to include only women; however, after the first round of data collection and analysis, we decided that it would enhance our understanding about IPV in India if we also interviewed men. By the time we had designed the interview guide for men, pilot tested it with two men (one rural, one urban), and received approval from both institutional review committees, we had already interviewed 20 women. We believed this approach serendipitously benefited us because we were able to use some of the themes we had discovered from the women's interviews to design the men's interview guide. For example, when we started interviewing men, we had already gained a better understanding of when physical IPV was justified, which enabled us to ask the men more focused questions.

The first author, a graduate student with experience working with victims of IPV, served as the sole interviewer during data collection. She is of Indian background but was born and lives in the United States. The second and third authors, who reside in India and the United States, respectively, assisted and advised the first author throughout the research process. The first author interviewed both men and women because we were unable to recruit a male interviewer of the same training and background. In particular, we were unable to find a male interviewer who had experience talking with individuals about IPV and would be available during the data collection time period.

Two interpreters, fluent in English, Hindi, and Mewari, assisted in recruitment and interviews; we used a female interpreter for women's interviews and a male for men's interviews. The interpreters were students from a local university in Udaipur who had experience working as interpreters. They resided in the city of Udaipur and had relatives in surrounding villages. We maintained confidentiality with regard to the interpreters in three specific ways: (a) by not recruiting in villages where the interpreters had family; (b) by providing training for the interpreters on multiple topics, including the importance of confidentiality and privacy during interviews; and (c) by not giving the interpreters access to audio recordings or written transcripts.

Although having interpreters as part of the data collection process was essential to our study, it added another level of complexity to the interviews. As Bramberg and Dahlberg (2013) wrote, "The process of translation is more complex than simply finding the right word and expressing it. An interpreter has to grasp the meaning of the questions asked by the researcher, and then echo the informant's response" (p. 243). Therefore, the training for interpreters was comprehensive and included information not only about the importance of confidentiality but also about basic qualitative methodologies, key considerations when conducting IPV-related research, the importance of empathy and kindness during interviews, and effective interpretation skills. We reviewed the interview guide with the interpreters to ensure that they understood the questions in English, Hindi, and Mewari and performed mock interviews to confirm that they had a working knowledge of the interview content and knew how to handle potential problems during the interviews. We held refresher training sessions throughout the data collection process, especially when we introduced new questions to the interview guide.

We interviewed members of the general population rather than victims and perpetrators of IPV, and asked about attitudes rather than personal stories. However, this study still was of a sensitive nature so, before beginning data collection, we made several decisions regarding how to protect the confidentiality of the participants. The first and second authors identified private areas in the health centers and villages where the interviews would take place. In the health centers, we decided to conduct interviews in private exam rooms that were not in use. In the villages, we found empty and private rooms in buildings that ARTH used for outreach services. We also developed "topic changers," that is, topics to begin discussing if we were interrupted during the interview, as stipulated by WHO guidelines (WHO, 2001). After some discussion among the authors and with fieldworkers, we decided on experiences with childrearing for women's interviews and experiences with employment for men's interviews.

One uncertainty related to confidentiality was whether we should interview participants alone. When initially designing this study, we considered the possibility that participants, especially women, might feel uncomfortable being alone with an interviewer and an interpreter. We discussed this concern with fieldworkers, authors, and institutional review committees and came to the conclusion that although interviewing participants alone could be considered culturally challenging, it was absolutely essential to ensure the safety of the participants (WHO, 2001). However, all participants were given the option of stopping the interview at any time; we believed that offering this alternative provided participants with a recourse if they felt uncomfortable.

A challenge we faced after we decided to interview men was ensuring that we did not interview a man and woman who were married. To protect confidentiality, we did not ask for participants' names and therefore it was possible that we inadvertently could have interviewed a husband and wife on separate occasions. We used several techniques to prevent this. First, all of the participants we recruited during a particular set of interviews were of the same gender, so we never interviewed both men and women on a given day. Second, we approached only participants who were alone or with companions of the same gender. We struggled with this but decided that although it might be methodologically preferable to approach any individual, it could compromise a participant's safety if we approached someone who could be with a spouse. Third, we used different topic changers (as described above) for male and female participants, surmising that this would make it difficult for women and men to recognize that the interviews they participated in were about the same topic.

Participant Recruitment and Data Collection

We recruited participants from ARTH's health centers and from villages during times when ARTH employees were providing outreach or educational services, utilizing stratified convenience sampling. We stratified the two samples (women and men) based on urban vs. rural residence, recruiting 75% of the participants from villages and 25% from the city of Udaipur, in line with 2011 census data (Government of India, 2011).[4] We did not use any other sociodemographic factors to stratify the samples. To be part of this study, participants had to be a patient or family member at an ARTH health center or a resident in a village where ARTH provided outreach services, between the ages of 18 and 60, and able to converse in Hindi or Mewari. All participants had to be somehow affiliated with ARTH, as stipulated by both institutional review committees.

During the recruitment process, the interpreter first approached a participant and asked if he or she would like

to be part of an interview. We chose participants randomly, with the only stipulation being that he or she was alone or with companions of the same gender. At this point, we presented the study to participants in a generic fashion (experiences regarding life in the community). We then explained that the interview was private and the participant would be alone with the interpreter and interviewer during the interview. If an individual agreed to participate in the study, he or she would leave his or her companions and accompany the interpreter and interviewer to a predetermined private location where the study was explained in more detail. We did not disclose specific information regarding the content of the interview until we reached the private location. This two-step approach is in accordance with WHO guidelines (WHO, 2001). We provided no compensation, monetary or otherwise, to participants.

We recognized that our methodology of approaching participants in this way could breach confidentiality because other individuals could see that the participant was leaving with the interviewer. However, we were confident that the multiple steps we took to protect a participant's privacy would make it challenging for an outside person to be privy to information shared during the interview. For example, we did not request any information from participants (during the participant recruitment process or any time thereafter) that could reveal their identities, such as names, spouses' names, addresses, or exact type of employment. Additionally, we did not interview more than two individuals from the same site in a single day and never interviewed two individuals from the same group. If more than one individual in a group wished to be interviewed, we explained that we were interviewing only one person from that location. Very rarely did people get upset when we politely declined to interview them.

After recruitment, the interpreter obtained verbal consent from the participant by reading an IRB-approved script. We decided on verbal rather than written consent because of the high rate of illiteracy in the community and because having verbal consent would ensure that there would be no written trail of identifying information. We emphasized that the participant could decline to answer a question or could stop the interview completely at any time, and that participation in the interview was voluntary and would not affect his or her ability to receive services from ARTH. We also acknowledged the sensitivity of the study topic and assured participants that we were interviewing members of the general population about their attitudes and did not choose them to be participants because we thought they were in abusive marriages. We assumed that if we approached a participant who was not alone, members of the group would ask the participant about the interview. Therefore, during the consent portion of the interview, we told the participant that he or she was free to share the content of the study or could say it was about life experiences.

The interpreter then asked for permission to audio-record the interview; all participants gave their permission. We conducted the interview immediately after recruitment and obtaining consent. The interview itself was semistructured and 30 to 45 minutes in length. During the interview, the interviewer asked a question in English, which the interpreter translated to Hindi or Mewari. The interpreter then translated the participant's answer into English. Each interview was given a random identification number; during the data collection, transcription, and analysis process, participants were identified only by identification number.

We began each interview with sociodemographic questions (age, caste, education, and employment) and then moved to neutral questions about the roles and responsibilities of a husband and a wife. Next, we inquired about reasons that it is acceptable for a husband or a wife to hit his or her spouse, opinions regarding why physical IPV occurs, perceptions of the relationship between alcohol and physical IPV, and explanations as to why it is difficult for women to leave abusive marriages. We refined the questions iteratively over the data collection time period based on our ongoing analysis and theme development. Examples of specific questions included: What are the responsibilities of a husband and a wife? Is there ever a situation when it is acceptable for a husband to hit his wife? Is there ever a situation when it is acceptable for a wife to hit her husband? How do you define an unhealthy or abusive marital relationship? Why is it difficult for a woman to leave an abusive marriage?

We asked all questions in a general rather than personal way using the third person (e.g., "if a husband hits his wife" as opposed to "if your husband hits you"). By using this strategy, we believed that participants would feel more comfortable discussing their opinions about this relatively taboo topic. If a participant disclosed that she or he was a victim of IPV, we followed a predetermined protocol. We stopped the interview and found out more about the situation, including whether any active abuse was occurring. We then offered the participant the option of speaking to a health care provider at an ARTH health center, explaining that these individuals provided both medical support and referrals to IPV-specific services. If these resources were declined, we ensured that participants knew that they could come to an ARTH health center if they required assistance. If the participant wished to continue speaking to us, we restarted the interview. We never reported disclosures of abuse to ARTH or any governmental organization; this decision was approved by both institutional review committees.

Data Transcription and Analysis

We used an adaptation of Brislin's 7-step translation method described by Lopez, Figueroa, Connor, and Maliski (2008) as a guide for our transcription and translation process. We used this model because it is a less time-intensive but established and published translation method. This process includes developing a verbatim transcription with annotations as needed, translating it, and then analyzing the transcript to determine if there are any questions or problems. If no issues arise, then the translation is proofread and reviewed by the lead translator or study leader. If questions arise, the complications are discussed and the problem recorded.

Following this method, a trained trilingual translator (from the city of Udaipur) transcribed and translated the audio recordings verbatim from Mewari or Hindi into English. She also wrote comments in the margins to explain her perspectives on the text, especially when an exact translation was difficult. The first and second authors then listened to each interview while concurrently reviewing the transcript with the translator to ensure conceptual and linguistic equivalence. We discussed any disagreements regarding language until a consensus was reached. During the transcription process, we also deidentified any specific identifying factors from the interview; for example, if a participant named a particular village, we would instead write "a village." We erased the audio recordings after completing the transcription process and stored the transcripts (and all subsequent analyses) on a secure computer to which only the first author had access.

We used a grounded theory approach for our analysis. Researchers using grounded theory are encouraged to develop theories inductively. This approach is a primary method for theory building, rather than theory testing (Starks & Trinidad, 2007; Strauss & Corbin, 1998). The aim of this study was to develop a definition of physical IPV based on the data, so grounded theory was an appropriate analytical approach. After completing 10 transcriptions, the first author uploaded the transcripts to the ATLAS.ti software package (ATLAS.ti, 2004) and coded each one line by line. During the coding process, the first author wrote memos to record relationships among themes and patterns. After reading and coding each set of 10 transcripts, the first author conducted a second round of more selective coding to identify core themes (Strauss & Corbin; Ulin et al., 2005). The first author completed all of the coding independently, with advice from collaborating authors.

Following each set of 10 interviews, the first and second authors re-examined the interview guide to determine if changes were needed before the next round of data collection. This allowed us to develop new and follow-up questions based on the themes we had already identified. For example, during the first round of data collection, we discovered the importance of *samjhana* (a Hindi term meaning to make someone understand; more thoroughly defined in the Results section). Then, in the next round of data collection, we added a specific question about samjhana. Had we not employed this iterative technique, we never would have been able to examine the meaning of this important concept in more detail. We added approximately one to two questions per iterative cycle and deleted questions that we thought were not productive. The first author worked closely with the second and third authors, as well as fieldworkers and interpreters, to navigate this process.

We continued this process until we reached data saturation, as indicated when using a grounded theory data analytical approach (Starks & Trinidad, 2007; Strauss & Corbin, 1998). We determined that saturation was reached when we heard no new themes and concepts during interviews (Guest, Bunce, & Johnson, 2006). After we completed data collection and coding, we performed a final read-through of the code outputs, which included the text for each code as well as accompanying memos. We used the code outputs to select quotations highlighting the majority and minority opinions, to compare men's and women's perspectives, and to guide the final analysis of the data. Finally, we ensured that all quotations used in this article or any other documents did not contain any information that could potentially identify a participant.

We paid close attention to reflexivity (attending to the context of knowledge construction and the effect of the researcher) while conducting our study (Malterud, 2001). To address this concept, we involved individuals other than the three authors in the data collection and analysis process. We held meetings with the interpreters and ARTH fieldworkers to ascertain their opinions on our theories and to determine the direction of future data collection. Also, at the end of some interviews (after the first 10), we shared with participants some of the general themes that we had developed from previous interviews to gain their perspectives on our emerging theories. Although this feedback was part of the interview, we labeled it separately in the transcripts to ensure that we did not bias the participants. Out of each set of 10 interviews, we elicited feedback from three or four participants. Engaging a variety of individuals (ARTH fieldworkers, participants, authors, and interpreters) in the data analysis process gave us a way to determine if our newly developed themes were broader reflections of community perceptions.

Participant Characteristics

Between October 2011 and February 2012 we recruited 56 women and 52 men for this study. The majority of the

Table 1. Sociodemographic Characteristics of the Participants.

Sociodemographic Factor	Women (*n* = 56)	Men (*n* = 52)
Location		
Rural	42 (75%)	39 (75%)
Urban	14 (25%)	13 (25%)
Married	46 (82%)	46 (88%)
Mean age (years)	29.7	30.4
Caste		
Scheduled tribe	19 (34%)	17 (33%)
Scheduled caste	9 (16%)	10 (19%)
Other backward castes	17 (30%)	13 (25%)
Other castes	11 (20%)	12 (23%)
Education		
No education	23 (41%)	10 (19%)
Passed 1st–5th grade	13 (23%)	5 (10%)
Passed 6th–10th grade	11 (20%)	22 (42%)
Passed 11th–12th grade	4 (7%)	9 (17%)
Graduated from college	5 (9%)	6 (12%)
Employed outside of home	17 (30%)	35 (67%)
Participants who reported past or current physical abuse	12 (21%)	0 (0%)

participants we approached agreed to participate, although 8 refused outright and 10 refused when we explained the study in detail. The average age of the participants was 30, and the majority were married. All participants identified as Hindu, but they represented multiple castes. Generally, the men reported higher educational levels and were more likely to be employed than the women. In fact, 41% of women reported having never gone to school, compared to 19% of men. All other demographic factors were similar between women and men. In Table 1 we provide details on a variety of the demographic characteristics of study participants.

Although we did not ask about personal histories of abuse, 12 out of 56 women (21%) reported during the interview that they had been physically abused by their husband in the past. No woman reported active violence at the time of the interview, requested immediate help, or wished to stop the interview. Nonetheless, all were given the number to the nearest ARTH health center in case they required assistance. None of the men reported that they were victims of physical IPV.

Results

We identified several core themes related to men's and women's perceptions about physical IPV in the Udaipur district. These included (a) clear delineations regarding the roles and responsibilities of a husband and a wife; (b) justification of physical IPV perpetrated by a husband; (c) justification of physical IPV perpetrated by a wife; (d) the relationship between alcohol and physical IPV; (e) the importance placed on making a spouse understand or modifying his or her behaviors; (f) participants' attribution of unjustified physical IPV to communities other than their own; and (g) reasons that it was difficult for a woman to leave an abusive marriage. Each of these themes is examined below. We selected quotations to illustrate each theme and to represent majority and minority opinions of women and men. In the results, we do not discuss the specific ways that physical abuse was perpetrated or personal histories of abuse because those topics have been explored in other qualitative studies (Go et al., 2003; Kaur & Garg, 2010; Krishnan, 2005; Panchanadeswaran & Koverola, 2005).

The Roles and Responsibilities of a Husband and a Wife

Participants explained that husbands and wives had defined social roles. The majority of women thought it was the husband's responsibility to earn money, manage the home, and help the children with schoolwork. They did not believe that a man should perform housework unless his wife was sick or he wished to do so. Women identified the responsibilities of a wife as caring for the children, performing housework, preparing food, and obeying her husband and in-laws. Many women stated that a wife earning money was appropriate only in situations when her husband was unable to earn. A rural woman who worked in a village shop commented,

> It is not important for a woman to have a job, but if the husband's income is low then it is necessary. In India, women are working more. In my community, all the men are drinking alcohol. If the economic condition is not good, then the women have to work.

Men believed that husbands and wives had defined roles very similar to those that the women described. Most men also explained that a husband had the responsibility of teaching his wife. A rural man stated, "He has to treat her like a small child after marriage. He has to teach her." The majority of men said that it was acceptable for women to work outside of the home only if they were able to concurrently manage the housework. An urban man commented, "If she is working and earning money, then she must take care that the work at home is done properly—like she needs to send the children to school, make the food, and clean." Men who were employed were less likely to approve of women working outside of the home.

Table 2. Actions That Participants Believed Justified a Husband Hitting His Wife.

Action	No. of Women who Responded[a] (n = 56)	No. of Men who Responded[a] (n = 52)
No action justified physical violence	4 (7%)	8 (15%)
Extramarital affair only	16 (29%)	8 (15%)
Extramarital affair or disobeying the husband (talking back, leaving without permission, or not following directions)[b]	28 (50%)	29 (56%)
Extramarital affair or housework-related mistakes (cooking food incorrectly, not working effectively, not caring for the children, and so forth)[b]	24 (43%)	15 (29%)
Any perceived mistake	12 (21%)	5 (10%)

[a]Numbers greater than 100% because some women and men mentioned more than one category.
[b]All participants who thought a husband could hit his wife if she disobeyed her husband or did not perform housework appropriately also condoned violence if she had an extramarital affair.

Justification of Physical IPV Perpetrated by a Husband

During pilot testing, we discovered that participants did not understand the meaning of the word *parivarik hinsa* ("intimate partner violence" translated into Hindi); therefore, we defined physical IPV by the word *marna*, which means "to hit." All 108 participants maintained that it was incorrect for a husband to hit his wife without a specific reason; however, the majority of women (52/56; 93%) and men (44/52; 85%) considered it acceptable to hit if a wife made a perceived mistake. They explained that the most grievous mistake a woman could make was having physical relations with another man. In fact, some women (16/56; 29%) and a few men (8/52; 15%) stated that an extramarital affair was the only appropriate reason for a husband to hit his wife. Other actions that participants believed justified physical IPV included not obeying the husband, not doing housework well on a daily basis, or not respecting the in-laws. See Table 2 for percentages regarding specific situations in which participants thought a husband hitting his wife was justified.

The definition of what specific mistakes warranted physical IPV varied among participants. One rural woman stated that hitting was appropriate if a wife was disrespectful or had an extramarital affair, but not if she made a mistake while performing housework:

> If a husband tells his wife to do work and the wife does not listen to him, then he will hit and it is okay. If she hits the children or goes anywhere without telling the husband, if she has an affair and the husband hits, then that is correct. [But] if she makes a mistake with housework then, for this, he should not hit her.

A rural man had a different opinion regarding when hitting was justified, explaining, "If she has an affair, then he can hit. However, if the wife does not do work well or is disrespectful, then the husband cannot hit. Instead he should explain to her that she needs to [do] work well." A minority of women (4/56; 7%) and men (8/52; 15%) did not believe that physical IPV was warranted for any reason. A rural woman asserted, "Men also make mistakes but their wives do not hit them, so why should men hit their wives?"

The character of an individual was often cited as an important determinant in whether physical IPV was justifiable. Participants explained that men thought to be lazy, alcoholics, or simply bad in character were more likely to hit their wives without justification. An urban man noted, "A man who is unemployed, who is an alcoholic, who is lazy—those men will hit. These men are bad. It is bad that they hit." A rural woman agreed, stating, "If he is a habitually angry person, if beating is his habit, then he will hit his wife. These men are evil and they give their wives so much trouble." Participants also considered it more acceptable for a husband to hit his wife if she was viewed as irresponsible or as not fulfilling her duties appropriately. A rural woman commented,

> If the woman is irresponsible, it is the husband's responsibility to hit. If the woman is good, then he will not have to hit her. Some wives order their husbands around; they are not good, and they do not do the housework themselves.

Participants often described physical IPV as unacceptable when asked about it generally ("What do you think if a husband hits his wife?"), but changed their responses when asked about specific situations. For example, a rural woman first said, "The woman is taking care of the home, making food, and taking care of the children. If the husband comes home and hits his wife, that is very wrong." She later commented, "The main reasons that the husband hits are if the wife has affairs, does not care about her husband or children, or goes wherever she wants without asking. In those situations it is okay to hit." A rural man held a similar opinion, first stating, "No, he should not hit. Why is he hitting? If

Table 3. Actions That Participants Believed Justified a Wife Hitting Her Husband.

Action	No. of Women who Responded[a] (n = 44)	No. of Men who Responded[a] (n = 48)
Never	25 (57%)	28 (58%)
In self-defense	7 (16%)	6 (13%)
If the husband drank alcohol excessively	4 (9%)	5 (10%)
If the husband did not earn money	4 (9%)	2 (4%)
If the husband had an extramarital affair	9 (20%)	8 (17%)

[a]Numbers greater than 100% because some women and men mentioned more than one category.

something happens, then he should talk to her." Later, he explained, "If she does something wrong, he can hit her. Why not? It is okay."

Justification of Physical IPV Perpetrated by a Wife

The majority of women (25/44; 57%) and men (28/48; 58%) did not believe there was a justifiable reason for a wife to hit her husband. A rural woman stated, "In my opinion, a wife should never hit her husband; even if he has an affair, she should not hit him." Those who thought a wife hitting her husband was tolerable cited the following circumstances: if he had an affair, in self-defense, if he drank alcohol excessively, or if he did not earn money. Participants emphasized that women rarely hit their husbands without a specific reason. A rural woman noted, "Mostly husbands hit their wives, torture their wives, but there are very few women who do the same. If a woman hits her husband, her situation must have been unbearable." Another rural woman used the word *majboori* (a Hindi term meaning a state of helplessness, or when a person considers herself to be without options) to describe why a wife might hit her husband. She explained, "A woman only hits her husband if it is her majboori and she has no other options. She hits because he has been hitting her and drinking alcohol for many years."

Many participants, especially men, expressed their belief that although a man could hit his wife in certain situations, a wife hitting her husband for any reason looked shameful in the eyes of the community. A rural man said, "This does not happen. Even if the husband hits his wife, his wife will not hit him. It is a question of reputation. The neighbors will look at this wife and think badly of her." Three women (all urban) disagreed, stating the minority opinion that a woman could hit her husband because men and women had equal rights. An urban woman declared, "The husband and wife should have equal rights. I do not think hitting is correct but if he can hit, so can she. She should not be inferior to him." See Table 3 for percentages detailing specific situations in which participants justified a wife hitting her husband.

The Relationship Between Alcohol and Physical IPV

The majority of women thought that alcohol consumption was a problem among men in the region and that those who drank tended to hit their wives more frequently. One rural woman declared, "The men who drink, those men hit their wives. They come home at night after drinking and do not bring food for the children. They break things and throw them outside. We need to close down the alcohol shops." Another woman stated that men who drank alcohol were more violent, noting, "The alcoholics, they beat their wives very hard. They hit, punch, or beat with a chain. It is not just one or two slaps." Women in general were strongly against alcohol consumption.

Male participants echoed these sentiments, expressing that men who drank alcohol excessively were more likely to hit their wives without a perceived reason. One rural man stated, "Yes, if he [a man] drinks and hits his wife, it is his fault." Some men believed that alcohol in moderation was acceptable and did not result in physical IPV. A rural man asserted, "Yes, it [hitting] happens because of alcohol. However, there are so many men who drink, and most do not fight and hit. Some just drink to be social and then fall asleep." Neither men nor women thought it was acceptable for a man to drink excessively and hit his wife. A rural man summed it up, explaining, "[Whether he can hit] depends on why he is hitting her. If his wife made a mistake, then he can hit her; but if he is hitting his wife because he is drunk, that is very wrong."

Making a Spouse Understand or Modify His or Her Behaviors

Women and men alike stated the importance of making a spouse understand if she or he made a perceived mistake. Participants frequently used the Hindi word *samjhana* to describe this idea. This complex term means to cognitively explain something or make someone understand, but can also mean teaching someone or modifying his or her behaviors. Almost all of the participants believed that making a spouse understand should start through verbal means. A rural man who did not think a husband should

hit his wife in any circumstance said, "He should make her understand that she should not do wrong things. He should not hit her." The majority of women and half of the men asserted that verbally making someone understand was a right afforded to both husbands and wives. An urban man noted, "If the husband is unemployed, drinks alcohol excessively, or does not have a job—for these reasons she should talk to him and make him understand. She should tell him that these actions are bad for the family."

If verbal means of communication were perceived as ineffective, several participants explained that a man could use physical violence to make his wife understand. Using violence in these situations was seen as a natural and appropriate extension of a husband's right to verbally correct his wife's behaviors. A rural woman said, "If the wife does not cook food well, the husband can hit. However, first he should try to make her understand that she should cook good food. He should only hit her if she does not learn." Similarly, a rural man stated, "He first should explain to her what her mistakes are and then, if she repeats the mistakes, that can irritate him and force him to hit her." Another rural man agreed, describing a situation in which a conflict might escalate:

> When the husband comes home, he might be tense. If he asks his wife something and the wife does not give him the correct answer or does not give him well-prepared food, for these reasons the husband will fight with his wife. Sometimes after fighting, he will hit. . . . He will feel provoked and angry.

Some participants thought that although women could justifiably hit their husband in certain situations, they generally did not hit their husband to modify behaviors but rather because they believed they had no other options. A rural woman expressed,

> When a husband makes a mistake, the wife will just talk to him to make him understand. She only hits her husband if her situation is unbearable—he hits, he drinks, and he has affairs. Only [then] can she hit.

A rural man agreed, describing the difference in the way women and men reacted to perceived mistakes: "If a wife makes a mistake, then the husband will hit. If the husband makes a mistake, the wife might say something to him or maybe will not say anything. She will not hit him."

Unjustified Physical IPV Attributed to Other Communities

Neither women nor men believed that, within their own communities, husbands perpetrated unjustified physical IPV against their wife. Many participants expressed their beliefs that negative attributes of a particular caste led to more unjustified physical IPV. For example, women and men of other castes and other backward castes (OBC) thought that physical IPV without a reason was a problem in scheduled castes (SC) and scheduled tribes (ST). A rural man of OBC commented, "This happens in the lowest castes [SC/ST]. The men of lower castes drink a lot and those men do not like to work so they hit their wives." In contrast, SC/ST participants thought abuse happened more in other castes. An SC rural woman noted, "In our community it is not a problem, but in the *Rajput* [other castes] community, this happens very frequently."

A similar pattern emerged in relation to other demographic factors, such as age and location of residence. Urban participants believed that rural men were poorer and less educated, so they tended to hit their wife. Rural participants disagreed, stating that men residing in cities hit their wife more frequently because they had fewer community ties and bigger egos. Younger participants, especially men, tended to blame the "older generation," asserting that men who were older, less educated, or more provincial were more likely to physically abuse their wife. A young rural man commented, "I do not think that the new generation of educated men hit their wives every day. Maybe the older generation; they do not work and they hit their wives. . . . [But] this is much improved today."

Why It Is Difficult for a Woman to Leave an Abusive Marriage

Several participants provided explanations as to why they thought women stayed in abusive marriages. Four main reasons emerged: reputation, structural barriers, concern about the children, and recognition by the woman that she had committed a mistake that justified violence. Many participants considered it unacceptable for a victim of IPV to end an abusive marriage. A rural woman stated, "[She stays] because she does not want her relationship to be ruined. She needs to remain married to her husband, in her husband's home." A rural man explained that taking action against an abusive husband would shame the natal family, noting, "She is trying to protect her mother's and father's images. Otherwise, people will tell her mother and father, 'Look what your daughter did.'" Another rural man affirmed that a virtuous or good woman would not take action against an abusive husband, commenting, "She does so [stays in an abusive marriage] because she is respectful. There are some women who do not say anything. They listen to their husbands and keep quiet."

Women in particular expressed the opinion that structural barriers also were a deterrent to leaving an abusive

marriage. They believed that, after marriage, a woman lacked rights to both her natal home and her husband's home and, therefore, might not have a place to live if she left an abusive husband. A rural woman stated, "Sometimes the natal family will not have space for her. It is not the right of the woman to go back to her parents' home." This particular problem was thought to be more pronounced if the natal family was poor. A rural woman said, "If her natal family is rich, then it is easier. If the wife's family is unable to support her financially, it will be difficult for her to leave." An urban woman agreed, explaining, "If the wife's family is very poor, then what will she eat when she goes to her parents' home? That is the reason [that] she will not leave her husband and go live with her [natal] family."

Many participants (primarily women) also were concerned that if a woman left an abusive husband, she would be forcibly separated from her children and eventually would destroy her children's futures. A rural woman said, "If she goes, she will have to leave her children behind. Then the children might not be able to get married and their reputations will be ruined. For the children, a woman has to bear an abusive husband." Another rural woman stated, "If her husband hits her for no reason, she might stay with him because she is worried about her children's futures." A rural man agreed, declaring that many women wanted their families to remain intact: "She stays with her husband even if he hits her because she wants her family to stay together; she does not want to leave her husband or her children."

The vast majority of participants thought that if a woman were hit because she made a perceived mistake, she would stay with an abusive husband. They added that, under these circumstances, she should tolerate her husband's actions. A rural woman said, "Only women who make a mistake bear beatings; otherwise they [would] never bear it." A rural man summed it up in this manner:

> A woman tolerates hitting if she made a mistake so he was forced to hit her. If she did not make a mistake, then she will think about her children. She also thinks this way if she comes from a good family, if she has a good mother-in-law and father-in-law, or if her husband's family is wealthy. Then she will think [that] even if he hits, she must bear it. She will not want her family to be broken. She hopes that he will try to improve.

Discussion

This study was one of the first qualitative examinations using feminist perspectives to better understand how individuals conceptualized the idea of physical IPV in northern India. Similar to the findings that Go et al. (2003) reported, we discovered that physical IPV was neither fully socially accepted nor prohibited. Rather, we found that the specific factors precipitating physical spousal abuse, in combination with the perceived character of the husband and wife, determined whether participants believed that violence was justified. There were a few differences between men's and women's perspectives, the principal being that women were more inclined to articulate the structural challenges associated with leaving an abusive marriage. Urban and rural participants also held generally similar viewpoints, except for the few urban women who condoned a wife's hitting her husband because of their belief in gender equity. Using the results from this study, we argue that there are multiple forms of physical IPV in these communities, each rooted in feminist perspectives but with its own unique characteristics and level of social acceptability.

As a framework for our article, we used a version of feminist theory that posits that IPV can be attributed to gender inequities and patriarchal attitudes as well as microlevel constructs (DeKeseredy, 2011; DeKeseredy & Dragiewicz, 2007; Jasinski, 2001). Consistent with previous studies, we found an association between deeply rooted structural and ideological patriarchal beliefs and attitudes toward physical IPV (Ahmed-Ghosh, 2004; Go et al., 2003; Krishnan, 2005; Tichy et al., 2009). Ideologically, the majority of participants supported the notion that hitting was justified when a woman made a perceived mistake. Structurally, women in particular described the financial and logistical difficulties that victims of IPV faced when leaving abusive marriages. Fixed and traditional gender roles of men earning money and women working at home also contributed to the patriarchal attitudes in these communities. Beyond gender inequities, participants described the intersection of other factors associated with physical IPV, including alcohol consumption and negative sociodemographic stereotypes such as caste, age, or location of residence.

A key tenet of our results was the concept of samjhana. Participants indicated that one of a husband's core duties was to make his wife understand. In fact, even the few participants who did not agree with physical IPV under any circumstances emphasized the importance of a husband verbally correcting his wife's behaviors if she made a perceived mistake. Although samjhana started with verbal explanation, most participants viewed physical violence as a justifiable and inevitable escalation if verbal methods were not effective. Escalation in partner violence has been heavily studied by Winstok (2012), who described it as a progression from verbal exchange and verbal aggression to threats and then acts of physical aggression. We uncovered a similar pattern, discovering that verbal explanation and physical violence were viewed as points on a continuum rather than two distinct phenomena. Whereas women were typically allowed to verbally correct a husband, the ability to move forward

Table 4. Overview of the Three Types of Physical Intimate Partner Violence (IPV).

Type of Physical IPV	Rationalized Violence	Unjustified Violence	Majboori Violence
Definition	Justified physical IPV, often used to make a spouse understand or correct behaviors	Unjustified physical IPV, often described to be perpetrated by men with undesirable characteristics	Physical IPV used in situations where the perpetrator believes that she has no other available options
Etiology	Occurs because of perceived mistakes committed by the victim	Occurs often without cause or reason	Occurs often in response to unjustified violence
General level of social appropriateness	Socially condoned	Socially prohibited	Generally socially condoned
Perpetrator	Generally husband	Husband	Wife
Victim	Generally wife	Wife	Husband
Comparison to Johnson's typological model[a]	Situational violence and intimate terrorism	Intimate terrorism	Violent resistance
Severity	Less severe	More severe	Variable severity

[a]Johnson (2008, 2011).

on the continuum from verbal explanation to physical violence was generally afforded only to men.

Using a feminist lens, we gained a better understanding of the phenomenon of physical IPV in the Udaipur region, finding that there was no single conceptualization of physical spousal abuse present in these communities; rather, perceptions regarding the definition of physical IPV were complex and nuanced. We found three key types of physical IPV in the marital relationship: husbands hitting their wife in a socially accepted fashion, husbands hitting their wife in a socially prohibited fashion, and wives hitting their husband in self-defense or based on extreme acts that their husbands have committed. These three types of physical IPV were not mutually exclusive, and some overlap could occur depending on how a particular individual defined and categorized an abusive situation. In Table 4 we provide a brief overview of the three types of physical IPV described below.

Johnson (2008, 2011), a feminist scholar, developed a typological approach to better define IPV. In his work, he described four main types of IPV that differ primarily based on the extent to which one partner is trying to control the other. His typologies include intimate terrorism (violence used by one partner to coerce and control the other), violent resistance (a victim of intimate terrorism responding with violence), mutual violent resistance (situations in which both partners are violent and controlling), and situational couple violence (a violent escalation of a conflict in a relationship, in which one partner is not trying to exert control over the other). We use these more established typologies to better classify the types of IPV elucidated in this article.

We start by analyzing the phenomenon of a husband hitting his wife in a socially condoned fashion. These violent acts were rooted in the patriarchal notion that a man had the duty to teach his wife if she was not fulfilling her traditional gender roles appropriately. In these cases, participants often attributed fault to the wife and thought she was deserving of physical violence. We label socially condoned violence perpetrated by a husband against his wife *rationalized violence*. Like situational violence, rationalized violent acts are viewed as escalations of conflicts in a relationship and manifest themselves in a variety of ways (Johnson, 2008, 2011). However, these acts differ from situational violence in that they stem from societal norms indicating that it is acceptable to hit under certain circumstances. In fact, these violent acts contain elements of intimate terrorism because they are used to gain control over a spouse and are legitimized as justifiable necessities by both the perpetrator and the community. Husbands generally perpetrate this type of violence against their wife; therefore, rationalized violence is not gender symmetric.

Whereas rationalized violence was generally socially condoned, participants considered it socially inappropriate for a man to perpetrate physical IPV against his wife without cause or reason. They viewed perpetrators of this type of violence in a negative way (e.g., alcoholics, uneducated, unemployed) and considered them to be at fault when they hit their wife. These acts of violence were so socially prohibited that participants would not admit that such practices occurred in their own communities. We label this type of physical IPV *unjustified violence*. Unjustified violence is similar to intimate terrorism because it is used by men to gain control over their wife and is often more severe than rationalized violence (Johnson, 2008, 2011). Participants did not describe situations in which women perpetrated acts of unjustified violence against their husband, and thus we conclude that these acts are considered to be gender unidirectional. We

did not examine the reasons that these men abuse; however, we hypothesize that regardless of the social implications, they hit in an effort to coerce and terrorize their wife, knowing that few help-seeking options exist.

With regard to physical violence perpetrated by a wife, previous researchers have found that women in India could never justifiably hit their husband (Go et al., 2003; Kaur & Garg, 2010; Krishnan, 2005). Similarly, we found that although this type of behavior generally violated social norms, it was condoned by some participants in extreme circumstances such as self-defense or when a husband was egregiously shirking his responsibilities. However, we uncovered a pronounced sentiment that women did not hit to modify their husband's behaviors but rather because their situations were unbearable. We define this last type of physical IPV *majboori violence*, because it occurs when a woman considers hitting her husband to be the only viable response to her husband's abusive actions. This type of violence is almost always perpetrated by women against their husband.

Majboori violence parallels the concept of violent resistance because it is often in response to unjustified violence and can be in self-defense or premeditated (Johnson, 2008, 2011). The extent to which majboori violence is condoned depends highly on the individual. Through our research, we found that leaving an abusive marriage was extremely challenging, even in situations when the husband was using unjustified violence. Therefore, we postulate that women perpetrate acts of majboori violence against their husband when unjustified violence is being used against them and they believe they have no other options. It is used as a way for a woman to temporarily resist an abusive relationship rather than to modify her husband's violent behaviors.

This article is meant to be an in-depth qualitative analysis of women's and men's perceptions about physical IPV in rural and urban regions of the Udaipur district. We recognize that there was an inherent bias in utilizing convenience sampling and recruiting only participants who were affiliated with an NGO. It is possible that the participants we approached and recruited had different perceptions about physical IPV than the general population, so we are cautious about generalizing these results to other areas in India. However, because ARTH did not specifically provide IPV-related services, we believe that drawing the sample from a service population did not significantly bias our results.

Although we maintained a highly rigorous and methodical interpretation and translation process, problems during this process might have occurred, particularly with specific words and concepts that did not easily translate from Mewari or Hindi to English. It is also possible that participants were not stating their beliefs but rather what they thought were socially desirable answers. This was particularly a concern with the men's interviews because the interviewer was a woman. We tried to minimize this by involving participants in the process of data analysis and by using trained, gender-specific interpreters; however, future research utilizing male interviewers is suggested.

Despite these limitations, we believe that our results can be used as the basis both for further theoretical development and for IPV prevention initiative design. It is up to future researchers to better understand the different types of physical IPV that we have developed (rationalized, unjustified, and majboori), including the characteristics of the couples affected by each type of IPV. It also would be helpful to examine perceptions regarding other forms of IPV in India (such as psychological and sexual) and relate those findings to the model we have created. We developed our theories by analyzing perceptions about physical IPV, so follow-up quantitative work is necessary to determine the actual numbers of individuals affected by the types of physical IPV described here. This is especially important in terms of majboori violence because there are few data in the literature about the prevalence of women hitting their husband in India. Finally, we suggest that future researchers assess the generalizability of our findings to determine if the theories we developed can be replicated in other parts of India.

We recommend a multipronged approach toward IPV prevention. Educational programming focused on the negative effects of physical IPV in all forms is crucial. For example, "*Bell Bajao*" (Ring the Bell) is an ongoing media and cultural campaign in India that urges individuals—especially men and boys—to ring the doorbells of houses where they hear IPV occurring (Aleya, 2012). Additionally, Das et al. (2012) described a unique intervention called Men's Action to Stop Violence Against Women (MASVAW), in which men in Uttar Pradesh, India, were trained to serve as activists trying to prevent gender-based violence in their communities. Implementing similar programming in Rajasthan might be helpful in changing attitudes about physical IPV, especially the notion that a man has the right to dominate his wife. Finally, more emphasis should be placed on developing multifaceted IPV victim empowerment resource centers with shelter, job training, counseling, childcare, and legal advocacy. These services are critical not only because physical IPV is a common problem in the region where this study took place, but also because structural barriers deter victims from seeking help.

In this article, we have focused on elucidating perceptions that women and men in the Udaipur district of Rajasthan held about physical intimate partner violence (IPV), gaining an understanding of the intricacies surrounding the social prohibition or acceptance of physical IPV. In line with feminist perspectives, we found multiple

intersecting factors associated with physical IPV, from structural and ideological patriarchal attitudes to micro-level constructs such as alcohol use. Drawing from Johnson's (2008, 2011) typological approach, we suggest that three unique types of physical IPV exist in the region of India where this study took place: rationalized violence, unjustified violence, and majboori violence. Through this research, we have contributed to the overall pool of knowledge about IPV in India and shed light on this complex phenomenon.

Authors' Note

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Notes

1. Multiple terms are used to describe the phenomenon of violence in an intimate relationship, including intimate partner violence, domestic violence, wife beating, gender-based violence, partner violence, and violence against women. We chose the phrase *physical intimate partner violence* because it most effectively describes what we were trying to explore: perceptions regarding acts of physical violence in a marital relationship perpetrated by a man or woman against his or her spouse. Although IPV can also refer to acts perpetrated by a nonspouse intimate partner, in our article we strictly focused on physical IPV in the marital relationship (Campbell, 2002; Heise et al., 1999).
2. In India, a village is defined as having a population of less than 25,000; a town between 25,000 and 100,000; and a city greater than 100,000. A town or city also can be defined as an area that has a population of at least 5,000, has a population density of at least 400 people per square kilometer, and has at least 75% of the working male population engaged in nonagricultural pursuits (Government of India, 2011). Please note that the classification system of the different areas in India is complicated and it is beyond the scope of this article to describe this topic in full detail.
3. In 2008, the mean age of marriage in Rajasthan was 20.7 years for men and 17.7 years for women (per the District Level Household and Facility Survey; Government of India, 2007–2008).
4. We identified participants from villages as "rural" and participants from the city of Udaipur as "urban." Udaipur is the only city in the Udaipur district. During the time in which this study took place, ARTH provided services only in villages and in the city of Udaipur, so we did not recruit any participants from towns (Action Research and Training for Health, 2010).

References

Action Research and Training for Health. (2010). [Endline data on project villages]. Unpublished raw data.

Ahmed-Ghosh, H. (2004). Chattels of society—Domestic violence in India. *Violence Against Women*, *10*(1), 94–118. doi:10.1177/1077801203256019

Aleya, S. (2012). *Breakthrough: Bell bajao! [Ring the Bell!] campaign. Report based on stories collected for monitoring and evaluation of social change, using the Most Significant Change Technique (MSCT)*. Retrieved from www.bellbajao.org/home/research/

ATLAS.ti. (2004). (Version 5) [Computer software]. Retrieved from www.atlasti.com/index.html

Bramberg, E. B., & Dahlberg, K. (2013). Interpreters in cross-cultural interviews: A three-way coconstruction of data. *Qualitative Health Research*, *23*, 241–247. doi:10.1177/1049732312467705

Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, *359*(9314), 1331–1336. doi:10.1016/S0140-6736(02)08336-8

Charsley, S. R., & Karanth, G. K. (1998). *Challenging untouchability: Dalit initiative and experience from Karnataka*. New Delhi, India: Sage.

Dalal, K., Lee, M. S., & Gifford, M. (2012). Male adolescents' attitudes toward wife beating: A multi-country study in South Asia. *Journal of Adolescent Health*, *50*(5), 437–442. doi:10.1016/j.jadohealth.2011.09.012

Das, A., Mogford, E., Singh, S. K., Barbhuiya, R. A., Chandra, S., & Wahl, R. (2012). Reviewing responsibilities and renewing relationships: An intervention with men on violence against women in India. *Culture, Health, and Sexuality*, *14*(6), 659–675. doi:10.1080/13691058.2012.677477

DeKeseredy, W. S. (2011). Feminist contributions to understanding woman abuse: Myths, controversies, and realities. *Aggression and Violent Behavior*, *16*, 297–302. doi:10.1016/j.avb.2011.04.002

DeKeseredy, W. S., & Dragiewicz, M. (2007). Understanding the complexities of feminist perspectives on woman abuse: A commentary on Donald G. Dutton's rethinking domestic violence. *Violence Against Women*, *13*(8), 874–884. doi:10.1177/1077801207304806

Dobash, R. E., & Dobash, R. (1979). *Violence against wives*. New York: Free Press.

Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *Lancet*, *371*(9619), 1165–1172. doi:10.1016/S0140-6736(08)60522-X

Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *Lancet*, *368*(9543), 1260–1269.

Go, V. F., Johnson, S. C., Bentley, M. E., Sivaram, S., Srikrishnan, A. K., Celentano, D. D., & Solomon, S. (2003). Crossing the threshold: Engendered definitions of socially acceptable domestic violence in Chennai, India. *Culture, Health, and Sexuality*, *5*(5), 393–408. doi:10.1080/136910501164119

Government of India: Ministry of Health and Family Welfare. (2007–2008). *District level household and facility survey: Fact sheet Rajasthan*. Mumbai, India: International Institute for Population Science. Retrieved from www.jsk.gov.in/dlhs3/Rajasthan.pdf

Government of India: Ministry of Home Affairs. (2011). *Census of India*. New Delhi, India: Author. Retrieved from http://censusindia.gov.in/

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82. doi:10.1177/1525822X05279903

Heise, L., Ellsberg, M., & Gottemoeller, M. (1999). *Ending violence against women* (Population Reports, Series L, No. 11). Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program.

Heise, L., & Garcia-Moreno, C. (2002). Violence by intimate partners. In E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), *World report on violence and health* (pp. 87–121). Geneva: World Health Organization. Retrieved from http://whqlibdoc.who.int/hq/2002/9241545615.pdf

Jasinski, J. L. (2001). Theoretical explanations for violence against women. In C. M. Renzetti, J. L. Edleson, & R. K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 5–21). Thousand Oaks, CA: Sage.

Jeyaseelan, L., Kumar, S., Neelakantan, N., Peedicayil, A., Pillai, R., & Duvvury, N. (2007). Physical spousal violence against women in India: Some risk factors. *Journal of Biosocial Science*, *39*, 657–670. doi:10.1017/s0021932007001836

Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*. Boston: Northeastern University Press.

Johnson, M. P. (2011). Gender and types of intimate partner violence: A response to an anti-feminist literature review. *Aggression and Violent Behavior*, *16*, 289–296. doi:10.1016/j.avb.2011.04.006

Kaur, R., & Garg, S. (2010). Domestic violence against women: A qualitative study in a rural community. *Asia-Pacific Journal of Public Health*, *22*(2), 242–251. doi:10.1177/1010539509343949

Kishor, S., & Gupta, K. (2009). *Gender equality and women's empowerment in India: National Family Health Survey (NFHS 3), India, 2005–06*. Mumbai, India: International Institute of Population Sciences. Retrieved from www.measuredhs.com/pubs/pdf/OD57/OD57.pdf

Krishnan, S. (2005). Do structural inequalities contribute to marital violence? Ethnographic evidence from rural south India. *Violence Against Women*, *11*(6), 759–775. doi:10.1177/1077801205276078

Lopez, G. I., Figueroa, M., Connor, S. E., & Maliski, S. L. (2008). Translation barriers in conducting qualitative research with Spanish speakers. *Qualitative Health Research*, *18*, 1729–1737. doi:10.1177/1049732308325857

Malterud, K. (2001). Qualitative research: Standards, challenges, and guidelines. *Lancet*, *358*(9280), 483–488. doi:10.1016/S0140-6736(01)05627-6

Martin, S. L., Moracco, K. E., Garro, J., Tsui, A. O., Kupper, L. L., Chase, J. L., & Campbell, J. C. (2002). Domestic violence across generations: Findings from northern India. *International Journal of Epidemiology*, *31*(3), 560–572. doi:10.1093/ije/31.3.560

Panchanadeswaran, S., & Koverola, C. (2005). The voices of battered women in India. *Violence Against Women*, *11*(6), 736–758. doi:10.1177/1077801205276088

Pandey, G. K., Dutt, D., & Banerjee, B. (2009). Partner and relationship factors in domestic violence: Perspectives of women from a slum in Calcutta, India. *Journal of Interpersonal Violence*, *24*(7), 1175–1191. doi:10.1177/0886260508322186

Ragavan, M. I., Iyengar, K., & Wurtz, R. M. (2012). *The conceptualization of intimate partner violence in southern Rajasthan* (Unpublished master's thesis). Northwestern University, Feinberg School of Medicine, Chicago, IL.

Ragavan, M. I., Iyengar, K., & Wurtz, R. M. (in press). Perceptions of options available for victims of physical intimate partner violence in northern India. *Violence Against Women*.

Rani, M., & Bonu, S. (2009). Attitudes toward wife beating: A cross-country study in Asia. *Journal of Interpersonal Violence*, *24*(8), 1371–1397. doi:10.1177/0886260508322182

Stanley, S. (2008). Interpersonal violence in alcohol complicated marital relationships (a study from India). *Journal of Family Violence*, *23*(8), 767–776. doi:10.1007/s10896-008-9202-7

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*, 1372–1380. doi:10.1177/1049732307307031

Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Tichy, L. L., Becker, J. V., & Sisco, M. M. (2009). The downside of patriarchal benevolence: Ambivalence in addressing domestic violence and socioeconomic considerations for women of Tamil Nadu, India. *Journal of Family Violence*, *24*(8), 547–558. doi:10.1007/s10896-009-9253-4

Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2005). *Qualitative methods in public health: A field guide for applied research*. San Francisco: Jossey-Bass.

Winstok, Z. (2012). *Partner violence: A new paradigm for understanding conflict escalation*. New York: Springer.

World Health Organization, Department of Gender, Women, and Health. (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women* (Reference No. WHO/FCH/GWH/01.1). Geneva: Author. Retrieved from www.who.int/gender/documents/violence/who_fch_gwh_01.1/en/index.html

Zhu, Y., & Dalal, K. (2010). Childhood exposure to domestic violence and attitude towards wife beating in adult life: A study of men in India. *Journal of Biosocial Science*, *42*(2), 255–269. doi:10.1017/S0021932009990423

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