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Treating posttraumatic stress disorder using Narrative Exposure Therapy: A study of domestic violence survivors in south India

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Abstract

The current understanding of domestic violence is largely nomothetic by design and does not adequately address the treatment and rehabilitation needs of survivors. This thesis aimed to gain a qualitative understanding of the culture-specific experiences of domestic violence in south Indian female survivors, with a focus on the treatment of posttraumatic stress disorder (PTSD), and comorbid psychopathology. An interpretative phenomenological analysis was undertaken with five south Indian women to investigate the in-depth, lived experiences of domestic violence and its mental health sequelae. Responses to, and appraisals of abuse were found to be heavily influenced by pre-abuse identity, interpersonal childhood experiences, societal perceptions of, and stigmatising attitudes towards survivors. These factors impact the experience of disclosure and help-seeking among survivors, with a clear preference for informal sources of support such as family and social care organisations. Further, the findings shed light on the experience of resisting and counteracting the abuse in this context, as well as the complex, non-linear and iterative process of leaving abusive relationships. This was found to be rooted in the sociocultural framework of Indian society, patriarchal ideologies of gender roles, and the systemic and structural disempowerment of women, perpetuating the perpetration and experience of abuse and violence.

The treatment protocol examined in this thesis is Narrative Exposure Therapy (NET), which is a short-form psychotherapeutic technique originally developed for survivors of war and organised violence in low-resource contexts. The comprehensive and up-to-date meta-analysis of its current evidence base along with a quality appraisal of the trials included was conducted. The findings revealed low- to medium-quality evidence of NET efficacy for the alleviation of PTSD. High heterogeneity estimates and low powered trials significantly impact the interpretation of the pooled intervention effect estimates. This review also revealed an overreliance on randomised controlled trial findings and a paucity of idiographic research investigating change mechanisms through NET.

In the final study, an inductive and deductive thematic analysis was undertaken to investigate the change mechanisms through NET for survivors of domestic violence. NET was administered to seven south Indian women and was well tolerated by the sample. Paired sample t-tests revealed a statistically significant improvement in PTSD and somatic symptoms at post-test. The raw testimony data was qualitative analysed, and a theoretically-informed framework of recovery was developed through thematic analysis to elucidate the specific processes that contribute to change and underlie improvement on symptom scores. There was evidence for several proposed mechanisms based on seminal PTSD theories, as well as some data-driven mechanisms such as positive memories and a focus on future aspirations that contributed to recovery in this sample. There are no published accounts of NET's use or efficacy in India, and practice implications include culture-specific and stressor-specific applications of NET using the template from the recovery framework. These findings complement the limited RCT evidence of NET from an idiographic perspective. Importantly, the need to consider and explore culture- and context-specific change mechanisms is demonstrated through the framework, which found additional processes contributing to recovery in this sample.

Recommendations for the adaptation of individual-focused, empirically supported treatments such as NET that are culturally sensitive and consider the complex socio-ecological milieu of the Indian context are discussed.

Publications and Conference Presentations

- Raghuraman, S., Stuttard, N. and Hunt, N. (2020) Evaluating Narrative Exposure Therapy for Posttraumatic Stress Disorder and Depression Symptoms: A Meta-Analysis of the Evidence-base. *Clinical Psychology & Psychotherapy*. Wiley.

- Raghuraman S., Hunt, N. (2019) A meta-analysis of Narrative Exposure Therapy efficacy. *Annual Institute of Mental Health Research Day.* University of Nottingham.

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1 Literature Review

1.1 Introduction

Domestic violence (DV) has far-reaching consequences on the physical and mental health and wellbeing of victims. When psychological distress following DV exposure is pathological, it may result in diagnoses of posttraumatic stress disorder (PTSD), related trauma-spectrum disorders, and other comorbid mental health conditions. The risk of onset, development, and severity of PTSD can differ significantly across socio-cultural, economic, and political contexts. To adequately respond to the recovery and treatment needs of victims and survivors, it is crucial to understand psychological trauma and its mental health sequelae from a cross-cultural perspective.

This thesis aimed to gain an in-depth understanding of the culture-specific DV experiences in south Indian female survivors, with a focus on the treatment of PTSD and comorbid psychopathology. The treatment protocol examined in this thesis is Narrative Exposure Therapy (NET), which is a short-form psychotherapeutic technique originally developed for survivors of war and organised violence in low resource contexts. Thus far, only one study from Iran has explored the efficacy of NET in survivors of intimate partner violence. There are no published accounts of NET use in any trauma population in India, where the risk for trauma exposure is substantially high. The literature pertinent to understanding the theory, concepts, and research spanning the above topics will be thus presented.

1.1.1 India: The politico-socio-cultural context

India's complex historical and cultural legacy has influenced its contemporary culture that embodies diversity, as is represented through distinctive social norms, customs, religions, languages, and political ideologies. With 28 states and 8 union territories, each with its unique language, traditions, customs, and practices, India, with its population of 1.36 billion, is a melting pot of cultural heterogeneity.

In the face of substantial ethnic, linguistic, and religious diversity, India has strived to maintain democratic governance. Of significance is India's religious diversity, which is arguably one of its defining characteristics (Singh, 2004). India is home to four world religions, of which Hinduism has the largest following at 79.8%, according to the Population by Religious Communities of Census of 2011 (The Hindu, 2016). India is also home to the second largest population of Muslims (at 14.23%),

followed by other minority populations of Christians, Sikhs, Buddhists, and Jains (The Hindu, 2016). The rich religious diversity of India is strongly intertwined with complex issues pertaining to caste, class, gender, region and language. India's policy of state secularism in a post-colonial world can be viewed as its attempt to sustain democratic governance in a diverse, multi-ethnic nation which strives to separate state from religion (Singh, 2004). However, the colonial state's role in politicising religious identities laid the foundation for a system where religious and identity politics continue to play a key role in India's public life. A clear example of this is the politics communalisation of the current ruling party of India, the Bharatiya Janata Party (BJP), a right-wing political party with the backing of a family of militant Hindu organisations that espouse *Hindutva*, a self-defined ideology of Hindu supremacy (Hasan, 2010) which strives to redefine Indian statehood in Hindu nationalist colours. As Peter Van Der (1994) posited, the enduring religious nationalism in India is clearly at odds with the 'institutional secularism', which demonstrates the stronghold of the constructed religious communities (Hindus, Muslims, Sikhs) on people's lives.

It is widely acknowledged that religion also has the power to be manipulated for political and economic gain in various world societies (Bradley, 2011). In India, this can be extended to the critical gender dimension, wherein gender is intrinsically believed to be linked to issues of religion and development, in that religion has been argued to be inherently patriarchal and exclusionary.

Bradley (2011) writes about her experience of interviewing activists and researchers in the field of women's empowerment in Rajasthan (a state in Western India which has recorded high numbers of DV cases) and found that the tight control imposed by several religious and cultural practices (such as child marriage, purdah, and dowry) on women's lives contributes to DV being endemic in the state. The foundations of religious patriarchy also prevents disclosure and help-seeking behaviour, and is often the cause for failed activism and empowerment programmes in these regions as women are seen as equally complicit in maintaining traditional socio-cultural systems and practices that disempower them (Bradley, 2011) This demonstrates the clear impact of India's religion-politics relationship to the issue of minority rights, and in specific, women's rights where religion often serves as a link between patriarchal traditions and women's daily lives.

Reform of personal laws in post-Independence India (previously viewed as a domain of religious and traditional authorities which have largely accorded women fewer rights than their male counterparts) was restricted to Hindu laws and included reforms of issues related to marriage and divorce, and

succession and inheritance to name a few. While these reforms were intended to be progressive in achieving gender equality, women's organisations have criticised their lack of translation into practice (Hasan, 2010). Furthermore, the religious personal laws of other minority religious communities was and continues to be left unchanged and unreformed to date (Hasan, 2010).

Indian society, nevertheless in all its enormous heterogeneity, is as 'collectivistic' as it is diverse, in that there is a clear preference of the values of social cohesion and interdependence with the family forming the focal point of this social structure (Chadda & Deb, 2013). A review of empirical studies conducted by Sinha and colleagues in the 90s to explore regional or locational diversity within India revealed seven pan-Indian cultural preferences, of which 'collectivist orientation', 'desire to be embedded in an in-group', and 'familism' are key to the subject under study in this thesis (Panda & Gupta, 2004). This is in line with Hofstede's (1980) landmark study, which found India to be moderately collectivist and masculine on the dimension of cultural facets used to profile a nation. Sinha et al. (2002; as cited in Panda & Gupta, 2004) found that while Indians combine collectivist and individualist in a complex way depending on the context, they are more collectivistic when it comes to family settings versus non-family settings. In this vein, one's 'family' is considered the most accepted in-group in the Indian context.

The family as a structure cannot and should not be ignored in India (Gupta, 1999; as cited in Panda & Gupta, 2004), because it has strong cultural basis in the Indian context. Familism, which was identified as a key defining feature of Indian society in the studies conducted by Sinha & colleagues found that it was closely related to 'hierarchy' and 'personalised relationships', which defines the desire of Indians to be integrated into a family system, but while maintaining class and caste hierarchy.

Closely related to caste and class hierarchies that define the fabric of Indian society is that of gender, when considered from an intersectional point of view. Agrarian economies such as India have been strongly correlated with existence of patriarchal systems (Dyson & Moore, 1983). Patriarchal ideology in India is formalized and enforced through laws, customs, and rituals and is evidenced by power relations within households. For example, the majority of households within India are headed by a male, with only 15% of the total number of households in India having a female head of household (IIPS and ICF, 2017). It was found that districts in India with higher patriarchy had higher levels of fertility, an indicator of women's primary value as child bearer (Singh et al., 2021). The construct of

patriarchy is universally recognised to compromise health, economic, and social outcomes in addition to being an impediment for women's empowerment and progress. It is clear that patriarchal values have and continue to influence social relations in India, and are in turn sustained through the continued acceptance and indoctrination of gender-based divisions and practices which overwhelmingly disadvantage and marginalise women, leaving them vulnerable to violence and abuse (Bradly, 2011).As such, gender identity and the gendered experience of women has to be considered from the intersectional perspective of religious diversity, cultural and political ideologies and social and structural factors in India.

1.2 Domestic abuse and violence against women

The United Nations' definition of violence against women is *'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life' (*United Nations, 1994, p. 2). This includes physical, sexual, and psychological violence when it occurs either in the family, within the general community, or perpetrated or condoned by the state. The term "domestic violence" is used in various countries to refer to intimate partner violence, but the term generally does encompass abuse by any member of a household and can include child and elder abuse as well (Kornblit, 1994). There are varying definitions of violence against women, with some publications using definitions based on national criminal codes, while others have allowed victims and survivors to self-define the abuse endured.

When violence occurs within the family, it includes a myriad of offenses such as battering, sexual abuse and marital rape, dowry-related abuse, genital mutilation, non-spousal violence, and exploitation (WHO, 1997). According to the World Health Organization (WHO), over 35% of women worldwide have experienced some form of violence either by an intimate partner or a non-partner. A majority of this violence is perpetrated by a partner, with at least 30% of ever-partnered women having experienced physical and/or sexual violence by their intimate partner (WHO et al., 2013). According to this report, the prevalence was highest in African, Eastern Mediterranean, and South-East Asian regions, where approximately 37% of ever-partnered women had faced intimate partner violence (IPV) (WHO et al., 2013). A multi-country population-based study estimated a lifetime

prevalence of physical and sexual partner violence at 15%-71% (Garcia-Moreno et al., 2006), which confirms the widespread global prevalence of DV against women.

The focus of this thesis is on DV, i.e., violence that occurs within the family. 'Domestic abuse' is often used interchangeably with DV. In this thesis, 'DV' will be used to refer to abuse and violence perpetrated by a family member/within the family context. IPV will be considered under the purview of DV when it is perpetrated specifically by an intimate partner.

In the UK, the commonly used definition of DV by law, research, policy, and practice has focused on the presence of physical abuse or assault as the key criterion. This definition has now been criticised for being too simplistic and being unable to account for the more nuanced, frequent, and low-level assaults that occur over a significant period, but maybe physically non-violent (Lombard & McMillan, 2013). The concept of 'coercive control' is thought to represent a largely unidentified form of subjugation, that goes beyond physical assault. Stark (2007) defines coercive control as an ongoing process whereby abusers use various means, including often, but not always, escalating physical violence, to "hurt, humiliate, intimidate, exploit, isolate and dominate their victims" (p. 5).

The inclusion of coercive control within the purview of DV in the UK is in line with Kelly's (1988) conception of an abuse continuum, which encompasses a range of interlinked behaviours and experiences, ranging from physical, sexual, verbal, emotional, and/or economic abuses of power. As a result, the concept of DV has been widened beyond the 'violence model', which characterises abuse as distinct, deviant, and episodic incidents. Currently, the cross-governmental definition of DV according to the Office of National Statistics (ONS) is –

> *"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality." (ONS, 2018, p. 4).*

DV, while considered a form of abuse between any two adults who are/have been intimately involved, is not gender-neutral. This is primarily due to the overwhelming asymmetry in the experiences, services, and agencies available to men and women, widely recognised as a direct consequence of the structural inequalities between men and women, including 'patriarchal disparities of power, discriminatory cultural norms and economic inequalities against women' (United Nations, 2006). Using data from the Crime Survey for England and Wales (CSEW), Myhill (2015) found that when

coercive control was included within prevalence estimates of intimate partner violence (IPV), such experiences of abuse became highly gendered with women being on the receiving end by an overwhelming majority.

In 2019, the CSEW found that an estimated 2 million adults, aged 16 to 59 years, experienced DV in the past year. Women are around twice as likely to have experienced abuse. This suggests that an estimated 1.3 million female victims experience DV, and when coercive control was considered, the gap is further widened between men and women. The most common type of DV is partner abuse. Once again, women are twice as likely to be on the receiving end of partner abuse as men (ONS, 2018).

DV is often not disclosed to the police or other authorities, which suggests that the estimated number of survivors may be higher than those currently reported. Barriers to disclosure include shame, fear of not being believed, and fear of future violence upon disclosure (Rose et al., 2011). This also complicates the issue of establishing the exact incidence and prevalence of violence against women; but what is clear is that these statistics are on the rise (Lombard & McMillan, 2013).

1.2.1 The impact of DV on survivors

The needs of DV survivors can be complex and encompass diverse psychological and physiological symptomatology and are reflected in the host of negative consequences on the victim's physical, psychological, sexual, and reproductive health. Studies have demonstrated that the impact of DV may persist over time, long after the incident has occurred (Cloitre et al., 2009). A high prevalence of DV experiences has also been documented by systematic reviews among mental health service users (Oram et al., 2013; Oram et al., 2017), which suggests a plausible bidirectional causal link between poor mental health and the risk of DV and related abuse.

Women experiencing DV tend to access primary care frequently (Plichta, 2007) but historically, the care received is generally poor due to a lack of DV knowledge and training, reluctance to screen for DV, and lack of support resources (Ramsay et al., 2012). When positive attitudes of primary care physicians were identified, these were countered by only a basic knowledge of DV diagnosis and intervention (Ramsay et al., 2012). There are few mental health professionals and services in the field of DV research and intervention (Chapman & Monk, 2015). According to the report by ONS, in 2018, 49% of referrals made to refuge and community-based services in England were declined by the

services, of which 32% were declined because of the lack of space/capacity. According to a 2018 Home Affairs Committee publication, the decline rate of referrals to refuge services recorded by Women's Aid was 60%. This is attributed to a severe lack of funding for core DV support services and has forced the closure of several services which could potentially go a long way in early intervention and support for survivors. (Home Affairs, 2018). Combined with the widely acknowledged low disclosure rates (Rose et al., 2011) and the high rates of hidden, under-researched abuse (García-Moreno et al., 2015) there appears to be a huge intervention gap for psychological and physiological consequences of DV.

The physiological consequences commonly reported by DV survivors include psychosomatic disorders and somatization, insomnia, chronic pain, gynaecological problems, eating disorders, and sexual dysfunction (Bewley & Welch, 2014a; Campbell, 2002; Lombard & McMillan, 2013; Robinson, 2003). Survivors of DV have also been found to suffer effects on their health behaviours such as diet and exercise, smoking, and risky sexual experiences (Lawrence et al., 2012). Women have been found to suffer overwhelmingly greater deleterious effects of DV (Lawrence et al., 2012).

A high prevalence of mental health disorders has been found in DV populations (Oram et al., 2017). Estimates of depression among survivors of abuse has ranged between 38% to 83%, which is significantly higher in DV populations when compared to the general population (Humphreys & Thiara, 2003). Heightened rates of suicide attempts and PTSD (31% - 84%) have also been found among DV survivors (Bewley & Welch, 2014b; Humphreys & Thiara, 2003).

Golding (1999) found the highest prevalence of PTSD in DV populations (63.8%), followed by depression (47.6%). One UK-based study found a showing a strong association between DV and symptoms of PTSD, depression, anxiety, and substance abuse (Coid et al., 2003). A meta-analysis of 41 studies found an increased risk of PTSD, depressive and anxiety disorders in women who had experienced DV and abuse (Trevillion et al., 2012). Another meta-analysis of 67 studies found an increased risk of perinatal depression, anxiety, and PTSD among women who reported experiences of DV (Howard et al., 2013).

One study demonstrated a clear association between the intensity of PTSD symptoms and the extent, severity, and type of DV (Jones et al., 2001). Moreover, PTSD and depressive disorders are found to

be highly comorbid among DV survivors (Cascardi et al., 1999; Lipsky et al., 2001; Nixon et al., 2004; Stein & Kennedy, 2001).

1.2.2 The link between PTSD and DV

Increasing awareness that a primary outcome for DV survivors is PTSD has developed over the years (Golding, 1999; Hughes & Jones, 2000; Jones et al., 2001). The American women's movement in the mid-1970s generated a wealth of research on sexual assault and rape which contributed significantly to the conceptualisation of the PTSD construct (Herman, 1997). Burgess & Holmstrom (1974) observed a pattern of responses such as insomnia, startle responses, nightmares, and dissociative and numbing symptoms as responses to rape, which they termed 'rape trauma syndrome'. The initial focus on rape then extended to investigations of domestic battery and coercion, which was defined as 'battered woman syndrome' (Walker, 1979). Parallels were drawn between the symptoms described in combat veterans and the psychological syndrome seen in survivors of rape and domestic battery, which led to the conceptualisation of PTSD in the DSM-III (American Psychiatric Association (APA), 1987; Herman, 1997).

There is also a dose-response relationship between experiences of DV and PTSD, which suggests that chronic abuse could lead to devastating cumulative effects on the mental health of survivors (Jones et al., 2001). Theories of DV have emphasised the traumatic context as crucial to understanding the deleterious effects of abuse, as opposed to discrete, isolated incidents of abuse (Kaysen et al., 2003). The traumatic context could include social isolation, constant proximity with the perpetrator, anticipatory anxiety, verbal and psychological abuse, behaviour monitoring or coercive control, all of which contribute to the experience of chronic traumatisation and heightened PTSD.

Chronic traumatisation or the repeated exposure to traumatic stressors within the same overall context over time (as in the case of DV) are known to be associated with increased PTSD symptomatology (Jones et al., 2001). Courtois (2004) refers to trauma that 'occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts' (p. 412) as 'complex trauma'. Complex trauma was studied extensively in the context of child abuse and now extends to all forms of DV occurring in family and other intimate relationship structures. The cluster of symptoms relating to complex PTSD was incorporated as criteria for Disorders of Extreme Stress-Not Other Specified in the DSM-IV, under the section of "Associated Features and Disorders (APA, 1994).

This was done to correct to the previously male-dominated conceptualisation of PTSD (such as victims of combat and war trauma) and further crystallises the link between PTSD and DV, as a result of persistent and ongoing stress related to family life or personal circumstances.

1.2.3 Treating the psychological consequences of DV

DV has not received enough attention in psychotherapy literature primarily because it is not classified as a mental health disorder diagnosis. Instead, it is manifested through other internalising or externalising disorders such as chronic pain and fatigue, PTSD, depression and anxiety disorders, and suicidality (Condino et al., 2016). Hackett et al. (2016) have noted the lack of studies reviewing the effectiveness of intervention programs for intimate partner violence aimed at victims and child witnesses. In general, treatment for the psychological consequences of DV commonly consists of brief and extended counselling and support, psychotherapeutic, and advocacy programmes (Hacket et al., 2016).

As previously detailed in sections 1.2.1 and 1.2.2., PTSD is one of the most commonly prevalent mental health consequences of DV and IPV. Cascardi, O'Leary, & Schlee's (1999) review found that the prevalence of PTSD ranged between 31 to 84% across studies on abused women, while Golding (1999) found a mean prevalence of PTSD in 64% of the sample in their meta-analysis. The strong link between DV and PTSD (specifically, complex PTSD), as espoused by the high numbers of victims experiencing PTSD has been advanced as the basis for using PTSD as a useful construct in treating victims of DV or IPV (Jones, 2001). In their review of victim-focused intervention research, Hacket et al. (2016) repeatedly refer experience of DV by women and children as comprising of 'trauma', suggesting that there is a notable trend towards generalising effective PTSD interventions to treat the psychological symptoms of DV.

Foa & Meadows (1997) recommended PE therapy as a standalone treatment for PTSD in a range of trauma situations. Since then, PE has been ascribed gold-standard status as a PTSD treatment technique across trauma populations (Rauch et al., 2012). The 2018 NICE guidelines for PTSD treatment recommended trauma-focused CBT as the first-line treatment for PTSD in adults (National Institute for Health and Care Excellence (NICE), 2018). Examples of trauma-focused CBT recommended by NICE include CPT, NET and PE therapy. These recommendations were based on

good evidence that providing up to 12 sessions of these interventions were both clinically and cost-effective.

In an early study by Resick, Nishith, & Griffin (2003), female rape victims with an extensive history of trauma were treated with Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) therapy and found both treatments to be equally effective in treating complex PTSD symptoms, with improvements maintained for atleast 9 months. Clinical trials of CBT with women survivors of DV by Kubany, Hill, & Owens (2003) and Kubany et al. (2004) have also found this type of treatment to be useful and effective. Johnson, Zlotnick, & Perez (2011) found significant treatment effects on PTSD diagnosis and symptom severity, along with reduced re-victimisation among DV shelter victims following a CBT-based intervention called Helping to Overcome PTSD through Empowerment (HOPE). Overall, Cognitive behavioural therapy (CBT) and its trauma-focused adaptations have found consistent support in reducing PTSD symptomatology in DV survivors (Eckhardt et al., 2013; Foa & Meadows, 1997).

1.2.4 DV in India

Violence, abuse and exploitation of women and children is a critical socio-politico-legal challenge in India. Recent reports on the prevalence of cases and incidents of gendered violence suggest that numbers are on a steady rise (*Crime in India 2013*, 2013; Ghosh, 2013), with a focus on matrimonial, domestic and intimate partner violence. Despite these statistics, Ghosh's (2013) examination of the legal and political framework in response to the issue of gender-based violence found it to be grossly inadequate; which only complicates the issue further.

Violence against women may be broadly classified as a) *physical abuse (*being slapped, hit, kicked, beaten or threatened by a male partner) and b) *psychological violence* (being insulted, belittled, threatened, or abandoned). More specifically, gender-based violence is often believed to range across the following categories: a) *physical violence*; (assault, battery, serious injuries or burns, and female genital mutilation) b) *sexual violence* (compromising the dignity of the woman through indecent conduct, molestation, rape etc.) c) *verbal violence*, (indecency or use of abusive and filthy language against a woman) d) *social violence*, (demeaning, disparaging and humiliating a woman) e) *emotional violence*, (deprivation of love, affection, concern, sympathy and care) f) *financial violence,* (depriving women of financial means required for bare necessities or daily sustenance, wrongfully taking away a

woman's assets or earnings), and g) *intellectual violence*, (the lack of involvement or the denial of a woman's rights to take part in decision making). In addition to the aforementioned types of exploitation, other forms of violence may include denial of education, access to health facilities, reproductive rights, etc. (Sharma & Gupta, 2004).

In India, DV has been recognised as a criminal offence and is chargeable under section 498-A of the Indian Penal Code since 1983. For this research, DV will be defined and categorised according to The Protection of Women from Domestic Violence Act of 2005, which is a civil law enacted by the Parliament of India to protect women from DV. Section 3 of the law provides a substantive definition of domestic as "any act, omission or commission, or conduct of the respondent shall constitute domestic violence in case it:

1. harms or injures or endangers the health, safety, life, limb, or well-being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse; or
2. harasses, harms, injures, or endangers the aggrieved person to coerce her or any other person related to her to meet any unlawful demand for any dowry or other property or valuable security; or
3. has the effect of threatening the aggrieved person or any person related to her by any conduct mentioned in clause (a) or clause (b); or
4. otherwise injures or causes harm, whether physical or mental, to the aggrieved person."

The National Family Health Survey (NFHS) conducted in 2015-16 found that 30% of all women surveyed (N=79729) reported physical violence since age 15, and 6% reported having experienced sexual violence. Moreover, 33% of ever-married women reported physical, sexual, or emotional spousal violence (International Institute for Population Sciences, 2017). A recent review of quantitative studies (N=137) from different regions in India found a median 41% of women sampled to report DV during their lifetime, and 30% in the last year (Kalokhe et al., 2017).

In 2000, a multi-site study on 9983 women in the community in diverse geographic regions of India reported that about 50% of the sample reported at least one of the abusive behaviours occured at least once in their married lives, 43.5% reported at least one emotionally abusive behaviour and 40.3% reported having experienced at least one form of abusive or violent physical behaviour (Ahuja

et al., 2000). Chandra, Satyanarayana, & Carey (2009) corroborated these findings in their study which found 56% of the their sample of women (N=105) in south India reported history of IPV and of this group, 70% had experienced sexual coercion. Chowdhary & Patel (2008) undertook a longitudinal, population-based study in Goa to estimate the impact of spousal violence on the psychological health of married women (N=1750). Lifetime spousal violence was reported by 16.6% of this sample, and 13% of the sample reported violence within the past three months. A population-based study from the three states in Eastern India (N=1718) found high rates any form of DV among women (52%), with emotional or psychological violence being reported most predominantly at 56% (Babu & Kar, 2009). Kalokhe's review (2017) has uncovered the large inter-study variance in DV prevalence estimates in Indian studies, which they attributed to both the diversity of DV experiences across regions in India and the lack of standardised research designs and instruments employed to measure DV in India.

1.2.4.1 **Studies on the impact of DV**

A few reports have documented the impact of DV against women in India on the development of clinical symptomatology such as PTSD, depression and anxiety, and somatic symptoms. The focus has primarily been on IPV and its correlates (Kalokhe et al., 2017).

The NFHS (1998-99) and its update in 2002-03 (International Institute for Population Sciences & Macro International, 1999) revealed at 10.7% of women surveyed (N=5703) reported outcomes of common mental disorders, which was significantly correlated with IPV and husband's substance abuse among other variables (Shidhaye & Patel, 2010). This replicates a previous cross-sectional survey of 2494 women wherein factors indicative of gender disadvantage, particularly sexual violence by an intimate partner was independently associated with common mental disorders such as depressive and anxiety disorders (Patel et al., 2006). A qualitative analysis of 32 in-depth interviews with women in a rural setting in Western India (Maharashtra) found that one of the most common stressors that were perceived to contribute to poor mental health was conflict with husbands and mothers-in-law and DV (Kermode et al., 2007). Kumar et al. (2005) conducted a seven-city household survey of 9938 women and found a strong association between any form of spousal DV and poor mental health. Vizcarra et al.'s (2004) multi-site, cross-sectional survey reported that over 25% of the Indian women sampled (N=1922) scored high on the scale to measure mental health symptoms

(depressive, anxiety and somatic symptoms). IPV was also associated with risk of suicide with 7.5% of the women in India having attempted suicide already. Indu et al. (2020) conducted a case-control study and found that DV was an independent risk factor for attempted suicide, with a significant dose-response relationship between reported DV and attempted suicide. Chowdhary & Patel (2008) found that the risks associated with DV exposure included a range of gynaecological complaints, sexually-transmitted infections, dysmenorrhea, dyspareunia, depressive disorders and suicidality.

Indian research largely reflects global estimates of PTSD prevalence found among DV survivors. Chandra, Satyanarayana, & Carey (2009) studied the prevalence and nature of PTSD symptoms among south Indian women (N=105) reporting IPV. Over 50% of the sample reported a history of IPV. Of these women, 14% of women exceeded the cut-off scores for PTSD and 20% exceeded cut-off scores for sub-threshold PTSD. The severity of violence and sexual coercion was correlated positively with PTSD severity in this sample. A majority of the women also reported the presence of a depressive disorder. In a study on victims of DV in south India by Tichy, Becker, & Sisco (2009), 84% of the sample (N=64) had indications of clinically significant PTSD or acute stress disorder (ASD). Psychological distress due to abuse was predicted by the one's ability to correctly recognize one's experiences as falling under the purview of abuse, and the chronicity of the abuse. In a review by Gilmoor et al. (2019), the second-highest prevalence of PTSD (28%) was reported by studies investigating the mental health consequences of violence and abuse. This was preceded by PTSD prevalence in natural disaster survivors at 31%. Overall, research on the DV and its mental health correlates in India have demonstrated a significant prevalence of PTSD, depression and anxiety symptoms, and suicidality among other conditions. At the same time, there are some research and knowledge gaps in the empirical understanding of DV and its psychopathological consequences in the Indian socio-cultural context.

1.2.5 Research gaps in Indian DV literature

A review of 137 quantitative studies published on the topic of DV among Indian samples found significant gaps and inconsistencies in the published literature on DV in India. These include varying methodological designs used by included studies, a lack of studies on older women populations, tribal populations, and those in same-sex relationships and a lack of studies measuring the impact of DV on physical health (Kalokhe et al., 2017).

Methodological research gaps also include a dearth of in-depth, qualitative accounts of the lived experiences of DV, coping and rehabilitation (Kalokhe et al., 2017). Studies have predominantly used quantitative, cross-sectional survey designs to measure the severity and prevalence of DV and its psychopathological consequences, antecedents, or correlates. Studies such as Jain et al. (2004) which have used qualitative data collection techniques such as focus group discussions have analysed the data using descriptive statistics and other quantitative techniques. Other methodological concerns are the lack of homogeneous research designs and uniform assessment techniques which could allow comparability between studies to provide a deeper understanding of the mental health impact of DV (Kalokhe et al., 2017).

There is a paucity of research detailing the rehabilitation of the DV survivors in the Indian context. The evidence for the negative mental health consequences of exposure to DV, supplemented by the growing concern over the rates of crime and violence against women in India, particularly in the domestic setting suggest that the rehabilitation of DV survivors is a public health priority in India. Personal correspondence with professionals who work with these populations revealed that various forms and adaptations of CBT, exposure therapy, supportive counselling and group therapy are used in clinical and community settings. However, there is no way to determine treatment fidelity and whether these interventions are efficacious or effective in this setting. The cultural relevance and applicability of these interventions developed predominantly for Western populations has been questioned (Bracken et al., 1997; Vijayakumar et al., 2006). Understanding culture-specific responses to global interventions are necessary to the betterment of clinical practice and rehabilitation of survivors who manifest PTSD, depression, and anxiety among other psychopathological responses to DV exposure.

1.3 Posttraumatic Stress Disorder

Defining psychological trauma (interchangeably used with *trauma* in this thesis) has proved fundamentally challenging owing to its multidimensional nature. There is a significant disparity in magnitude, complexity, frequency, duration, predictability, and controllability of traumatic stressors, an issue further complicated by the issue of *subjectivity* in perception (Weathers & Keane, 2007). An early definition of psychological trauma by Kardiner (1941) suggests that it is an externally imposed

situation that overwhelms the host's defences to manage an unmanageable situation; thereby emphasizing the role of the individual or host in its manifestation.

Schauer et al. (2011) define psychological trauma as the 'experience of and the psychological impact of an event that is life-threatening or carries a severe danger of serious injury.' (p. 7). In this definition, the complexity lies in the subjective nature of trauma appraisal, wherein the notions of 'life-threatening', 'severe danger and 'serious injury' can vary significantly from person to person. This is in line with Kardiner's emphasis on the subjective meaning of trauma.

The concept of 'traumatic stressor' has increased in its breadth and inclusivity today, compared to the 1980s when it was first included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; APA, 1980; DSM-III-R 1987). At that time, the concept of *trauma* was confined to catastrophic events that fell outside the perimeter of everyday experience (Rosen, 2008) but has been modified to include a wide range of stressors to fully encompass the experience of traumatic stress in the most recent edition of the DSM.

Today, PTSD as a construct incorporates disparate types of trauma such as war and combat, sexual assault, and natural disasters by recognizing the commonalities in the core aspects of psychological trauma and its devastating aftermath (Weathers & Keane, 2007). However, the diagnosis of PTSD has undergone significant changes and development since DSM-III, owing to issues around definitions and conceptualisations of its core elements.

1.3.1 DSM Classification and symptomatology

A historical account of trauma psychopathology and PTSD is beyond the scope of this thesis. PTSD was defined as a construct for the first time in 1980 in DSM-III (APA, 1980). In the most recent classification, the DSM-V categorises PTSD under a diagnostic cluster called Trauma and Stressor-Related Disorders, alongside other disorders that involve the exposure to a traumatic or stressful event as a diagnostic criterion such as reactive attachment disorder, disinhibited social engagement disorder, ASD, and ADs (APA, 2013).

According to the DSM-V, for a diagnosis of PTSD following exposure to one or more traumatic events, the development of characteristic symptoms such as intrusion symptoms, persistent avoidance, negative alterations in mood and cognition, and marked alternations in arousal and reactivity is mandatory. Symptoms typically become apparent in the first 3 months of experiencing the traumatic

event, though in some cases, symptoms that meet the full criteria for a diagnosis may take months or even years to fully manifest. This is referred to as 'delayed expression' in the DSM-V (APA, 2013).

Other symptoms that are not central to the diagnosis, but commonly manifest in individuals include, but are not restricted to heightened reactivity to unexpected stimuli, concentration difficulties, problems with sleep onset and maintenance, aggressive verbal or physical behaviours, recklessness, and self-destructive behaviour (APA, 2013). The DSM-V also acknowledges the presence of the 'dissociative subtype' of PTSD in patients who demonstrate overmodulation of emotions (Friedman et al., 2011). When making a diagnosis of PTSD, it is necessary to specify whether dissociative symptoms such as *depersonalizatio*n (persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or *derealization* (persistent or recurrent experiences of unreality of surroundings) are present.

PTSD is associated with high levels of impairment across social, occupational, interpersonal, educational, and physical health (APA, 2013). Individuals with PTSD are at a heightened risk of comorbid mental conditions such as depressive disorders, bipolar disorder, anxiety disorders, or substance abuse disorders (Brady, 1997; Breslau et al., 1991; Helzer et al., 1987; Kessler et al., 1995; Shore et al., 1989).

The DSM-V finds that the highest rates of PTSD are found among rape survivors, combat veterans and victims of captivity, and survivors of ethnically or politically motivated internment or genocide (APA, 2013). Women demonstrate a higher prevalence of PTSD symptomatology following trauma exposure, while less likely to report trauma exposure (Tolin & Foa, 2008). Studies have also demonstrated that controlling for experienced distress accounted for gender differences in fulfilling criteria for PTSD diagnoses (Frans et al., 2005; Lilly et al., 2009).

1.3.2 PTSD prevalence

Using the DSM-V criteria, the 12-month population prevalence for PTSD is about 3.5% in the United States of America (APA, 2013). The projected lifetime risks for the same population at age 75 is 8.7%, which refers to the proportion of a population that might become develop PTSD at any point in their lifetime. For Europe and most Asian, African, and Latin American countries, prevalence estimates are much lower, clustering around 0.5%-0.1% (APA, 2013). The highest rates of PTSD are found among rape survivors, military combatants and survivors of ethnically and politically motivated

internment and genocide (APA, 2013). When rates of trauma exposure are similar, the conditional probability of developing PTSD could vary significantly between diverse cultural groups. There are several plausible reasons behind this disparity. First, it could be due to variability in reaction to trauma exposure, which means that certain socio-cultural contexts, ethnic and racial groups are more prone to the development of post-trauma mental illnesses. Second, cultural variability could also be due to a differential response to disorder criteria (Hinton et al., 2011). As Summerfield (1999) notes, PTSD was a medical response to the mental health and other related issues of a particular group (Vietnam war veterans) at a particular time, in a particular socio-cultural context (USA) which is primarily Western in its ethical, moral and socio-political set-up. The disorder criteria that were developed to govern the diagnosis of PTSD and the decades of research that followed were all primarily conducted keeping a similar population and condition in mind. How this applies to a context largely dissimilar in terms of type and severity of exposure, socio-cultural, political, and economic setup and racial and ethnic make-up, is a point of contention.

1.3.3 Cross-cultural PTSD

Cultural variability in the risk and onset of PTSD may be due to factors such as variations in the meaning attributed to the traumatic event, the ongoing socio-cultural context and other factors. Since DSM-III, researchers have argued that PTSD is a 'timeless phenomenon', dating back to Homer's Iliad, to the Great London Fire of 1666, or the US Civil War (Jones et al., 2003). However, Eisenbruch (1991) stressed the importance of the role of culture when trying to define and measure complex human experiences that are closely associated with trauma. Young (1995) argued for the influence of the cultural milieu in the 20th Century in shaping the PTSD construct -

> *"The disorder is not timeless… Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated and represented and by the various interests, institutions, and moral arguments that mobilised these efforts and resources" (Young, 1995; p. 5)*

War pension files of UK servicemen post 1854 were studied to evaluate the validity of the 'timelessness' and 'universality' of the PTSD phenomenon by Jones et al. (2003). Flashbacks, a core PTSD symptom, were virtually non-existent before WW1, and sparsely evident in WW2. Somatic symptoms such as headaches, tremors, abdominal and chest pain etc. appeared more frequently in

presentations of post-trauma illnesses before the 20th century (Micale, 1990), and continued to be reported as the most common symptoms among British soldiers in WWI (Bracken, 2001). In comparison, records from the 1990 Gulf War demonstrated a significantly higher incidence of PTSD cases that would meet today's criteria. Jones et al. (2003) used this evidence to support Young's (1995) contention that the current manifestation of PTSD is influenced by contemporary cultural factors that govern today's world. Similarly, Bracken (2001) suggested that the reactions to trauma that characterize PTSD in Western societies, such as a 'loss of meaningfulness' are embedded in the culture of post-modernism and cannot be construed as being universal reactions to trauma. He argued that PTSD must be seen as a product of *trauma and culture* acting together, positioning it as a disorder of our times.

1.3.3.1 ***PTSD: A tyranny of Western expertise***

A lot has been written about the 'tyranny of Western expertise' in trauma research and practice. Bracken, Giller, & Summerfield (1997) noted that all knowledge of trauma and its rehabilitation was at that time, "located firmly within the framework of Western psychology and psychiatry" (p. 7). These disciplines are based on traditional assumptions of objectivity, medicalisation and value neutrality which may or may not reflect the cultural framework in a non-Western context.

Epidemiological studies have also illustrated the role of demographic variables such as race in determining trauma experiences (Bromet, Sonnega, & Kessler, 1998; Breslau, 2002). Kirmayer (1996) cautioned against ignoring the social and cultural embedding of distress by highlighting the tendency towards somatizations and dissociation as typical responses to trauma in non-Western societies.

Summerfield (1999) rejected the universality of Western notions of the typical human response to a stressor and discussed why Western-led interventions that constitute emotional ventilation and talking therapies may not always be the best approach in different settings. By drawing upon evidence from research conducted with Rwandan war victims and refugees among other non-Western societies, Summerfield described posttraumatic stress or PTSD is a 'pseudo-condition' for a majority of survivors as a result of the medicalisation of distress and the reframing of war-related suffering as a pathological entity to which short-term solutions like counselling apply.

These arguments have received support from Wessells (1999), who noted the practical shortcomings of Western disaster interventions in developing countries. He discussed the appropriateness of

harnessing local expertise over interventions led by Western science following trauma exposure. Summerfield (1991) had previously highlighted the complex interplay of political, socioeconomic, and cultural forces that operate in a particular region where interventions are planned. He endorsed the value of unique, indigenous, and community-based interventions as opposed to generalisable, technical and targeted interventions.

1.3.3.2 **PTSD: A universal trauma response**

The above position is contrasted by the works of several researchers who support the notion of a universal PTSD construct. (Herman, 1997, 1992) argued that the phenomenon of psychological trauma and PTSD has always existed but attempts to explore these subjects in the late 19th and early 20th centuries were abandoned due to the lack of wider support. Hinton & Lewis-Fernández (2011) found substantial evidence of the cross-cultural validity of PTSD. The authors reviewed research across a range of cultural contexts to examine the validity of the DSM-IV-TR's PTSD diagnosis criteria, i.e., the hallmark clusters of re-experiencing, avoidance/numbing, and arousal. Studies included in their review were set in diverse settings such as Cambodia, Tibet, Vietnam, Ethiopia, Palestine, Nigeria, South Africa, South Korea and minority populations in Europe and America. Various types of validity were explored, including biomarker validity, general and trauma-specific causal validity, structural validity, and content validity. A synthesis of the findings suggested that while the DSM-IV-TR PTSD category is a cross-culturally valid construct, further research on diverse populations is required to strengthen its applicability on these populations. This includes an exploration of the relative universality of the avoidance/numbing symptoms, the value of including somatic symptoms as a separate cluster, and the role of interpretation of trauma and symptoms in the onset of, and recovery from illness.

Schauer et al. (2011) have further endorsed the concept of a 'universal trauma response'. They argue that current epidemiological research and research into the neurobiological substrates of PTSD have offered strong arguments for the cultural universality of PTSD. Neuner & Elbert (2007) have warned against the dangers of withholding knowledge and advancements in the field from non-Western and non-industrialised countries, who in their view, have already chosen to adopt and adapt Western, Eurocentric mental health concepts and corresponding treatment methods. The authors have argued that denying access to modern progress and scientific innovations (such as in the field of PTSD) could further widen the knowledge and treatment gaps between countries.

Despite the controversy around the validity of the PTSD construct in non-Western settings like India, the construct has nonetheless been a useful means to identify people in need of psychosocial care following trauma exposure (Pillai et al., 2016). This is reinforced by Schauer et al.'s (2011) perspective on the need for knowledge transfer between Western and non-Western contexts regarding the universal applicability of the PTSD construct and treatment protocol.

1.3.4 Trauma and PTSD in India

India is a lower-middle-income country situated in South Asia. It is the world's largest democracy, with a population of nearly 1.3 billion (*India Overview*, 2019). India is considered one of the most ethnically diverse and complex societies in the world (Manor, 1996). This 'wealth of diversity' is considered to be a contributing factor to the high risk of trauma exposure (Gilmoor et al., 2019). Due to the geographical vastness of the country, India is susceptible to various types of natural disasters such as earthquakes, floods, cyclones, and tsunamis. There is also a considerable risk for man-made disasters such as industrial accidents, communal conflicts, terror attacks, and other forms of interpersonal and organised violence (Pillai et al., 2016; Rasmussen, 2013). Researchers have argued for a high degree of variability in cultural perceptions of trauma exposure owing to factors such as unique cultural norms, collectivist nature of society, external locus of control, and desensitization to trauma in a setting like India (Pillai et al., 2016). Nevertheless, trauma psychopathology is a legitimate concern owing to the high risk of trauma exposure

1.3.5 The construct of PTSD in India

Mehta, Vankar, & Patel, (2005) assessed the validity of PTSD on women survivors of communal violence through qualitative interviews and found that core symptoms of PTSD such as avoidance, hyperarousal and re-experiencing behaviours were present. Kar et al. (2006) reported vivid flashbacks, nightmares, persistent avoidance, and numbing in their sample of natural disaster survivors. Other studies on natural disasters have found that survivors report core PTSD symptomatology including flashbacks and intrusion symptoms (Tharyan, 2005; Kar et al. 2007), and hyperarousal and panic symptoms (Rajkumar, Premkumar & Tharyan, 2008). Gilmoor et al. (2019) reported avoidance symptoms were significantly underreported in at least four studies when compared to other trauma symptoms, the contrary was true in an equal number of studies reviewed. Prevalence studies conducted on diverse trauma samples have found evidence of PTSD symptoms

such as hyperarousal, avoidance, intrusions and recurring thoughts (Chadda et al., 2007; Kumar et al., 2007; Sharan et al., 1996). Disparate findings can be attributed to varying assessment methods and research designs employed across studies. These findings indicate the presence of hallmark PTSD symptoms according to DSM classifications in clinical presentations of PTSD in India.

1.3.6 PTSD prevalence studies

The most recent, large-scale prevalence estimates of PTSD was conducted by the National Institute of Mental Health and Neuro Sciences (NIMHANS) on a representative sample of 34,802 individuals in 12 Indian states (Gururaj et al., 2016). The ICD-10 DCR (WHO, 1993) weighted prevalence estimates for PTSD at the time of the survey was 0.24%. However, individual prevalence studies present highly varying estimates of prevalence ranging from 0.6.% to 70.7%.

A brief review of Indian studies on PTSD prevalence in adult, trauma-exposed populations is presented in Table 1-1. These studies include exposure to a range of diverse traumas including natural disasters, armed conflict, mass violence, terror, abuse and violence, and road traffic accidents. Considering the widespread prevalence of DV and gender-based violence documented in India, only two studies provided an estimate of PTSD prevalence in DV victims and survivors (see Table 1-1).

Table 1-1 PTSD prevalence studies in India

Adult Studies		
Bhat & Rangaiah (2015) **Location:** Kashmir	**Exposure:** Armed conflict (N=797) **PTSD measure:** NA	**Findings:** -- **PTSD symptoms reported by 49.81% of the sample**
Kar et al. (2014) **Location:** Tamil Nadu	**Exposure:** Natural disaster (tsunami) (N=666) **PTSD measure:** Self-Rating Scale for PTSD (SRS-PTSD)	**Findings:** -- Surveyed 4.5 years post-exposure -- **PTSD prevalence of 70.9% was found**

Shoib et al. (2014) **Location:** Kashmir	**Exposure:** Natural disaster and mass violence, conflict, and terror (N=3400) **PTSD measure:** Structured interview based on DSM-IV-TR criteria, CAPS	**Findings:** -- **Estimated PTSD prevalence was 3.76%**
Shah (2013) **Location:** Gujarat	**Exposure:** Natural disaster (earthquake) (N=2498) **PTSD measure:** Modified PTSD rating scale	**Findings:** -- Survey was conducted at one and 10 months post-exposure -- **PTSD prevalence of 89.7% found at one month** -- **PTSD prevalence of 10% found at 10 months**
Ishikawa et al. (2012) **Location:** Ladakh	**Exposure:** Natural disaster (floods) (N=318) **PTSD measure:** Semi-structured interview based on DSM-IV-TR criteria	**Findings:** -- Survey conducted one month post-exposure -- **Significantly low estimates of PTSD at 0.6% was found** -- Strong influence of local cultural factors such as widespread social support and religiosity were implicated for low symptom prevalence
Chandra et al. (2009) **Location:** Karnataka	**Exposure:** Survivors of DV (N=105) **PTSD measure:** Post-traumatic Symptom Checklist (PCL; Blanchard, 1996; Weathers et al., 1993)	**Findings:** **-- 14% of women with IPV exceeded cut-off scores for PTSD** **-- 20% exceeded cut-off scores for sub-threshold PTSD**
Tichy et al. (2009) **Location**: Tamil Nadu	**Exposure:** Survivors of DV (N=64) **PTSD measure:** Post-Traumatic Screening and Diagnostic Scale (PSDS; Kubany, 2004)	**Findings:** **-- 37% of sampled women suffered from chronic PTSD** **-- 25% of sampled women suffered from acute PTSD**
Kumar et al. (2007) **Location:** Tamil Nadu	**Exposure:** Natural disaster (tsunami) (N=314) **PTSD measure:** Harvard Trauma Questionnaire, algorithms based on DSM-IV	**Findings:** -- **PTSD prevalence of 12.7% was found** -- Commonly reported symptoms included recurring thoughts and disturbed sleep

Chadda et al. (2007) **Location:** Jammu & Kashmir	**Exposure:** Natural disaster (earthquake) (N=450) **PTSD measure:** Clinical assessment based on ICD-10 criteria	**Findings:** -- Surveyed within six weeks of exposure -- **PTSD diagnostic prevalence of 3.3%** -- Over **66% presented with PTSD-like symptoms** such as hyperarousal, persistent anxiety, and sleep disturbances
Seethalakshmi et al. (2006) **Location:** Maharashtra	**Exposure:** Road traffic accidents (N=30) **PTSD measure:** IES	**Findings:** **-- PTSD symptoms reported by 20% of inpatients studied**
Kar et al. (2004) **Location:** Orissa	**Exposure:** Natural disaster (super cyclone) (N=540) **PTSD measure:** IES, Post Traumatic Symptom Scale (PTSS)	**Findings:** -- **PTSD prevalence of 44.2% was found**
ICMR (2000) **Location:** Maharashtra	**Exposure:** Natural disaster (earthquake) (N=2498) **PTSD measure:** Modified self-reporting questionnaire	**Findings:** -- Survey was conducted 18 months post-exposure -- **A low PTSD prevalence of 1.28% was found** -- Low estimates were attributed to the time elapsed between exposure and testing
Sharan et al. (1996) **Location:** Maharashtra	**Exposure:** Natural disaster (earthquake (N=56) **PTSD measure:** Semi-structured interviews based on DSM-III criteria for PTSD	**Findings:** -- PTSD emerged as the most prevalent diagnosis -- **23% of those sampled presented with PTSD** -- **11% of the sample presented with sub-syndromal symptoms** of avoidance, hyperarousal, and intrusions

Abbreviations: *IES – Impact of Events Scale; DSM – Diagnostic and Statistical Manual of Mental Disorders, DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition; DSM-IV-TR - Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Revised; ICD-10 - International Classification of Diseases 10th Edition; ICD 10 DCR International Classification of Diseases 10th Edition*

There was a preponderance of studies conducted in the aftermath of natural disasters. Overall, studies vary significantly in determining prevalence estimates in samples exposed to similar/identical traumatic experiences. This disparity could be attributed to varying severity of the trauma exposure

and proximity to trauma, sampling methods, use of different assessment measures (including use of diagnostic interviews vs. self-report symptom scales), length of time elapsed between exposure and data collection, and participant demographics such as age, gender and socioeconomic background (Contractor et al., 2014; John et al., 2007; Kar et al., 2001). Gilmoor et al. (2019) reviewed 56 studies conducted on PTSD in India and found 17 different types of traumatic events studied, 25 different methods for PTSD screening used, various cut-off values used to determine diagnostic status, and a diverse group of researchers administering screening and diagnostic tools. The time elapsed between trauma exposure and data collection varied from immediately after the event, to as late as 35 years following the event (Gilmoor et al., 2019). It is difficult to synthesize and interpret the findings from such a heterogeneous body of knowledge to arrive at a clear conceptual understanding of PTSD prevalence in India.

Studies in this setting have also found that PTSD is significantly comorbid with symptoms of anxiety and depression in several studies (Chadda & Malhotra, 2006; Kar et al., 2007; Math et al., 2008; Sharan et al., 1996; Vijayakumar et al., 2006; Yaswi & Haque, 2008). Alcohol abuse was also found to correlate with PTSD diagnosis (Shoib et al., 2014). The prevalence of somatic symptoms is also routinely reported including headache, sleeplessness, abdominal pain, decreased appetite and fatigue (Crescenzi et al., 2002; Kar et al., 2007; Shoib et al., 2014; Terheggen et al., 2001; Vijayakumar et al., 2006; Yaswi & Haque, 2008). This reinforces Hinton et al.'s (2011) recommendations for the consideration of cross-cultural differences in salience and presentation of somatic symptoms in trauma populations.

These findings from India do not entirely conform to the notion that PTSD is a purely Western phenomenon. Comparable prevalence estimates, presence of core symptomatology and presentation with comorbidities are indicative of the fact that PTSD is a plausible clinical phenomenon which needs to be adequately explored and understood in the Indian socio-cultural context to aid rehabilitation efforts (Pillai et al., 2016).

1.3.7 Psychological processes and models of PTSD

An understanding of the psychological processes and theoretical models underlying disorders on the trauma spectrum such as PTSD is relevant to this thesis, especially regarding treatment and rehabilitation.

1.3.7.1 **Memory systems and functioning**

Changes in memory functioning are key to the presentation of PTSD and treatment response (Brewin & Holmes, 2003; Van der Kolk et al., 1994). Fundamentally, different kinds of 'memory systems' operate to make up our knowledge and understanding of ourselves, our experiences and the world (Foster & Jelicic, 1999). There are interrelated yet distinct conceptualisations of the various memory systems that are closely associated with our understanding of psychological trauma.

The distinction between *declarative* or explicit memories and *non-declarative* or implicit memories is crucial to understanding how trauma memories are encoded and activated (Squire, 1994). Declarative memories are memories of personal events, facts, and knowledge of the world, which can be deliberately retrieved and articulated, as necessary. Nondeclarative memories refer to skills, habits, emotional associations and conditioned responses that do not require conscious recollection and are not deliberately retrieved (Squire, 1994).

1.3.7.2 **Sensory-perceptual representations**

According to Tulving (1972, 2001), two of the main subsystems of *declarative* memory are episodic memory and semantic memory. Episodic memory refers to our memory for personally experienced events or the memory of what happened where and when whereas semantic memory refers to our knowledge base or memory for general facts of the world (Tulving, 2001). Episodic memory is closely connected to 'recollective experiencing', which is the ability to consciously re-experience previous events in the form of a sensory-perceptual representation of that event. This refers to the vivid, detailed recollections of sensory information and the sequential and contextual nature of that event.

Episodic memories are considered to be mostly sensory-perceptual representations in nature (Conway & Pleydell-Pearce, 2000). These representations contain information stored in different sensory modalities such as visual, tactile, auditory and olfactory, and allow for the recollective experience to take place (Conway & Pleydell-Pearce, 2000). These event-specific, experience-near memories are only expected to last a short period (minutes or hours) unless they are stored in a

highly emotional state (Conway & Pleydell-Pearce, 2000). In such cases, they endure in memory by becoming linked to more permanent memory or knowledge structures.

1.3.7.3 **Autobiographical memory system**

Conway & Pleydell-Pearce (2000) defined autobiographical memory as a 'general-purpose, long-term memory knowledge base that includes all types of declarative knowledge (p. 272). Autobiographical memory systems are closely related to Tulving's (1972, 2001) conceptualisation of episodic memory, but a clear distinction involves the introduction of the temporal duration of each system; episodic memories are short while autobiographical memories are longer lasting (Tulving, 2001). When short-term sensory-perceptual episodic memories of an event are perceived as significant, they become linked to a more permanent, long-term memory structure, i.e., autobiographical memory (Schauer et al., 2011).

These independent, yet overlapping conceptualisations of memory systems have led to an explanation of how experience-near, detailed, sensory-perceptual representations of experiences are integrated and consolidated within larger, more long-lasting autobiographical memory knowledge structures (Conway & Pleydell-Pearce, 2000).

1.3.7.4 **Trauma memories**

While memories of an event or experience may be stored as declarative memory, elements of the memory may also be stored as a nondeclarative memory in that they are not accessible to conscious retrieval. Instead, they can be activated by environmental or internal cues involuntarily and without conscious effort, as in the case of intrusion symptoms (Schauer et al., 2011). Intrusion symptoms are a core feature of PTSD. They consist of vivid, fragmented, recurrent, involuntary, and distressing memories, dreams, or flashbacks, in which the individual *reexperiences* the traumatic event as if it is occurring in the present moment (APA, 2013). Reexperiencing or flashbacks are often triggered by cues and reminders that are reminiscent of the traumatic experience(s).

Traumatic memories are processed and stored differently from memories of everyday events or non-traumatic, stressful events or experiences which results in intrusion symptoms. Although the individual reexperiences the event through sensory-perceptual representations which are vivid and long-lasting, they may not be able to translate the experiences into communicable language and explicit/declarative recall period due to the lack of autobiographical structure and context (Conway &

Pleydell-Pearce, 2000). The result is a disorganised, distorted narrative of events, with a high tendency for flashbacks and involuntary, intrusive recollections. As a result, the verbal or declarative recollection of a traumatic event is often incoherent, incomplete, or inaccurate (Brewin & Holmes, 2003; Van der Kolk & Fisler, 1995). In a review of 46 studies, Van der Kolk & Fisler (1995) differentiated highly stressful memories from traumatic memories to show that traumatic memories are dissociated, distorted and fragmentary while lacking in a coherent semantic component. In sum, although the individual's sensory-perceptual representations (hot memories) of the traumatic event(s) are strong, detailed and easily activated, there is a lack of a reliable autobiographical memory structure (cold memories) within which these representations are situated. This results in highly intrusive, arousing recollections of the event(s), without the ability to narrate the event(s) consistently, coherently, and sequentially (Schauer et al., 2011).

This overall understanding of trauma memories has clear treatment implications. Foa et al. (1995) demonstrated that through exposure therapy, a coherent, chronological narrative can be developed, wherein the main focus of therapy is on the most fragmented aspect of the autobiography, and the most intensively represented sensory-perceptual details (Schauer et al., 2011). By reliving the memories that are most prone to intrusive recollections and flashbacks (non-declarative memory), one can activate sensory-perceptual representations with detailed knowledge that is not yet available in the declarative memory.

The sections below will elucidate concepts from relevant PTSD models that have contributed to a comprehensive understanding of PTSD and treatment protocols such as NET.

1.3.7.5 **Emotional processing theory**

Emotional processing theory (EPT) was put forth by Foa and colleagues based predominantly on research with rape and assault victims (Foa & Kozak, 1986; Foa & Riggs, 1993; Foa & Rothbaum, 1998). EPT was an elaboration of Lang's associated model of emotion, which proposed that information about a feared stimulus is accompanied by associated verbal, physiological, sensory, and behavioural responses as well as interpretative information such as the degree of threat (Foa et al., 1989; Lang, 1977, 1979). When the information in the fear network does not accurately represent the threat of danger/harm, or when the activation of the fear network is in response to non-threatening stimuli, it may be considered pathological (Foa & Kozak, 1986). When it is pathological, the fear

network involves (i) excessive response elements such as avoidance and hyperarousal, and (ii) resistance to modifications due to persistence of fears (Foa & Kozak, 1986).

Foa et al. (1989) extended Lang's (1979) fear network theory of anxiety disorders to explain the development and maintenance of PTSD symptoms. The size of the fear structure in PTSD patients is unusually large with a wide range of neural elements (sights, sounds, smells, emotions, physical sensations) coded in an associated manner (Foa et al., 1989). This results in a low threshold for activation of the fear/trauma network in the case of PTSD, which is not entirely available to conscious awareness. The interconnectedness between the various elements of the fear/trauma network is especially powerful, suggesting that the activation of a single element (such as smell) can activate the entire fear/trauma network (Schauer et al., 2011).

EPT also explains the link between cognition and affect, implicating the role of pre-trauma beliefs and views as crucial to the development of PTSD (Foa & Rothbaum, 1998). Individuals with more rigid pre-trauma positive and negative views about the self and the world are at a greater risk for developing PTSD. EPT also considers the role of peri- and posttraumatic negative appraisals of trauma responses, symptoms, and behaviours in the development of chronic PTSD. Peritraumatic dissociative symptoms are associated with higher levels of fragmentation and disorganization in the trauma narrative. This assumes that the cognitive processes of attention and memory are disrupted at the time of trauma experience, which produces dissociative states. As a result, the trauma narrative is disjointed and fragmented and is resistant to modification. This prediction has received empirical support from studies of both self-reported and expert-rated measures of narrative disorganisation (Halligan et al., 2003; Harvey & Bryant, 1999; Murray et al., 2002).

EPT has significant treatment implications. It led to the development of PE therapy, which is currently recommended as a first-line treatment for PTSD (Cooper et al., 2017; Foa et al., 2007). Foa & Kozak (1986) identified the mechanism of *emotional processing* in the modification of the fear/trauma network which is on two conditions: (1) activation of the fear structure and (2) incorporation of safety information that is incompatible with the pathological fear structure (Foa et al., 1989). This allows for the modification or extinction of the pathological fear structure by weakening erroneous associations or acquiring new associations through repeated exposure, also known as habituation (Foa et al., 2006) and is critical to recovery from a traumatic event (Foa, 1997). Other factors include a change in

trauma-related cognitions (about the self, about the world), and the level of organisation of trauma narratives (Foa et al., 2006).

The lack of consistent empirical support for some of EPT's hypothesised mechanisms of change, especially that of narrative organization has been noted (Brewin & Holmes, 2003; Cooper et al., 2017). Alternatively, strong evidence was found for mechanisms of belief change and between-session habituation, both of which are implicated by EPT as crucial to PTSD.

1.3.7.6 **A cognitive model of PTSD (Ehlers & Clark, 2000)**

Ehlers & Clark (2000) developed a comprehensive PTSD theoretical model to explain the maintenance and treatment of PTSD. They expanded on EPT's focus on the relevance of negative appraisals. Several different types of appraisal have been theorised as crucial to the development of PTSD, including the appraisal of the traumatic event, own actions, other people's reactions, life prospects and the over-generalisation of danger. According to Ehlers & Clark (2000), negative appraisals have a basis in pre-trauma beliefs and expectations as well as peritraumatic thought processes. In a study on responses to intrusive symptoms in ambulance workers, negative interpretations of post-traumatic intrusions correlated with PTSD symptom severity (Clohessy & Ehlers, 1999). This finding was replicated in several other studies (Dunmore et al., 1999; Halligan et al., 2003; Steil & Ehlers, 2000)

In their cognitive model, Ehlers & Clark introduced the novel concept of 'mental defeat', or a perceived loss of autonomy or humanity or perception of the self as being weak, inferior, and unworthy as a crucial risk factor for developing negative self-appraisals. There is evidence in support of the role of mental defeat in predicting persistent PTSD symptoms (Dunmore et al., 1999, 2001a; Ehlers et al., 2000). Other risk factors implicated in the development and maintenance of PTSD include prior victimisation, feelings of helplessness or weakness which are supported by a growing body of empirical evidence (Brewin & Holmes, 2003).

Ehlers & Clark's cognitive model also places significant importance on the peritraumatic processing of trauma. Two distinct mechanisms are put forth: data-driven processing and conceptual processing. According to Ehlers & Clark (2000), data-driven processing, which is focused on sensory-perceptual impressions of the traumatic event(s) is a risk factor for developing PTSD. In instances of data-driven processing, the event is poorly incorporated into the autobiographical memory system without

encoding spatial and temporal information. This results in a memory that is hard to consciously retrieve and is susceptible to strong perceptual priming, or the involuntary activation of responses to similar internal and external cues. This aspect of the theory can explain the core PTSD symptom of intrusive re-experiencing.

Alternatively, conceptual processing is focused on attributing meaning and organisation to the experiences and attributing context which facilitates the integration of the trauma memory into the autobiographical memory system. This results in a memory that is well-organised and contextualised and can be intentionally retrieved and communicated.

Ehlers & Clark (2000) also implicated a range of maladaptive cognitive coping styles (selective attention to threat cues, rumination, or dissociative responses) and cognitive strategies (active thought suppression, avoidance, distractions, and adoption of safety behaviours to prevent or minimise negative outcomes) in the maintenance of PTSD symptoms (Clohessy & Ehlers, 1999; Dunmore et al., 1999; Steil & Ehlers, 2000). There is evidence to support the link between PTSD symptoms and rumination (Clohessy & Ehlers, 1999; Murray et al., 2002; Steil & Ehlers, 2000; Szabo et al., 2017) and peritraumatic dissociation (Halligan et al., 2003; Murray et al., 2002). However, several reviews have highlighted the methodological constraints of this evidence base (Candel & Merckelbach, 2004; Van Der Hart et al., 2008).

Overall, Ehlers & Clark's (2000) cognitive model of PTSD posits that when individuals process trauma in a way that leads to a sense of current threat (data-driven processing), there is a high risk of developing persistent symptoms. With good research backing for several postulations of this model, there are comprehensive implications for treatment in the form of cognitive-behavioural techniques. Ehlers et al. (2003) demonstrated that treatment based on the cognitive model was highly effective. The cognitive-behavioural treatment targets excessively negative appraisals of the trauma and its sequelae, as well as autobiographical memory distortions and fragmentations, characterised by poor elaboration and contextualisation, strong associative networks, and perceptual priming. This treatment also targets maladaptive cognitive and behavioural strategies that play a role in persistent PTSD.

EPT and the cognitive model of PTSD show a strong overlap in identifying the important role of cognitive and affective factors in the development and maintenance of PTSD symptoms. There is a

clear consensus on the treatment implications of imaginal reliving in aiding the elaboration and contextualisation of trauma memories. The tenets of these models have led to the development of highly evidence-based treatment protocols for PTSD, PE (Foa et al., 2007) and cognitive therapy.

1.3.8 PTSD Treatment

The clinical presentation of PTSD is complex and heterogeneous, with a range of comorbidities ranging from depressive and anxiety disorders to severe psychotic or somatic symptomatology (APA, 2013). Treatment goals are various, from reducing PTSD symptom severity such as intrusion and hyperarousal symptoms to preventing and/or treating comorbidities. This has implications for treatment protocol, resulting in a range of recommended first- and second-line pharmacological and psychotherapeutic treatment techniques, and sometimes a combination of both (Hamner et al., 2004).

The aetiology of PTSD is fairly well-grounded in theory (*section 1.3.7*), so psychotherapeutic treatment strategies for PTSD have received significant research interest in the last 25 years (Solomon & Johnson, 2002). Several evidence-based approaches are efficacious in targeting specific PTSD symptoms in a range of trauma populations. Reviews of PTSD treatments show that active, 'bonafide' psychotherapeutic treatments for PTSD are highly effective and perform significantly better than waitlist controls (WLC) (Benish et al., 2008; Cloitre, 2009).

Clinical guidelines for PTSD treatment such as the American Psychological Association, Department of Veterans Affairs and Department of Defense (VA/DoD), International Society for Traumatic Stress Studies (ISTSS), and NICE routinely update their recommendations for first- and second-line treatments for PTSD in keeping with updated research evidence for efficacy and effectiveness in alleviating symptomatology. The 2018 NICE recommendations highlight CBT, CPT, PE therapy and NET as first-line treatment options for PTSD (NICE, 2018). In 2017, the American Psychological Association guidelines published strong recommendations for CBT, CPT, and PE (American Psychological Association, 2017). Similarly, VA/DoD found PE and Eye Movement Desensitization and Reprocessing (EMDR) to have the strongest evidence-base (VA/DoD, 2017). ISTSS also provided a strong recommendation for CPT, EMDR and trauma-focused CBT (ISTSS, 2018). The evidence-base for CBT, CPT, PE and EMDR appears to be strongest according to a range of recent publications for PTSD clinical guidelines.

Cognitive-behavioural interventions have received the most research attention over the years and is quite consistently effective in alleviating symptoms of PTSD across trauma populations (Bisson et al., 2013; Bradley et al., 2005; Cahill & Foa, 2004; Foa & Meadows, 1997; Harvey et al., 2003; Kar, 2011; Solomon & Johnson, 2002). Several treatment programs fall under the umbrella category of cognitive-behavioural interventions, including PE therapy, CPT, trauma-focused cognitive behavioural therapy (TF-CBT), and stress inoculation training (SIT) (Bisson et al., 2013; Blankenship, 2017; Foa & Meadows, 1997).

Prolonged Exposure (PE) therapy: PE therapy (Foa et al., 1991, 2007) is an effective approach to treating PTSD symptoms owing to its strong evidence base (Powers et al., 2010; Rauch et al., 2012; Van Minnen et al., 2015). PE draws extensively from EPT and focuses on *in vivo* exposure and imaginal exposure, followed by emotional processing too aide recovery. PE has demonstrated large effects sizes in reducing symptoms of PTSD and comorbid depressive and anxiety disorders, substance abuse disorders, personality and psychotic disorders, pathological levels of anger, guilt, and negative health perceptions (Powers et al., 2010; Rauch et al., 2012; Van Minnen et al., 2015). Further, in their review, Rauch et al. (2012) highlighted the efficacy of PE in diagnostically complex populations, including survivors of both single- and multiple-incident traumas.

Cognitive Processing Therapy (CPT): CPT is also an exposure-based cognitive technique and was developed by (Resick & Schnicke, 1992) for treating PTSD symptoms in sexual assault victims. It was later adapted for use with veterans and military personnel (Monson et al., 2006; Resick et al., 2008). CPT relies on the general cognitive processes of assimilation of the reality of the trauma and accommodation of specific belief systems in effecting recovery from trauma symptoms. Developed specifically for PTSD, CPT includes activation of trauma memories in conjunction with conflicting and maladaptive beliefs, so that corrective information may be introduced. CPT was based on the presumption that the core PTSD symptoms were the result of conflicts between new information and prior schemata (Resick & Schnicke, 1992). A trial comparing CPT with PE found comparable, significant treatment effects using both interventions in survivors of female sexual abuse (Resick et al., 2002), a finding that has been established by several reviews (Najavits, 2015). Large effect sizes for the reduction of PTSD symptoms have also been found in veteran populations with military and

sexual trauma (Monson et al., 2006; Surís et al., 2013). CPT appears to show significantly greater likability and lesser harm to the patients when compared to PE (Borah, 2015).

Trauma-focused cognitive behavioural therapy (TF-CBT): TF-CBT was developed by Cohen et al. (2006) and is a variant of CBT integrated with trauma-sensitive interventions, aspects of attachment, developmental neurobiology, and humanistic theoretical models. TF-CBT was developed with a focus on treating traumatised children and adolescents but has also been used with adult populations.

Narrative Exposure Therapy (NET): NET is a short-form, exposure-based technique that heavily draws upon the theoretical underpinnings of Foa & Kozak's (1986) associated fear network model of PTSD, EPT (Foa et al. 1998) and Ehlers & Clark's cognitive model of PTSD (2000). It also incorporates elements of Testimony Therapy (Cienfuegos & Monelli, 1983) due to its original focus on treating PTSD symptoms in victims of war trauma and organised violence. Due to its relevance to this thesis, a detailed account of NET is presented in *section 1.4.*

Other protocols such as EMDR (Shapiro & Solomon, 2010; Shapiro, 1989, 2001), SIT (Meichenbaum 1975), and Dialectic Behavioural Therapy (DBT; Linehan, 1993) have been evaluated in the context of PTSD treatment but are beyond the scope of this thesis.

Despite their status as the first-line treatment for PTSD, there are some clear issues regarding the use of exposure-based therapies in routine clinical practice (Becker et al., 2004; Cook et al., 2004). Most cognitive behavioural and exposure techniques have relatively large dropout and nonresponse rates (Bradley et al., 2005; Najavits, 2015; Schottenbauer et al., 2008). There are also concerns regarding the safety of using exposure therapy with certain PTSD populations which are based on case studies conducted with veteran populations. Complications such as exacerbation of symptoms, emotional fallout and relapse of comorbidities were documented (Pitman et al. 1996; as cited in Cahill & Foa 2004). Clinicians have cited issues such as suicidality, dissociation, self-destructive behaviours and impulsivity as reasons for their resistance to the clinical utility of exposure therapy (Becker & Zayfert, 2001). Becker et al. (2004) reported clinicians' reluctance to use PE due to the risk of exacerbation of comorbid symptoms.

1.3.8.1 **Treatment of PTSD in India**

In India, there is a dearth of coordinated trauma response systems (Undavalli et al., 2014). A survey on trauma care offered by 50 institutions across India revealed that a large majority of facilities available (76%) comprised only of physiotherapy services; while there was a marked dearth of occupational and psychotherapeutic available at these institutions (Joshipura, 2008). Moreover, there is an absence of clear clinical guidelines for the treatment of any mental health illness including PTSD in India. This reflects a lack of research into empirically supported treatments for mental health conditions in India and a larger issue regarding healthcare demand and provision. In 2016, the National Mental Health Survey conducted by the NIMHANS identified an overall treatment gap of 83% for mental health conditions in India (Gururaj et al., 2016). On average, there are 0.3 psychiatrists per 100,000 people in India, which is similar to other lower- and middle-income countries (Patel et al., 2016). When the complex needs of PTSD patients are considered, there appears to be a lack of appropriately trained and regulated practitioners to address their specific needs.

Most of the treatment guidelines employed by Indian psychiatric care facilities are guided by Western protocols. Only a small number of studies have focused on the treatment of PTSD in India. Most have been conducted on disaster-affected populations (Descilo et al., 2010; Telles et al., 2010; Lakshmi Vijayakumar et al., 2006). The research consists largely of descriptive, experience accounts of unstructured, community-based, group or one-on-one psychosocial care efforts that various disaster management and non-governmental organizations have undertaken following trauma exposure in affected areas. There is a lack of detail regarding treatment protocol and outcomes measured in these accounts. Vijayakumar et al. (2006) detailed a psychosocial intervention on an ad-hoc basis to the provision of relief material to tsunami survivors, wherein relief workers were trained in counselling over 2 weeks. The authors reported significant improvements in symptoms such as emotional outbursts, lack of motivation, anxiety, depression and ASD after four sessions on an average, but it was unclear how these outcomes were measured. Chadda & Malhotra (2006) detailed their experience of providing psychiatric care for survivors of the earthquake survivors in the form of psychiatric assessment, medication, counselling, and psychoeducation. PTSD was not measured as an outcome due to the lack of prevalence, and no clear information regarding improvements on symptomatology was provided.

Descilo et al. (2010) applied a form of exposure therapy known as Traumatic Incident Reduction (TIR) in addition to a yoga-based breath intervention to treat tsunami survivors with a score of 50 or above on the Post-Traumatic Checklist (PCL-17; Weathers et al., 1993). Participants were flooded with cues associated with the traumatic experience to safely activate the fear response. Repeated activations were aimed at modifying and inhibiting the fear response. Non-randomised intervention and WLC groups were compared at 6 weeks post-intervention, with no significant differences observed between the breath intervention group and the breath + TIR groups. Both intervention groups significantly improved compared to WLCs, suggesting that improvements could not be attributed to TIR alone.

There is a dearth of rigorous research using adequately controlled designs to evaluate PTSD treatment protocols in India (Gilmoor et al., 2019; Pillai et al., 2016). The lack of empirically supported treatments for PTSD symptom reduction DV survivors is noteworthy. In the absence of indigenous, locally developed interventions, Vijayakumar, Kannan, Kumar, & Devarajan (2006) have questioned the relevance and applicability of typically Western interventions such as trauma-focused CBT, group CBT, and EMDR in the Indian socio-cultural context. They highlighted variables such as socioeconomic conditions, family structures and functions, religion, philosophy, and culture that differentiate endemic Indian and Western systems of thought and behaviour. This is in line with the generally accepted notion that the political, social, economic, and historical context can play a defining role in the manifestation of symptoms and adaptive behaviours in response to trauma exposure (Bracken et al., 1997; Perilla et al., 2002).

Understanding protective factors against the development of psychopathology in the aftermath of trauma exposure are valuable for rehabilitation efforts. Bhushan & Sathya Kumar (2007) reported community interdependence and societal and family bonds as buffering factors against the development of PTSD. Similarly, Dar et al. (2018) emphasized the importance of social support in mitigating the effects of trauma exposure. The role of religiosity and spirituality has also been highlighted as protective mechanisms against PTSD symptomatology (Ishikawa et al., 2012; Math et al., 2008; Rajkumar et al., 2008; Vijayakumar, 2016). India is a predominantly collectivistic society, which can either enhance resilience and coping (Kayser et al., 2008; Tharyan, 2005), or pose as a risk factor wherein individuals operate with an external locus of control (Suar et al., 2010).

Community-level workers who are familiar with the cultural context in effectively planning and delivering intervention should be involved, especially following exposure to large scale trauma such as natural disasters (K. Rao, 2006). Grounding interventions in the specific ethnocultural beliefs and practices that govern the Indian context has been stressed, to strengthen prevailing community coping strategies to facilitate recovery and reliably inform clinical practice (Rajkumar et al., 2008; Shah, 2013). Intervention studies in the context of abuse and violence have predominantly focused on using empowerment-based, culturally sensitive and community-based protocols that focus more on prevention and mitigation of abuse as opposed to treatment of survivors (Krishnan et al., 2012; Magar, 2003)

There is a need in India to carry out well-designed, systematic research towards developing, adapting, and evaluating empirically supported treatments to alleviate symptoms of psychological trauma such as PTSD. These interventions should consider culturally specific risk and protective factors, unique social fabric, as well as cultural presentations of psychiatric morbidity in the target population.

1.4 Narrative exposure therapy

Narrative Exposure Therapy (NET) (Neuner et al., 2002), which is the main focus of this thesis, is a narrative approach to treating psychological manifestations of trauma in survivors (Neuner et al., 2020). Based on the principles of CBT and testimony therapy (Cienfuegos & Monelli, 1983), NET follows a manualised treatment protocol which is aimed at constructing a consistent, coherent autobiographical representation of the traumatic event(s) within the context of a narrative account of one's life. This is done to facilitate emotional processing of trauma memories and alleviate emotional, cognitive, and behavioural symptoms of PTSD. The NET paradigm is based on the theoretical foundations of PTSD such as the associated fear network model, EPT, and Ehlers and Clark's cognitive model (Neuner et al., 2020; Schauer et al., 2011).

NET was developed specifically for use in low- resource settings, and victims of organized violence such as refugees. NET is a short-form technique that can be delivered by non-mental health professionals following a short training programme, so it is suitable for use in India where the need for psychotherapeutic support due to trauma exposure far outweighs the resources available (Patel et al.,

2016). Through the use of narratives as a medium to recovery, NET relies on the oral tradition of storytelling, which is intrinsic to many cultures, including India (ITRHD, 2017; Onyut et al., 2004)

Correspondence with mental health and social workers, counsellors, and clinical psychologists revealed that many of the techniques employed in treating the psychological symptoms of assault, abuse and violence victims and survivors in India loosely overlap with the narrative approach (Raghuraman, personal communication, February 26, 2017). This suggests that a version of NET may already be in use in the Indian setting, albeit in an informal, unstructured format and can be adapted as a locally relevant intervention for individuals with trauma exposure in this setting.

1.4.1 Process of NET

The NET protocol has been manualised by the developers with detailed information regarding the process of administration (Schauer et al., 2005). On average, it consists of 8-12 sessions, includes appropriate psychoeducation, involves elaboration and processing of traumatic memories, helps overcome avoidance, and involves the processing of trauma-related emotions and cognitions.

NET typically begins with a session on psychoeducation. The core elements of psychoeducation consist of normalising, legitimising, and describing trauma symptoms to the client, in addition to explaining the therapeutic process for the client's clarity and understanding (see Table 1-2). In the following session, the clients undertake a physical, *gestalt* construction of their autobiographical timeline or life story to serve as a roadmap for the upcoming sessions. Flowers are used to denote significant, positive life events and tea candles to denote significant, negative events. In this session, the client is encouraged to merely focus on the contextual elements of the memories such as names, dates, and places as opposed to the emotional, sensory-perceptual aspects.

In the sessions that follow, each positive and negative event is explored and discussed chronologically in rich detail, guided by the therapist in a directive manner. Sensory, physiological, emotional, and behavioural re-imagining is encouraged as the client narrates each memory. The experiences during the exposure are closely monitored to maintain the dual focus on the present and the past as is typical of 'exposure conversations.' Contextual information is important in this stage to aid habituation wherein the emotional and sensory-perceptual elements of the narrative (hot memories) are put into a coherent narrative (cold memories). Situating intense trauma memories that

are activated within the associated fear network within the appropriate space and time of their occurrence is a crucial process. In the re-telling and reliving of the experiences, the client is also encouraged to consider the meanings and perceptions of each memory to enable cognitive re-evaluation and re-structuring of maladaptive thought patterns and behaviours that maintain PTSD symptoms.

The therapist takes records (either digitally or manually) during each session of the client's narrative account. At the end of every session, the session's narrative is transcribed verbatim by the therapist (in the client's own words) and re-read before the start of the next session to encourage exposure to, activation of, and habituation to trauma memories. The client is encouraged to attend to distortions and inconsistencies in the narrative during the re-reading to aid autobiographical re-construction. The detailed account of the client's life story, i.e., the testimony is finally compiled at the end of therapy, re-read, signed, and delivered to them. The signed testimony serves as a written acknowledgement of their experiences in a consistent, chronological manner.

The process of NET is summarised in Table 1.

Table 1-2 Manualised NET process

Session 1	Informed consent	Establishing voluntary consent, building rapport, gaining trust	
Session 2	Psychoeducation	i)	Normalization: "it is normal/understandable to have such reactions after a trauma".
		ii)	Legitimization: the symptoms experienced today are the result of responses from the traumatic situation.
		iii)	Description of trauma reactions (including related symptoms).
		iv)	Explanation of therapeutic procedure (imaginative exposure & habituation, narration, and a step-by-step explanation of the therapeutic process).
Session 3	Lifeline	Physically constructing the life story to highlight highly arousing, positive and negative/traumatic events across the lifeline in a chronological manner.	

Session 4/n	Narration exposure	i)	Focus on context, details, emotional engagement, context, chronology, description of sensory, emotional, physiological, and behavioural experiences.
		ii)	Structuring and recording testimony by therapist between sessions.
		iii)	In sensu exposure through re-reading narrative from the previous session by the participant for corrections, enhanced detail and reprocessing.
		iv)	The procedure is repeated across sessions along the timeline until the final version is reached.
Penultimate session	Future	A positive discussion revolving hopes and aspirations for the future	
Closing session	Testimony	Re-reading and signing the complete testimony after correcting inaccuracies/making changes	

According to Schauer et al., (2011), the therapeutic elements that have proven effective in the treatment of trauma psychopathology include –

i. active chronological reconstruction of the autobiographical memory
ii. exposure to 'hot spots' through detailed narration and imagination of traumatic events through high levels of emotional involvement,
iii. cognitive re-evaluation of behaviour and patterns and re-interpretation of meaning associated with negative, fearful, and traumatic events,
iv. revisiting positive life-experiences to activate resources and to adjust basic assumption, and
v. regaining dignity

1.4.2 NET evidence base

NET's efficacy has been evaluated through RCTs in a range of trauma-exposed populations in a variety of settings. Most studies have been conducted on survivors of war or organized violence (Gwozdziewycz & Mehl-Madrona, 2013).

A systematic, narrative review of NET efficacy by Robjant & Fazel (2010) included studies conducted on a range of trauma populations, in different cross-cultural and income contexts, from Sudanese refugees living in Uganda (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004) to asylum seekers and refugees in Germany (Neuner et al., 2010) and Norway (Halvorsen & Stenmark, 2010). NET was deemed superior in reducing PTSD symptoms compared with other treatments such as psychoeducation, trauma counselling, supportive counselling, and group interpersonal therapy. Further, long-term effects of NET were synthesised to show positive sustained change based on studies that included follow-up time points.

In a quantitative analysis of NET efficacy primarily on refugee populations, Gwozdziewycz & Mehl-Madrona (2013) reviewed seven trials reporting effect size estimates. In the included trials, NET was compared to treatment-as-usual, interpersonal therapy and other techniques. An aggregated average effect size estimate of 0.63 (medium) was calculated, with a higher estimate (1.02) reported for studies wherein the administrators were ex-refugees. While this review provided the first quantitative synthesis of NET evidence, the studies were not appraised for bias, quality, and internal validity by either of the aforementioned reviews.

Based on these early reviews, NET appears to demonstrate significantly greater improvements on outcomes of PTSD, anxiety and depressive symptoms when compared to Stress Inoculation Training (Hensel-Dittmann et al., 2011), treatment as usual (Stenmark et al., 2013), Emotional Freedom Technique (Al-hadethe et al., 2015) and waitlist controls (Alghamdi et al., 2015; Hijazi et al., 2014; Jacob et al., 2014). Improvements through NET have also found to be reflected in neuroimaging evidence (Adenauer et al., 2011; Morath, Moreno-Villanueva, et al., 2014). One review comparing NET with PE therapy demonstrated that NET therapies (N = 15) have observed consistently lower dropout rates (PE = 27.20%, NET =5.06%) (Mørkved et al., 2014). Mørkved et al. (2014) also demonstrated the number and duration of NET sessions as typically lower than that required in PE therapy; typically, seven sessions of 90 minutes duration each were found across NET trials (8 times lesser than PE). A different position was adopted by Mundt et al. (2014) who critiqued the short duration of NET as being insufficient in comprehensively addressing PTSD developed as a response to repeated, long-term exposure to trauma. In some studies, lay counsellors have shown reliable success in effectively administering NET across research groups through evidence from several train-

the-trainer studies (Jacob et al., 2014; Köbach et al., 2017), which has contributed to NET's position as an accessible trauma intervention.

NET has been adapted for use in a range of cross-cultural, socio-economic and political settings such Rwanda, Somalia, Uganda, Iraq, Iran, Norway, Romania, and China (Raghuraman et al., 2020). It has also been adapted for use with juvenile populations across different LMIC settings (KIDNET) (Catani et al., 2009; Onyut et al., 2005; Ruf et al., 2010), and forensic offenders (FORNET) (Hermenau et al., 2013; Hinsberger et al., 2016; Köbach et al., 2017). This suggests that it can be adapted to aid recovery in a range of trauma populations across cultural contexts. However, Mundt et al. (2014) have critiqued the applicability of NET as a post-disaster intervention in non-Western, low- and middle-income contexts. They examined the lack of connectedness of NET trials to the local psychosocial care systems and questioned its efficacy as a stand-alone intervention in settings where political contexts, collective healing mechanisms, family and social dynamics, and community functioning were not appropriately considered by the studies.

Two recent meta-analyses of NET have been conducted taking into account the risk of bias estimates and quality appraisal of the included studies (Lely et al., 2019; Raghuraman et al., 2020). Both reviews highlighted low study quality and high heterogeneity between trials as crucial limitations of the NET evidence base, and advise caution when interpreting the aggregated data estimates to inform clinical practice (Lely et al., 2019; Raghuraman et al., 2020). Overall, Raghuraman et al. (2019) present the most comprehensive and conservative estimate of NET treatment effect. A detailed explanation of the meta-analysis is presented in Chapter 4 of this thesis.

NET fulfils the major criteria for trauma-focused CBT interventions outlined by NICE (2018) and has been recommended as a first-line treatment for PTSD and as a second line PTSD treatment by other clinical guidelines (American Psychological Association, 2017; VA/DoD, 2017; ISTSS, 2018). These recommendations have been made based on the evidence base published and reviewed before 2018. With the recent publications of meta-analytic evidence from Lely et al. (2019) and Raghuraman et al. (2020) where estimates of bias, quality and heterogeneity are considered, these recommendations must be reviewed appropriately.

1.4.3 NET's applicability for DV survivors

Three published RCTs have evaluated the efficacy of NET on survivors of assault, violence, and abuse. Pabst et al., (2014) did not find evidence for NET's treatment effect when compared to a 'treatment-by-experts' control group on outcomes of PTSD for physical and sexual assault survivors in Germany. Orang et al. (2018) found NET to be significantly superior to treatment-as-usual in alleviating outcomes of PTSD and depression in 45 Iranian female survivors of IPV. Lely et al. (2019) compared NET with present-centred therapy on outcomes of PTSD for older adults with political, sexual and childhood trauma and did not find a significant treatment effect for NET at mean follow up. In an uncontrolled, retrospective analysis of NET in victims of trafficking and sexual exploitation in the UK, Robjant et al. (2017) found a significant reduction in PTSD severity scores at posttreatment and 3-month follow up. Overall, the evidence of NET's treatment effect in abuse and violence survivors is limited and inconclusive. The results appear promising when the target population is female, young to middle-aged and the abuse is predominantly gender-based violence. When consideration paucity of the global and specifically, Indian psychotherapy research for DV, a deeper exploration of NET's applicability for this specific population is warranted.

1.5 Research Gaps

While the narrative approach has gained a lot of support cross-culturally, it has not yet been studied empirically in the Indian setting. There is no known research to suggest that NET has been tested for efficacy or effectiveness in the treatment and management of PTSD in India. It has, however, been found to be significantly efficacious in its adapted KIDNET format in similar a socio-cultural and economic context; Sri Lanka (Catani et al., 2009). India and Sri Lanka are neighbouring countries with a similar and comparable ethnic, racial, cultural, and socioeconomic context which indicates cultural relevance and applicability of NET for the Indian setting.

RCTs have predominantly contributed to NET knowledge and evidence base, with little understanding of its process and underlying change mechanisms; both of which can contribute significantly to cross-cultural adaptations and implementations. Relying heavily on nomothetic and quantitative evidence in intervention research has been largely criticised (Cooper et al., 2017; Shean, 2014). Goldfried (2015) have emphasised the need for a renewed focus on the fundamental processes underlying recovery

ranging from neurobiological, cognitive, social, and behavioural evidence as key to understanding interventions. A preliminary understanding of NET's cultural relevance for DV survivors in India will address a wide research and knowledge gap in this setting. Psychosocial care for DV survivors is limited in both availability and scope, and research informing healthcare systems that adopt a bottom-up, translational approach can be vastly informative for implementation and evaluation in clinical practice. Finally, there is an opportunity to make a significant contribution to NET's evidence base as an adaptable, effective, cross-cultural therapeutic technique to manage trauma psychopathology. A comprehensive meta-analytic evaluation of the evidence base which considers internal validity, quality and heterogeneity and an idiographic approach to understanding process and mechanisms of change provide novel insight for NET researchers and practitioners. By exploring the utility of NET in managing PTSD in victims of abuse and violence, this research has the potential to inform the diverse applicability of NET as a PTSD management option across a range of trauma samples.

1.6 Research aims

This thesis aims to gain an in-depth understanding of the culture-specific DV experiences in south Indian female survivors, with a focus on the treatment of PTSD and comorbid psychopathologies such as depression, anxiety, and somatic symptoms. There is a paucity of empirical research into the experiences of DV in Indian women, including the psychopathological manifestations of DV exposure, individual treatment and rehabilitation efforts. There is a need to address the growing rise in the prevalence of DV by giving voice to lived experiences of DV using qualitative research designs with survivors.

NET is the main focus of this thesis. There are no published accounts of NET use in any trauma population in India, where the risk for trauma exposure is substantially high. NET is considered suitable for this sample for two reasons: (1) it is based on story-telling as a means of emotional, sensory-physiological, and cognitive processing, and (2) it was developed for use in low-resource contexts (such as India) where the demand for mental health services outweighs its availability. This research aims to contribute to the knowledge base by examining the process and utility of structured trauma intervention with proven efficacy among vulnerable populations in other settings.

1.6.1 Research questions

To make a valuable contribution to the knowledge base, address research gaps and fulfil the aims of the thesis, the following research questions will be addressed:

1. What are the lived experiences of DV in a sample of south Indian, adult women?
2. What are the psychopathological manifestations of DV in the above sample?
3. How rigorous is the current evidence base for NET in terms of mean treatment effect for trauma-exposed populations?
4. What is the process of NET when applied to DV survivors with symptoms of PTSD?
5. What are the underlying mechanisms of change and/or recovery when NET is used with the aforementioned sample?
6. What recommendations can be made for the treatment of PTSD, support, and rehabilitation of DV survivors?

2 Methodology

2.1 Introduction

The aims and research questions were realised by employing a mixed-methods approach. Each study chapter will provide a detailed elaboration into the research design and method that is applicable for the relevant study such as study populations, design, and procedure and analytic methods. This chapter contains a general overview of the research approach to the thesis, including justifications for the choice of designs, methods, analytic strategy, assessments measures used, and the overall ethical considerations of undertaking this research.

2.2 Research design and analytic methods

The research questions outlined in Chapter 1, *section 1.6.1* were addressed through three studies –

1. **Lived experiences of DV in south India: An Interpretative Phenomenological Analysis**
   An idiographic approach was chosen to conduct an in-depth, qualitative analysis of the experiences of DV in the specific and unique socio-cultural context.
2. **A meta-analysis of NET efficacy for the treatment of PTSD and comorbid symptoms**
   A meta-analysis of NET efficacy in alleviating diagnoses and symptoms of PTSD and symptoms of depression was undertaken with the key aim of aggregating and evaluating the evidence base.
3. **Developing a framework of change and recovery: A thematic analysis of NET testimonies**
   To address the dearth of idiographic studies of NET, a qualitative approach was chosen to examine NET with the aim of better understanding mechanisms of change and recovery. A thematic analysis (TA) was used to develop a framework of recovery from PTSD through NET.

2.3 Epistemological stance

Adopting an epistemological position is essential in any attempt to answer the question, 'how, and what, can we know?' (Willig, 2013; p. 2). In this thesis, I use a mixed-methods approach with both quantitative and qualitative methods to address the research aims. Mixed methods have been

considered a methodological ‘minefield’ because of the complex ontological and epistemological issues involved in combining the two methods (Blaikie, 1991).

Generally speaking, quantitative research is associated with positivism and empiricism while qualitative research relies on hermeneutics, constructivism, and relativism (Ma, 2012). The approach I have taken does not conform with this polarized dichotomy of reality because neither is qualitative research ultimately subjective nor is quantitative research is definitively objective (Ma, 2012). Methodological pragmatists have argued that neither set of methods is sufficient to develop a complete analysis, and advocate for switching between alternative paradigms or using them in combination to complement each other (Creswell et al., 2004). To this end, the philosophical and epistemological approach that underpins the analysis is captured broadly by a critical realist perspective.

Critical realism validates and supports key aspects of both quantitative and qualitative approaches (Maxwell & Mittapalli, 2012; McEvoy & Richards, 2006). Critical realism “accepts the existence of some reasonably stable and mind-independent reality but rejects the possibility of verifying research findings in any absolute or ‘objective’ sense” (Modell, 2009; p. 2). When it comes to the study of DV, it is paramount to acknowledge that each victim or survivor’s experience is unique, subjective, and relies heavily on the historical, social, and cultural backdrop of developing this knowledge. The phenomena of interest to this research are diverse and complex, and the focus is primarily on how the participants and the researcher develop our meaning of these phenomena. This led me to choose qualitative methods to develop a contextual understanding of the lived experience of DV and response to NET, with a discernible focus on the meaning-making process, recognition of the larger context, and the inherent subjectivity in knowledge formulation and production (Madill et al., 2000).

I employ statistical analyses to contextualise the in-depth analyses of the social and cultural phenomena or DV, PTSD and recovery. Meta-analytic techniques are used to determine a statistical, pooled intervention effect for NET, which is an attempt to evaluate the current evidence-base of randomised clinical trials. This is not done to determine the suitability of NET for this specific sample, because in line with the critical realist philosophy, the role of the historical, cultural, and social context of DV will play an inherent role in how the population receives and responds to NET (Maxwell & Mittapalli, 2012). Instead, the meta-analysis is expected to contribute to a growing body of knowledge regarding NET efficacy on diverse samples across socio-cultural and geographic settings.

RCTs can vary in quality and are subject to issues such as publication bias where studies reporting non-significant findings are less likely to be published (Dickersin et al., 1987; Doshi et al., 2013; Franco et al., 2014). Nevertheless, the findings gleaned from RCTs are still regarded as the most unbiased measure of cause-effect relationships between outcomes of interest and psychotherapy (Deaton & Cartwright, 2018) and are an effective method for estimating intervention effects. From a realist perspective, there have been calls for including process-oriented qualitative investigations in social-experimental research to complement regularity-based quantitative research (Maxwell & Mittapalli, 2012). Shadish et al. (2002) has distinguished *causal descriptions* (using experimentation to describe the consequences of varying a treatment) *from causal explanations* (clarifying mechanisms through which and the conditions under which the causal relationship holds) (p. 9). The critical realist paradigm supports the design and execution of research that maintains the 'delicate balance' between these concepts, which is expected to strengthen the understanding of causal mechanisms in experimental investigations (Maxwell & Mittapalli, 2012). In doing so, realist paradigms acknowledge that relationships between causal mechanisms and their effects are not fixed, but contingent in the context within which they operate.

In Chapter 5, change in symptom scores from baseline to post-intervention time points were calculated. The use of statistical analyses to determine sample differences in mean scores is intended less as a means of 'objectively measuring' change and more as a means to provide context to the study of processes and change mechanisms when NET is used. It is also a means of achieving methodological triangulation, which entails 'using more than one method or source of data in a study of social phenomena' (Bryman & Bell, 2003, p. 291). Specifically, in this study, qualitative data were triangulated with quantitative data for *completeness*, which refers to the attempt to obtain complementary perspectives, or in the case of this study, the context in terms of change and recovery (Risjord et al., 2001). This complementary nature of data will provide richness and detail to the analysis, which would be unavailable from one method alone (Risjord et al., 2001). I place value on the social interactions between the study population and the world around them, their families, peers, social structures, and institutions, and myself, but at the same time, also consider the clinical and practical importance of measuring symptom recovery and change when interventions are delivered in a particular setting. This triangulation approach is compatible with the critical realist perspective in achieving both goals of revealing different aspects of a phenomenon and providing a wide range of

perspectives (McEvoy & Richards, 2006). The use of NET in this sample is not aimed at empirical generalisation either to the type of trauma exposure (DV) or sample (south Indian women). It is expected to provide highly contextualised, interpretative analysis that aims at naturalistic generalisability or transferability, which are non-probabilistic sampling ways of understanding generalisation (Smith, 2018).

In sum, using a critical realist epistemological framework provides a way of marrying quantitative and qualitative research methods. It recognizes the explanatory power of the context of the phenomena being studied, and at the same time, stresses upon an understanding of the processes and particular situations, as opposed to addressing only general patterns (Maxwell & Mittapalli, 2012).

2.4 Population and setting

The population of interest is victims and survivors of self-reported DV and related forms of abuse. The main eligibility criterion for recruitment of participants is that they must identify as an adult victim or survivor of any form of DV. I use the terms 'victims' and 'survivors' interchangeably based on the following relevance: (1) individuals who report ongoing DV or risk or threat of future DV are referred to as 'victims' and (2) individuals who report a history of DV but no longer identify future threat are referred to as 'survivors'. When the terms are used generically and not in reference to the research sample, they are context-dependent and either term may be used. Apart from DV, the other phenomenon of interest to this thesis is PTSD.

Qualitative methods were primarily used in the analysis of data from the studies using research participants, so purposeful sampling was used in line with the qualitative principle of 'appropriateness' for recruitment in these studies. According to Morse et al. (1991), a 'good' informant is characterized as one who is articulate, reflective, and willing to share expertise with the interviewer (as cited in Coyne, 1997). The sample was determined in the interest of 'information power' (Malterud et al., 2016) or obtaining access to 'information-rich' participants (Patton, 2002). The type of purposeful sampling was opportunistic, which means that both the sample and the sample size was determined by pragmatic considerations such as access, availability and eligibility (Vasileiou et al., 2018).

Research participants were recruited from south India, a region that is native and familiar to me. This was important in ensuring that this research was economically viable while using pre-existing networks and gatekeepers to gain access to research participants. Collaborations with local charities

and non-governmental organisations (hereafter referred to as 'charity') working with survivors of DV and various forms of abuse facilitated access to participants. Participation was strictly voluntary and based on informed consent (*section 2.6*).

Participants were not remunerated for their time, but they were offered reimbursement for travel costs. Two cities were chosen as the site of research: Bengaluru and Chennai, both of which are urban, metropolitan areas. These cities were chosen based on language criteria. India is linguistically diverse and four different languages are spoken in the five south Indian states. As I would be establishing contact and undertaking the research, the bulk of which is qualitative, my linguistic ability was a factor. I am fluent in the regional languages spoken in these cities which were Kannada (Bengaluru) and Tamil (Chennai). This was especially pertinent for the study wherein I administered NET to participants as the therapeutic (i.e., data collection) process was interactive and depends extensively on building trust and rapport with the participants. If any of the recruited participants did not speak English or were more comfortable with the local, regional language, it was important for me to be able to communicate with them fluently.

Study-specific details regarding sampling such as the size of the sample, demographic details or other study-related information are provided in the methods section of the relevant chapter. Each chapter also provides detailed research procedure including recruitment, data collection and data handling.

2.5 Assessment measures

Eligibility criteria and measurement of symptom change post-NET in Chapter 5 were determined using a range of psychometric assessment measures. All the measures were self-report forms of standardised, reliable, and valid instruments used in the PTSD and comorbid psychopathology research globally and India.

2.5.1 Instrument translation process

The validity and reliability of research instruments when cross-cultural studies are undertaken is of paramount importance to ensure that the meanings of the measures' component constructs are equivalent between languages and cultures (Munet-Vilaró & Egan, 1990). A review of instrument translation based on 47 studies found that researchers approach this process in several different ways (Maneesriwongul & Dixon, 2004). Brislin (1973) recommended one or more of the following

methods in translation– (1) back-translation; (2) bilingual techniques; (3) committee approach; and (4) pre-test. According to Maneesriwongul & Dixon (2004), each method deals with one or two types of equivalence and can be complementary when used in tandem. India is a linguistically diverse country, and it was anticipated that the sample recruited for this research would reflect this diversity. To account for the potential linguistic multiplicity of the sample, three techniques recommended for cross-cultural research were used – back-translation, bilingual techniques, and pre-testing (Brislin, 1970, 1973). A recent review of guidelines for cross-cultural adaptations of assessment measures did not find consensus on the best methods, which suggests that evidence for the same is lacking (Epstein et al., 2015). A discussion with my primary supervisor revealed that use of multiple, complementary recommended techniques would yield the most satisfactory results in achieving semantic and conceptual equivalence between the source and target versions of the measures.

When translated, valid, and reliable assessments were not available in the local languages of Kannada and Tamil, all the assessments were translated and back-translated by two multilingual local language experts with a background in healthcare research. Back-translation is highly recommended by experts on cross-cultural research where participants may complete assessments in different languages and diverse cultural settings (Werner & Campbell, 1970). In the next stage, both the source and target language versions of the tools were tested with a small sample (N = 3) of bilingual subjects for comparisons between the original and back-translated versions. Finally, the essential pre-test technique was employed with a small sample (N=4) of multilingual laypersons to reveal any potential problems with clarity or the target language version among the target population. No changes were required based on the pre-testing, and linguistic, semantic, and conceptual equivalence of the measures with the English version was considered to have been achieved (Maneesriwongul & Dixon, 2004). This process is different to the process of validation (Epstein et al., 2015), which was not undertaken due to the limited resources, time, and availability of testing samples within the scope of the PhD. Further, as the measures were not being employed with the aim of quantitative generalisability based on probability sampling, this stage was not considered necessary to fulfil the aims of this thesis.

Based on the linguistic preferences of the participant, the measures were completed either in English, or the translated versions of Kannada or Tamil. The details of the measures used are presented below.

Impact of Events Scale-Revised (IES-R; Appendix B1): The Impact of Events Scale (IES; Horowitz et al., 1979) was based on Horowitz's model of emotional processing and is one of the most widely used self-report measures in trauma literature. The 22-item revised version of IES (IES-R; Weiss & Marmar, 1997) was used, aimed at capturing the level of symptomatic response to specific traumatic stressors as manifested in the past 7 days. The revised version was developed to improve its utility by making it more applicable to the tripartite DSM criteria for PTSD. IES-R has shown good concurrent and discriminative validity and the absence of social desirability, thereby proving to be a solid measure of post-trauma symptomatology in clinical and research settings (J. G. Beck et al., 2008). IES has been used to measure posttraumatic stress symptoms in several Indian studies, with one study finding satisfactory psychometric properties for the Tamil version (Russell et al., 2004). Therefore, the revised version (IES-R) was deemed suitable for this sample. In this study, the Tamil translated version was used with participants who were not native English speakers. Higher scores on the IES-R indicate higher levels of symptomatology and cut-off scores are available in the freely accessible version of IES-R based on psychometric research: > 24 = clinical concern, > 33 = probable PTSD, > 37 = PTSD case (Asukai et al., 2002; Creamer et al., 2003; Kawamura et al., 2001). When determining clinically important change, item scores (5-point scale ranging from 0-4) was averaged to generate a mean total score (range: 0-4). Previous research has also identified a ≥ 1.6 threshold to define substantial PTSD symptoms (Bienvenu et al., 2018). The Minimal Clinically Important Difference (MCID) estimates for between-group comparisons for this scale is 0.2 (Chan et al., 2016).

Hospital Anxiety and Depression Scale (HADS; Appendix B2): The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) was developed to assess both anxiety and depression in a general medical population and is widely used tool in both clinical and research settings. The 14-item self—report measure has been widely translated and validated in both clinical and community settings and is included as one of the NICE recommended tools to measure anxiety and depression (NICE, 2011). HADS has been used previously in studies in India to measure psychological morbidity, with one study finding good psychometric properties for the scale using a Malayalam translated version (Thomas et al., 2005). Mean Cronbach's alpha for HADS-A is 0.83 and for HADS-D is 0.82 and a threshold of ≥ 8, on either subscale was found to be associated with sensitivities and specificities of ~ 0.8 for the detection of clinically important anxiety or depression conditions in general medical patients (Bjelland et al., 2002). The measure contains seven items

each for depression and anxiety subscales. Scoring for each item ranges from zero to three, with three signifying the highest anxiety or depression level. Higher scores on the HADS subscales indicate higher levels of symptomatology. The following cut-off scores are available for quantification based on the literature review by Bjelland et al. (2002): 0-7 = Normal, 8-10 = Mild, 11-14 = Moderate, 15-21 = Severe (Stern, 2014). The MCID estimates for between-group comparisons for both subscales of HADS is 2.0 – 2.5 (Chan et al., 2016).

Bradford Somatic Inventory (BSI; Appendix B3): The Bradford Somatic Inventory (BSI; Mumford et al., 1991) is a 44-item, multi-ethnic inventory of somatic symptoms associated with anxiety and depression symptoms. Items are scored on a nominal 'yes/no' scale, with one point attributed to each item that was scored in the affirmative (as 'yes'). The measure was derived from the psychiatric case notes of Pakistani and indigenous British-Pakistani patients based on the International Classification of Disorders-10 (WHO, 1993). The content and cultural validity of 44-item BSI for a south Indian sample were achieved against the psychiatric case notes in south India (Christian Medical College, Vellore, Tamil Nadu) wherein over 90% coverage of all somatic symptoms was found. Personal communication with the developer of the assessment revealed a 20/21 score threshold to determine case-ness, where a score above such threshold would indicate somatic symptom psychopathology.

2.6 Ethical considerations

The study was granted ethical approval by the Research Ethics Committee, Faculty of Medicine and Health Sciences, University of Nottingham (Ethics Reference No.: 103-1704; Appendix A1). For both studies that employed research participants (Chapters 3 and 5), recommendations for participation were made at the discretion of the social workers, based on their knowledge of the study aims, procedure and timeframe. All the social workers who would be involved in the research as well as the management staff at the charity attended a one-day seminar that I facilitated on the topics of psychological trauma, PTSD, NET and the research plan. The seminar was interactive with participants' completing a lifeline construction of their own lives, as well as role play activities of a typical NET session. The social workers were also given an opportunity to discuss any queries they had regarding the inclusion/exclusion criteria so they would be the first point of contact for potential participants. They contacted the potential participants (following on an anonymised discussion with me regarding eligibility) for an initial, closed-door meeting which I did not attend. Once the individuals

provided verbal consent to their assigned social workers, an appointment was scheduled by the social worker for me to meet with the potential participant. In this meeting, I discussed the Participant Information Sheet (Appendices A2 and A3) and Informed Consent form (Appendix A4) in accordance the key values and ethical standards outlined by the British Psychological Society Code of Human Research Ethics (The British Psychological Society, 2014, 2018) (The British Psychological Society, 2018). Presently, there are no India-specific ethical guidelines for conducting qualitative research with human participants. The charities also did not require me to apply for ethical clearance.

Each participant was provided with a written PIS and was given between 2-4 days to read and respond with questions/clarifications either directed at their caseworker or me. At the subsequent meeting, consenting participants and I signed the Informed Consent form after clarifying questions and queries. Baseline data were collected to ensure eligibility at this meeting.

Ethical considerations such as preserving total anonymity and lack of personal identifiers in reports and publications, complete confidentiality regarding data collected, the participants' right to withdraw or refuse participation during the research, and the access to share concerns and complaints with the University of Nottingham Research Ethics Committee were explained in detail. There was no direct contact between me and the participants, and caseworkers scheduled and organised all appointments.

Before commencing, I discussed specific guidelines for handling various forms of disclosure during the research process with each charity. It was anticipated that some research participants may disclose ongoing abuse or a threat of future abuse. There was also the possibility of disclosures of self-harm and/or suicidal thoughts or verbalisations, or risk or threat to self or others. It was recommended that I report any disclosures of abuse, risk of abuse, and a threat to self/others that emerge either in the interview or the therapy to the participants' caseworkers immediately after the session was complete. The charity would then access the necessary and appropriate resources to support the participants. During the explanation of research and consent procedures, each participant was made aware that the strict ethics of confidentiality would not apply to any disclosures of threat or harm to self/others and that the caseworkers would be informed of such information as necessary.

At the end of participation (interview or therapy), participants were provided with a debriefing document (Appendix D) in line with the BPS Code of Ethics. This document primarily contained

information on domestic abuse helplines in India, and guidance on how to access them if necessary. This document was also shared with the caseworkers at each charity.

Ethical considerations that are specific to a particular study are discussed in the respective chapter.

2.7 Reflexivity and Researcher subjectivity

The concept of 'reflexivity' in qualitative research has evolved over the decades from introspection towards critical realist and subjective accounts (Finlay, 2002a), and has challenged the positivist notions of objectivity, neutrality, and validity, particularly by feminist theorists and critical thinkers (Gough, 2016).

Reflexivity generally refers to an examination of how the 'researcher and intersubjective elements impinge on and even transform research' (Finlay, 2002, p. 210). The approach I have taken acknowledges that I, as the researcher am a central figure who influenced the collection, selection, and interpretation of data and that my position and behaviour inadvertently affects the participants' responses and influences the direction and interpretation of the findings (Finlay, 2002b). My subjectivity is viewed not as a source of contamination or bias but is reframed as a resource, and as an opportunity to contextualise and enrich the research processes and outputs (Finlay, 2002a).

As Wilkinson (1988) argued, reflexivity in this context informed the design of my research at three levels: (1) personal, which refers to individual preferences, motivation, and knowledge which influenced the topic, research expectations and focus, (2) professional, which refers to research practices and effects including communication styles, perceptions of participants, and interpersonal dynamics, and (3) disciplinary, which refers to my stance towards theory, method, and psychology.

Personal reflexivity: I was born and raised in a country (India) which subscribes to traditional patriarchal gender norms. I have witnessed first-hand the impact of gender power imbalances that are rarely in favour of women. While violence against women has existed through the ages in diverse cultural and social settings, I find that these issues are being talked about more openly in India as a result of the efforts of more women becoming aware of the nature of abuse, recognising their experience as abuse, and engaging in disclosure. As a cisgender woman who has consumed news and media reports of crimes against women as well as engaged directly with personal and anecdotal accounts in the recent years, this is a topic has deeply affected both my world view and my professional interests and exploits. Choosing this topic for my PhD research is my way of bringing this

issue to the fore, as well as contributing to the academic discourse and interest in this topic among Indian and global researchers.

Professional reflexivity: I chose to primarily use qualitative methods as there is immense value in using the storytelling capabilities of survivors to examine a phenomenon such as DV in-depth. The use of one-on-one, semi-structured interviews and testimonies allows me to generate rich data, with thick descriptions, which provide detailed and complex accounts of complex phenomena. This is done to create ample and deserving space for the narrative the participants produce, without reducing their complex and diverse experiences to a statistic, a general pattern or an 'average response'. I believe that my identity as a young, cisgender woman combined with my previous experience of working with vulnerable populations in a non-profit setting would create an interpersonal dynamic that could benefit the carrying out of this research. I intended to position myself as a non-intimidating, empathetic listener to the extent possible, with little in common with the abuser/oppressor to facilitate greater openness and likelihood to engage from the participants' perspective. I also acknowledge my privilege as someone who does not identify as a survivor of abuse or violence. However, I, like countless Indian women, have been on the receiving end of other forms of gender-based harassment such as stalking and sexual provocation from male perpetrators. While I do not regard these experiences as abuse or violence, they provide a small measure of common ground with the participants that could facilitate a shared understanding of what it is to be a woman living in a male-dominated society such as India. I also am aware of my class privilege, which has undoubtedly afforded me access to quality education, job opportunities and opportunities for personal and professional growth. In India, where there are significant inequalities from the perspective of class and caste, this may not be the case with every participant I may encounter in this research. This could interfere with my ability to form a connection with the participants on a deep and meaningful level, demonstrate real empathy, and establish trust and rapport, all of which are essential to qualitative research. It could also create a knowledge divide between myself and the participants, which is something I had to be aware of throughout the process of data collection and therapy facilitation.

Disciplinary reflexivity: This was elaborated upon on *section 2.3* of this chapter under the epistemological stance of this research. The use of critical realism is an attempt to reclaim 'reality', as opposed to other constructivist-interpretivist paradigms which reject reality in some form. The emphasis in my research is on the negotiated and socially constructed nature of the research

experience, which erodes my privileged position as the researcher, while at the same time, realising my unexamined power (Finlay, 2002a). This overlaps with the feminist version of reflexivity, which I believe is important to consider from the perspective of my research which aims at giving voice to the experiences of vulnerable women who have experienced gender-based violence (Wilkinson, 1988). This allowed me to utilize the participants' life experiences as expertise.

In the final discussion section, I will discuss reflexivity from an analytic and interpretative standpoint.

3 Lived experiences of DV in south India using Interpretative Phenomenological Analysis

3.1 Background

As the literature review identified, most of the research in India has thus far investigated the prevalence, severity, and correlations between DV and mental health outcomes using quantitative analytic techniques. As pointed out by Ashworth (2008), qualitative methods have a unique ability to capture the diverse ways in which individuals make sense of their own experiences and the world, and in particular, provide a platform for hearing voices that may otherwise be excluded. An in-depth understanding of the individual experience of trauma among survivors of DV in India could provide appropriate context to administering and evaluating NET in this context.

For this research, DV was defined and categorised according to The Protection of Women from Domestic Violence Act of 2005, which was enacted by the Parliament of India to protect survivors. Section 3 of this civil law provides a substantive definition of DV as "any act, omission or commission, or conduct of the respondent shall constitute domestic violence in case it:

5. harms or injures or endangers the health, safety, life, limb, or well-being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse; or
6. harasses, harms, injures, or endangers the aggrieved person to coerce her or any other person related to her to meet any unlawful demand for any dowry or other property or valuable security; or
7. has the effect of threatening the aggrieved person or any person related to her by any conduct mentioned in clause (a) or clause (b); or
8. otherwise injures or causes harm, whether physical or mental, to the aggrieved person."

The Act goes on, through section Explanation 1, to define "physical abuse", “sexual abuse", "verbal and emotional abuse" and "economic abuse".

3.1.1 Research Question

This chapter aims to investigate the following research questions –

a) What are the lived experiences of DV and its psychopathological manifestations among female survivors in the south Indian context?
b) What are the psychological and socio-cultural implications for clinical intervention and service development for DV in this context?

3.2 Design and Methods

3.2.1 Analytic design: Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) was used to design the interview schedule, collect, and analyse the data (Smith et al., 2009; Smith & Osborn, 2008). IPA is wedded to phenomenological epistemology, which gives the 'experience' of individuals primacy while attempting to understand a specific phenomenon through first-person accounts (Smith & Osborn, 2008). It is also a humanist, person-centred approach that is situated within the critical realist perspective of studying how individuals socially construct and interpret their world, while incorporating theories and philosophies that complement the realist stance (Smith, 1996). The goal was not to establish an objective, quantifiable description of DV and its impact on individuals, but to focus on how individuals experienced those events from their unique perspective. IPA can elicit a 'detailed examination of the participant's life' to attain the individual's 'personal perception or account' of an event or experience as opposed to arriving at a generalisable, 'objective statement of the event itself' (Smith, 2008, p. 53). The individual's interpretation of their experiences and the meaning they make out of them are crucial to the understanding of psychological trauma and recovery in their particular psychosocial and cultural context. Meaning is central to IPA, where the aim is to understand the content and complexity of experiences, as opposed to measuring their frequency (Smith & Osborn, 2008). IPA also acknowledges that the context (socio-cultural, political etc.) in which the accounts are produced is crucial to understanding phenomena (Griffin & May 2011). This was suitable f individuals' experiences and their interpretations of them were considered as expertise.

IPA was also chosen due to its focus on the idiographic perspective over the nomothetic perspective. The idiographic approach emphasizes the subjective and unique experience of an individual, without an attempt to generalise (Smith & Osborn, 2008). Most of the Indian research into DV has been largely nomothetic, i.e., aimed at making claims or inferences at the group or the population level to establish generalisations. The experience of DV is subjective and unique and is determined by a

variety of factors that cannot be defined and quantified as an objective phenomenon. IPA enables the confluence of the 'particular' and the 'general', wherein by delving deeper into the 'particular', we are one step closer to the making generalisable inferences about universal phenomena (Smith et al., 2009). The focus on the individual experience to investigate the psychosocial impact of DV allows an examination of recovery at the individual level, thus paving the way for future nomothetic enquiry.

This is an exploratory study given the dearth of research investigating the in-depth experiences of DV and their psychological impact on survivors in India. A foundational analysis of the complex poorly understood phenomenon of DV in this setting is an attempt to address this research gap. IPA's focus on phenomenological material, i.e., people's first-hand understanding of their experiences is fitting for studies of an inductive and exploratory (as opposed to an explanatory) nature (Smith et al., 2009). IPA aims to come as close as possible to an individual's experience, especially those from marginalised groups and using the rich detail from their personal stories to build a deep understanding of the research topic (Weatherhead, 2011)

Smith et al. (2009) and Smith & Osborn's (2008) guidelines on analysing the interview data using IPA were followed. IPA combines both thematic (inter-case) and idiographic (individual and specific) analyses, so relatively small, homogenous samples are considered suitable for IPA studies (Pietkiewicz & Smith, 2014), where a detailed, extensive case-by-case analysis is the goal.

3.2.2 Participants and setting

Participants were recruited using purposive sampling to find a well-defined, predominantly homogeneous sample for whom the research question has relevance and personal significance. The inclusion criteria were that the individual had to a) identify as female, and b) report a history of DV (including but not restricted to IPV).

Five women who identified as survivors of DV, with a specific focus on abuse perpetrated by the intimate partner and/or spouse (intimate partner violence/IPV) participated in the interviews. All the interviews were conducted by me. Table 3-1 provides detailed sociodemographic details of the participants and details regarding the experience of abuse.

The sample was recruited from the south Indian city of Bangalore, which is currently the fifth most populous urban agglomeration in India ("Bangalore," n.d.). They reported varying socioeconomic

status. The participants ranged from 23 to 42 years of age. All participants self-reported exposure to DV perpetrator by an intimate partner. The abuse included physical abuse, emotional and verbal abuse, sexual abuse, and neglect. Four participants were/had been married for the duration of the abuse, which ranged from 6 months to over 10 years. In this study, intimate partner violence (IPV) is used to in place of DV as all the participants identified their spousal or intimate partner as the primary perpetrator of DV. In all the cases, the status of abuse was reported as ongoing and the risk for future abuse was in the affirmative.

Table 3-1 Sociodemographic details of the participants

Pseudo-nym	Age	Relationship status	Years of Education	Monthly income (INR)	Current abuse status	Risk of future abuse	Perpetrator (s)	Duration of abuse
Annie	31	Separated	15	> 2,00,000	Ongoing	Yes	Male spouse + in-laws	6 months
Meena	34	Married	06	10,001-20,000	Ongoing	Yes	Male spouse	> 10 years
Geeta	33	Married	12	20,001-40,000	Ongoing	Yes	Male spouse + in-laws	5 years
Sonia	23	Married	10	1,000-5,000	Ongoing	Yes	Male spouse + in-laws	> 10 years
Vinny	42	Single	04	5,001-10,000	Ongoing	Yes	Male intimate partner	10 years

3.2.3 Tools and Assessments

Sociodemographic details of the participants and details of the abuse were collected at the time of pre-test assessments (Appendix B4). This included age, marital or relationship status, the status of dependents, educational and occupational status, income status, details of DV, perpetrator information, and help-seeking behaviour. Baseline outcome scores on PTSD, depression, and anxiety symptom severity was also collected. The details of the assessment measures and relevant translation processes are discussed in detail in Chapter 2, *section 2.5*. All the measures were self-report forms and were completed by the participants in my presence.

3.2.4 Interview Schedule

The aim was to elicit and examine rich, context-specific, first-person accounts of DV experiences. An open-ended semi-structured interview schedule was prepared using interviewing guidelines for IPA (Smith et al., 2009) in conjunction with the primary supervisor (NH) and administered by me. The

semi-structured style of the interview allowed the researcher (myself) and the interviewee to engage in a two-way dialogue which enabled space and flexibility for unique and unexpected issues to arise and for their deeper exploration (Pietkiewicz & Smith, 2014). It also enabled other relevant foci to be decided in conjunction with the interviewee. As per IPA interviewing guidelines, co-construction of the narrative was built into the schedule through probes, clarifications and corrections and request for detail and description at the appropriate times. As recommended by Flick (2006), the interview guide was used as a means to orient the interview to elements from which the narrative was invited, i.e., relationship with the perpetrator(s), the details of the abuse and the participants' responses to it. The schedule was split into chronological, key life events: before the abuse, during the abuse and after the abuse. To achieve depth, questions regarding the individual's behaviours, emotions, cognitions, and sensory perceptions when discussing key events were included in line with Pietkiewicz & Smith's (2014) recommendations for IPA. Other topics that were considered important to understanding the lived experience of the individual included discussions of identity before and after the abuse, current emotional states, managing the abuse and coping. The interview schedule was pre-tested with two participants from the target population to identify practical problems in administration, errors in linguistic relevance of word ambiguity, reduce respondent burden, and improve the overall validity of the schedule (Hurst et al., 2015). The pre-testing did not identify major problem areas and no amendments were required. The interview schedule can be found in Appendix C.

3.2.5 Procedure

The interviews were conducted in a private room in the charity premises. For non-native English speakers, the interviews were conducted in the local language. I maintained case notes throughout the interview to aide analysis. Interviews were closely monitored for participants' emotional engagement or disengagement, awkwardness, hesitation, and avoidance of specific topics, and other general discomfort.

The interviews lasted from 41.16 to 89.47 minutes. Short breaks were offered and taken when necessary. All interviews were audio-recorded with prior consent and then transcribed verbatim in the language they were conducted. Two interviews were in English, two interviews were in Tamil and one interview was in Kannada (regional South Indian languages). Transcripts were then translated and back-translated to check for conceptual equivalence. Final, line numbered, English-language transcripts were analysed. It was not feasible to return transcripts for comments and corrections due

to time constraints and unavailability of the participants for a second meeting. For the same reasons, it was also not possible to invite the participants for their feedback on the findings.

3.2.6 Analytic process

IPA entailed a two-stage interpretation process known as the *double hermeneutic. Hermeneutics* or the theory of interpretation is the method by which "something foreign, strange, separated in time, or experience, is made familiar, present, comprehensible; something requiring representation, explanation or translation is somehow 'brought to understanding' – is 'interpreted'. (Palmer, 1969, p. 14). The two-stage *double hermeneutic* refers to the participant's understanding and meaning-making process along with the researcher's interpretation of the participant's interpretation.

To achieve a level of interpretation consistent with the double hermeneutic, I maintained detailed case notes of participants' conceptualisations, paradigmatic assumptions, and personal, social, and cultural viewpoints throughout the interviewing and analytic process. The case notes were useful for documenting body language, filler words, pauses, and non-verbal communication. These were discussed extensively with the primary supervisor to achieve appropriate reflexivity and integration into the analytic and interpretative process. The transcripts were coded first by me, and second coded by my third supervisor, EH using the software NVivo 12 (QSR International, 2012).

Table 3-2 presents a step-wise process for IPA based on the recommendations of Smith et al. (2009) and Smith & Osborn (2008) and its adaptation for the NVivo 12.

As per Smith & Osborn's (2008) recommendations, the first interview (P01) was analysed in detail before moving on to the other interviews and each analysis informed the analysis of subsequent interviews. This process is in line with the idiographic commitment of IPA, wherein each study participant's perspective receives a detailed case exploration (Pietkiewicz & Smith, 2014).

Table 3-2 IPA Process (adapted from Smith et al. 2009; Smith & Osborn, 2008)

IPA STEPS	NVivo Process
Steps 1: In-depth reading and familiarisation	**Open coding:** The transcript was read through and coded using the participant's own words as far as possible to summarise the sense or meaning about a specific experience as narrated by the participant.
Step 2: Initial noting and annotating	
Step 3: Developing emerging themes.	**Category creation:** This was the first step in data reduction, whereby open codes were reviewed and reordered into broad

	categories which were labelled accurately to enable an in-depth understanding of the participant's lifeworld.
Step 4: Searching for connections across emergent themes	**Category development:** IPA strategies were employed to create super-ordinate themes for clusters of codes. Categories were linked, reduced further, and reorganised into category themes that reflect both the descriptive and the interpretative elements of the data. Category themes were created with relevance to the research questions. An initial framework was developed.
Step 5: Moving to the next case	**Moving to the next transcript:** The process is repeated for the subsequent transcript which is treated as a new analysis. As far as possible, references to the codes and code categories from the previous transcript are bracketed out.
Step 6: Looking for patterns across cases	**Consolidation and matrix coding:** Emergent themes from each transcript were merged and consolidated based on theory as well as unique and diverse features of each transcript.

Throughout the analysis, the double hermeneutic allowed the researcher to move between the *emic* and the *etic* perspectives (Pietkiewicz & Smith, 2014). From an emic perspective, I focused my interpretations of the participants' meaning-making process and their interpretations of their lived experiences to better understand the phenomenon of DV. Concerning the etic perspective, the narratives were examined through the psychological lens of PTSD theory and conceptual models (Ehlers & Clark, 2000; Foa & Rothbaum, 1998). Based on field notes taken during data collection, as well as familiarization based on initial reading of the interview transcripts, relevant social psychology theories and ethological theories were also considered when analysing the data. Some of these theories are explicated below, while others were expected to emerge as relevant as the analysis became more detailed and in-depth.

1. **Adult attachment theory** (Ainsworth, 2014; Bowlby, 1969; Hazan & Shaver, 1987): Attachment theory draws on concepts from ethology, developmental psychology, psychoanalysis and information processing. It is considered as a framework for understanding romantic relationhips in adulthood (Fraley & Shaver, 2000). This is based on the 'protoype' hypothesis, according to which early close relationships create internal working models which comprise of memories concerning

early attachment figures and affect cognition, affect, and behaviour involving later attachment figures such as those in romantic relationships (Simpson & Rholes, 2010). There has been significant longitudanal support for this hypothesis, in addition to the Bowlby's (1969) view that attachment is one of four interrelated systems (along with caregiving, exploration, and sex) governing human behaviour (Simpson & Rholes, 2010). These hypothesis backed by evidence suggest that experiences of IPV/DV could be conetxtualised using the lens of attachment theory or theories of adult attachment. Conversely, a systemtic review exploring the relationship betrween IPV and attachment failed to find consistent associations between insecure attachment and IPV victimisation/perpetration (Velotti et al., 2018).

2. **Social Cognitive Theory** (Bandura, 1997): Social Cognitive Theory (SCT) emphases the dynamic interplay between personal, behavioural and the environment influences in governing human behaviour. It is based on the key tenet of 'human agency' in self-development, adaptation and change (Bandura, 2001). SCT posits that environmental and social structures and systems affect human behaviour *through* the influence on self-regulatory influences such as self-efficacy, beliefs, personal standards, and aspirations. For instance, Bandura (1997) proposed that "people's motivation, affective states, and actions are based more on what they believe than on what is objectively true" (p. 2)." As a result, human behaviour can be better predicted by perceptions and beliefs about one's capabilities as opposed to an objective measure of capability, as the concept of self-efficacy has a determining effect on people's behaviour.

3. **Theory of Social Comparison** (Festinger, 1954): Social comparison theories suggest that comparisons of the self with others on abilities, personal characteristics or any self-aspects is a human need for acquiring information about the self (Festinger, 1954). Social comparison is closely related to the concept of self-esteem and is concerned with an innate desire to form accurate appraisals of the self, and in the absence of objective, non-social means to achieve this, they rely on social comparisons to achieve the same (Festinger, 1954). For instance, a greater tendency to engage in social comparison is theorised to be associated with a greater degree of uncertainty about the self, which is associated with poor self-worth (Gibbons & Buunk, 1999). Social comparisons can be either upward (comparisons with someone perceived to be superior), or downward (comparisons with someone perceived to be inferior). There is evidence to indicate that upward social comparisons typically stem from self-improvement as well as self-

enhancement motives, downward social comparisons rely primarily on self-enhancement motives Guyer & Vaughan-Johnston (2020). For instance, when under conditions of psychological threat, individuals are likely to involuntarily enagage in downward social comparisons in an effort to bolster-esteem.

4. **Posttraumatic Growth (PTG) Theory (Tedeschi & Calhoun, 2004):** PTG theory posits that 'growth occurs concomitantly with attempts to adapt to highly negative sets of circumstances that result high levels of psychological distress' (p. 2). This is based on the general understanding that psychological distress can be a potential source of positive change. PTG is hypothesised as a related but distinct concept from those of resilience, hardiness, optimism, and a sense of coherence which are all construed as personality traits or characteristics in the face of adversity. In contrast, PTG refers to a *change* that involves a movement beyond pre-trauma levels of adaptation following adverse events. Understanding the experience of psychological trauma beyond the medical model that focuses on disorder and pathology, PTG provides a varying lens through which the experience of major crises can be understood.

In addition to these theoretical perspectives, relevant socio-cultural and contextual factors were also used to contextualise the findings. This process was secondary and followed the interpretative process of the emic perspective which centres the participant and the researcher's (my) interpretations are the crux of the analysis. Using the participants' own words to exemplify themes and to support the analysis helped retain the participants' voice, thereby facilitating the *emic* perspective (Pietkiewicz & Smith, 2014). Every effort was made to avoid force-fitting the data to a predetermined categorical system, through the process of 'bracketing' preconceptions and allowing the data to illustrate the phenomenon on its own (Pietkiewicz & Smith, 2014). Quotes were followed by the interpretative commentary through a psychological and socio-cultural lens, which allowed for the *etic* perspective to emerge and were used to support my interpretation of the respondent's narrative. The number of instances or their repetitive prevalence in the data was not the criteria for inclusion in the analysis. On the contrary, the strength and richness of the extracts in illustrating the particular theme were of greater importance. Each quotation is treated as an example of a larger subset of extracts, which when taken together grounds the analysis. Personal identifiers were removed and replaced with a generic term within rounded brackets. Pseudonyms were used to refer to each participant in place of their given names.

3.3 Results

This study has been reported in accordance with the COREQ, a 32-item checklist to ensure explicit and comprehensive reporting of qualitative studies (Tong et al., 2007) (Appendix E). The sample was homogeneous in the cultural and geographical context, presence of exposure to DV (with a specific focus on IPV), and consequent symptomatology on PTSD, depression, and anxiety assessment scales. Four women scored above cut-off on the PTSD assessment (see table 3-3).

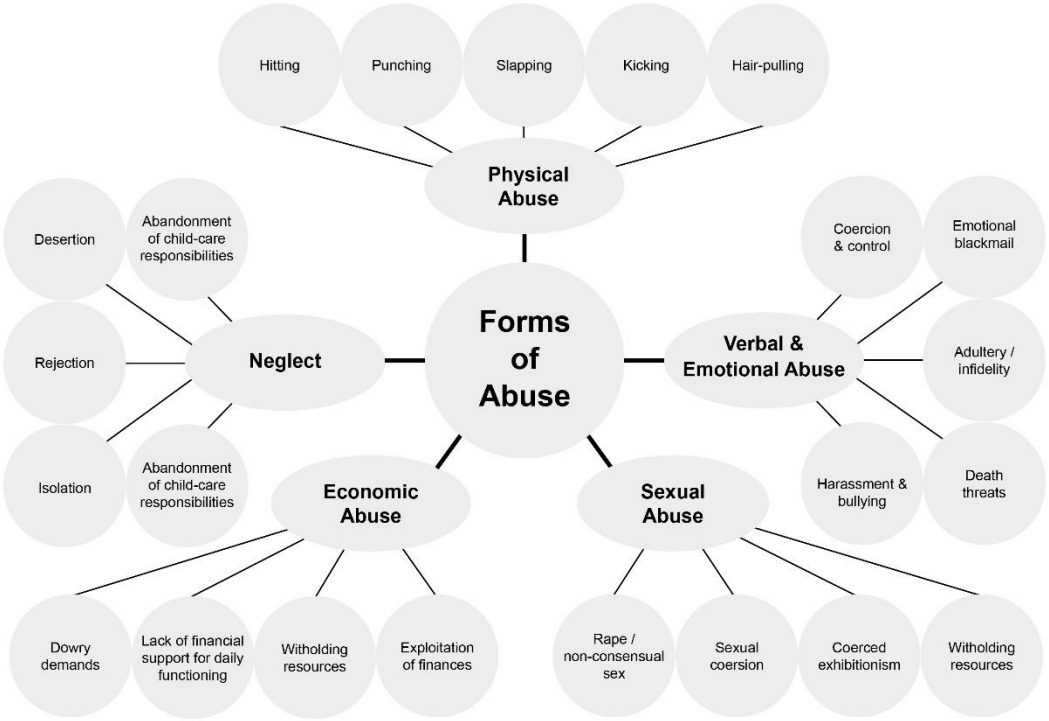
Table 3-3 Participant symptom scores

	IES-R		HADS			
Pseudonym	**Total**	**Status**	**Depression**	**Status**	**Anxiety**	**Status**
Annie	54	PTSD	12	Case	10	Case
Meena	49	PTSD	9	Borderline	16	Case
Geeta	26	Clinical concern	13	Case	13	Case
Sonia	72	PTSD	20	Case	20	Case
Vinny	50	PTSD	16	Case	15	Case

IES-R = Impact of Events Scale-Revised; HADS = Hospital Anxiety and Depression Scale

The interviews provided in-depth information regarding the type of abuse, violence and atrocities experienced by the participants. This was not analysed using IPA due to the descriptive nature of these findings. Consistent with previous research (International Center for Research on Women (ICRW), 2000; Krishnamoorthy et al., 2020; Panchanadeswaran & Koverola, 2005), all participants reported multiple forms of violence including physical abuse, emotional and verbal abuse, and economic abuse (Figure 3-1) which allowed for a comprehensive understanding of the lived experience of DV/IPV in this setting. Figure 3-1 depicts details regarding the forms of abuse experienced by the individuals.

Figure 3-1 Forms of abuse reported by the participants



Five superordinate themes emerged from the data and were considered to adequately capture the lived experiences of DV survivors in the Indian context. Table 3-4 provides an overview of the superordinate and subordinate themes for the data corpus overall and is discussed in turn.

Table 3-4 Master table of themes

Superordinate Themes	Subordinate Themes
Pre-abuse identity	Childhood precursors
	Life choices and expectations
Responses to abuse	Emotional and psychological reactions
	Somatic Symptoms
Inability to leave	Normalising and rationalising
	Coercion and manipulation

	Optimism and hope
Appraisals of abuse	What will people say?
	Resistance and counteracting
	Appraisals of the self and relationship
Managing abuse	Informal social and practical support
	Formal, institutional support
	Thinking about a future self

3.3.1 Pre-abuse identity

Owing to the narrative life-story technique of interviewing, it was possible to uncover participants' pre-abuse expectations from life, relationships, and personal ambitions. These views and perspectives are analysed with relevance to the abuse experience(s) and how they might have shaped the individuals' reactions to the abuse endured, and its long term impact.

3.3.1.1 **Childhood precursors**

Two conflicting, yet interrelated narratives emerged when discussing the childhood and upbringing of the participants. Both narratives are interpreted as uniquely relevant to the individuals' future reactions to, and appraisals of IPV. Some participants narrated happy memories from their childhood, characterised by close social bonds, affection, and a sense of trust and belonging. Geeta shared -

> *"My family pampered me because I was the only girl child, they would buy me everything I wanted. They took care of me well, bought me presents for birthdays, Christmas, weddings, and special occasions. They would give me everything I wanted."*

However, she remembered these memories in stark contrast to the abuse that followed.

> *"(Throughout my childhood) I never experienced any difficulties. I have never had to go hungry or starve. All of that changed with my marriage."*

Similarly, when narrating her experiences of physical abuse, Sonia found herself comparing her marital relationship to her childhood relationship with her family.

> *"No one has ever beaten me like this. In the rare event that I was hit as a child, it became a huge issue in the family. I would only get scolded verbally, never beaten."*

While participants were able to recollect positive memories from life periods that predated the abuse, such reminiscence was affected by how their lives had changed as a consequence of the abuse.

A difficult childhood marked by a lack of close social bonds, interpersonal relationships and warmth also seemed to be connected to how the narrator perceived the experience of abuse. Participants commented on how their adult lives were an extension of the same misfortune. This is interpreted through the lens of attachment theory, which emphasizes the importance of early childhood relationships in developing later social and emotional development (Ainsworth, 2014; Bowlby, 1969)

Meena, who spoke of losing her parents early in life had been raised by her grandmother who she perceived as distant. She spoke of wishing for a better life when she met her husband. However, this was not to be –

> *"I was feeling devastated about my life. I didn't receive love and care from anyone when I was young, not from my mother, and not from my grandmother. Moreover, the man I married doesn't care about me either."*

Similar to Meena, Vinny had grown up without parental bonds. Throughout her narrative, she shared her longing for close relationships with people around her. Through a potential marriage, she was eager to establish a connection with her partner's family which would allow her to fulfil her need for belongingness.

> *"I don't have a mother or a father, so I believed him when he said he wouldn't betray me. I trusted him, and I thought that I will have a better life and be part of a good family if I was with him."*

Vinny's relationship with the perpetrator was marked by severe neglect and physical abuse. These excerpts illustrate how childhood experiences of interpersonal relationships and attachment set

certain expectations of intimate relationships in adulthood. Positive memories could result in an expectation of perpetuity and security, thereby leaving the individual unprepared for the adverse experiences of abuse in the future. This was especially devastating to individuals who reported positive memories, wherein they felt unprepared to face such adversity.

Individuals who endured challenging childhood experiences displayed a hopeful outlook for their future. When these expectations were not met, they remarked on how they felt let down, deceived, and deflated. Overall, participants' narratives of their childhood and upbringing were strongly connected to how they viewed the experience of IPV. This is in line with Hazan and Shaver's adult attachment theory, (Hazan & Shaver, 1987; Shaver & Hazan, 1988) which proposed that adult romantic relationships are characterized by similar emotional and behavioural dynamics are child-caregiver relationships. Expectations and beliefs that individuals form about themselves and close relationships in adulthood are a result of their attachment histories and childhood experiences.

3.3.1.2 **Aspirations and expectations**

Taking the form of educational or career ambitions or their expectations from relationships, participants' personal aspirations had the potential to impact their meaning-making process.

Participants referred to their educational background and achievements as crucial to their life-story narration. Annie stated -

> *"I really enjoyed my studies. I was a meritorious student in school and in college. I wanted to do a Master's in Social Work but you know, in India, people start saying 'why don't you get the girl married?' I wasn't interested. I wanted to continue my studies."*

Annie's parents insisted on arranging her marriage due to societal pressures and norms that confer added status to the family, signals the completion of parental duty and preservation of the family line. Education has emerged as a significant contributor to the delay in the age at marriage for women in India (Bloom & Reddy, 1986), with recent research demonstrating that early age at marriage impacts women's educational status (Maertens, 2013). Annie's recollections were strongly impacted by her inability to pursue her educational and career choices, which she attributed to the marriage. She repeated her desire for higher education throughout the narration of her life story and decried future

relationships its favour. She implied that she did not believe that the two elements could co-exist for her -

> *"(I'm) excited just for my studies. After a while, I will continue my degree and then I can look for a job. Marriage is over in my life. I never want to get married."*

Other personal ambitions for participants were connected to societal notions of financial security and stability. Geeta's recalled –

> *"I felt that everybody else who was working was making a lot of money, and I wanted that life as well. I wanted to earn more than I was currently earning."*

These desires were reflected in her expectations of her partner -

> ***"**In my mind, I wanted someone who had good character, a good person. I wanted to settle down in life. But he has no responsibility towards me. When everyone shifts from a bachelor to family life, they become responsible for another person. They have to look after the house, they have to run it. As a man, he can't even do the bare minimum."*

In traditional patriarchal societies, women and men are expected to fulfil distinct roles in relationships. Familial ideologies dictate that the husband is expected to be the provider, while womanhood is constructed as economically dependent, acquiescent and passive (Tichy et al., 2009). While these notions are changing with more women seeking employment and financial independence in India, a large section of the population continues to favour the status quo. Sonia's narrative reflected the same –

> *"Neither does he give me money to run the household, nor does he give me money for the children. What will become of their future? I have cousins who married people in big houses with a lot of money. And this is my condition…"*

Sonia's faced significant IPV (physical, sexual, and emotional abuse) and severe neglect. She was also prohibited from pursuing any professional ambitions, which forced her to remain financially dependent on her husband. Sonia was the youngest participant from the sample and was fuelled by

her profound regret over time ‘lost’ as a result of the abuse. She shared her plans for the future, which challenged her previously-held outlook of relationships and marriage -

“I'll never get married again. I don't need to get married. If anything, I'll work hard and do it alone. I'll find a job and live alone. I don't need anyone in my life. One man has already ruined my life."

This was similar to Annie’s perspective of future relationships. In contrast, some participants persisted in their need for love, affection, and togetherness, reflecting strong-held beliefs about marriage and relationships. Geeta admitted –

“I want to be together. Isn’t that what marriage is about? He’s my husband. Why did I have to get married if we were going to live separately? I could have just lived with my parents. I wouldn’t have to deal with the stress of being apart.”

Varied perceptions of IPV experiences are indicative of individualised meaning-making processes. Despite a shared socio-cultural background, distinct pre-abuse self-concepts, notions of, and expectations from relationships differentially impact post-abuse beliefs. Pre-abuse identities are shaped by individual and family experiences and are guided by the prevalent social and gender discourse specific to the setting. Other factors that shape these identities and how they are impacted by the abuse include the degree and nature of abuse endured, situational factors and unique personality factors.

3.3.2 Responses to abuse

This theme covers the psychological and somatic responses of the participants to the abuse and/or the perpetrator.

3.3.2.1 **Emotional and psychological responses**

In the context of PTSD, emotions are categorised as primary or secondary. The former refers to emotions such as fear, anxiety, helplessness, or horror, while the latter refers to emotions such as sadness, anger, guilt, shame, and fear for the future (Hellawell & Brewin, 2004).

Sonia’s abuse was chronic and consistent, and she was on the receiving end of constant death threats. When recounting these instances, she expressed a great deal of peri-traumatic fear and anxiety.

"I was so scared. Why is he saying these things to me? If something like this happens what will my mother do with me? I was so anxious all the time, I was worried that he would come home and do something to me. I didn't know. If his father knows about this what will he do to me? I was so scared."

Flashback narratives are characterised by constant, unintentional shifts between present and past tense, occurring during a state of heightened emotion (Hellawell & Brewin, 2004; Pillemer et al., 1998). This is reflected in Sonia's narrative. In line with Pillemer et al. (1998), the dramatic shift occurred when Sonia was narrating an incident when her life was in danger, and the shifts indicated that she was no longer recounting an episode but reliving a salient aspect of it.

Annie recounted several instances of feeling helpless–

"He took me upstairs and said, 'no turning around'. I was totally in his control. My phone was with him. He would check my messages. If my parents called me, he would respond. I couldn't speak to my parents."

Annie referred to both physical control (not being allowed to leave the physical environment) as well as a figurative inability to escape the situation or feeling trapped, which are common in narratives of DV and IPV (Wuest & Merritt-Gray, 1999).

There were references to self-harm, suicide, and death in several interviews, indicating significant psychological distress. For Meena, her suicide attempt was accompanied by a sense of helplessness and despair.

"I poured kerosene on myself. I was feeling devastated about my life. Now I tell myself that I should have left but at that point, I couldn't do it. I thought to myself it would stop only if I died."

Sonia was still living with her perpetrator at the time of the interview. She saw no way to escape the cycle of abuse, echoing Meena's sentiments of a way out -

"I'm hurting everywhere, I can't speak. He does this to me every day. I cannot tolerate physical abuse anymore. I want to leave; I never want to come back. If I

have to stay here, then I think it's better to kill myself by drinking or eating something (poison)."

Secondary emotions indicate a degree of appraisal and interpretation. Several participants shared feelings of anger, frustration, sadness, grief, and loneliness. Vinny experienced a severe case of neglect and a perceived sense of betrayal. Throughout her narrative, she experienced constant shifts between emotional states. She was grieving the separation from the perpetrator and when asked to elaborate, her emotions instantly shifted to anger and numbing –

"I get very angry. I get very, very angry. My body, my hands, and my legs become numb. I get very angry and I don't know what I am capable of."

This was also reflected in other participants' interviews where emotions of fear were followed by intense anger and sadness or vice versa. This may be due to the familiarity with the perpetrator in all the cases (intimate partner) as opposed to an unfamiliar or unknown individual.

Several participants also shared feelings of guilt and/or shame when recounting their experiences of abuse. Meena was deeply affected by the impact of the tumultuous relationship she had with her perpetrator on her children –

"My daughter asks me why we keep fighting. I am so embarrassed. People fight, but they keep it confined within their home. I cannot. I shout on the streets, I go to the police station, so it is out in the open. Everyone witnesses everything, so I don't know what impact this has on my children. My daughter tells me that she's upset, and that is what makes me feel guilty."

In this instance, her feelings of shame and guilt arise from her appraisal of the abuse and what it means in the larger context of her life, i.e., her children. This is reflected in Sonia's narrative when she talks about her decisions regarding disclosure -

"I didn't say anything to my family. If I had said something, my mother would have been very stressed. She has high blood pressure and diabetes which get worse with stress. If I say anything and something happens to my mother, what will happen to us? I have a younger sister who is 10 years old. Now if this is

happening to me, what will happen to her? I think about all this and so I don't say anything."

Fear for their future or for that of their loved ones was a concern. Vinny expressed her fears –

"Because my childhood did not go well, so I felt that my daughter will also suffer the same fate as I did. I was upset about having a girl child. So I spat at the ground and cursed myself."

In India, filial and parental duties, along with societal perceptions assume substantial importance. The responses to DV/IPV transcend the individual and permeate other aspects of the domestic situation such as children, parents, financial matters, legal issues (in the case of separation or divorce), gender imbalances, and social norms and expectations. This results in a complex, multidimensional emotional and psychological state, with a predominance of both primary and secondary emotions.

3.3.2.2 **Somatic symptoms**

The presence of somatic symptoms associated trauma exposure in certain non-Western cultures has been established (Escobar, 1995; Hinton et al., 2011), and specifically, among Indian women and children with a history of abuse and sexual coercion (Varma et al., 2007). The data from the current study lend support to these findings. Most of the participants made references to somatic and physiological symptoms ranging from breathlessness and exhaustion, sleeplessness, loss of appetite and weight loss, fever, stomach-ache, and vomiting. Sonia recounted -

"He had his foot on my neck, and it turned blue. I started to bleed. When he saw this, he stopped and left. My clothes were soaked in blood. I was so scared, and I got a fever."

The physical abuse compounded by the intense fear and pain resulted in her developing a fever. High stress causes the body to produce greater levels of cortisol. Over time, high cortisol levels can cause inflammation and lower immune function, increasing the body's risk for viruses.

For Geeta, noticeable changes in her physical appearance over time seemed to reflect the emotional suffering and distress that she was facing.

"He took me to his client's house. They asked me why I looked so unhealthy. I used to be plump enough before with no health problems. Now, my appetite has reduced, I feel very low, and I've also lost a lot of weight. They asked me 'is that really you?'"

Vinny's distress led to a loss of energy and motivation, and like Geeta, she attributed the change to the abuse.

"I used to be extremely active. I could get so much done. But now I have no energy left to work. I have not had the interest to do anything for one year. I have been so tired; my body has no energy left. It is not possible for me to work. When I have to go to work, I feel like 'no I can't do it, there's no need to work today.'"

The chronicity of the abuse seemed to have taken a toll on the general health of the participants. In addition to experiencing illness during the course of the abuse as a result of high stress and emotional suffering, it is apparent that long-term abuse led to a gradual deterioration of physical health.

3.3.3 Appraisals of abuse

This theme attempts to capture how participants perceived the abuse beyond immediate emotional and physiological consequences.

3.3.3.1 **What will people say?**

A commonly heard phrase in India, this subordinate theme captures the importance of family, community, and culture and the interplay of these factors on the perception of IPV. Societal perceptions are paramount in determining and maintaining social class and status. The influence that these factors exert on individuals' perceptions of what is acceptable provide insight into the experience of abuse. Sonia struggled for years to share what she was experiencing with her family for the fear of being derided.

"Everybody used to ask me about what was happening in my home. How could I tell outsiders about the problems that happen at home? People mock me for being abused at home, so I don't say anything to anyone. I laugh and talk to everyone.'"

In traditional cultures, family strife and conflict are expected to stay within the 'four walls of the home'. Within a culture that places the family unit above the individual, victims and survivors are encouraged

to stay silent and endure the abuse, for the alternative is bringing shame to the family. This results in low disclosure rates and underreporting of abuse in these cultures. When Sonia finally managed to disclose the abuse to her mother, she did not receive the support she was seeking for these reasons.

“I called my mother and told her what was happening to me. She simply said, "you have just gotten married. If people find out that you want to leave already, what will they think? They'll make comments about you".

Maintaining appearances also emerged as a significant motivation to keep silent. Geeta had been forced out of her home and had to move back in with her family. While the separation in itself caused her significant agony, the stress of how their separation might appear to outsiders compounded her distress.

“We were apart from each other. I was pregnant. People asked me why I was back home within four months of marriage. This is not a happy situation for anyone. Why couldn’t he understand that? If a man is married and lives at home with his family, no one will question it. But I get questioned.”

When individuals learn to attribute importance to society’s perceptions of their actions, these notions influence how the abuse is perceived, understood, and responded to.

3.3.3.2 **Appraisal of self and relationships**

Adverse and insidious experiences such as IPV have the potential to effect long-term changes in the individual’s perspective of themselves. Survivors of IPV vary in the extent that they associate their personal identity to the abuse, either during or in its aftermath. Vinny’s referred to herself as betrayed, a lost cause, and unloved. This impacted how she viewed interpersonal relationships in general in the aftermath of the neglect.

“I don't have the faith that he will do anything for me. Or that anyone will do anything for me. I don't think my kids will look after me. He (perpetrator) will not look after me. In the end, I don't want to live.”

There is a sense of despair and worthlessness in Vinny’s narrative. This is in contrast to the optimism and hope that characterised the relationship in the beginning, which implies that the abuse had

changed her perception of herself from someone who deserved intimacy to someone who cannot be loved.

An excerpt from Meena's interview is linked to attribution theory and bias (Jones & Davis, 1965; Kelley, 1967) –

"He says dreadful things. He alludes that I sleep around with people, with the police. It's unbearable. I'm complaining to others because his physical abuse is painful, but he refuses to accept his mistake. What have I done to deserve this?"

When Meena's attempts to attribute causality to the perpetrator are futile, her perception of causation turns inwards. Meena attributes the actions of the perpetrator to her own failings and misgivings as a means of explaining his behaviour. She recounted the first instance of physical abuse –

"He beat me for not cooking, that's the first time he beat me. It was a brutal beating. I told myself it's because I didn't cook. Since then, whatever happens, I would cook food."

Pyszczynski & Greenberg (1987) called this a depressive self-focusing style, wherein an inability to reduce the discrepancy between actual and desired states results in a negative self-image.

Annie expressed that she had not been ready to get married at the start of the interview. In her case, the failed marriage and IPV felt like an affirmation that she was not meant to be married.

"A: Marriage is over in my life.

SR: Why do you say that?

A: Because I have gone through a lot. I just want to live with my parents."

She felt that she had been hindered in her quest for education and independence due to the marriage (and subsequent IPV). This sentiment was endorsed by Sonia, who had also felt forced into marriage as a result of societal norms.

"I'll never get married again; I don't need to get married. If I'm going to do anything I'll work hard and do it alone. I'll find a job and live alone. I don't feel the need for anyone in my life. One man has already ruined my life."

This excerpt illustrates an inherent faith in her capabilities to build a better life for herself. This exemplifies self-efficacy, a key construct of Bandura's Social Cognitive Theory (Bandura, 1997). Viewed in the context of the social structures of gender, power, and patriarchy that governed her early marriage to the perpetrator, this is viewed as personal growth in her identity and self-concept. The need for achievement was evident in both of the above excerpts, which are from the youngest participants in the sample. Gender roles in India are changing, as are notions of dependency and economic self-sufficiency among young women.

Annie articulated her learnings from the experience, implying posttraumatic growth (PTG) in the face of substantial trauma –

> *"I feel like I have taken it as a good experience. We learn certain things through experience. I have learnt who to trust. I never thought I would step into a police station. I did it and I learnt so much through fighting this battle. I feel good."*

PTG proposes that continuing personal distress and growth often coexist, which is apparent from this narrative (Tedeschi et al., 2018; Tedeschi & Calhoun, 2004).

3.3.3.3 **Resistance & counteracting**

While the tendency to endure the abuse was evident, IPV was also judged as unacceptable and intolerable by the same participants in other parts of the narrative. This demonstrates internal contradictions in how participants perceive IPV and its impact on their identity. They challenged their experiences and the fact that they had to endure them by raising questions of right and wrong, often accompanied by strong emotions of anger, justice-seeking, and reprisal. Although Meena's IPV was chronic and long-term, she was consistently intolerant of physical abuse.

> *"I couldn't bear the pain. When I woke up the morning, I was angry that he's slapped me. We were both yelling, so what was the need to slap me? I was furious. Over the years, if he beat me, I would go to the police station. I would let it go if it were only verbal."*

This is an act of negotiation with the perpetrator, where she was tolerant about some aspects of IPV (alcoholism, verbal abuse) but she communicated her breaking point.

The notion that women exercise varying levels of power in different circumstances is described by Hartsock (1990) as 'concrete multiplicity' of perspectives and is made evident within this superordinate theme. Vinny struggled to maintain a congruity between her affections for her partner, her hopes for a normal relationship and family life with the stark reality of the abuse as it unfolded over time. The resulting multiplicity of perspectives was reflected in her narrative –

"V: I want to die at his feet. I want him to die with me. If I don't get justice, I will not spare him.

SR: What kind of justice do you want?

V: I want my husband. I want him to love me. I want some standing in society. I want my husband to be with me until I die. I am very, very angry. I want him to realise how it feels when someone betrays a woman. I feel this way only because he has betrayed me."

For participants, the forms of strategic resistance vary in their strength and effectiveness based on the degree of cognitive dissonance they experience. In Vinny's case, the dissonance between her expectations or identity and the reality of the neglect and abuse became apparent over a period of time. She experienced a constant fluctuation in her ability to resist. Geeta, who also started from a place of optimism and hope quickly began to reconstruct what the relationship meant to her and the degree of dissonance between expectations and reality. She put up a fight early into the relationship by questioning the actions of her perpetrator, challenging the abuse, and involving family intervention.

"When he hurt me, I asked him 'Who would do this? Are you a man?' No one has ever beat me If there was no abuse, I would adjust. I couldn't raise my arm when he punched me. I called home and told them that he was beating me. My mom and younger brother came home and questioned him."

Geeta's narrative was strongly evocative of clearly defined gender roles and marital responsibilities. When her preferred identity contrasted her situational experience, she used resistance as a means of counteracting the dissonance.

In situations where the level of resistance was insufficient in resolving the dissonance, or wherein the degree of abuse was perceived as excessively severe, participants spoke of wanting to leave or

escape the abusive relationship. Sonia had planned to take an overnight bus to stay with a relative for safety until the perpetrator agreed to legally separate.

> *"I don't want to talk to him or see his face. I really hate looking at his face. That's why I came here, to ask when I should get the divorce papers when I can sign when I can leave from here. I don't want to live here in <name of place>. I want to leave him for good."*

The timing of separation, ending the abusive relationship and achievement of safety depends on the availability and effectiveness of support services such as family and peers (emotional and/or financial support) and welfare services (other forms of support and guidance). This is a crucial consideration when care planning or offering support services for victims and survivors.

3.3.4 Inability to leave

Four out of five participants reported ongoing IPV, and two of them were still living with their perpetrator at the time of the interviews. The process of leaving an abusive romantic or conjugal relationship is cyclical and can span several years. Characteristics of the relationship, personal factors, structural factors, and socio-cultural influences play a role in the leaving process (Wuest & Merritt-Gray, 1999). Three main processes were found to influence the participants' decisions to leave.

3.3.4.1 **Normalising and rationalising**

The participants used a few interrelated, yet distinct processes which rationalised and/or normalised the abuse and impeded the process of leaving. In some cases, participants covered up acts of violence. Before she sought help and protection, Sonia spent several years hiding bruises or attributing them to non-abuse related injuries –

> *"When he hits me with a belt, my hands and legs turn fully red. The marks and bruises remain for over 10 days, they don't fade. Everybody used to ask me, 'why are your hands red, what happened to you?' I'd lie and say say 'nothing happened, I just fell, hit something.'"*

This state of *enduring* is a part of a process of entrapment and recovery (Landenburger, 1989). Some participants suffered years of IPV before they disclosed their plight to outsiders. Years of socialisation

condition women in patriarchal societies to endure, forgive and forget, while safeguarding the public image of powerful male counterparts in society.

In a related vein, Meena appeared to absolve the perpetrator of his transgressions as an attempt to keep the peace within the household.

> *"Sometimes he gets drunk and beats the children and me, but he'd apologise later. He didn't do this before, but he does that now. I have to explain to the children that their father doesn't know any better."*

This is resonant with the '*boys will be boys'* sentiment, wherein men are not expected to assume responsibility for their damaging actions (Murnen et al., 2002; Weiss, 2009). In this excerpt, the intergenerational transference of unequal gender and power roles is evident, with Meena attempting to make excuses for the perpetrator's physical abuse to her children by attributing it to gender.

Often, situational attributions were offered as excuses for abusive behaviour. In Geeta's case, she repeatedly tried to find external causal judgments to excuse the perpetrator's behaviour.

> *"I wondered 'why is he hitting me?' I thought he was angry about something else, and so I used to keep quiet. I consoled myself that all this is being done because of anger, so he doesn't know what he's doing."*

In saying that the perpetrator is unaware of his actions and their repercussions, Geeta undermines the agency of the perpetrator in making a reasonable decision (i.e., *not* perpetrating physical violence). In the above excerpts, participants are effectively absolving the perpetrator of blame, which results in them staying in the abusive relationship.

The relativity of abuse was also identified as a means of rationalising by the victims. Meena recalls the decision-making process that drove her to stay in the relationship for over 10 years –

> *"Worse things have happened. Men would come home drunk and abuse and fight their wives. My friend's husband doesn't care about her. He talks to a lot of women and harasses them. She's his third or fourth wife. When she can accommodate her husband, why can't I? What is the point of blaming only my husband? So, I would let it go."*

In Meena's case, she deemed the nature of her abuse to be less significant when compared to her neighbour's experiences. Theories of social comparison provide a useful framework for understanding this tendency (Festinger, 1954; Hakmiller, 1966; Suls & Wheeler, 2000). Wills (1981) hypothesised that individuals can increase their subjective well-being by comparing their situation with those less fortunate, known as downward social comparison. Research on individuals facing relationship distress or low marital quality examined the hypothesis that these individuals would be more inclined to engage in downward comparisons leading to an enhanced evaluation of their relationship as 'not so bad after all' (Buunk et al., 2001). The effortful process of downward comparisons allowed participants to develop a lower reference point to evaluate their distressing experiences. Making downward social comparisons led to normalising red flags, problematic behaviours, or violent or manipulative tendencies.

3.3.4.2 **Coercion and manipulation**

Some participants considered themselves to be misled before entering a relationship or marriage with the perpetrator. They claimed false promises and/or material assurances were made that evoked a sense of optimism and hope for a 'normal' relationship and family life. In Vinny's words -

> *"At first, I wasn't very fond of him. But he said he loved me, and that he wouldn't leave me or betray my trust. He promised me and said that he has sisters like me so he would never do anything to hurt or betray me. He convinced me and based on all of his promises, I agreed to spend the night with him."*

Vinny claimed that the perpetrator had misled her into having sexual intercourse. At one point, she referred to it as *rape* when recounting that he broke off all ties with her after the first night. While Vinny felt manipulated into a sexual relationship, she attributed her inability to leave the relationship thereafter to having had sex with him. Premarital sex is still considered as a taboo by large sections of Indian society. A woman's worth is perceived to be intrinsically linked to her sexual choices and women are held to a different moral standard than men. Vinny's inability to move on from this relationship is interpreted against this backdrop of women's sexuality. Throughout the relationship, the perpetrator continued to maintain a sexual relationship with Vinny through coercion and material gifts. Vinny perceived these aspects of the relationship as a token of the perpetrator's love and affection and struggled to come to terms with the neglect for a long time.

Meena reported emotional manipulation throughout her relationship which prevented her from leaving.

"He would drink at night and abuse me. In the morning, he would apologise and say that he doesn't remember anything. Every single time, he would give me the same excuse of not knowing what he was doing or not being in his senses. How could I hand him over to the police? How could I leave? He loves me."

Meena had justified the abuse wholly as a result of the perpetrator's alcoholism. The situation was further complicated by the perpetrator's persistent remorse after every episode of abuse. The perpetrator also threatened self-harm and engaged in self-destructive behaviours as a response to her attempts to leave him. In one instance -

"He came to fetch me, but I didn't go back with him. He said if I didn't go with him, he would die. He went home, drank alcohol and he lit the house on fire. Everything burned down our clothes, our belongings. They had to break the door down and rescue him. He did this because I didn't go with him."

Blackmail is a form of emotional abuse and can be used by the perpetrator as a weapon of coercion to induce compliance, fear, guilt, or obligation. It could be used as a means to force the victim to endure the cycle of abuse over time, making it increasingly for them to difficult to leave.

In Sonia's case, she managed to seek help from a charity. When the perpetrator found out, he used death threats as a means to silence her.

"When I finally decided to come here (charity), he hit me. He threatened me - 'come on, let's go, I'll hit you in front of everyone, let's see who can stop me. I don't care if the police come, let me see what you can do.' I managed to come here anyway, and as I was leaving, he said 'I'll hit you right here, I'll kill you in front of everybody.'"

This is an example of how perpetrators of abuse use extreme forms of coercive power and emotional abuse to prevent victims from counteracting the abuse. According to Wuest & Merritt-Gray (1999), the basic social psychological process of leaving was known as *'reclaiming self'.* This involves counteracting the abuse and breaking free as the first two crucial steps, which is made difficult when

victims are faced with severe forms of emotional, sexual, and physical coercion to remain in the relationship.

3.3.4.3 **Optimism and hope**

A feminist-constructivist grounded theory model of women's responses to abuse highlighted women's construction of the meaning of their relationships as a crucial element of resistance and leaving (Allen, 2011). According to this theory, women's journey to leaving the abusive relationship can be traced to a starting point of optimism involving personal and family expectations. This was evident in Vinny's narrative. Their relationship was built on the foundation of hopes for intimacy –

> *"We were very close friends. I didn't know that he was married already to someone else. But I liked him a lot, his family, his sisters everyone were very nice. And he gave me so much love in the beginning."*

Vinny's journey was a quagmire of optimism and hope, interspersed with neglect and abuse. The incongruity in the relationship was reflected in the contradictions within her narrative, where she narrated aspects of abuse along with a deep sense of optimism and hope, and the lack thereof.

> *"I still love him as I did before, I still dream of him coming back. Every day I think that today is the day that he will come back to me. My true feeling is that he hasn't betrayed me and that he will come back. But now I realise that he has already betrayed me."*

At the time of Meena's interview, she had just gone back to living with her husband after being in a shelter for two weeks. She attempted to explain her reasoning behind multiple failed attempts to leave –

> *"He'd say that he trusts me and loves me and that he wouldn't have begged me not to leave if he didn't love me. He'd also say that he accepts his mistake, and that he would slowly give up alcohol, and that he couldn't do it all at once. He would cry to my children as well and they would ask me to forgive him. I felt really bad and I thought he would change his ways, so I went back to him".*

Meena tried to maintain congruity between her affections for the perpetrator and reality of the abuse. The optimism is drawn from the perpetrator's proclamations of love and apparent willingness to

change, a process that has been repetitive, tortuous, and inadequate. Every time Meena tried to negotiate, withdraw affections, or move away from their home, she was drawn back into the relationship through a renewed hope of transformation. Further, with children in the picture who maintained an affection for the perpetrator and hope for family life, it is often difficult for victims to make decisions with their well-being in mind.

"I don't want them to feel like they don't have a father. This is what I'm confused about and what I was worried about when I was in the shelter. My children kept asking me to try to talk to him. They want both of us."

Meena had already expressed significant guilt over the impact of the family discord on her children and hoped that by staying in the relationship, she would be able to nurture them with a stable family environment. According to Landenburger (1989), the stage two process of *enduring* is often centred around doing the best thing for children and is often accompanied by feelings of responsibility.

A different perspective is the Investment Model by Rusbult (1980). Victims' perception of rewards and costs, a fair balance between the parties involved, and their personal investment in the relationship are among the factors that influence leaving versus staying. Vinny's inability to move on from the abusive relationship was because felt that she was owed more than she had received -

"He is very rich and comes from a big, wealthy family. If he gives us what we deserve and what he owes us, then I could be happy, and I wouldn't cause him any trouble. But he hasn't done for me what a husband should do. All he did was buy us a TV. I want some standing in society. I want him to give my children what he owes them. He should get them married and stand by us."

Tichy et al. (2009), questioned the applicability of the Investment Model in India, where decisions about leaving are often made for the good of the family, as opposed to personal stakes. They posited that in this cultural setting, the family might encourage the victim to stay in the relationship to maintain a public image of normalcy. In this instance, Vinny perceived the imbalance in the relationship as a reason to stay and endure the abuse.

3.3.5 Managing abuse

Most of the participants had faced chronic, long-term abuse and neglect, and had managed its impact in their own way. A key concern of this study was to position the participants as experts, whose subjective experiences were considered valid in their own right. Hence, the analysis will refrain from commenting on the adaptational value of coping strategies that were used.

3.3.5.1 **Informal social and practical support**

The experience of abuse is impacted by the availability or non-availability of social support, resources, and services. This includes support from informal sources such as close family, friends, and the larger community that participants identified themselves to be a part of.

In Annie's case, unwavering support from her parents and close family provided both emotional and structural solace during difficult periods.

> *"Finally I feel like I am out of it. Basically, it's because of my parents. My relatives were of strong support for me too. When he was making death threats and trying to find out where I was, we had to hide, and our relatives supported us a lot. That is what helped me come out of all of this."*

Maintaining safety and fortifying their defences were crucial concerns for Annie and her family in the face of threat and danger from the perpetrator. This is especially critical when considering the plight of victims and survivors who do not have the access to informal support networks.

Vinny's neighbours consistently watched out for her health and safety during the worst years of neglect. When Vinny attempted suicide, they rescued her and supported her until she was physically and psychologically stable. In another instance, they arranged for the delivery of her child in a hospital due to the extended absence of the perpetrator.

> *"In the end, my neighbours admitted me to <name of hospital>. When the doctor asked me where the father of the child is, my neighbours covered for me and signed all the forms so that I could be operated upon. They prayed for my baby's health and mine, and they stayed with me the whole time."*

A combination of emotional and practical support from family and the community play an important role in the victim's experience of IPV, especially at their most vulnerable.

Material and financial support are crucial in circumstances of abuse. In the absence of financial support or access to employment, some participants subsisted on financial support from their own families. Sonia recalled –

"He took all the money we had. He spent all of it on girls (sex workers). I told mummy that there isn't any money at home, so we'll have to move out of the house. We hadn't paid rent for three months. I had no food at home. I told mummy that I couldn't do this alone. So once again, mummy gave me money."

Newman (1993) emphasizes the importance of structural factors such as interest from 'helpers' and financial assistance in making decisions about leaving or staying in abusive relationships. The findings here suggest that these structural supports are crucial to the emotional well-being and safety of victims and survivors, regardless of whether the abuse is ongoing or the decision to give up/leave has been made.

3.3.5.2 **Formal, institutional support**

Formal support sources include police and legal systems, social care, and welfare systems, and when necessary, judicial systems and processes.

Meena accessed local resources such as police in protecting herself and communicating to the perpetrator that abuse was unacceptable. In the absence of informal and community support, she was able to manage and cope with the worst aspects of the abuse such as physical violence and destructive behaviours with the help of the local police.

"I don't have brothers or a father to defend me. I have no neighbours who can defend me either because he would send them away saying they had no right to defend me. So, what was I supposed to do? The only people who could defend me is the police. They would come to my house when I would call them, they would keep him in custody to protect me."

However, there was no lasting action was taken against the perpetrator against any complaint that was made.

"… they said these things are 'between a husband and a wife'. They would advise him to behave, to not drink alcohol, and send him home. And the same thing would happen again."

Law enforcement authorities are part of a larger institutional ethos that is heavily influenced by the socio-cultural context. Conjugal relationships, especially when the couple is legally married is considered private, not subject to interference. In a system where gender roles and power structures are systemically unequal, men and women are expected to function within their attributed roles without disturbing the status quo. This explains the lack of escalation and legal action in instances of severe abuse and violence. This was reflected in Annie's negative experience with law enforcement authorities.

"The police were also supporting him. The inspector said to him, 'don't give her a divorce. Let her suffer for 10 years.'. When we were in hiding, he went to the police station to see if they could find my address. The police called us to the station and demanded our address. Why? They wouldn't tell us why."

Previous research has documented instances wherein police responses to abuse were compromised by law enforcement officers' personal relationships with perpetrators (Websdale, 1995). Annie was convinced that they had been bribed by the perpetrator and felt more unsafe due to their involvement. While it is not possible to verify the validity of her accusations, her experience and perceptions are important in the context of IPV experiences in India.

Other forms of social support include social care and welfare organisations. All participants had been recruited through a charity that provided support, legal, and counselling services to victims and survivors of abuse. When Annie failed to secure the support from law enforcement authorities, her social workers stepped in to enlist their backing. The police subsequently filed a First Information Report (FIR) which improved the case against the perpetrator. The social workers also provided emotional and practical support which helped Annie manage her stress with renewed optimism -

"I'm like I can face anything because <name of social worker> is there for me. And <name of caseworker> is there for me. And with their support, I am ready to face anything."

In the absence of other forms of crucial support such as family and community, formal social care support was incontrovertible. Sonia shared –

"There is no one to help me from the family or the outside (cries). I can only do something with the help of <name of charity>. If I need to get a divorce, they are the only people who can help me. There is no way out for me without their support."

In the presence of adequate support from social care and welfare organisations, participants were able to manage and cope with IPV, highlighting their crucial role in scaffolding victims and survivors.

3.3.5.3 **Thinking about a future self**

All the participants began their interviews with hope, ambition, and positivity, be it educational or career aspirations, hopes and expectations for relationships and family lives, or other achievement-related factors. Thinking about a future self-emerged as a significantly effective coping technique for almost all of the participants.

Sonia was eager to experience a life that was not characterised by abuse and demonstrated a strong desire for adventure and independence.

"If he gives me a divorce, I can live alone and I can be so happy. I think of the life I can have. I can learn some skills in a beauty salon, get a passport and get out of this country and work. I want to stand on my own two feet and live in peace. I don't want any stress; I want to be happy always."

Similarly, Annie aspired to achieve her unfulfilled ambition of studying social work and achieving financial security and independence.

"I just want to get a divorce and I can do whatever I want I still want to get my MSW done. I feel really good about that. I'll work hard and I can support my parents financially if I do this. This is still strong for me."

Both participants had a positive outlook for a future that did not involve the perpetrator. Looking forward was a form of coping or managing the impact of current abuse; they perceived their ambition as a motivation to end the cycle of abuse and move on.

Apart from personal ambition, financial stability and independence, some participants were motivated to build a better life for the sake of their children. Meena had negotiated with herself on several occasions when she thought about taking her life.

> *"I comfort myself when I think of my children. Why I should take my life for him? I should live for my children; there are four of them. My children deserve the love I didn't have. If I died, what would become of them? These thoughts helped me cope with his behaviour so many times."*

When Vinny reflected on having parented her children singlehandedly, she was able to envision a future for herself without the perpetrator.

> *"What will my children do if something happens to me? I have raised them completely on my own. I have worked in people's houses, paid the rent, fed, and clothed them and educated them. He did nothing for us, so when I look at my children, I think to myself that I don't need him. I can do this on my own."*

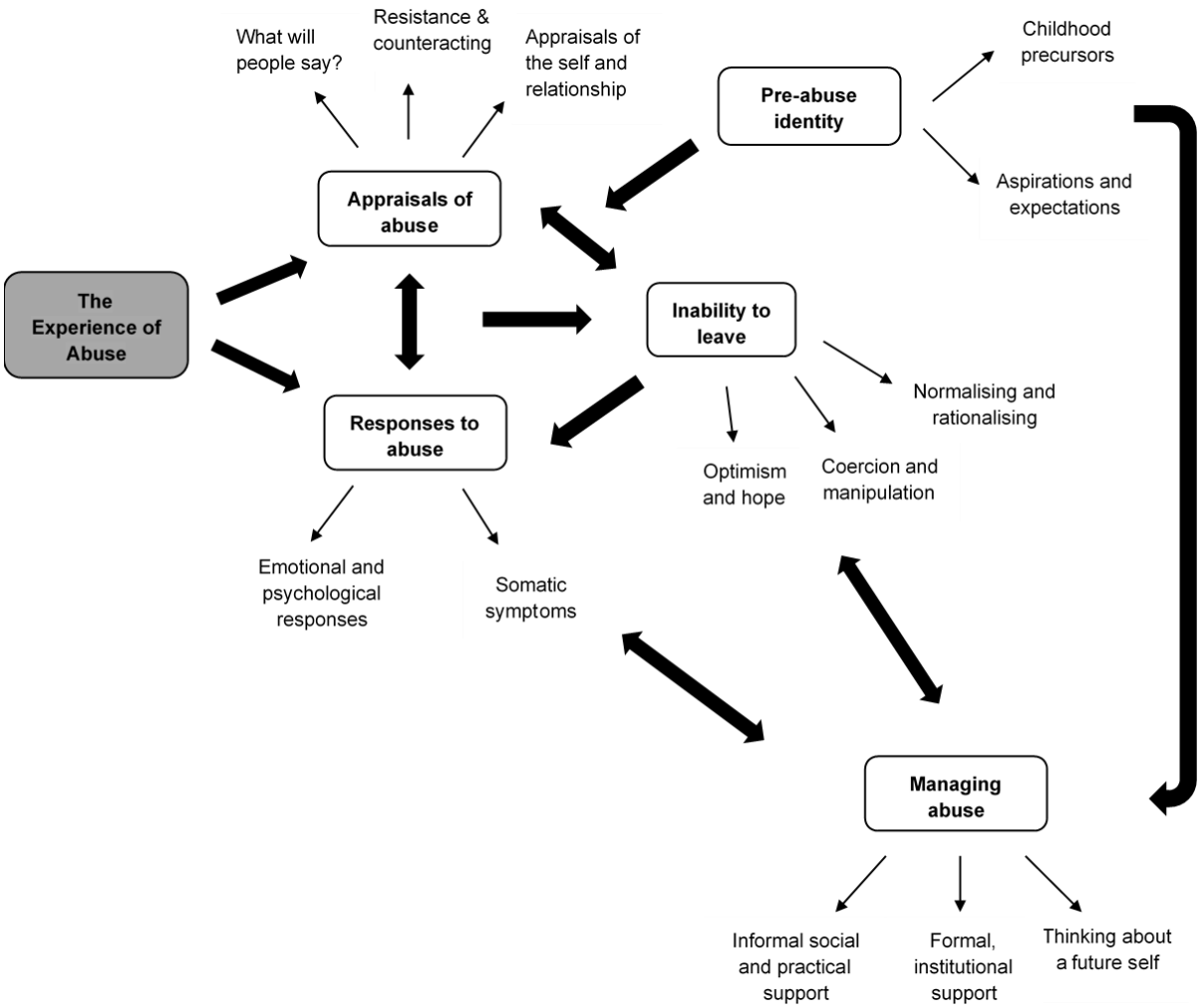
These findings collectively demonstrate how motivations for better life impacted the participants' ability to cope with the abuse. Imagining a future self that is empowered and unfettered by the abuse can be a powerful tool to manage the adverse impact of ongoing abuse on the well-being and mental health of abuse victims and survivors.

3.4 Discussion

An in-depth IPA of the lived experiences of DV was conducted on a sample of five women from south India to gain a holistic understanding of the DV experience. In Figure 3-2, the IPA model is presented to show the complex interplay of factors that characterise the experience of DV and abuse in this setting. The victim's appraisals and responses to DV interact with and influence each other in a multitude of ways. Negative appraisals of the self and the relationship result in heightened emotional distress. Alternatively, the experience of somatic symptoms plays a role in the victim acknowledging the severity of DV, which may lead to resistance and counteracting. Together, these factors impact the decision of the victim to endure chronic, long-term abuse and stay in the abusive relationship. Concern over societal stigma and shame results in the rationalising or normalising the DV experiences to avoid internal conflict. Alternatively, heightened psychological or physiological

responses to the abuse ultimately result in seeking help and leaving the abusive relationship. Factors that contribute to an inability to leave such as coercion and manipulation could lead to heightened distress. These factors mutually interact with the participant's appraisal of the abuse, of themselves, and the relationship. Together, these two superordinate themes are further influenced by another, which is pre-abuse identity. Pre-abuse factors such as childhood, upbringing, and life expectations were factors in how participants appraised their experiences of abuse, and their decision to stay or leave. Expectations of 'happy', secure relationships with an intimate partner led to an optimistic and hopeful perspective of the relationship, which played a role in their unwillingness to recognise abuse or leave. Some participants' upbringing within a traditional, patriarchal structural setting led concerns over how society would perceive their circumstances.

Figure 3-2 Lived experience of DV: A model



The IPA was influenced by my nuanced understanding and familiarity with the socio-cultural context. Specifically, the impact of systemic social, gender, class, legal and cultural domains on DV experiences were considered in the analysis and interpretation of the findings.

3.4.1 Help-seeking, disclosure, and avoidance

All the women had sought various types of formal support, ranging from emotional (individual and marital counselling services), financial and structural support (access to safe-homes, shelters), legal and judicial support (filing a case with the local police, filing a divorce petition), and educational (workshops, vocational training, capacity-building). While this indicates high disclosure rates and help-seeking behaviours, the amount of time it had taken participants to seek help following IPV varied within this sample. This is comparable to global accounts of disclosure among women survivors of DV, wherein research has found that while over three quarters of women disclose abuse, the nature and time to disclosure is highly variable (Evans & Feder, 2016). The feeling of being trapped and held under threat is commonly experienced when the abuse is domestic or perpetrated by an intimate partner and was echoed by several participants. In line with findings from other parts of the world, feelings of shame and guilt as a result of internalised or cultural stigma surrounding DV/IPV hindered help-seeking behaviours among survivors in this study (Fugate et al., 2005; Overstreet & Quinn, 2013; Lelaurain et al., 2017; Schauer et al., 2011).

An analysis of the 2015-2016 NFHS-4 data found a lifetime prevalence of spousal violence at 31% in India, with help-seeking behaviours found in only 13.5 % of this sample (Krishnamoorthy et al., 2020). They concluded that while one in three women in India faces IPV, only one in 10 women seek help following IPV. One of the factors associated with help-seeking behaviour was a higher level of education. In this study, the only participant who had a higher education degree had sought help immediately following the abuse, while also imminently initiating legal proceedings against the perpetrator. Separated/divorced women were also found to demonstrate a higher level of help-seeking behaviours in the survey (Krishnamoorthy et al., 2020), a finding which is supported by the data from this study. While three participants were currently separated from the perpetrator, two participants were seriously considering, and making plans for separation. Finally, exposure to sexual violence was found to be a determinant of help-seeking behaviour, a finding which is replicated in this study. Both women in this sample who reported sexual abuse had sought help relatively sooner than those women who primarily faced physical abuse, emotional and verbal abuse, or neglect. This is in contrast to the findings from a review of 90 studies from around the world by Lelaurain et al. (2017). In this review, while type of DV was found to influence help-seeking behaviour, victims of physical violence were more likely to disclose DV and seek help compared to victims of sexual or psychological violence. However, the to the differences in the type of help sought, i.e.,

formal versus informal in the case of sexual violence survivors. In the current study, the survivors of sexual violence first approached informal sources of support, similar to those in the studies reviewed by Lelaurain et al. (2017). As Satyen et al. (2019) have documented, there are wide ranging cross-cultural differences in disclosure rates and help-seeking behaviours practiced by women following IPV. This further cements the need to undertake in-depth research into the culture-specific barriers and facilitators to help-seeking behaviours in order to improve service development and delivery.

There was also a lack of avoidance observed in this sample as all participants demonstrated a clear willingness to construct and narrate details of DV and atrocities endured. There is mixed evidence from several small- and large-scale studies regarding the presentation of avoidance symptoms in the Indian context under Western DSM classification systems (Gilmoor et al., 2019). The average score on the avoidance subscale of IES-R was the lowest (M = 64) when compared to intrusion (M = 111) and hyperarousal subscales (M = 76). This lack of avoidance could be linked to the fact that all the participants had already sought help from the charity (varying disclosure rates aside) and had been engaging with their assigned social workers. They had also consented to participate in this research, which demonstrates a willingness to share their experiences. Another explanation is that the collectivist culture in India promotes cohesive social bonds and fosters an open environment for sharing burdens with the community (Gilmoor et al., 2019; Rajkumar et al., 2015). This is encouraging from the perspective of recovery and rehabilitation because interventions such as PE therapy and NET require clients to confront the trauma, overcome avoidance, and verbalise and communicate their experiences to aid recovery and adjustment.

3.4.2 Cognitive and affective responses

The semi-structured nature of the interviews allowed exploration into how women engaged closely and deeply with their experiences of DV. Overall, participants explicitly discussed the emotional, psychological, and physical burdens experienced as a result of IPV. It is well known that survivors of family violence and civil trauma are known to experience feelings of helplessness, isolation, and bullying (Schauer et al., 2011). The transcripts were strife with intense primary emotions such as fear, anxiety, and helplessness along with secondary emotions such as anger, guilt, shame, sadness, isolation, and numbing. These findings have particular relevance to better understanding the link between IPV and PTSD in this setting.

Brewin & Holmes (2003) reported that high levels of primary emotions during the experience of trauma were strongly correlated with the risk of PTSD 6 months later. The interviews reveal significant distress related to these emotional experiences, which aligns with the high PTSD symptom scores present in this sample. Further, some participants demonstrated *mental defeat,* which is a significant predictor of PTSD in trauma-exposed

samples according to the cognitive model (Ehlers & Clark, 2000). Mental defeat or the perceived loss of autonomy and a state of *giving up* in one's mind during the trauma is associated with persistent PTSD. Interpersonal violence such as DV, especially when perpetrated by a close, intimate partner can shatter an individual's self-esteem and self-worth over time (Barnett, 2000; Cascardi & O'Leary, 1992; Childress, 2013; Duxbury, 2006; Matheson et al., 2015), thereby contributing to a diminished ability to face adversity, retain one's identity, and lead to further entrapment (Follingstad et al., 1992). Mental defeat goes beyond helplessness, and it is a cognitive-affective reaction that has received little to no attention in DV and PTSD literature in India.

The sample also demonstrated a prevalence of secondary emotions such as anger, frustration, shame, guilt, and justice-seeking in their narratives. According to PTSD theorists, these emotions require a relatively high level of appraisal of the trauma, its impact on the sense of self and future goals (Brewin et al., 1996; Hellawell & Brewin, 2004). Through IPA, it was apparent these individuals had engaged in repeated re-telling of their trauma experiences either to sources of informal social support sources (family, friends, and relatives), or formal, institutional support services (law enforcement authorities, social care, and welfare workers). This is not uncommon when considering the intrepid role of community in the rehabilitation of psychological distress in India (Rajkumar et al., 2008; Rajkumar et al., 2015). Through such re-telling, they may have employed significant cognitive resources in processing their DV-related trauma, re-evaluating its meaning and re-structuring their thought patterns, beliefs and perceptions of their experiences (Schauer et al., 2011). Until now, there have been no in-depth investigations of the cognitive and affective responses of DV victims in India. These preliminary qualitative findings call for a deeper exploration of these factors in effecting recovery and adjustment through empirically supported treatments such as NET and PE therapy.

3.4.3 Socio-cultural and structural disempowerment of women

Understanding the conceptualisations of DV from women's perspective is essential to the work of social care and welfare workers, activists, and clinicians working with women in abusive relationships. While there is significant research into the prevalence, determinants, antecedents, and overall impact of DV in India, there is a lack of understanding of how women perceive their own experiences and how these experiences affect them. This knowledge is crucial when working to help and support these women and developing services and interventions that take their unique, expert perspective into account.

Tichy et al. (2009) discussed the notion of *patriarchal benevolence* in India, wherein women and men are expected to fulfil distinctly different, unequal roles largely affected by power dynamics and harmful stereotypes that favour men. While these notions and being challenged in certain sections of society (urban middle, upper-

middle, upper classes), a majority of the population still subscribes to these inherently inequitable social values, norms, and traditions (Ragavan et al., 2015). This is largely supported by the findings from this study, especially with regards to how participants appraised the abuse, themselves, and the world around them. Research by feminist theorists has consistently documented the impact of patriarchal ideologies on the prevalence of IPV in a range of cultural contexts (Lin et al., 2018), confirming that similar to the context in the present study, 'the endorsement of male dominance and inequitable gender roles significantly predict men's perpetration and women's experience of IPV' (Lin et al., 2018, p. 70) in other cultural settings as well. For instance, patriarchal ideology in the study by Lin et al. (2018) on Chinese women's experiences of IPV was represented through four variables including the *endorsement of male dominance, gender inequality, justification of IPV against women,* and *family privacy.* References of all of the above concepts were found in the interviews in this study as factors associated with the perpetration and perpetuation of violence against the participants, which further links patriarchal ideology to creating a culture of inequity, stigma and shame for survivors.

Overstreet & Quinn (2013) discussed an IPV stigmatization model of which *cultural stigma* refers to negative beliefs and stereotypes about IPV as a result of societal structures and influence. The authors found a significant impact of the sociocultural context in which IPV occurs; contexts with increased cultural stigma around IPV heightens internalized and anticipated stigma for survivors and victims. In fact, in this study, disclosure, help-seeking, resistance, and counteracting abuse were negatively impacted by the perception that relationship conflicts must be kept private, lest they cause shame and public embarrassment to the family and/or community at large. Some participants had internalised feelings of shame and guilt at the initial disclosure. In other cases, families of victims and survivors discouraged resistance, by offering short-term solutions and support such as financial assistance, practical support and other forms of aid that contributed to the prolongation and persistence of abuse.

A related effect of patriarchy and family-oriented belief systems was the negativity and lack of support from local law enforcement authorities in providing the victims with a safe space or sense of security. By either siding with the perpetrator, or by failing to provide long-term solutions due to preconceived notions regarding marital relationships and the role of women, police personnel's inaction led to increased vulnerability and depletion of personal resources of victims at a time of great need. These findings replicate those of Ahmed-Ghosh (2004), Panchanadeswaran & Koverola, (2005), and Ragavan et al. (2015). In line with the findings from this study, Panchanadeswaran & Koverola, (2005) also found that the most effective support services were provided by counselling centres and women's shelters. The reluctance to seek outside help, fear of shame and embarrassment to the family's reputation, the lack of backing from law enforcement and other formal support

services in other non-Western cultures is documented in a review of qualitative research into the lived experiences of DV (Childress, 2013) and further adds credence to the findings from this study.

This fundamental understanding of the link between patriarchal ideologies and IPV experiences of women needs deeper exploration. However, a review of IPV literature conducted by Lelaurain et al. (2017) found that only a few studies identified the role of patriarchy or male dominance as a social structure underlying IPV. While the impact of family values and collectivist mindsets in disempowering DV survivors are well-established in India, (Ragavan et al., 2015; Ragavan et al., 2014; Tichy et al., 2009), there is an urgent need to recognise that these orthodox approaches to gender, power, relationships, and abuse are harmful to victims and survivors. Firstly, they perpetuate the cycle of abuse without giving victims a way out. Negative social environments and negative appraisals of support are strong indicators of PTSD symptomatology, especially for women (Andrews et al., 2003; Dunmore et al., 2001; Ullman & Filipas, 2001). Secondly, they heavily impact victims' sense of self, thereby weakening their resolve to resist and counteract the abuse. Participants in this study discussed their lack of trust in romantic relationships and/or marriage while decrying their need for a male companion. They spoke of their '*lives being ruined by men'*, of being unable to control themselves, and feeling *'crazy'.* There is a wealth of evidence from other contexts and settings to suggest the negative impact of trauma exposure on the belief systems of individuals, wherein there is a general increase in negative beliefs about the self, others, and the world around (Brewin & Holmes, 2003; Dunmore et al., 1999). The study also uncovered a troubling pattern wherein women held a generally negative view of themselves in the face of trauma, signalling a sense of failing. There is evidence to show that negative perceptions of the self or symptoms predict slower recovery from PTSD (Brewin & Holmes, 2003). When compounded by the systematic oppression of women in this context, the effects of negative appraisals of the abuse, the self, social support, and trauma experiences can have devastating effects on the mental health and wellbeing of survivors. Accordingly, the social context must be critically considered when developing interventions and services aimed at DV support and recovery.

3.4.4 Reclaiming the self

A crucial aspect of DV research is investigating the experience of *leaving,* and it is especially relevant in a setting where abusive behaviours are normalised to the extent that women fail to recognise their experiences as abuse (Tichy et al., 2009). According to Wuest & Merritt-Gray (1999), the four-stage social psychological process of leaving, known as '*reclaiming the self'* consists of counteracting the abuse, breaking free, not going back, and moving on. The first stage, counteracting the abuse is a form of resistance which emerged as a significant aspect of the DV experience, despite the socio-cultural structures and systems that are unfavourable to women's rights. Resistance for the women in this study took the form of recognising maltreatment, abuse,

and neglect, questioning problematic behaviours, resisting in the face of continued, pervasive abuse, and fighting back. Once these women began to resist, disclosure to family and law enforcement authorities followed. In the face of ambivalent, inconsistent support, women reached out to social care and welfare organisations, sometimes without family support or a threat of severe danger and abuse. While women from different backgrounds face varying obstacles in their efforts to resist and counteract, all the women in this study were determined to effect change. However, only one participant had managed to reach the third stage of Wuest & Merritt-Gray's four-stage process of leaving. This could be ascribed to the varying duration of abuse and the time elapsed since disclosure within the sample. Nevertheless, it raises the question of why *leaving* is a difficult process. Childress (2013) conducted a meta-summary on the culturally diverse lived experiences of DV and found that in non-Western cultures, 'resilience' in the face of DV was encouraged as *leaving* was not a 'real' option. Examples from Jordan and Japan where women attempting to leave were faced with disparaging responses from formal services (law enforcement and lawyers) resonate strongly with the findings from this research and reiterate the cultural elements of *resisting* and *leaving* abusive relationships. Overall, Childress (2013) found that literature from non-Western countries consistently documented a greater emphasis on *endurance* as opposed to *exit*, a finding which was replicated in this research.

Women were also withheld in their efforts to leave by adverse retaliation from the perpetrator. When participants attempted to resist, disengage, break free or leave, they were met with emotional blackmail, death threats, threats of self-harm or destructive behaviours, sexual coercion, and entrapment, enhanced economic dependency, and further physical abuse. Leaving is a prolonged, iterative social psychological process that can potentially deplete the victim's personal, emotional, financial and community resources depleted (Wuest & Merritt-Gray, 1999). It becomes increasingly difficult to stay committed and motivated to leaving in rebuttal of the larger social context of family and community norms and beliefs when the abuse becomes increasingly severe, adverse, and insidious.

Abuse is often normalised and rationalised when the woman's subjugated position redefines what is right versus wrong and what is to be endured versus condemned (Ratna Kapur & Brenda Cossman, 1996; Sharma & Gupta, 2004; Tichy et al., 2009). To survive in a male-dominated society like India, women are forced to internalise and live by the social norms and values that dictate the tenets of conjugal, heterosexual relationships. Tichy et al. (2009) refer to the paradox of benevolence through subjugation, wherein the 'guidance' of women 'overshadows the identification of abusive application within these roles when they do occur, not only for the perpetrator but also for the victim' (p. 549). In such situations, women try to reduce the cognitive dissonance that occurs between their expectations from a relationship and the reality of abuse by

finding ways to deny, explain or cover up the abuse. According to Landenburger's (1989) theory of entrapment and recovery, this stage is known *binding*¸ or an early stage in the relationship where victims ignore, minimise, or explain away signs of abusive behaviour, coercion, or manipulation in an attempt to build a loving and long-term relationships. In this study, it took some participants years of *enduring* (stage two), before they actively tried to *disengage* (stage three). Childress' (2013) systematic review of qualitative findings consistently documented the normalisation and justification of DV against women based on cultural and societal structures across a range of contexts and settings such as Mexico, Japan, New Zealand, Jordan, and other Muslim countries.

A related cognitive coping strategy employed by participants in this study to manage the incongruity of their expectations versus reality was persistent optimism for change and transformation. Also known as *unrealistic optimism,* or optimistic bias, this is a well-established empirical phenomenon in social psychology (Weinstein, 1980). Optimistic biases are unfounded beliefs about positive outcomes which are unlikely. Both cognitive biases and self-serving motivational factors such as protecting self-esteem and guarding against psychological distress play a role in effecting optimistic bias (Taylor & Brown, 1988). In DV research, the optimism bias has mostly been researched in the context of *returning* to the abusive relationship (Handsel, 2007; Martin et al., 2000). In this study, perceiving a positive outcome (end of abuse, partner's change and transformation) as more likely than a negative outcome (continued abuse, severe danger) could arise from the need to sustain a *normal* relationship and family life. The possibility of diminishing marital/relationship discord by acquiescing to established social and gender norms could serve as motivation to sustain the optimism bias. Importantly, unrealistic optimism can reduce the victim's risk perception and impact safety behaviours.

Overall, a comprehensive understanding of why women *endure and* don't *leave* abusive partners in this context must be highlighted for the attention of social care and welfare organisations, clinicians and other first responders who work directly with victims of DV as they have strong clinical and practical implications. \

3.5 Methodological considerations

An effort to include participants who reported a wide range of IPV experiences might have impacted the homogeneity among the sample. While all the participants uniformly reported IPV, the nature and duration of abuse ranged from severe sexual abuse to severe neglect over a period of 6 months to over 10 years. According to Pietkiewicz & Smith (2014), the homogeneity of the sample depends on the extent that the similarity and variation can be contained in the analysis of the phenomenon. While the focus of this research was not on a particular form or type of abuse, future studies that seek to inform clinical practice about specific populations may purposively sample a more homogeneous cohort.

The participants were all at different stages in their individual process of managing DV. Consequently, the challenge was in finding the balance between respecting the diversity of individual experiences while also highlighting shared patterns, perspectives, and strategies. All of the diverse perspectives that arose have been analysed against theories and models that consider the stage-wise process of the DV experience and must be interpreted as such by the reader. It was not the intention of this research to provide insight into a particular stage of the process, and hence, the varied perspectives were crucial to a holistic understanding of DV in south India.

Due to the sampling technique, only women who had already sought help and were actively managing their abuse (in their own way) were enlisted in this study. As a result, the voices of those who had chosen not to, or were unable to seek help could not be included. Future research could employ community sampling techniques or access research participants through other channels (such as primary care/hospitals, law enforcement agencies) where diverse perspectives and interpretations of DV experiences may emerge.

Overall, the value of this research is grounded in the varied perspectives that arose, and the strength of an in-depth analytic method such as IPA allows for a rich exploration of diverse, individual voices who have a shared experience of a particular phenomenon.

3.6 Conclusion

This chapter aimed to contextualise the lived experiences of DV in the socio-cultural and geographical setting of south India. Through in-depth IPA, participants' unique perspectives of IPV from their vantage point were examined. Participants demonstrated a willingness to engage narratively and meaningfully by providing access to highly sensitive and complex thought processes and memories. Their interpretations and meaning attributions of DV, its deleterious impact on their social, emotional, cognitive, and practical resources, and their personal experiences of managing abuse provide a rich understanding of DV in this setting. IPV was emotionally and economically devastating and had long-term effects on the participants' belief systems and identity. In addition to endurance, an important set of findings that emerged through this analysis was women's experiences of defiance and resistance in opposition to being silenced. However, a related theme suggested that despite a sense of what abuse is, most of the participants continued to struggle with the decision to leave. The crucial role of family, community, and the shortcomings of formal institutional services were discussed in this context. The double hermeneutic allowed for an interpretation of the social context that fosters and enables the perpetuation of DV and must be considered as a vital factor when building explanatory models of DV in this setting. This research also uncovered the long term physical and mental health consequences of abuse. There

is an urgent need to develop culturally competent support services and models of care that focus on the alleviation of suffering at the individual level.

4 A meta-analysis of NET efficacy

4.1 Introduction

NET was developed specifically for use in low resource settings, and victims of organized and family violence. It has been evaluated using randomised-controlled trials (RCTs) primarily with refugee populations and asylum seekers, wherein the trauma experienced may be naturally caused or man-made. The focus in these situations is on the atrocities endured, usually at the hands of single or multiple perpetrators. Over time, NET has been used to treat other traumatised populations with/without a perpetrator, with acute or chronic PTSD sufferers. This has been evaluated in RCTs situated in a range of socio-cultural-economic settings.

NICE recommends NET as a first-line treatment option for PTSD along with CBT, CPT, and PE therapy (NICE, 2018). The American Psychological Association guidelines published a conditional recommendation for NET, claiming the evidence was insufficient for a strong recommendation (American Psychological Association, 2017). Strong recommendations were made for CBT, CPT, and PE. Similarly, VA/DoD found PE and EMDR to have the strongest evidence-base, while NET was found to have 'sufficient' evidence for a strong recommendation (VA/DoD, 2017). ISTSS also provided a standard recommendation for NET (ISTSS, 2018) and a strong recommendation for CPT, EMDR and TF-CBT. Overall, the evidence-base for CBT, CPT, PE and EMDR appears to be stronger when compared with NET. A systematic evaluation of the NET evidence base is essential to better inform clinical and practice guidelines regarding its efficacy.

4.1.1 Rationale for Review

Evaluating the existing evidence base of NET efficacy is a crucial preliminary step towards its implementation in low-resource settings. Narrative reviews of NET efficacy have found NET favourable to controlled comparisons in reducing traumatic stress in a range of socio-economic and cultural contexts including low dropouts and sustained improvements over time (McPherson, 2012; Robjant & Fazel, 2010). In one meta-analysis of NET efficacy, the authors found a medium effect size (g = 0.63) for PTSD symptom reduction post-intervention (Gwozdziewycz & Mehl-Madrona, 2013). This estimate was interpreted as evidence of NET efficacy, although it is not clear how the average effect size was calculated in terms of follow-up time points. The control groups used for comparisons with NET are varying and not restricted to 'bona fide' or active treatments, i.e., treatments that were intended to be 'therapeutic' (Wampold & Imel, 2015). RCTs used waitlist groups, no treatment groups, and supportive counselling as controlled comparisons to NET. Importantly, most reviews have not critically appraised the quality of the evidence, which makes these findings inconclusive regarding NET's true treatment efficacy.

4.1.2 Previous Reviews of NET

NET trials have been included in large meta-analytic studies of a range of psychological therapies for traumatic stress (Bisson et al., 2013; Patel et al., 2014). In these reviews, the methodological rigour of the included NET trials was questioned. Further, both reviews included only a small number of NET trials each (N = 07, Bisson et al., 2013; N = 04, Patel et al., 2014), and since their publication, several recent trials investigating NET efficacy have been published. This suggests a need to conduct a comprehensive, up-to-date quality appraisal of the NET evidence base to inform researchers and practitioners.

Only one other comparable meta-analytic review was identified at the time of this review (Lely, Smid, Jongedijk, Knipscheer, & Kleber, 2019). The authors of this review concluded that despite methodological weakness in the included trials, there is empirical support for NET as a trauma intervention for symptoms of PTSD and depression. However, at least seven published RCTs of NET efficacy have not been included in the review, and only trials published before 30 April 2018 were included. Moreover, the authors have used 'last follow-up' as the uniform follow-up time-point. NET trials vary significantly in their measurement of outcomes, especially concerning data points. In Lely, Smid, Jongedijk, et al.'s (2019) meta-analysis, this ranged from 09 – 52 weeks. They also do not include PTSD diagnostic status (i.e., meeting the criteria for a diagnosis of PTSD) as a measured outcome, which could potentially be an important consideration when making a recommendation for clinical efficacy.

In this paper, a meta-analysis of NET efficacy is conducted using all available data from NET RCTs published before 08 December 2019. The term 'efficacy' is used unequivocally throughout this paper as NET RCTs have predominantly evaluated the intervention under ideal and controlled circumstances (Roland & Torgerson, 1998).

For the meta-analysis, the pooled intervention effect of NET will be estimated against controlled comparisons on outcomes of PTSD (symptom severity and diagnostic status) and depression symptom severity. Due consideration will also be given to issues of heterogeneity and methodological quality of the included trials.

4.1.3 Aim

This research aimed to systematically evaluate the evidence-base for NET efficacy in alleviating PTSD and depression outcomes through a meta-analysis of RCTs. The data reported in this meta-analysis conforms to the PRISMA framework, which is an evidence-based minimum set of items for reporting in systematic reviews and meta-analyses (Moher et al., 2009) (Appendix F).

4.2 Methods

4.2.1 Research Question

The PICO strategy was employed in framing the research question for this review (Higgins et al., 2019; Richardson et al., 1995). PICO represents an acronym for Patient or Problem, Intervention, Comparison and Outcome. Table 4-1 presents the PICO framework for this review.

Table 4-1 PICO framework

PICO	Description
Patient/**P**roblem	Individuals with trauma exposure presenting with PTSD outcomes, symptoms of psychological stress or psychological trauma
Experimental **I**ntervention	Narrative Exposure Therapy
Comparison Intervention	All comparisons interventions to be included
Outcomes	Reduction in PTSD symptom severity, depression symptom severity, change in PTSD diagnostic status

4.2.2 Search Strategy

The search strategy was based on the PICO framework and the key search terms are presented in Table 4-2. The local databases searched were PubMed, CINHAL, PsycINFO, Medline, Cochrane Library, and Embase. The original authors of NET were contacted and asked to provide a full publication list of NET research. The reference lists of relevant journal articles were also hand-searched to identify all eligible RCT publications.

Table 4-2 Key search terms

narrative exposure*[Title/Abstract] OR "narrative exposure therapy"[Title/Abstract] OR "NET"[Title/Abstract] OR narrative therapy [Text Word]
"ptsd"[Text Word] OR posttraumatic stress*[Text Word] OR post-traumatic stress* [Text Word] OR "psychological trauma "[Text Word]
randomi?ed controlled trial[Publication Type] OR "RCT"[Title/Abstract] OR controlled clinical trial[Publication Type] OR randomi?ed[Title/Abstract] OR randomly[Title/Abstract] OR trial[Title/Abstract]

4.2.3 Study Selection

Search results that fulfilled the selection criteria were scrutinised at the abstract and full-text stage independently by two reviewers, myself (SR) and an MSc student (NS) who was completing an internship with my primary supervisor (NH). Appropriate data were extracted independently by SR & NS and disputes if any were resolved by NH.

4.2.4 Inclusion Criteria

4.2.4.1 **Types of studies**

Original RCTs using NET (or an adaptation of NET) were included. Inclusion criteria for the trial population were individuals with a history of exposure to trauma, and reporting PTSD outcome measures (diagnostic status and/or symptom severity) following such exposure. No restrictions were placed based on the type of trauma experienced by the population. The search was not limited to RCTs with participants over 18 years of age. Instead, we chose to exclude studies that used the version of NET adapted for children below the age of 18 years; KIDNET (Onyut et al., 2005). From an initial scoping review of the NET literature, it was anticipated that some trials may include a combination of both adults and underage (< 18 years) participants, especially in the case of refugees and asylum seekers. Further, KIDNET was developed and tested for efficacy merely three years since the first publication of NET (Neuner et al., 2002), which would make it the preferred choice for studies strictly recruiting participants under 18 years of age. By not placing an explicit age-restriction, and instead of using the KIDNET filter, we aimed to include all available data published on NET trials conducted with adult participants.

Studies from any part of the world, implementing any control comparisons were included. No restrictions were placed on the number of control comparisons. Outcome measures included PTSD (scales or diagnostic interviews) and depression symptoms. Only English language publications were chosen for inclusion. Conference abstracts were excluded.

4.2.4.2 **Timing of outcome assessment**

End-point assessments were used. NET does not have a fixed number of sessions or intervention duration, and we anticipated some variations in timings of outcome assessments across studies. As a result, we estimated effects: a) short term (3-4 months), b) mid-term (6-7 months), and c) long-term (12 months or above).

4.2.5 Selection and Screening

Two reviewers independently screened all titles and abstracts. Full-text articles were reviewed for inclusion and data was extracted independently by SR & NS. Cohen's Kappa statistic was calculated to indicate inter-rater

agreement at the title and abstract screening stages (Cohen, 1960). Kappa values were interpreted using Landis & Koch's (1977) guidelines. Included publications were extracted for relevant data, and disagreements were resolved by the primary supervisor.

4.2.6 Risk of Bias

Two reviewers (SR & NS) independently assessed the risk of bias by using criteria according to version 1.0 of the Cochrane Collaboration's risk of bias tool for randomised trials (Higgins & Green, 2011). At the time of completion of this review, there was no mandate to use the updated version (RoB 2.0; Sterne et al., 2019), and it was still being pilot tested by the Cochrane Review teams (Cochrane Library, 2019).

4.2.6.1 **Inbuilt domains**

These included random sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessment, incomplete outcome data and selective reporting.

4.2.6.2 **Additional domains**

In addition to the inbuilt domains in the risk of bias tool, two domains of risk were included: assessment issues and therapist qualifications.

4.2.6.2.1 *Assessment issues*

Criteria for low risk of bias included the use of valid and reliable measures or the use of translated measures with sufficient psychometric properties. In the absence of such information for translated versions, the risk was deemed unclear. When trials failed to report whether measures were valid and reliable, or when there was a lack of clarity regarding attempts to translate and back-translate standardised measures, the trials were considered to have a high risk of bias.

4.2.6.2.2 *Therapist qualifications*

Trials that reported details of the therapist's NET training and qualifications qualified for a low risk of bias. If such information was found insufficient or lacking, the trials were rated as having an unclear risk of bias. If the intervention was delivered by untrained individuals with a lack of relevant qualifications, or if the study did not report any information at all, it was rated as having a high risk of bias.

Funnel plots were examined for comparisons with 10 or more trials to indicate publication bias in line with the rule of thumb recommended by the Cochrane Handbook for Systematic Reviews (Higgins et al., 2019). Disagreements were resolved by NH.

4.2.7 Data Synthesis

A random-effects (RE) model was used to calculate the standardised mean differences (SMD) and 95% confidence intervals (CI) for continuous outcomes. The odds ratio (OR) and 95% CIs were calculated by using a RE model for dichotomous variables. When trials reported multiple treatment arms, the non-NET active treatment arm was treated as a control group and was combined with the non-active treatment control group (such as waitlist or no-treatment controls) to generate pooled mean and SD values. Study authors were contacted for missing data, such as means and SDs. If these data could not be obtained, those trials were excluded from the meta-analysis. The desktop version of Review Manager (RevMan, version 5.3) was used for data analysis (*Review Manager (RevMan)*, 2014).

4.2.8 Assessment of Heterogeneity

Visual inspection of graphs, a mantel-Haenszel Chi^2 statistic, and I^2 statistic was used to test for heterogeneity. An I^2 estimate greater than or equal to 50% accompanied by a statistically significant Chi^2 statistic, was interpreted as evidence of substantial levels of heterogeneity.

4.2.9 Subgroup Analysis

From a clinical perspective, combining studies that varied by the type of trauma experienced by the participants and the type of control conditions used in the analysis could impact the findings. To investigate the influence of such variability, two subgroup analyses were conducted. The first subgroup analysis was based on the type of control, i.e., active treatment vs no treatment. Type of traumatic event was also used for a subgroup analysis between trauma with a perpetrator (such as war trauma, combat trauma, abuse and violence, torture), and trauma without a perpetrator (such as natural disasters, occupational trauma).

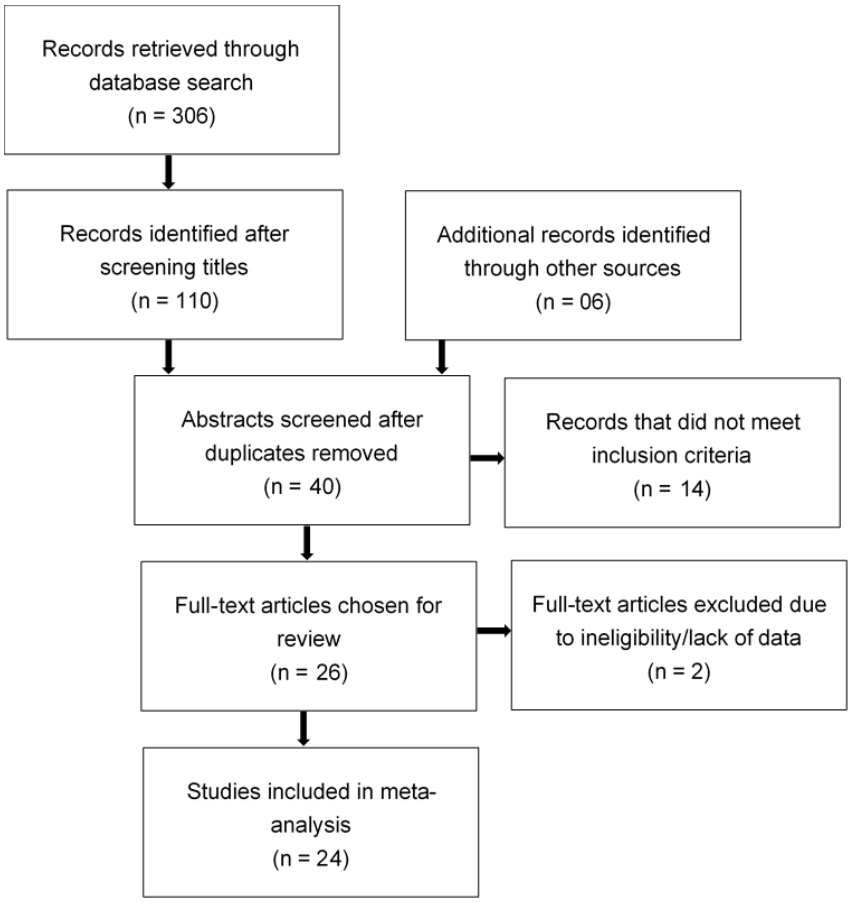
Further, an initial scoping review of the NET evidence-base suggested that several trials used adaptations of NET in their intervention arm. This could potentially contribute to heterogeneity estimates. A subgroup analysis based on the version of NET used as the experimental intervention was planned to investigate such effects. Age is also a potential effect-modifier. If enough studies (N = 10; Higgins et al., 2019) with participants below 18 years of age are found, a subgroup analysis based on age was planned.

4.2.10 Sensitivity Analysis

The effects of excluding trials with a high risk of bias or those that appeared to be outliers upon a visual inspection of forest plots were conducted as part of the meta-analysis. When the removal of these studies did not change the direction or significance of the treatment effect, they were included in the final analysis.

4.3 Results

Figure 4-1 PRISMA flow diagram



A total of 306 results were retrieved from the database search and 110 were chosen after screening titles. Inter-rater agreement for screening titles was substantial (k = 0.676*).* Six studies were added from the NET reference database received from NET authors. After discarding duplicates (N = 76), the abstracts of 40 records were screened for inclusion. The PRISMA flow diagram in Figure 4-1 illustrates the selection of the studies.

Fifteen studies were excluded due to the following reasons: a) conference abstracts (02), b) study protocols (03), c) dissertation copy of an included study (01), d) KIDNET studies (03), e) non-RCTs (02), f) non-experimental study (01), g) NET was not the intervention in question (02), and h) PTSD not measured as an outcome (01). Interrater agreement for screening abstracts was almost perfect (k = 0.896).

Twenty-six full-text studies were retrieved for full-text review. Two studies had to be excluded at this stage; one study did not meet the randomisation criteria (Crombach & Siehl, 2018) and the authors of the other study were unable to provide the required data for the meta-analysis (Hinsberger et al., 2017). Twenty-four trials were included in the final meta-analysis. For a detailed description of the studies, please refer to Table 4-3.

4.3.1 Description of Studies

4.3.1.1 **Sample sizes**

A total of 1391 participants were recorded in the trials included, with sample sizes ranging from 18 to 277. All studies provided details of attrition during treatment except one (Morath, Moreno-Villanueva, et al., 2014). The rate varied between 0% to 38.64% attrition, with a mean attrition rate of 7.43% during treatment. Studies that reported dropout data suggested the sensitive nature of refugee and asylum status (such as camp closures, receiving asylum, disappearance, transfers, etc.) were commonly reported causes. Other reasons included lack of motivation or trust, psychosocial problems, spontaneous remission, and lack of time. In one study, two NET participants and one control group participant dropped out due to the high intensity of emotions experienced evoked by reliving traumatic memories (Orang et al., 2018).

Table 4-3 Characteristics of included studies

Study	Population	Location	Intervention	Controls	Psychological outcomes
Adenauer et al. (2011)	Refugees and asylum-seekers	Germany	NET (N = 16)	WLC (N = 18)	Trauma exposure PTSD symptoms Depressive symptoms Comorbidities
Alghamdi et al. (2015)	Firefighters	Saudi Arabia	NET (N = 17)	WLC (N = 17)	PTSD symptoms Depression symptoms Anxiety symptoms Coping skills Social support

AlHadethe et al. (2015)	Young refugees	Iraq	NET (N = 20)	Emotional Freedom Technique (N = 20), No intervention (N = 20)	Traumatic events PTSD symptoms Anxiety symptoms Depression symptoms Coping strategies Religious coping Social support
Bichescu et al. (2007)	Former Romanian political detainees	Romania	NET (N = 9)	Psychoeducation (N = 9)	PTSD diagnosis PTSD symptoms Depression symptoms
Crombach & Elbert (2015)	Former street children	Burundi	FORNET (N = 15)	Treatment-As-Usual (TAU) (N = 25)	Exposure to traumatic events PTSD diagnosis PTSD symptoms Recent offences Appetitive aggression
Ertl et al. (2011)	Former child soldiers	Uganda	NET (N = 29)	Academic catch-up (N = 28), WLC (N = 28)	Potentially traumatic events PTSD diagnosis PTSD symptoms Major depression symptoms Suicide risk and ideations Trauma-related guilt Survivor guilt

					Perceived stigmatization
Hensel-Dittmann et al. (2011)	Refugees & asylum-seekers	Germany	NET (N = 15)	Stress Inoculation Training (N = 13)	Experiences of organized violence PTSD symptoms Depression symptoms Comorbidities
Hermenau et al. (2013)	Former child soldiers and ex-combatants	Congo	FORNET (N = 19)	No intervention (N = 19)	PTSD symptoms Appetitive aggression Integration
Hijazi et al. (2014)	Iraqi refugees	USA	Brief NET (N = 41)	WLC (N = 22)	Posttraumatic growth Well-being Posttraumatic stress Depression symptoms Somatic symptoms
Hinsberger et al. (2019)	Ex-prisoners & at-risk youth	South Africa	FORNET (N = 20)	CBT (N = 20), WLC (N = 48)	PTSD symptoms Appetitive aggression Perpetrated Violence
Jacob et al. (2014)	Genocide victims (widows & orphans)	Rwanda	NET + IPT (N = 38)	WLC (N = 38)	PTSD severity & frequency PTSD diagnosis Functional impairment

Köbach et al. (2017)	Former members of military groups	Congo	FORNET (N = 29)	TAU (N = 23)	Exposure to violence PTSD diagnosis PTSD symptoms Appetitive aggression Depression diagnosis Depression symptoms Drug dependence
Lely, Knipscheer, Moerbeek et al. (2019)	Older adults with trauma exposure (political, sexual and childhood trauma)	The Netherlands	NET (N = 18)	Present-Centred Therapy (N = 15)	PTSD diagnosis PTSD symptoms
Morath, Gola, et al. (2014)	African & Middle Eastern refugees	Germany	NET (N = 17)	WLC (N = 17)	Exposure to violence PTSD symptoms Depression symptoms Comorbidities Somatic complaints
Morath, Moreno-Villanueva, et al. (2014)	African & middle eastern refugees	Germany	NET (N = 19)	WLC (N = 19)	PTSD diagnosis PTSD symptoms
Neuner et al. (2004)	Sudanese refugees	Uganda	NET (N = 17)	Supportive counselling (N = 14), Psychoeducation (N = 12)	PTSD diagnosis PTSD symptoms Traumatic experiences, health Depression symptoms Anxiety symptoms Psychological Functioning

Neuner et al. (2008)	Rwandan & Somalian refugees	Uganda	NET (N = 111)	Trauma counselling (N = 111), No intervention	PTSD diagnosis PTSD symptoms Physical health
Neuner et al. (2010)	Asylum-seekers	Germany	NET (N = 16)	TAU (N = 16)	Traumatic experiences PTSD diagnosis PTSD symptoms Pain symptoms Depression symptoms
Orang et al. (2018)	Intimate partner violence survivors	Iran	NET (N = 24)	TAU (N = 21)	PTSD symptoms Depression symptoms Perceived stress Abusive behaviours Traumatic events Childhood traumatic events Disability Borderline symptoms
Pabst et al. (2014)	Physical/sexual abuse/assault survivors	Germany	NET (N = 11)	Treatment by experts (N = 11)	PTSD diagnosis PTSD symptoms BPS Depression Dissociative symptoms
Schaal et al. (2009)	Genocide orphans	Rwanda	NET (N = 12)	IPT (N = 14)	PTSD diagnosis PTSD symptoms Depressive symptoms Depression symptoms Guilt

Stenmark et al. (2013)	Refugees	Norway	NET (N = 51)	TAU (N = 30)	PTSD diagnosis PTSD symptom Depression diagnosis Depression symptoms
Zang et al. (2013)	Earthquake survivors	China	NET (N = 11)	WLC (N = 11)	PTSD symptoms Depression and anxiety General mental health Positive and negative posttraumatic changes Social support Coping style
Zang et al. (2014)	Earthquake survivors	China	NET & Brief NET (N = 20)	WLC (N = 10)	PTSD symptoms Depression and anxiety General mental health Positive and negative posttraumatic changes Social support Coping strategies

NET = Narrative Exposure Therapy; FORNET = Narrative Exposure Therapy for Forensic Offender Rehabilitation; WLC = Waitlist Controls, PTSD = Posttraumatic Stress Disorder, IPT = Interpersonal Psychotherapy, CBT = Cognitive Behavioural Therapy, N = number of participants randomised

4.3.1.2 **Setting**

Studies were conducted across the world. Studies from Europe were mostly conducted in Germany, with one study each from The Netherlands, Norway, and Romania. One study was conducted in the USA. Many studies were conducted in African countries including Rwanda, Uganda, Burundi, and Congo, with one study from South Africa. Studies from Asia were conducted in China, Iraq, Iran, and Saudi Arabia.

4.3.1.3 **Participants**

The mean age across trials ranged between 17 to 70 years. Most participants were survivors of war trauma and organised violence and were either refugees or asylum seekers. In four studies, traumatized offenders such as former street children, former child soldiers and ex-combatants were included. In two studies, survivors of genocide comprised of the population studied. Survivors of sexual and/or physical abuse were included in three studies. Survivors of natural disasters such as floods victims in Burundi and earthquake victims in China were included in three studies. One study focused on the traumatic exposure of firefighters.

4.3.1.4 **Interventions**

Manualised NET was administered in the intervention arm in 18 studies. Four trials used an adaptation of NET known as Narrative Exposure Therapy for Forensic Offender Rehabilitation (FORNET) (Hecker et al., 2015) meant for persons with a history of perpetrated violence. In two trials, different versions of brief NET were used. In one trial, a combination of NET and Interpersonal Psychotherapy (IPT) was used.

The most common control condition was waitlist controls (WLC; ten trials). Five studies provided Treatment-As-Usual (TAU). NET was compared with no intervention groups in three trials, to psychoeducation in two trials and 'Treatment-By-Experts (TBE) in one trial. NET was also compared to other active trauma-focused interventions including Emotional Freedom Technique (EFT), Academic Catch-Up, Stress Inoculation Training (SIT), Interpersonal Therapy, and Present-Centred Therapy (see Table 4-3). No studies were identified using pharmacological control conditions. A mean of 7.58 sessions of NET therapy was delivered across all 24 included trials with a range of 14.2.

4.3.1.5 **Outcomes & Assessments**

Twenty-three trials reported the severity of PTSD symptoms as one of the primary outcomes, and 13 trials reported PTSD diagnostic status as a measured outcome. The Clinician-Administered PTSD Scale (CAPS) (APA, 1994) was used to diagnose and assess the frequency and severity of PTSD symptoms in nine trials. Other measures that were used included the PTSD Symptom Scale (PSS – I) (Foa et al., 1993; Foa & Tolin, 2000), Composite International Diagnostic Interview (CIDI) (WHO, 1990), Post-Traumatic Stress Diagnostic Scale (PDS) (Foa et al., 1997), Scale of Posttraumatic Stress Symptoms (SPTSS), Harvard Trauma Questionnaire (HTQ) (Arabic version) (Shoeb et al., 2007), and the Impact of Events Scale-Revised (IES-R) (Weiss & Marmar, 1997b).

Depression symptom severity was most commonly measured in trials along with PTSD symptoms (N = 18). Trials used a range of diagnostic interviews and self-report measures to diagnose and assess depression outcomes. These included the Hamilton Depression Rating Scale (HAM-D) (Hamilton, 1960, 1967), Hospital

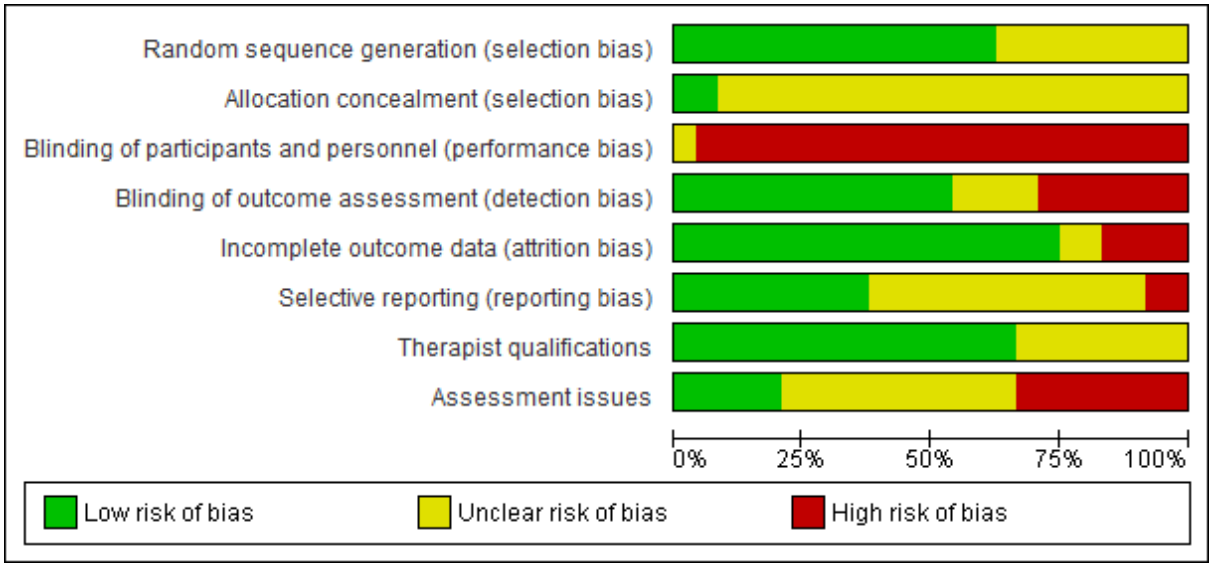
Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), Patient Health Questionnaire – 9 (PHQ-9; Spitzer, Kroenke, & Williams, 1999), Beck's Depression Inventory (BDI; Beck, Steer, & Brown, 1996), Self-Reporting Questionnaire-20 (SRQ-20; Harding et al., 1980), Mini-International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al., 1998), Hopkins Symptoms Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974).

4.3.2 Risk of Bias

4.3.2.1 **Random sequence generation.**

Recognised randomisation procedures were used in 15 out of 24 trials, and these trials were rated as low risk. Nine trials were judged as reporting unclear randomisation techniques. Some of these trials did not report the randomisation technique while others used techniques that may or may not ensure complete randomisation (e.g. randomising only a section of eligible participants and not the others, using restricted randomisation which could introduce selection bias). In two of these trials, assessment of baseline outcomes was used for the assignment of participants to treatment and control groups, which suggests that the sequence generation may not have been random (Crombach & Elbert, 2015; Hermenau et al., 2013). Figure 4-2 depicts the Risk of Bias assessment for all the trials included in the meta-analysis.

Figure 4-2 Risk of bias graph



4.3.2.2 **Allocation concealment.**

Only two studies were judged to report adequate information about allocation concealment. The remaining 22 trials did not indicate information about allocation concealment. Most of these studies reported that groups did not significantly differ at baseline on outcomes or demographics, which could indicate adequate randomisation. These studies were categorised as having unclear risk.

4.3.2.3 **Blinding of participants and personnel.**

Only one study reported blinding of participants to decrease the likelihood of further unblinding of outcome assessment. However, there was no mention of blinding personnel, as this is not possible in an RCT using a psychological intervention such as NET. This led to the trial being rated as unclear for performance bias (Jacob et al., 2014). The remaining 23 trials were rated as having a high risk of performance bias.

4.3.2.4 **Blinding of outcome assessment.**

Seven trials were judged to be at high risk for detection bias due to not implementing appropriate blinding while assessing outcomes post-intervention and at follow-up. In four of these trials, some patients accidentally revealed their treatment condition to the assessors. In two trials, the lead author, who was also one of the therapists assessed outcomes which placed these trials at high risk for detection bias. Four trials did not provide adequate information, or suggested plausible, accidental unblinding and were rated as having unclear risk. The remaining studies were rated as having a low risk of bias.

4.3.2.5 **Incomplete outcome data.**

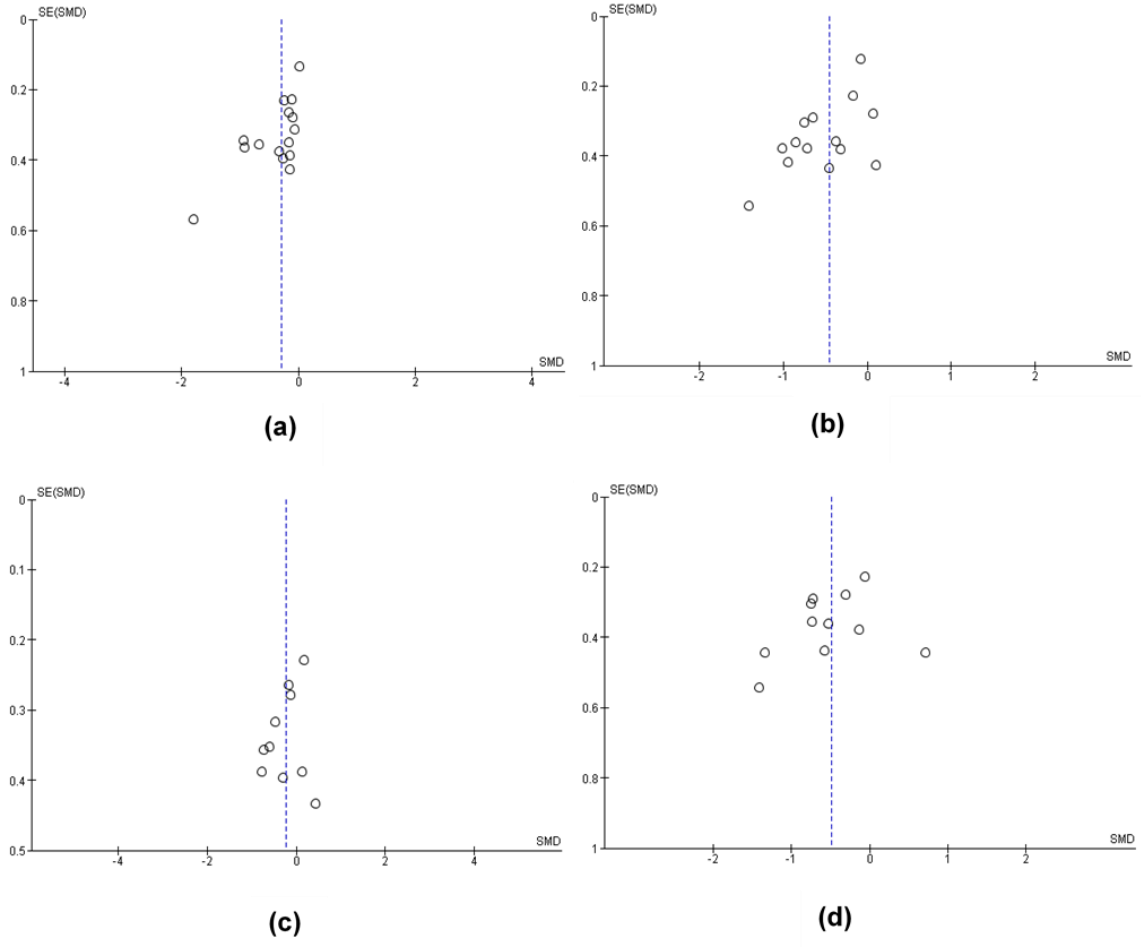
Four trials were at high risk for attrition bias due to analysing only treatment completers. In one trial which analysed only treatment completers, the authors found that demographics and study variables did not significantly predict treatment completers or dropouts in a logistic regression analysis (Orang et al., 2018). Further, the type of therapy did not significantly predict dropouts either. In a second trial, missing data from dropouts were replaced by estimation with a restricted maximum likelihood procedure, and no significant differences were found before and after data was replaced (Alghamdi et al., 2015). Thus, the authors analysed only treatment completers. The authors in both trials did not publish these results in the final report. These trials have been classified as having unclear risk. The remaining trials were classified as low risk due to either reporting no dropout or using some form of intention-to-treat (ITT) methods to account for missing data.

4.3.2.6 **Selective reporting.**

Nine trials were judged as low risk for selective reporting as all primary and secondary outcomes reported in the protocol were matched with those reported in the final publication. A further six trials with published protocols were judged as having unclear risk due to not reporting secondary outcomes mentioned in the protocol in the

final publication. Other trials judged as unclear risk were due to the lack of a protocol available. Two studies were categorised as high risk for selective reporting due to not reporting primary outcomes indicated in the protocol. Only four out of eight comparisons had 10 or more trials contributing to the analysis (PTSD symptoms at short- and mid-term and depression symptoms at short- and mid-term). A visual examination of the funnel plots (Figure 4-3) for these comparisons did not clearly indicate asymmetry.

Figure 4-3 Funnel Plots of comparison: NET vs Controls (All): (a) PTSD Symptoms (Short-term), (b) PTSD Symptoms (Mid-term), (c) Depression Symptoms (Short-term), and (d) Depression Symptoms (Mid-term)



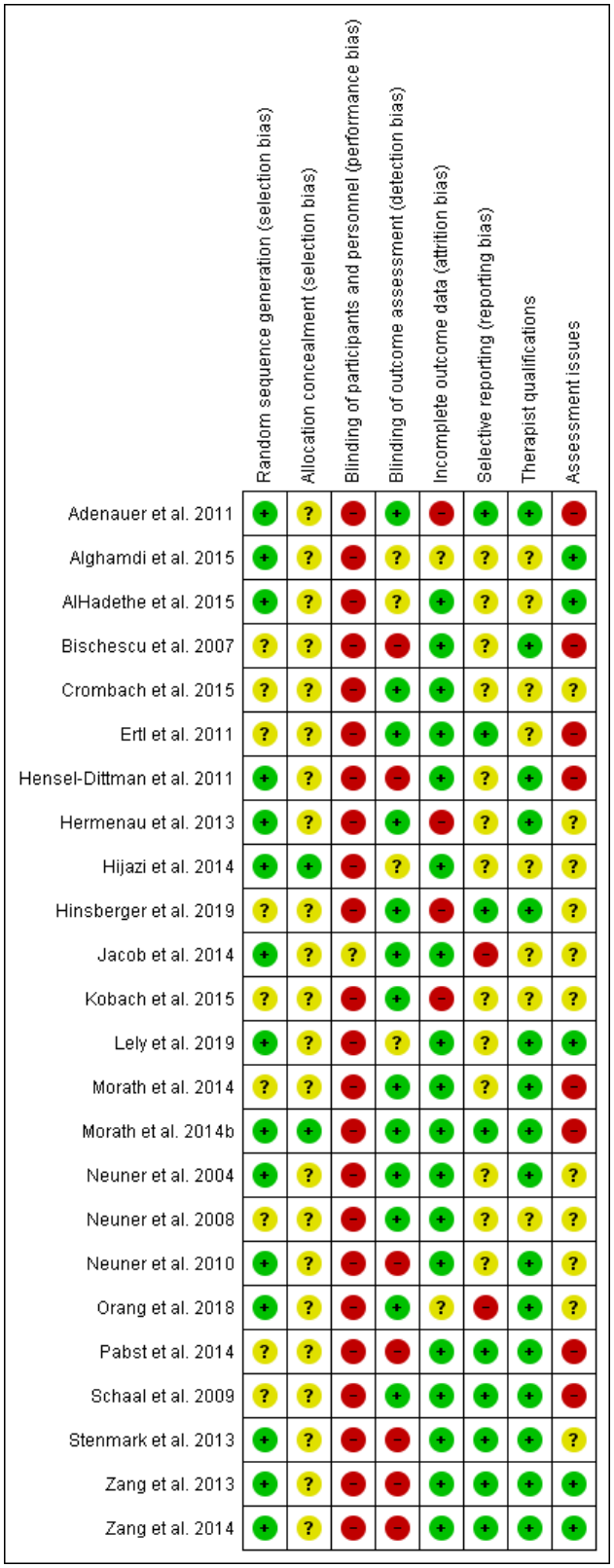
4.3.2.7 **Other sources of bias.**

4.3.2.7.1 *Therapist qualification.*

Seven trials reported that the interventions were delivered by clinical psychologists/counsellors with NET and trauma experience. Nine trials reported that the therapist was a Ph.D./graduate student or therapist who had explicit NET training per the manual. These studies were classified as low risk. Two trials did not specify the training or manual adherence procedures of their therapists (clinical psychologists, clinical psychology doctoral students). Hence, these trials have been classified as unclear risk. Three trials used trained "lay counsellors" to deliver therapy. In these trials, the qualifications of the therapists were unclear. One trial used trained final year undergraduate psychology students, while another used clinical psychology undergraduate degree holders who

were trained in NET. These trials were classified as having unclear risk since NET is a manualised technique that does not require clinical or medical qualifications for its administration (Schauer et al., 2005). However, the lack of graduate qualification/healthcare training does not allow for these trials to be completely devoid of risk of bias.

Figure 4-4 Risk of bias summary



4.3.2.7.2 *Assessment issues.*

Only five studies used valid and reliable measures for the assessment of outcomes. These trials have been categorised as low risk. Eleven trials performed real-time translation and back-translation of outcome measures to capture the symptoms of PTSD and depression which are primary outcomes of interest to this review. No information was provided about the psychometric properties of the translated measure. Further, translations and back translations achieve linguistic equivalence, which often subsumes the importance of cultural meaningfulness and appropriateness to the context. One trial used structured interviews using interpreters to measure outcomes (Neuner et al., 2010). In these cases, one cannot rule out the risk of the assessor's influence in achieving the desired outcome. These trials were classified as having an unclear risk of bias. A further eight trials did not report information regarding the translation of English language outcomes or the use of valid instruments to measure outcomes, which suggest these trials are at a high risk of bias. Figure 4-4 depicts the risk of bias summary for the trials included.

4.3.3 Effects of Intervention

The main comparison was NET versus all controls for the treatment of PTSD and depressive symptoms and PTSD diagnostic status.

4.3.3.1 **Comparison: NET versus any control.**

Twenty-four full-text studies were included in the meta-analysis. Due to different scales of assessment being used to measure the outcomes discussed, results were combined as standardised mean differences (SMDs). All 24 included studies contributed to the above comparison. This comparison had eight analyses and the results have been summarized in Table 4-4.

Table 4-4 Summary of findings

OUTCOMES		TREATMENT EFFECT					HETEROGENEITY			
		SMD/OR	95% CI	Z	P	N	Chi^2	df	P	I^2
PTSD	Diagnosis (ST)	0.28 (OR)	0.12 to 0.66	2.89	0.004	173	3.09	3	0.38	3%
	Diagnosis (MT)	0.26 (OR)	0.13 to 0.55	3.59	0.0003	150	1.75	3	0.63	0%
	Diagnosis (LT)	0.68 (OR)	0.16 to 2.87	0.52	0.6	190	9.96	2	0.007	80%
	Symptoms (ST)	-0.30 (SMD)	-0.49 to -0.11	3.05	0.002	813	21.62	14	0.09	35%
	Symptoms (MT)	-0.45 (SMD)	-0.68 to -0.23	4.01	<.0001	763	23.29	13	0.04	44%
	Symptoms (LT)	-0.49 (SMD)	-0.80 to -0.18	3.06	0.002	302	9.19	5	0.16	35%
Depression	Symptoms (ST)	-0.23 (SMD)	-0.46 to 0.01	1.88	0.06	425	12.25	9	0.2	27%
	Symptoms (MT)	-0.49 (SMD)	-0.79 to -0.20	3.25	0.001	424	20.64	10	0.02	52%

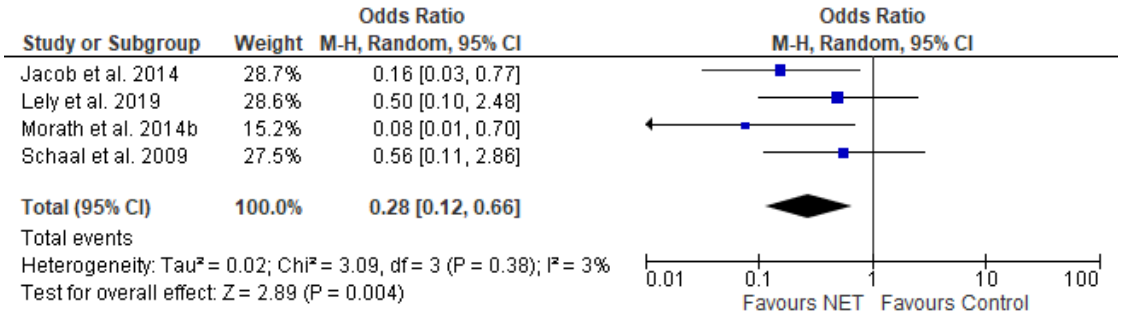
Symptoms (LT)	-0.19 (SMD)	-0.46 to 0.09	1.34	0.18	224	1.66	4	0.8	0%

4.3.3.1.1 *PTSD Diagnostic Status.*

4.3.3.1.1.1 Short-term (3-4 months).

Four studies relevant to this outcome were identified (total N=173; Figure 4-5). There was a significant effect of NET intervention on diagnosis compared to control, with an odds ratio (OR) of 0.28 (95% confidence interval

Figure 4-5 Forest Plot: PTSD diagnosis (short-term)

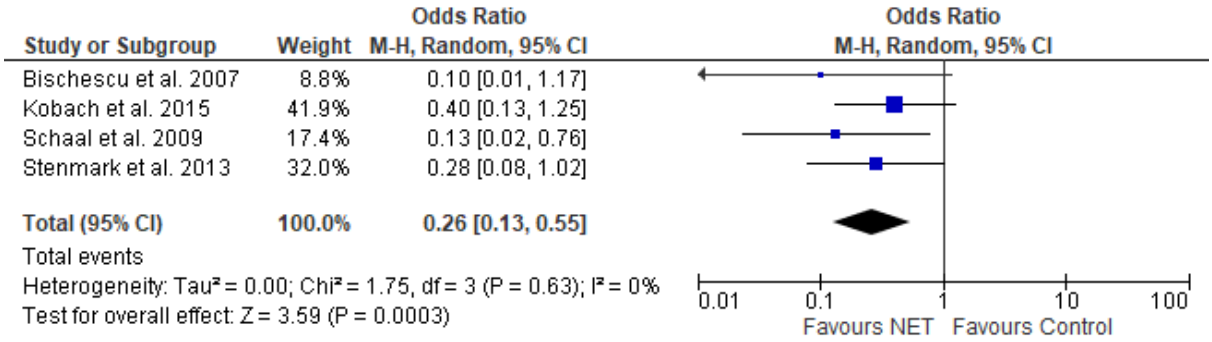


(CI) 0.12 to 0.66, Z = 2.89, P = .004). Heterogeneity was low at 3%.

4.3.3.1.1.2 Mid-term (6-7 months).

Four studies contributed to this outcome (total N=150, Figure 4-6). There was evidence of a significant effect of intervention on diagnostic status compared to control (OR 0.26; 95% CI 0.13 to 0.55, Z = 3.59, P = .0003).

Figure 4-6 Forest Plot: PTSD diagnosis (mid-term)



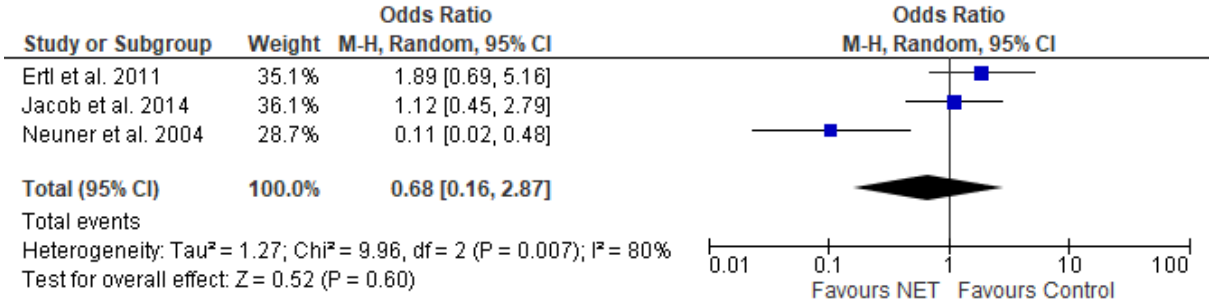
Heterogeneity was 0%.

4.3.3.1.1.3 Long-term (≥ 12 months).

Three relevant studies with a total of 190 participants were identified (Figure 4-7). NET did not significantly outperform controls in this analysis (OR 0.68; 95% CI 0.16 to 2.87; Z = 0.51, P = .60). Further, significantly high levels of heterogeneity were found (Chi^2=9.96; df=2.0; P=.0071; I^2=80%). One study which appeared to be an outlier (Neuner et al., 2004) was removed from the analysis and while this reduced the heterogeneity estimates

to 0% (Chi² = 0.45, df = 1 (P = .45); I² = 0%), the direction or significance of the effect was not altered and the study was retained in the final analysis.

Figure 4-7 Forest Plot: PTSD diagnosis (long-term)

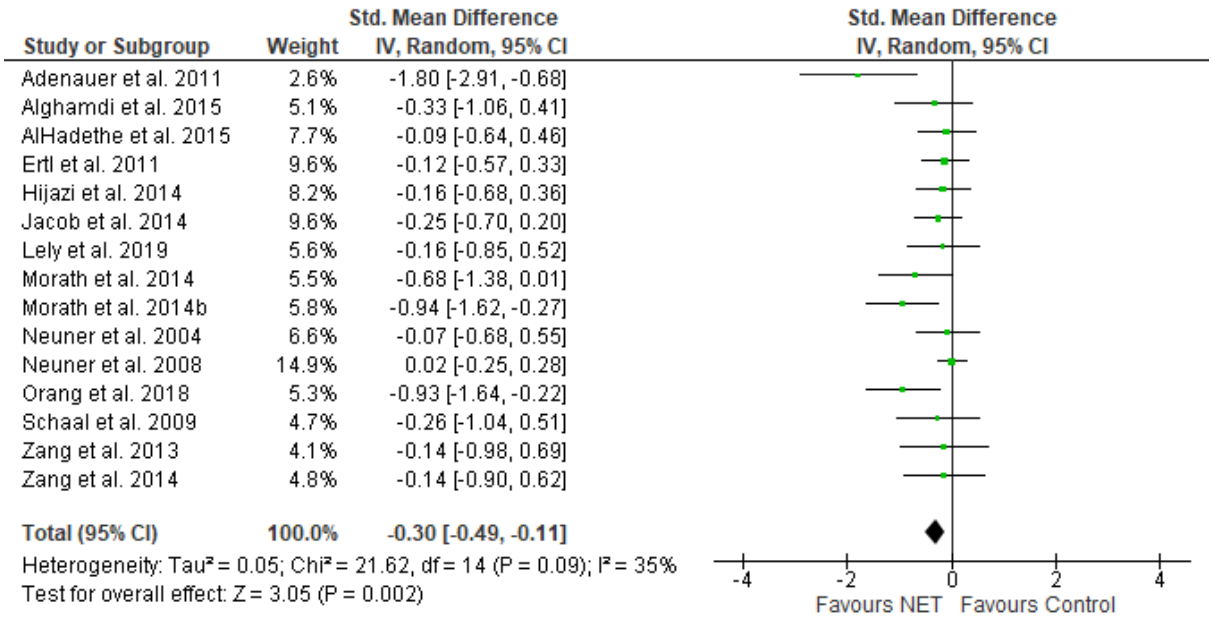


4.3.3.1.2 *PTSD Symptoms.*

4.3.3.1.2.1 Short-term (3-4 months).

Fifteen relevant studies contributed to this outcome, with a total of 813 participants (Figure 4-8). Small effect size evidence that NET was significantly different in its effects compared with controlled comparisons was found (SMD -0.30, 95% CI -0.49 to -0.11, Z = 3.05, P = .002). Moderate, but non-significant heterogeneity was found (Chi² = 21.62, df = 14 (P = .09); I² = 35%). A sensitivity analysis was conducted in which an outlier study was removed from the analysis (Adenauer et al., 2011). This study also had a high risk of bias in three domains This reduced the heterogeneity (I² = 6%) and did not alter the significance of treatment effect (SMD -0.21 CI -0.37 to -0.06, Z = 2.78, P = .005). Therefore, it was considered in the analysis due to not altering the direction/significance of the treatment effect.

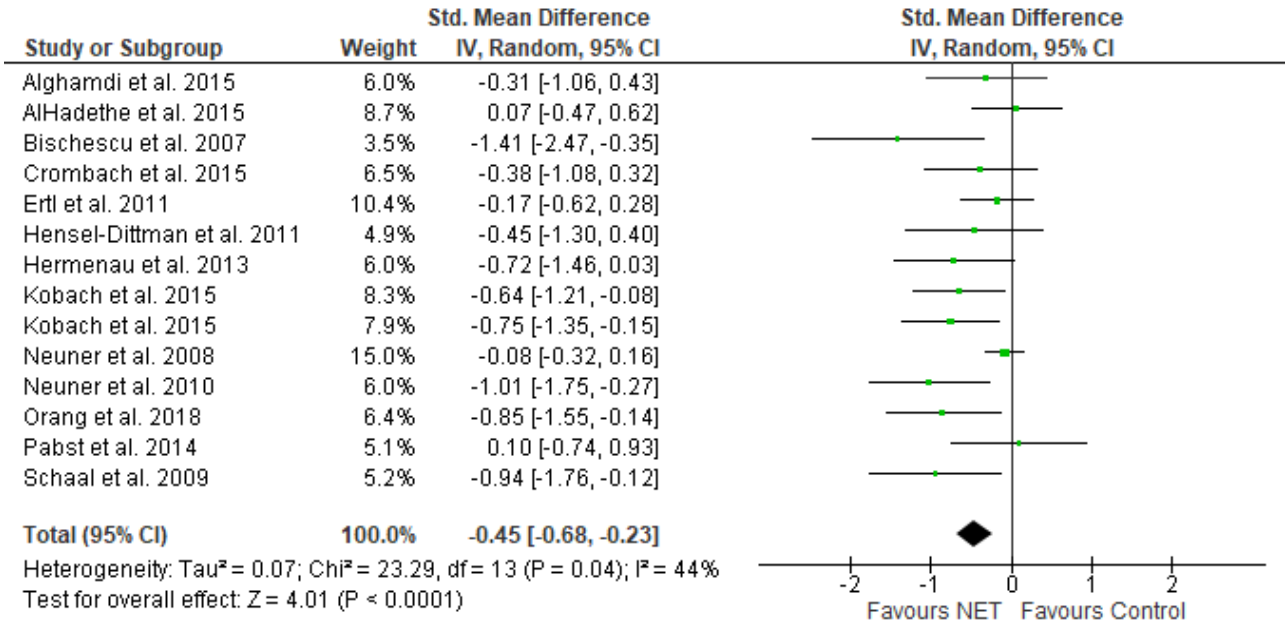
Figure 4-8 Forest plot: PTSD symptoms (short-term)



4.3.3.1.2.2 Mid-term (6-7 months).

Fourteen trials across 13 studies relevant to this outcome (total n=763; Figure 4-9) were identified. NET emerged significantly superior to controlled interventions with a medium effect size (SMD -0.45, CI -0.68 to -0.23, Z = 4.01, P < 0.0001). Moderate, yet significant levels of heterogeneity were found (Chi^2 = 23.29, df = 13 (P = .04); I^2 = 44%). A visual inspection of the forest plot suggested that point estimates across trials were not drastically different. The removal of the high risk of bias trials (with three or more domains showing a high risk) slightly increased heterogeneity estimates (Chi^2 = 18.22, df = 10 (P = .05); I^2 = 45%) but did not alter the direction or significance of treatment effect. As a result, they were considered in the final analysis.

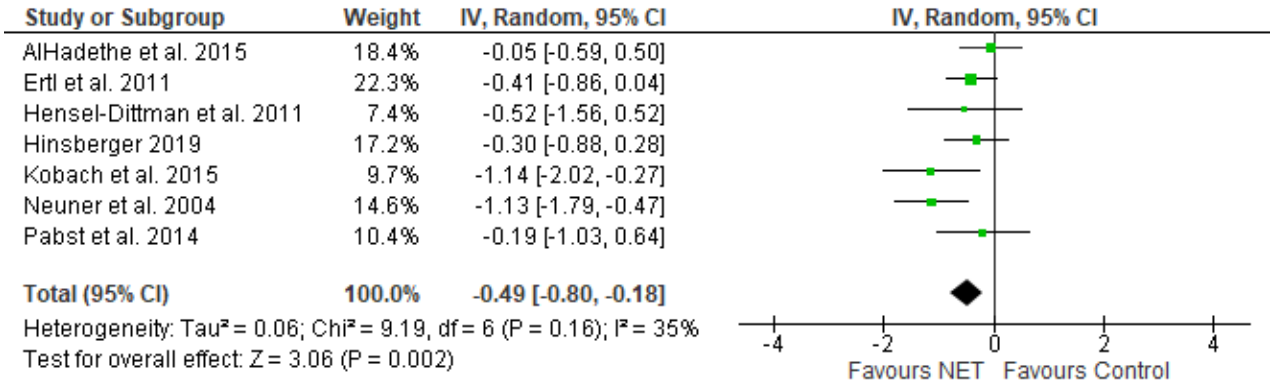
Figure 4-9 Forest plot: PTSD symptoms (mid-term)



4.3.3.1.2.3 Long-term (≥ 12 months).

Seven relevant studies contributed to this outcome with a total of 302 participants (Figure 4-10). NET emerged superior to control interventions (SMD -0.49 CI -0.8 to -0.18, Z = 3.06, P = .002) with a medium effect size. Moderate, statistically non-significant heterogeneity was noted among studies (Chi^2 = 9.19, df = 6 (P = .16); I^2 = 35%). Two outliers were identified using the forest plot (Köbach et al., 2017; Neuner et al., 2004) and their removal lowered heterogeneity estimates (Chi^2 = 1.25, df = 4 (P = .87); I^2 = 0%). The removal of these trials did not alter the significance or direction of the effect (SMD -0.28 CI -0.55 to 0.01, Z = 2.03, P = .04), and hence, will be considered for the final analysis.

Figure 4-10 Forest plot: PTSD symptoms (long-term)

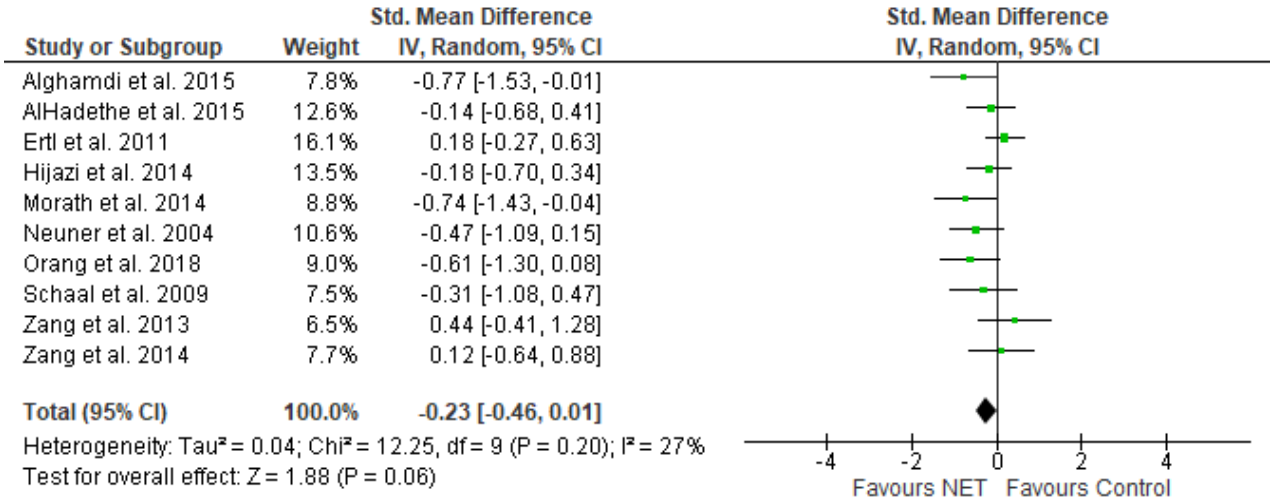


4.3.3.1.3 *Depression.*

4.3.3.1.3.1 Short-term (3-4 months).

For this outcome, 11 relevant studies were found with a total of 444 participants. NET emerged statistically superior to controlled comparisons, albeit with a small effect size (SMD -0.32 CI -0.61 to -0.03, Z = 2.15, P = .03). Further, this outcome had high, significant levels of heterogeneity (Chi^2=20.89; df=10.0; P=0.02; I^2=52%). One study which appeared to be an outlier based on visual inspection of the forest plot was removed from the analysis (Adenauer et al., 2011). This reduced the level of heterogeneity (Chi^2 = 12.25, df = 9 (P = .20); I^2 = 27%). However, the treatment effect emerged non-significant (SMD -0.23 CI -0.46 to 0.01, Z = 1.88, P = .06) and lowered the effect size value further. This trial also had a high risk of bias in three domains. As a result, this study will be excluded from the final analysis and the final forest plot will contain 10 studies (Figure 4-11).

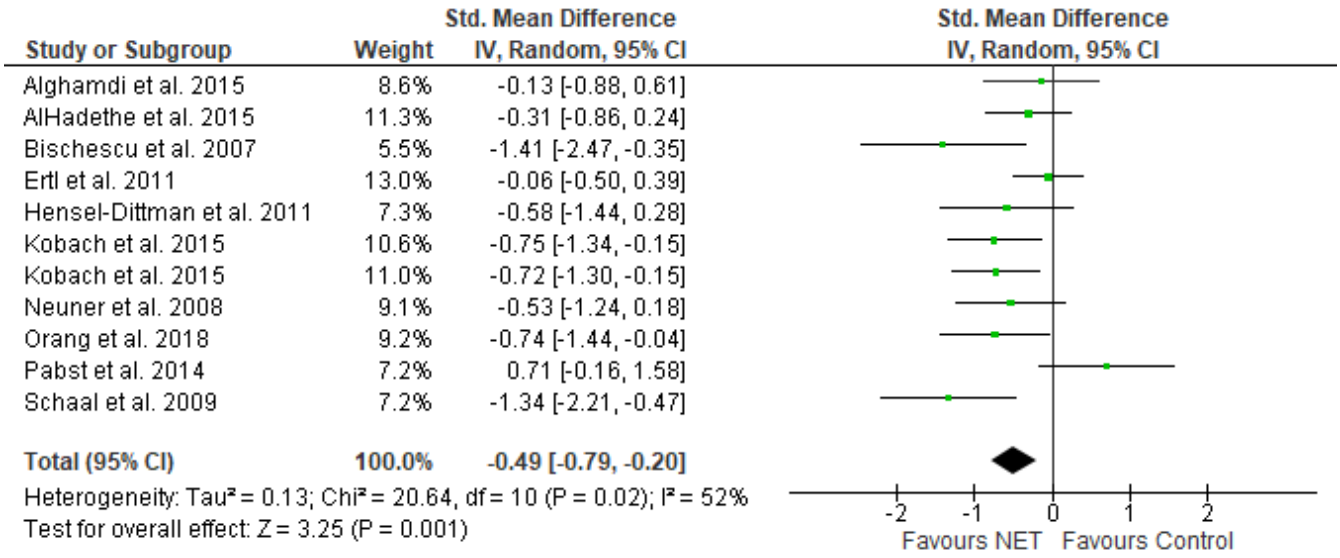
Figure 4-11 Forest plot: Depression symptoms (short-term)



4.3.3.1.3.2 Mid-term (6-7 months).

Eleven trials across 10 studies involving 424 participants were included in this comparison (Figure 4-12). NET was significantly superior to controls (SMD -0.49 CI -0.79 to -0.20, Z = 3.25, P = .001) with a medium effect size. This outcome had significant levels of heterogeneity (Chi² = 20.64, df = 10 (P = .02); I² = 52%). Three trials were identified as outliers (Bichescu et al., 2007; Pabst et al., 2014; Schaal et al., 2009). Removing these trials

Figure 4-12 Forest plot: Depression symptoms (mid-term)

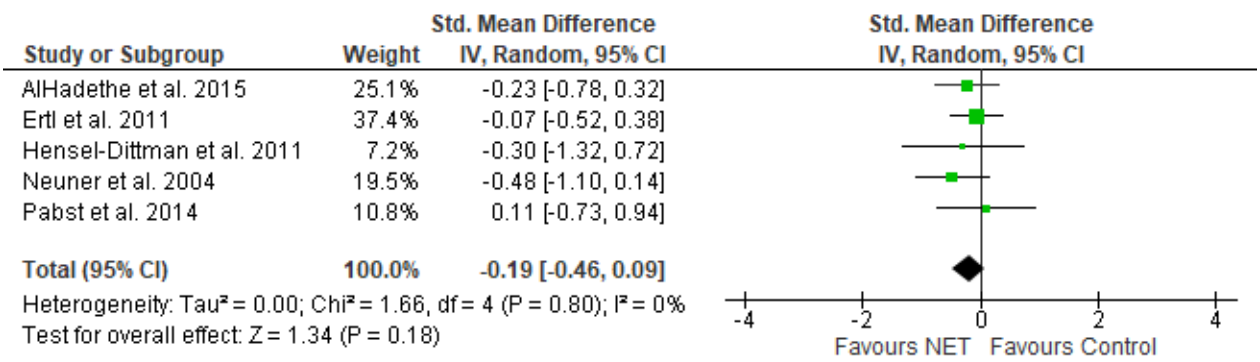


reduced heterogeneity (Chi² = 6.54, df = 7 (P = .48); I² = 0%) and did not alter the significance or direction of treatment effect (SMD -0.43 CI -0.65 to -0.22, Z = 3.91, P < .001). Hence, they will be used for the final analysis.

4.3.3.1.3.3 Long-term (≥ 12 months).

Six studies with a total of 273 participants were included in this outcome. There was a significant treatment effect of NET (SMD -0.37 CI -0.75 to 0.01, Z = 1.92, P = .05). Heterogeneity was found to be high (Chi² = 10.04, df = 5 (P = .07); I² = 50%). A visual inspection of the forest plot identified an outlier (Köbach et al., 2017). A sensitivity analysis with its removal reduced heterogeneity (Chi² = 1.66, df = 4 (P = .80); I² = 0%). With its removal, the test for the overall treatment effect became non-significant (SMD -0.19, CI -0.46 to 0.09, Z = 1.34, P = .18). As a result, this study was removed from the final analysis, which contained five studies (Figure 4-13).

Figure 4-13 Forest plot: Depression symptoms (long-term)



4.3.3.2 **Subgroup analysis.**

4.3.3.2.1 *Types of controls.*

To account for the clinical heterogeneity in the type of control groups, a subgroup analysis of active controls (e.g. other psychological therapies, treatment-as-usual, psychoeducation) versus inactive control (e.g. no treatment, WLC) was performed at the three-time points. Subgroup differences were significant only for PTSD symptom severity at the short-term. Categorising studies by type of intervention, NET demonstrated a difference between subgroups (P = .04) and reduced heterogeneity in the no intervention group (N = 407, I^2 = 23%). In this group there was evidence of a medium effect of NET (SMD -0.44, 95% CI -0.68, -0.21, P = .0002). In contrast, the active intervention group demonstrated a lack of effect (N = 454, SMD -0.07, 95% CI -0.34, 0.20, P = .62). Within the active intervention subgroup, substantial, non-significant heterogeneity estimates were revealed (P = .12, I^2 = 40%).

For depression symptoms at mid-term, NET significantly outperformed active interventions (SMD -0.50, 95% CI -0.84, -0.16, P = .004), while a non-significant overall effect was found when compared with the no intervention subgroup. However, the subgroup differences did not reach statistical significance (P = .27). In this analysis, the active intervention group was characterized by significant heterogeneity (Chi^2 = 21.28, df = 9, P = 0.0, I^2 = 58%) and the no intervention subgroup consisted of only three studies. Subgroup differences for PTSD and depressive symptoms were not significant at any other time point based on the type of control groups.

Table 4-5 Subgroup analysis: active controls vs no intervention

OUTCOMES		TREATMENT EFFECT										TEST FOR SUBGROUP DIFFERENCES			
		Active Intervention					No Intervention								
		N	SMD	95% CI	Z	P	N	SMD	95% CI	Z	P	CHI^2	df	P	I^2
PTSD Symptoms	Short-term	454	-0.07	-0.34, 0.20	0.49	.62	407	-0.44	-0.68, -0.21	3.68	.0002	4.12	1	.04	75.7%
	Mid-term	608	-0.41	-0.74, -0.08	2.43	.02	320	-0.46	-0.69, -0.23	3.91	<.0001	0.05	1	.82	0%
	Long-term	241	-0.42	-0.88, 0.04	1.8	.07	380	-0.44	-0.78, -0.10	2.56	.01	0.00	1	.95	0%
Depression Symptoms	Short-term	199	-0.15	-0.51, 0.20	0.85	.40	293	-0.34	-0.73, 0.05	1.71	.09	0.48	1	.49	0%
	Mid-term	354	-0.50	-0.84, -0.16	2.90	.004	127	-0.23	-0.58, 0.12	1.28	.20	1.21	1	.27	17.1%
	Long-term	213	-0.19	-0.57, 0.19	0.98	.33	96	-0.35	-1.12, 0.42	0.88	.38	0.13	1	.72	0%

4.3.3.2.2 *Type of trauma.*

For this analysis, types of trauma varied between trauma with a perpetrator and trauma without a perpetrator in trials and these categories were compared in a subgroup analysis. Trauma without a perpetrator included singular events such as natural disasters or trauma-induced by occupational stress. Trauma with a perpetrator consisted of either repetitive or consistent trauma or threat of trauma such as war, combat, torture, and abuse.

Subgroup differences for PTSD and depressive symptoms were not significant at the short-term and mid-term time points based on the type of trauma. PTSD and depressive symptoms in the long-term could not be analysed for subgroup differences based on trauma due to a lack of relevant trials in the simple trauma subgroup.

Table 4-6 Subgroup analysis: trauma with a perpetrator vs trauma without a perpetrator

OUTCOMES		TREATMENT EFFECT										TEST FOR SUBGROUP DIFFERENCES			
		With a perpetrator					Without a perpetrator								
		N	SMD	95% CI	Z	P	N	SMD	95% CI	Z	P	CHI^2	df	P	I^2
PTSD Symptoms	Short-term	732	-3.39	-5.92, -0.86	2.63	.009	81	-1.84	-5.82, 2.13	0.91	.36	0.42	1	.52	0%
	Mid-term	741	-0.47	-0.70, -0.23	3.91	<.0001	28	-0.31	-1.06, 0.43	0.83	.41	0.15	1	.70	0%
	Long-term	315	-0.49	-0.79, -0.19	3.18	.001	NA								
Depression Symptoms	Short-term	363	-0.39	-0.73, -0.06	2.29	.02	81	-0.09	-0.79, 0.62	0.24	.81	0.59	1	.44	0%
	Mid-term	402	-0.53	-0.85, -0.21	3.17	.002	28	-0.13	-0.88, 0.61	0.35	.72	0.93	1	.33	0%
	Long-term	289	-0.28	-0.53, -0.03	2.23	.03	NA								

4.3.3.2.3 *Version of NET*

A subgroup analysis was performed to compare trials that used the original version of NET with trials that used an adapted version of NET such as FORNET, brief NET or NET in combination with treatments. These differences were statistically significant only for depression symptom severity in the short-term (P = .03). NET

significantly outperformed controls (SMD -0.43, 95% CI -0.78, -0.09), while in the subgroup with NET adaptations, there were no statistically significant differences between the groups. On the contrary, the point estimate was in favour of the control group in this subgroup analysis (SMD 0.16, 95 % CI -0.26, 0.59). The heterogeneity estimates for both subgroups were high, yet non-significant. The only other analysis which demonstrated a difference between subgroups was PTSD symptoms at the short-term. While the subgroup differences were not statistically significant (P = .14), the findings were similar to depression symptoms at the short-term, with only the NET group significantly outperforming controls (SMD -0.37 CI -0.63, -0.11). Table 4-7 illustrates the summary findings for this subgroup analysis.

Table 4-7 Subgroup analysis: NET versus NET adaptation

OUTCOMES		TREATMENT EFFECT										TEST FOR SUBGROUP DIFFERENCES			
		NET					NET Adaptations								
		N	SMD	95% CI	Z	P	N	SMD	95% CI	Z	P	CHI^2	df	P	I^2
PTSD Symptoms	Short-term	579	-0.37	-0.63, -0.11	2.79	.005	224	-0.09	-0.36, 0.18	0.64	.52	2.18	1	.14	54.1%
	Mid-term	524	-0.45	-0.78, -0.13	2.72	.006	245	-0.48	-0.74, -0.22	3.59	.0003	0.01	1	.90	0%
	Long-term	122	-0.47	-0.98, 0.04	1.82	.07	163	-0.50	-0.90, -0.10	2.48	.01	0.01	1	.93	0%
Depression Symptoms	Short-term	296	-0.43	-0.78, -0.09	2.50	.01	177	0.16	-0.26, 0.59	0.76	.45	4.63	1	.03	78.4%
	Mid-term	250	-0.51	-0.91, -0.10	2.47	.01	183	-0.48	-0.95, 0.00	1.95	.05	0.01	1	.92	0%
	Long-term	132	-0.27	-0.61, 0.08	1.52	.13	81	-0.46	-1.34, 0.42	1.03	.30	0.16	1	.69	0%

4.3.3.2.4*Age*

There was insufficient data to perform a subgroup analysis based on the age of participants.

4.4 Discussion

4.4.1 Summary of main results

A meta-analysis of NET treatment effect on PTSD diagnosis and symptoms and depressive symptoms yielded partial evidence of efficacy. The effect size of treatment on PTSD symptoms is small in the short-term (SMD = -0.30, 95% CI -0.49, -0.11) but medium at the mid-term (SMD = -0.45, 95% CI -0.68, -0.23), and long-term (SMD = -0.49, 95% CI -0.80, -0.18), suggesting sustainable treatment gains. These findings are consistent with previously published narrative analyses of NET efficacy (Mundt et al., 2014). Conversely, a statistically significant effect of NET was found on PTSD diagnostic status in the short- and mid-term time points, but these effects were not sustained at long-term follow-up. It is important to note that the outcome at long-term was characterised by very high heterogeneity estimates. Further, only a small number of trials contributed to the analyses for PTSD diagnostic status at all time points (N < 5) which impacts the interpretation of the summary statistic for this analysis. When using random-effects models, including a substantial number of studies is believed to be necessary to make reliable inferences, especially in the presence of high between-study heterogeneity (Guolo & Varin, 2017; Seide et al., 2019).

For depression symptoms, NET was statistically superior to controlled comparisons only at mid-term with a medium effect size (SMD = -0.49, 95% CI -0.79, -0.20). Lely, Smid, Jongedijk, et al. (2019) found that NET outperformed non-active controls with medium to large effect sizes (g = 0.79) for depression symptoms. In our study, this was not reflected in the subgroup analysis for types of control for depression symptoms at any time point. However, in line with their overall conclusion, it appears that NET is relatively less effective in treating depressive symptomatology when compared to PTSD symptoms. This is not surprising considering NET was developed specifically to treat traumatic stress disorders. It is based on the theoretical and neurobiological foundations of psychological trauma, PTSD, and memory in the context of trauma, which suggests that the therapeutic technique is targeted at symptom manifestations of PTSD and other trauma and stressor-related disorders (Schauer et al., 2005, 2011). Specifically, the exposure element is based on the associated fear-network model (Foa et al., 1989) and the emotional-processing theories of PTSD (Foa et al., 1993; Foa & Rothbaum, 1998). Further, cognitive theories of PTSD have also informed the development of NET (Ehlers & Clark, 2000) and its treatment protocol. The success in treating depression symptom

severity in individual trials may be attributed to the elements of cognitive revaluation of thoughts patterns and behaviour, and cognitive reprocessing of negative trauma appraisals, which are considered crucial to recovery via NET. Cognitive behavioural treatments are considered to have robust evidence for the treatment of depressive disorders (American Psychological Association, 2019; Butler et al., 2006), which might explain the remission of depressive symptoms in some PTSD patients with a comorbid mood disorder.

Subgroup analyses for the type of controls emerged significant only for PTSD symptoms at the short-term, with NET performing better than no-intervention controls when compared to active interventions. Within the active intervention subgroup, a non-significant overall effect of NET was found (P =.62). While this could imply that NET does not outperform active interventions as efficaciously as WLC and no-treatment controls, the wide 95% confidence intervals of the point estimate (-0.07, CI -0.34, 0.20) suggest caution in the interpretation of the summary statistic for this subgroup. The relatively high, yet non-significant heterogeneity estimates (I^2 = 40%, P = .12) also suggest that within the active intervention group, there is potential for further subgroup analysis based on the type of the controls. Subgroup differences were not statistically significant for either outcome at any other time point. Lely, Smid, Jongedijk, et al., (2019) found that NET significantly outperformed only non-active controls for both PTSD and depression symptoms. However, they do not specify the follow-up timings for controlled comparisons in their study, thereby limiting the comparability of these findings. Regarding the type of trauma, the lack of subgroup differences suggests that NET is similarly efficacious across a range of trauma populations.

Regarding the version of NET used in the experimental arm (NET versus NET adaptations), subgroup analyses revealed considerable differences only at the short-term for both PTSD and depression symptoms, and these differences were statistically significant only for the depression outcome. NET outperformed control groups only when the original, manualised version of NET was used in the intervention arm. When adapted versions of NET were used, the test for overall effects remained insignificant in both analyses. This is indicative of the fact that at the shortest follow-up, NET demonstrates treatment gains when in its original format, as compared to adapted versions. However, with the progression of time, these differences cease to be important. To the best of the researcher's knowledge, no other narrative or meta-analytic reviews have systematically focused on discerning NET from its adaptations in evaluating the evidence-base. The lack of substantial differences between

the subgroups over time suggests that NET is amenable to adaptations to suit specific populations, trauma exposure or socio-cultural context.

Overall, conclusions about the evidence of treatment efficacy (especially when applied to clinical practice) must be made with caution due to high heterogeneity estimates when the data were statistically pooled. An exploration of heterogeneity using the visual inspection method allowed us to identify outliers, and the removal of these trials did not reduce heterogeneity in all trials. This is especially true in the case of PTSD symptoms at 6 months (significant effect), and PTSD diagnosis at 9-12 months (non-significant effect).

4.4.2 Quality of the evidence

In a previous review of NET by Gwozdziewycz & Mehl-Madrona (2013), the authors noted that the trials included in the review were validly designed and executed. However, we found varying degrees of bias across the included trials. Unclear randomisation procedures were identified in a handful of trials, thereby potentially compromising the quality of these trials. The risk of allocation bias was mostly unclear across the review, due to a lack of adequate detail provided by study authors to make a definitive judgment. Almost all trials were considered to have a high risk of performance bias. This was due to treatment allegiance to a single psychotherapeutic intervention (NET), making the blinding of personnel impossible due to the nature of the intervention. However, while blinding of participants could be possible to some extent, the extensive use of WLC and no-treatment control groups made this impossible in most trials. The risk of bias regarding outcome assessments suggested most studies used self-report or assisted-report psychometric scales, translated and back-translated from English. No information was provided about the psychometric validity and reliability of the translated tool and one cannot rule out the effect of interpreters or translators in achieving desired outcomes during assessments. As a result, several trials were judged as having an unclear risk of bias.

Studies used varying assessment methods such as scales of assessment, the language of administration, use of interpreters, diagnostic interviews versus self-report versus assisted report, etc. This could potentially explain high heterogeneity among trials. Many RCTs did not clearly report methodological aspects such as information on blinding, allocation, and use of valid and reliable outcome measures which led to several studies being judged as having unclear risk bias. Only twelve studies provided information about treatment fidelity or allegiance to the manual (Adenauer et al.,

2011; Ertl et al., 2011; Hensel-Dittmann et al., 2011; Jacob et al., 2014; Köbach et al., 2017; Morath, Gola, et al., 2014; Neuner et al., 2004, 2008; Pabst et al., 2014; Stenmark et al., 2013; Zang et al., 2013, 2014). The methods reported included direct observations, videotaped sessions and regular supervision meetings.

There were other methodological concerns to be considered. Most of the trials reported WLC in addition to no-treatment conditions. Only a handful of studies used other active, bona fide interventions as controlled comparisons. As in Lely, Smid, Jongedijk, et al. (2019), NET performed better against non-active comparators, but the difference was not statistically significant. The use of WLC in anxiety disorders research has been criticized (Patterson et al., 2016). Studies have identified ethical and humanitarian issues of delaying treatment to individuals who are undergoing acute distress or may be at risk for self-harm and suicide (Devilly & McFarlane, 2009). The use of WLC may be associated with other methodological concerns related to increased risk of bias (Mohr et al., 2009) and larger effect sizes for the psychotherapy group (Furukawa et al., 2014). For PTSD research, a meta-analysis of 20 studies and 418 participants demonstrated small to medium effect sizes (g = 0.34) for WLC, while bona fide trauma-focused treatments yielded very large effect sizes (g = 1.5) (Devilly & McFarlane, 2009). Similar findings were demonstrated in a review of WLC effect sizes in social anxiety disorder research (Steinert et al., 2017). In agreement with a narrative review of NET efficacy (Robjant & Fazel, 2010), it is problematic to draw conclusions regarding NET's superior efficacy compared to other trauma-focused treatments due to lack of sufficient RCTs using such active treatments as controls.

4.4.3 Limitations of the current review

The first limitation of this meta-analysis is that a protocol was not registered *a priori.* Pre-registered protocols ensure methodological rigour and commitment, and the lack of a published protocol before the commencement of data collection and analysis is acknowledged as a shortcoming of this paper.

The risk of bias assessments were conducted with the Cochrane Collaboration's risk of bias tool available at the time of analysis (Higgins & Green, 2011). Since that time, a new version of the tool (RoB 2.0) was released by the Cochrane Collaboration (Sterne et al., 2019). The updated tool is not yet available on the Review Manager software and is currently being piloted by the Cochrane Review

team. Future studies may employ RoB 2.0 to perform a comparative analysis of internal validity and quality appraisal.

Another limitation is the exclusion of RCTs that were not published in English. A German-language study was retrieved which compared NET with TAU on a group of traumatised asylum seekers in Germany (Schauer et al., 2006). The authors could not provide the English-translated version of the study, and due to limited resources, it was not possible to get this article professionally translated. From the English-language study summary, it was clear that the trial was controlled but not whether it was *randomised*. No other studies that emerged as a result of the search strategy were excluded based on the English-language criterion. However, since it is not possible to be certain that this did not result in the exclusion of other studies not retrieved from the search, it must be regarded as a limitation of this review.

Other limitations of the paper are related to the included studies themselves. Some RCTs had very small sample sizes (in some cases below 10), with only two notably well-powered studies. Further, only four comparisons had over 10 studies contributing to the analysis. This raises the issue of small-study effects (i.e. the overestimation of intervention effects in trials with small to moderate trial size). Underpowered studies tend to show exaggerated treatment effects when compared to well-powered studies while contributing to higher heterogeneity estimates (Turner et al., 2013). Further, one of the possible causes of small-study effects could be publication bias (Higgins et al., 2019). Only published trials were included in this analysis, and the number of trials included in each comparison was low. It could be argued that with the inclusion of unpublished trials, smaller estimates of treatment effects for NET would emerge. Only four comparisons were eligible for funnel plot analyses, and a visual inspection did not reveal clear evidence of asymmetry. However, it is well known that asymmetry interpretations are subjective, and maybe caused other issues such as methodological heterogeneity (Sedgwick, 2013). It must also be noted that tests for publication bias using funnel plots (such as the Egger's test) are less reliable when small trials dominate the meta-analysis, which is the current case (Egger et al., 1997). The issue of small-study effects complicates the reliability of the NET evidence-base considerably.

4.4.4 Strengths and comparisons to other reviews

An attempt was made to access and include all relevant trials through the search strategy. In addition to the trials included in Lely, Smid, Jongedijk, et al. (2019), a further eight trials have been reviewed. While some data might have been missed, correspondence with the NET authors suggests that this review is the most comprehensive and complete analysis to date. The ratings of quality in this review are more conservative with several trials being rated as having a high risk of bias on domains rated as unclear by Lely, Smid, Jongedijk, et al. (2019). Subgroup analyses conducted also attempted to address the issue of potential clinical heterogeneity caused by combining different trauma groups, varied control groups and versions of NET together into a single analysis. Lely, Smid, Jongedijk, et al. (2019) concluded that despite methodological issues and high heterogeneity estimates, NET trials provide evidence of favourable treatment efficacy. However, this review recommends greater caution in the interpretation of pooled NET intervention effect.

4.5 Conclusion

4.5.1 Implications for Practice

Currently, low-quality evidence indicates the efficacy of NET over both active and non-active psychotherapeutic control treatments in primarily decreasing PTSD symptom severity and to a small extent, depression severity. The data were significantly heterogeneous across most outcomes measured. Further, there was no impact of the type of trauma, type of controls or version of NET on treatment effect, which leaves heterogeneity estimates unexplained. Low dropout rates from therapy are an indication of NET's acceptability and feasibility with sensitive populations. NET has been tested with a range of trauma groups, i.e., with and without perpetrators. While NET shows promise with both groups, the evidence-base for NET is most strongly suited to the group it was originally intended for, i.e., victims of war and organised violence. This suggests that NET may be suitable for diverse trauma groups, but there is not enough data to draw conclusions regarding NET's applicability when there is no perpetrator involved. The highly heterogeneous treatment groups (trauma history, risk of a future threat and socio-cultural-economic settings) further confound the pooling of effects.

A recent report by Neuner et al. (2020) found that the most pronounced effects of NET are observed at (long-term) follow-up. According to Neuner et al. (2020), this highlights the benefits of a short-form treatment like NET in sustaining change to trigger long-term healing. The current meta-analysis

confirms these findings, especially for PTSD symptoms (mid- and long-term) and to some extent for depression symptoms (mid-term only). When used in clinical practice, the duration of time it takes for symptom improvements to emerge through NET must be considered. The lack of improvement immediately post-intervention might be demoralising for both the client and the therapist. This is especially pertinent to victims who report ongoing exposure to trauma or a high risk of future exposure, such as DV victims. However, evidence for sustained effects over time on psychological outcomes such as PTSD is encouraging. Most RCTs have measured outcomes for up to 12 months. Longer term follow-up studies can illuminate the extent of NET's sustained benefits.

NET is currently recommended by a range of clinical guidelines for PTSD treatment including Americana Psychological Association, NICE, VA/DoD and ISTSS. Regarding clinical efficacy, it is important to consider findings from reviews and meta-analyses. This involves considering the quality of the evidence-base as opposed to focusing on data from individual RCTs or using narrative summaries. While these trials may have found promising effects, the small sample sizes and methodological issues warrant caution when using the findings to inform policies and guidelines. Further, clinical guidelines have questioned the applicability of NET to non-refugee trauma populations. Since a majority of the trials so far have used NET with refugees and asylum-seekers, we highlight this as a further limitation of the evidence-base. In future research with NET, diverse trauma exposure across a range of socio-cultural settings must be considered, specifically with non-refugee populations to warrant its recommendation as a PTSD treatment approach.

4.5.2 Implications for Research

NET evidence-base mostly comprises of RCTs conducted in diverse settings. Mundt et al. (2014) critiqued the NET evidence-base as being inapplicable to Low- and Middle-income Countries (LMIC), as well as being unable to address aspects of psychosocial well-being. In their review of interventions for torture survivors, Patel, Kellezi, and Williams (2014) raised similar concerns about the need to consider legal, contextual and psychosocial factors in the delivery of trauma interventions.

From a research perspective, RCTs of short-term interventions (of which NET is an example) have long-since been criticised for underestimating or altogether missing out on some of the most crucial aspects of psychotherapy such as its self-correcting nature, addressing multiple, interacting problems and comorbidities and therapist/practitioner related moderators that impact outcomes and treatment

effects (Fensterheim & Raw, 1996; Persons & Silberschatz, 1998; Seligman, 1995; Shean, 2014). However, as Rasmussen (2014) argue, RCT findings cannot be expected to address all aspects of psychosocial wellbeing but can augment components of care packages intended to effect recovery at multiple levels of wellbeing. The larger issue concerns the need for empirical health systems research, in that the scope of NET research needs to be widened to include the socio-economic, political, and cultural contexts of the local communities they are intended to be implemented in. Holistic treatment and care systems must be evaluated for efficacy as opposed to a single component, i.e., the intervention. This is especially applicable to NET research, a technique whose basis, i.e., storytelling, is woven into the unique socio-cultural fabric of diverse societies.

Mechanisms of change is an important, under-researched area when it comes to NET inquiry. A few included trials have isolated neurobiological and molecular correlates of recovery when NET is used (Adenauer et al., 2011; Morath, Gola, et al., 2014; Morath, Moreno-Villanueva, et al., 2014). Psychological mechanisms of change can add rich detail to bettering intervention protocols. NET has clear theoretical underpinnings in recent models of PTSD such as EPT (Foa & Rothbaum, 1998) and the cognitive model of PTSD (Ehlers & Clark, 2000). In conceptualising the development and maintenance of PTSD in victims of trauma exposure, these theories have various implications for treatment protocol (Brewin & Holmes, 2003). First-line PTSD treatments such as PE, TF-CBT and CPT are rooted in these theories and have robust evidence for efficacy and effectiveness for PTSD outcomes. A rigorous, in-depth examination of the mechanisms of change using theory-driven analyses of NET narratives or final testimonies could provide insight into indicators of recovery or deterioration. Such research has the potential to add depth to quantitative evidence, as testimonies are largely personal accounts of change, and are bound to integrate the psychosocial, political, economic, and cultural context of the treatment setting.

The low-quality of evidence due to high risk of bias on various domains has implications for future researchers conducting NET RCTs. Rigorously reporting adequate data on randomisation, allocation concealment, blinding and attrition are crucial to publishing high-quality RCTs and presenting unbiased data estimates of the intervention effect. Further, details about using valid and reliable assessment measures and providing sufficient detail about therapist effects and treatment fidelity will enable a better understanding of NET's cross-cultural applicability.

Finally, homogenous, well-powered trials using uniform methodological design and comparable outcome assessments (e.g. measures, follow-up time) are needed to substantiate NET's position among active, gold-standard trauma interventions. When complemented by deeper, qualitative analyses of mechanisms of change, NET's evidence base can be strengthened to reveal its true effect across trauma populations.

5 Thematic Analysis of NET testimonies: Developing a framework of change and recovery

5.1 Background and Rationale

In this chapter, an idiographic approach was taken to investigate *how* or *why* NET brings about symptom change during the therapeutic process. Globally, the bulk of the NET evidence-base consists of RCT designs. RCTs are generally regarded as the 'gold standard' for evaluating the efficacy of therapeutic interventions (Jones & Podolsky, 2015). Chapter 4 demonstrated the issues with the current RCT evidence base and the pooled intervention effect estimates for NET (Raghuraman et al., 2020). Mundt et al. (2014) have also criticised the use of RCTs as the primary tool for evaluating the efficacy of NET in low- and middle-income countries (LMICs). It is proposed that efficacy studies (such as RCTs) should be complemented with evidence from in-depth, qualitative analyses of change mechanisms (Piccirillo & Rodebaugh, 2019).

Kazdin (2007) found that despite progress in evidence-based psychotherapy research, there is still a lack of understanding of the mechanisms and processes through which treatments operate. Identifying underlying mechanisms of change are believed to improve our understanding of illnesses, while also optimizing interventions by improving treatment response and reducing attrition (Kazdin, 2007). So far, there have been a handful of studies investigating the neurobiological mechanisms underlying NET symptom change (Adenauer et al., 2011; Morath, Gola, et al., 2014; Morath, Moreno-Villanueva, et al., 2014). There are no known studies on the psychological mechanisms of symptom change in NET research. Kazdin (2007) defined a change mechanism as "the basis for the effect, i.e., the processes or events that are responsible for the change; the reasons why the change occurred or how the change came about" (p. 3). Using individual-level designs is a useful means of examining the therapy processes, meaning, characteristics and context of psychotherapy (Audrey et al., 2006). Finlay (2014) has highlighted the lack of research that directly analyses what happens in a therapy session, which is concurrent with calls for process research based on therapy data (Henton, 2012; Mallinckrodt, 2011). The current study responds to these calls by rethinking the 'best' way to measure the efficacy of psychotherapeutic interventions.

5.1.1 NET: Theoretical basis

NET integrates effective therapeutic components of a combination of treatment approaches including PE therapy, cognitive-behavioural therapy (CBT) and testimony therapy (Neuner et al., 2002). NET stresses upon multiple exposures to a series of stressful events as being characteristic of trauma resulting from organised violence, interpersonal violence, or human rights violations. The additional element of Testimony Therapy was thought to be a crucial addition to address the multiple atrocities endured over the lifespan (Cienfuegos & Monelli, 1983). When applied to NET, the development of the final testimony results in the construction of a biographical account of the individual's entire life story, wherein revisiting positive memories provides the context of time and space, while becoming valuable resources for life. Testifying is also expected to fulfil the need for acknowledgement of atrocities endured, thereby helping the individual regain their dignity restore their capacity to resume the course of their lives. A combination of these treatment protocols is believed to achieve the treatment goals of NET to reduce PTSD in survivors of interpersonal violence.

NET is based on EPT and cognitive models of PTSD and the treatment protocols they have informed (Chapter 1, *section 1.3.7*) (Schauer et al., 2011). The treatment focus of NET is twofold –

i. The activation of the fear/trauma structure and subsequent habituation of the emotional, cognitive, and sensory-perceptual responses
ii. Active, chronological reconstruction of the autobiographical memory resulting in the construction of a coherent, consistent, declarative narrative

A third element was identified in the manual through the influence of testimony therapy –

iii. Extending the narrative across the lifespan of the individual through the final testimony by focusing on significant positive and negative life experiences

Taken together, these theory-informed protocols are the treatment focus of NET.

5.1.2 Research gaps

In India, there is a lack of rigorous empirical research into PTSD treatment. NET was specifically developed for use in low- and middle-income countries (LMIC) (Schauer et al., 2011) where there is a distinct lack of adequate mental health coverage in treatment of any mental health condition (Patel et al., 2016). NET is manualised, and research has shown that it can be efficacious when delivered by

trained, lay counsellors (Jacob et al., 2014; Köbach et al., 2017; Neuner et al., 2008). This makes it pragmatic, adaptable and applicable in diverse cross-cultural settings including India, where narratives and storytelling are traditional to the cultural context (BBC News, 2013; ITRHD, 2017). Currently, there are no published accounts of NET usage in the Indian socio-cultural setting.

Through NET, the client builds a narrative account of their life-story known as the *testimony*. There have been no published accounts examining the narratives or the testimony elicited *during* NET. This chapter aims to conduct an empirical examination of the distinctive nature of trauma narratives elicited *naturalistically* through NET and the relationship of the narrative to psychopathology, recovery, and adjustment. This study is different from the previously mentioned literature in two aspects – a) the focus is not solely on the most traumatic event(s) or the most threatening portions of those memories, and b) indicators of change was analysed from the testimony data; which is the end product of therapeutic time and effort. Indicators of recovery achieved *during* therapy (NET) as opposed to post-therapy was studied.

5.1.3 Research aim and questions

This chapter aimed to conduct a qualitative investigation of NET as an intervention for PTSD and related comorbidities in a 'real-world', practical setting to account for external factors such as individual patient characteristics and contextual and systematic factors which potentially serve as moderators of intervention effect (Singal et al., 2014).

The following research questions were addressed in the analysis –

i. Is there a post-treatment, quantitative effect of NET in terms of PTSD, depression, anxiety, and somatic symptoms for a sample of DV survivors in south India?
ii. Do the final testimonies of the participants show evidence of the various psychological mechanisms that are hypothesised to underlie PTSD symptom recovery?
iii. What other mechanisms and processes (if any) contributed to therapeutic change during NET (recovery or deterioration) in the sample?

5.2 **Methods**

5.2.1 Statistical approach

A quantitative analysis was undertaken to address the first aim of this study, which is to measure changes post-intervention using NET on chosen outcomes relevant to DV and trauma history. All participants who completed the NET treatment were assessed for eligibility before therapy, i.e., baseline (Time 1). Subsequently, they completed the same outcomes assessments at post-test, i.e., two days after signing their final testimony (Time 2). Longer follow-up was not possible due to the uncertain availability of participants living in shelters. A **paired sample t-test** was conducted to determine whether the mean difference between the two time points is significant in outcome improvement on the assessment measures. All statistical analyses were performed using IBM SPSS Statistics for Windows, Version 27.0

5.2.2 Idiographic approach

The idiographic perspective specifically focuses on an individual case, place, or phenomenon. The application of the idiographic perspective to the study of clinical, psychological processes has been endorsed by Shapiro (1961, 1966) and Skinner (1966). According to Shean (2014), idiographic enquiries answer the question of whether the intervention works for *a particular* individual, which is important to the clinical relevance of psychotherapies. Barlow & Nock (2009) suggest the use of idiographic strategies to identify and isolate sources and causes of inter-subject variability once nomothetic strategies have been used to test the efficacy and/or effectiveness of psychotherapeutic interventions.

5.2.3 Unit of analysis

The unit of analysis is the final testimony that emerges from the process of NET. The testimony is co-created by the participant and the therapist; the therapist produces a first-person, written, narrative account of each session in the participant's own words. The written narrative is re-read by the participant at the start of the succeeding session, allowing them the opportunity to clarify details, edit or re-organise the narrative. This process aids in habituation and is a crucial element of NET. At the end of the treatment, the participant is presented with a complete testimony consisting of each session's narrative account; ordered, narrated, and presented according to the participant's version of the events. The final testimony is re-read, signed and delivered and serves as a written

acknowledgement of their experiences in a consistent, chronological manner. The testimony is indicative of the time spent processing the trauma experience and re-constructing the autobiographical account of the participant's experiences. For analysis, I used a version of the testimony for each participant that contained my notes taken during each session. During sessions, patients may demonstrate symptoms of arousal, emotional engagement/withdrawal, or sensory re-experiencing, which may be communicated both verbally and non-verbally. Therefore, recording and analysing non-verbal communication, fillers, and pauses is valuable to the analysis of change.

5.2.4 Population and setting

The target population and setting were DV survivors in the unique south Indian socio-cultural context. The participants were recruited through collaborations with charities in two south Indian cities, a) Bengaluru, and b) Chennai. Eligibility was decided based on the following inclusion criteria, i) identifying as an adult (aged above 18 years) woman survivor of DV, and ii) scoring above the pre-determined cut-off score on a reliable and validated measure of PTSD. Exclusion criteria were restricted to availing other forms of intervention such as i) currently taking medication to treat psychological symptoms or conditions such as trauma- and stressor-related disorders PTSD, depression, and anxiety disorders, and ii) currently undergoing other forms of psychotherapy. Participation was voluntary and based on informed consent. The process of recruitment is detailed in Chapter 2, *section 2.4*.

5.2.5 Participants

Eleven participants provided written, informed consent to participate in the study. Three participants did not meet the inclusion criteria (did not score above cut-off on PTSD symptom assessment). One participant discontinued participation after the psychoeducation session after a consultation with a private psychiatrist who offered them treatment services within their facility. Seven female participants began NET and all of them completed the prescribed treatment. They were aged between 19 – 42 years. I use the term 'participant' in the research context. In other contexts, NET recipients are referred to as 'clients'. All participants reported experiences of DV, which ranged from intimate partner to familial abuse. Abusive experiences across the sample. included physical abuse, emotional and verbal abuse, sexual abuse, coercive control, and neglect. Detailed sociodemographic participant information is provided in Table 5-1.

Table 5-1 Sociodemographic characteristics of the participants

Anon. ID	Age	Relationship status	Family monthly income (INR)	Highest education level	Perpetrator(s)	Duration of abuse
Maya	27	Separated	80001-100000	Postgraduate degree	Spouse, in-laws	3 years
Anna	31	Divorced	> 2,00,000	Postgraduate degree	Ex-spouse, in-laws	6 months
Tara	38	Separated	5001-10000	Undergraduate Degree	Spouse, in-laws	7 years
Jenny	42	Separated	40001-60000	Undergraduate Degree	Mother, spouse, in-laws	> 10 years
Vani	33	Separated	80001-100000	Undergraduate Degree	Spouse, in-laws	3 years
Gauri	38	Married	5001-10000	Up to 10th standard	Spouse	> 10 years
Asha	19	Single	5001-10000	Up to 10th standard	Mother, uncle	> 10 years

5.2.6 Ethical considerations

The study was granted ethical approval by the Research Ethics Committee, Faculty of Medicine and Health Sciences, University of Nottingham (Ethics Reference No.: 103-1704). An important ethical consideration is the disclosure of ongoing abuse, risk of future abuse, and a threat to self/others (including self-harm or suicidal tendencies) during therapy sessions. It was expected that potential participants could indicate ongoing or future risk of exposure to DV. The NET manual does not include any specific guidance on the use of the intervention with populations who report ongoing risk of trauma exposure. However, due to constraints of this being a doctoral research project, and the fact that I am not a trained clinician/clinical psychologist, it was decided that only those participants who showed mild to moderate scores on baseline assessments on outcomes of PTSD, depression and anxiety would be included in the study. This was done to reduce the likelihood of including participants presenting with complex, psychological and emotional needs requiring intensive therapeutic support. This also ensured that no adaptations had to be made to the intervention for the target audience. I familiarised myself with the de-escalation procedures delineated in the NET manual under the supervision of my primary supervisor who is a chartered psychologist before commencing this study. Further, each charity had trained professionals on standby (as per normal protocol) in the event of disclosures that emerged in the NET sessions. All of the above precautionary measures

were clearly discussed with the liaison social workers at each charity during the seminar (*section 2.6*). This ensured appropriate sample selection as well as identifying clear safety protocol to handle disclosures of abuse or ongoing harm. This is discussed in depth Chapter 2, *section 2.6.*

5.2.7 Assessment Measures

Baseline outcome scores on PTSD, depression, anxiety and somatic symptom severity were collected. Previous research in this socio-cultural context has found the presence of somatic complaints among trauma-exposed populations (Varma et al., 2007; Vizcarra et al., 2004). The findings from the IPA study in Chapter 3 also suggested that somatic complaints are an important aspect of survivors' response to their experience of DV. The details of the assessment measures and relevant translation processes are discussed in detail in Chapter 2, *section 2.5.*

5.2.8 Process of NET

Upon completing the pre-test assessments, participants began the individual NET programme per the NET manual (Schauer et al., 2005, 2011). I delivered all sessions of NET to the participants, following NET training from two chartered psychologists with extensive NET clinical and research expertise. The two-day training workshop included sessions on psychological trauma, PTSD, principles and theoretical underpinnings of NET, and practical exercises of using NET (lifeline sessions, practising a NET session in group and one-on-one settings). Feedback and assessment by the trainers (primary and third supervisors) were key elements of the training.

Treatment fidelity and therapeutic competence were monitored through weekly supervisions with the primary supervisor, who is a trained NET clinician. This monitoring was based on a discussion of case notes and a review of the written narratives from each session. The sessions were reviewed during supervision for trauma focus, exposure, and richness of detail. The charities did not permit videotaping of the NET sessions for ethical and confidentiality reasons. Weekly supervision with my primary supervisor also included a discussion of my own experiences of delivering the NET sessions, any positive or negative incidents during the sessions, any distress I was feeling as a direct result of delivering NET and other issues that provided much needed support during this stage of the research. This was done virtually as I was based in India during this stage of fieldwork and my supervisor were based in the UK but the quality of the supervision was not affected by its virtual setting.

The process of NET strictly followed the manual (Schauer et al., 2011), with no amendments or adaptations. Details about the manualised process of NET was presented in Chapter 1, *section 1.4.1*. Strategies to counter dissociative symptoms were prepared per the manual (Schauer et al., 2011). All safety protocol to ensure the participants' wellbeing and comfort were discussed in detail with the primary supervisor (a chartered psychologist) as well as during weekly supervision meetings. On the field, each charity had counsellors who were trained in managing safety protocols during sessions. They were asked to be present on the premises during NET sessions in case in-session safety protocols were not successful/sufficient. No dissociation or related adverse reactions were experienced by any of the participants during exposure.

On average, the participants completed 7.5 sessions over 20 weeks (November 2017 – April 2018). Post-test evaluations and debriefing were conducted 02 days after the final testimony session for each participant. The scoring of the self-report assessments and the analysis of the cases were both completed by me and was corroborated by my third academic supervisor (EH), who is trained in NET and experienced in qualitative research methods.

5.3 **Analysis**

5.3.1 Justification of the analytic approach

The methodological approach to address the remaining aims integrated an inductive, data-driven qualitative analysis with a template-based, deductive approach that is rooted in the theoretical understanding of PTSD. The deductive analysis was influenced by the paradigmatic assumptions made based on the tenets of relevant PTSD models. The inductive analysis was derived from the data and focused on data-specific mechanisms that could have contributed to change.

For the qualitative analysis, TA was employed to analyse the final testimonies that emerged from NET sessions. TA is a form of pattern recognition within data, wherein the emerging themes are considered crucial to the interpretation and description of the phenomenon under enquiry. It is not wedded to a specific epistemological or theoretical position and can be used across a range of phenomenon guided by specific theoretical underpinnings (Braun & Clarke, 2006). This makes TA suitable to this study as the analysis of the testimonies was guided by a theoretical understanding of PTSD and NET. The focus of this study was on identifying, analysing, and reporting patterns indicating change mechanisms across testimonies. Researchers have underlined the usefulness and

suitability of TA as an analytic method for psychotherapy process research (Mortl & Gelo, 2015), making it a suitable choice for this study.

5.3.2 Analytical technique

I used a codebook approach that combines the template coding procedures of 'small q TA', with the underlying qualitative philosophy of the 'Big Q TA'; dubbed as 'medium Q TA' (Braun et al., 2018; Clarke & Braun, 2018). First, 'small q' qualitative research consists of using qualitative tools and techniques for data generation within a positivist framework. 'Big Q' refers to the use of these tools and techniques within the qualitative paradigm and emphasise an organic approach to coding and theme development (Kidder & Fine, 1987). A combination of these approaches was defined as 'medium Q TA' (Clarke & Braun, 2018) and was used in this study in the form of a 'hybrid' inductive and deductive approach.

The inductive analysis was guided by Braun & Clarke's (2006) 6-phase approach to TA with an emphasis on depth of engagement in the data, researcher subjectivity as a resource, reflexivity, and the contextual nature of meaning. The 6 phases include –

i. Familiarizing yourself with your data:
ii. Generating initial codes
iii. Searching for themes
iv. Reviewing themes
v. Defining and naming themes
vi. Producing the report

In addition to an inductive, data-driven approach to the analysis of the testimonies, a template approach was used which was deductive and was informed by the theoretical understanding of PTSD. This was guided by the works of Crabtree & Miller (1999), who established a middle-ground approach between a closed, structured technique that relies entirely on *a priori* defined codes and an unstructured, editing approach wherein codes are derived from reading large amounts of textual material.

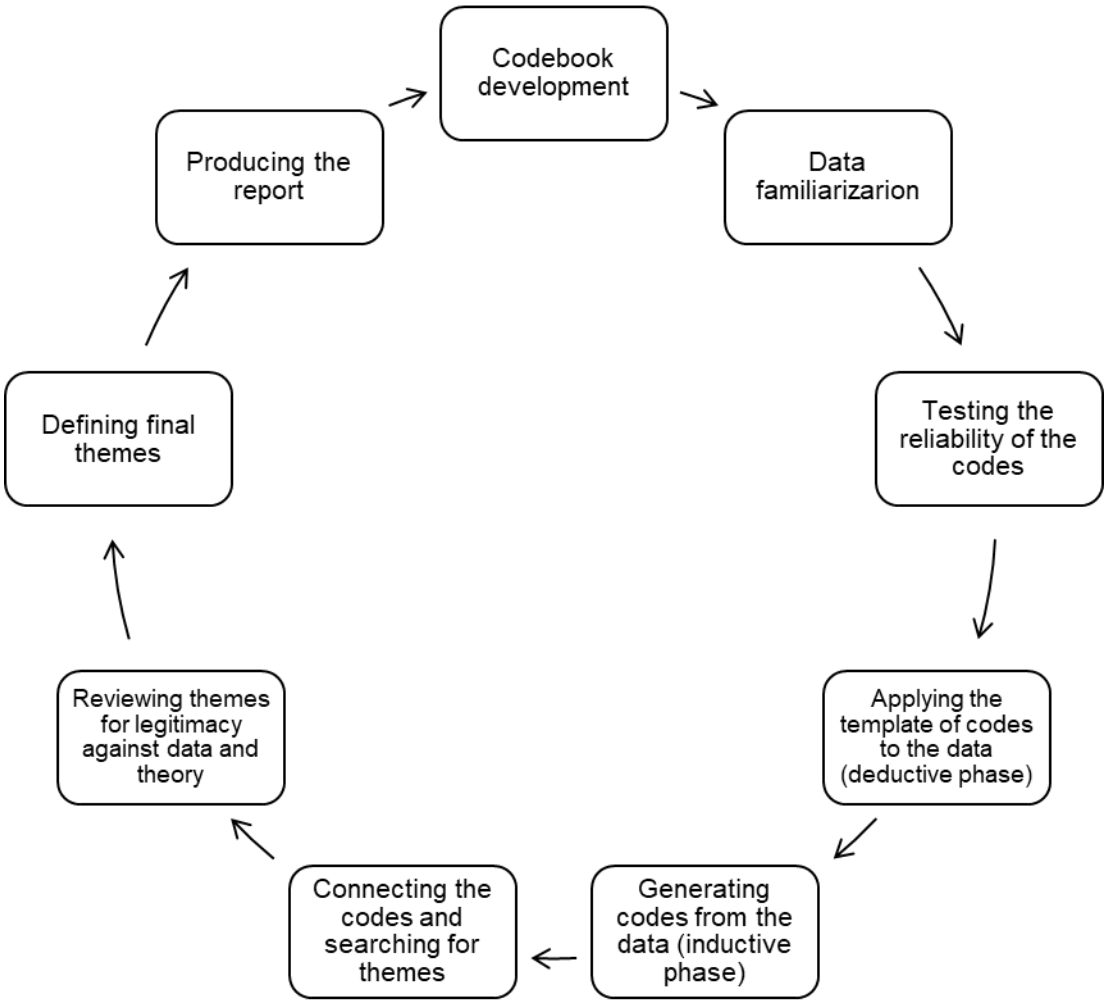
A template in the form of a predetermined codebook was applied to the testimony data as a means of organising the text for further interpretation. The analysis of the testimonies was not confined strictly to the codebook and the predefined templates, conforming to the qualitative philosophy of TA (Clarke

& Braun, 2018). Due to the novel context of the research and its setting, unexpected codes and/or themes emerged from the data, which were then either coded separately or were integrated with an existing category in the codebook. This hybrid approach aligns with the 'medium Q' TA approach where the focus is not on ensuring strict reliability or accuracy of coding (Braun & Clarke, 2018).

5.3.3 Analytic process

A step-wise process was undertaken to analyse the testimonies. Due to the hybrid approach used, Braun & Clarke's (2006) 6-phase TA approach (Table 4) and Crabtree & Miller's (1999) template approach were integrated into the analysis. A diagrammatic representation of the analytic process is presented in Figure 5-1. Although the process is presented as a linear, step-by-step method, the analytic process was iterative and reflexive (Crabtree & Miller, 1999).

Figure 5-1 The stages of coding and analysis (adapted from Braun & Clarke, 2006, and Crabtree & Miller, 1999)



5.3.3.1 **The codebook development**

A codebook template was developed before commencing the analysis and was guided by the PTSD theoretical models and NET treatment protocol. The codebook served as a data management tool to organize segments of similar/related text which could then be interpreted in tandem with the inductive codes and was revised and refined through the process of analysis (Crabtree & Miller, 1999)

Six broad code categories or themes were determined as essential to the study of trauma narratives and their relationship to psychopathology and recovery. They include –

a) Narrative organisation

b) Spatial context

c) Temporal context

d) Sensory-perceptual processing

e) Emotional processing

f) Cognitive processing

Each predetermined broad code category was used to code the testimony data. Next, these broad code categories were further subcategorised into refined codes to capture differing or contrasting ideas or elements of the data (Crabtree & Miller, 1999). The code categories were documented in accordance with Boyatzis (1998) and were identified by the code label and a definition of what the theme concerns. Table 5-2 illustrates the documentation of code categories.

Table 5-2 Template codebook sample

	Label	Definition
Code Category 1	**Narrative organisation**	Refers to utterances that indicate chronology, interconnection, context and flow of thought and recall.

	Label	Definition
Code Category 2	**Sensory-perceptual processing**	Refers to utterances that indicate detailed descriptions of sensory information (visual, auditory, tactile); bodily sensations and responses to reliving

	Label	Definition
Code Category 3	**Emotional processing**	Refers to emotions that are conditioned responses to reliving traumatic and fearful memories by incorporating safety information and/or incompatible evidence to modify the fear/trauma network.

	Label	Definition
Code Category 4	**Cognitive processing**	Cognitive revaluation of thought patterns and behaviours, i.e., negative appraisals of trauma and/or its sequelae, cognitive distortions, automatic thoughts, beliefs, and responses; re-interpretation and re-processing the meaning of the content

	Label	Definition
Code Category 5	**Time and space context**	Building explicit, semantic representations of the trauma experienced with an established temporal and spatial context to defragment the autobiographical memories.

5.3.3.2 **Data familiarisation**

I facilitated the NET sessions and collected all the data. Throughout the data collection (therapeutic) process, I maintained case notes and noted down any initial analytic insights (Braun & Clarke, 2006).

The testimony requires me to produce a written narrative from each session in the words of the participant for reliving before the next session. Therefore, I was able to commence the process of data immersion and familiarisation throughout the therapeutic process. I continued to actively re-read the testimonies and make further case notes and analytic insights after data was collected.

5.3.3.3 **Testing the reliability of the codes**

The first complete testimony was chosen as a test document for the application of the template codebook to assess how applicable the deductive codebook is to the raw data (Boyatzis, 1998). Following my coding process, my supervisor (EH) applied the template codebook to the same document. The results were compared, and minor discrepancies were discussed and resolved. No modifications were required to the template codebook.

5.3.3.4 **Applying the template of codes to the data (deductive phase)**

Once the codebook was finalised, I applied the template to all the testimonies successively with the intent of identifying meaningful units of text. The computer program N-Vivo was used to manage and analyse the data (QSR International, 2012).

5.3.3.5 **Generating data-driven codes (inductive phase)**

Segments of data that were found to indicate mechanisms of change beyond that which was theory-driven were created as inductive codes. These codes were grounded in the data, but the interpretation of these codes was informed by the theoretical underpinnings of PTSD and NET.

5.3.3.6 **Connecting codes and searching for themes**

'Candidate' themes and patterns were discovered by connecting the codes to the research question. Similarities and differences between individual testimonies emerged and due to the idiographic focus of this study, these areas of conflict and consensus were highlighted and analysed accordingly.

5.3.3.7 **Reviewing themes for legitimacy against data and theory**

The inductive and deductive codes were scrutinized to ensure that they were representative of the data set and the template codebook. Several iterations of the patterning and clustering of data segments, codes, and themes were performed at this stage to maintain consistency with the data and address the research questions clearly.

5.3.3.8 **Defining final themes**

In this stage, themes were further clustered and defined using a representative phrase that was consistent with the meaning of the data that underpinned the theme.

5.3.3.9 **Producing the report**

The findings are reported in the sections below.

5.4 **Results**

The results section is presented in three parts. **Part one** presents the quantitative, statistical analysis on change post-NET on the outcomes of PTSD, depression, anxiety, and somatic symptoms which are aimed at contextualising the findings from the qualitative analysis. The findings from the qualitative TA of NET testimonies is presented in **part two** to identify proposed mechanisms of change and/or recovery. This analysis led to the development of the framework of recovery through NET, which is presented in **part three**. The framework of recovery is a key contribution of this chapter and the thesis and its implications are further discussed in this section.

5.4.1 Changes in PTSD, depression, anxiety, and somatic symptom scores post-NET

The results from the paired-sample *t*-test tests for PTSD, depression, anxiety, and somatic symptoms are presented. Assumptions of parametric tests that applied to paired sample *t*-test were checked.

a The data was found to be normally distributed using the Shapiro-Wilk statistic which is ideal for small sample studies (Mohd Razali & Bee Wah, 2011). Graphical methods including histograms, Q-Q plots and box plots were used to confirm normality.

b The data were measured at the interval level.

Table 5-3 Paired samples t-test on outcome measures

Symptoms	Mean	Std. Error Mean	t	df	Sig. (2-tailed)
PTSD	26.85	7.61	3.52	6	0.01
Depression	1.57	2.16	0.72	6	0.49
Anxiety	4.57	2.14	2.12	6	0.07
Somatic	12.85	4.79	2.68	6	0.03

The results from the paired sample *t*-test (Table 5-3) show that on average, participants experienced significantly lower PTSD and somatic symptoms at Time 2 when compared to Time 1. Lower, yet non-statistically significant scores on depression and anxiety symptom scales were reported at Time 2. Table 5-4 shows the individual absolute scores on symptom scales and the difference between Time 1 and Time 2 for each participant.

Table 5-4 Pre- and Post-NET scores on symptom scales

Anon. ID	PTSD Symptoms			Depression Symptoms			Anxiety Symptoms			Somatic Symptoms		
	Pre-therapy	Post-therapy	DIF	Pre-therapy	Post-therapy	DIF	Pre-therapy	Post-therapy	DIF	Pre-therapy	Post-therapy	DIF
Maya	41	19	**22**	3	0	**3**	4	1	**3**	11	1	**10**
Anna	73	29	**44**	10	0	**10**	17	2	**15**	44	11	**33**
Tara	48	53	**-5**	13	17	**-4**	16	12	**4**	33	13	**20**
Jenny	77	43	**34**	11	18	**-7**	18	12	**6**	48	36	**12**
Vani	45	32	**13**	8	8	**0**	10	12	**-2**	33	16	**17**
Gauri	73	17	**56**	5	0	**5**	3	4	**-1**	23	31	**-8**
Asha	47	23	**24**	6	2	**4**	14	7	**7**	6	0	**6**
Mean	**57.71**	**30.86**		**8.00**	**6.43**		**11.71**	**7.14**		**28.29**	**15.43**	
SD	**15.76**	**13.15**		**3.56**	**8.08**		**6.18**	**4.91**		**15.83**	**13.77**	

DIF = difference between Time 1 and Time 2; SD = Standard Deviation

Although this is an uncontrolled study, these findings suggest that NET could be useful in reducing PTSD and somatic symptoms in this sample.

5.4.2 TA: final testimonies

Six themes emerged from the TA of testimonies. These themes were deductively and inductively derived (Table 5-5) and will be explicated through subthemes.

Table 5-5 Thematic framework of recovery through NET

THEME	SUB-THEME
Anecdotal reliving	Chronology and sequencing
	Descriptive details
	Coherence and structure

	Narrative clarity
Contextual reliving	Spatiotemporal processing
Associated network processing	Re-experiencing the trauma using the senses
	Emotional engagement and processing
Cognitive re-structuring	Appraisals of trauma
	Self-appraisals
	Appraisals of others
Adaptive positive memories	Perpetrator-relevant memories
	General positive memories
Planning for the future	Ambitions for the future self
	Growth and learning for the future
	Planning beyond the self

5.4.2.1 **Theme 1: Anecdotal reliving**

This theme signifies the ability of the participant to produce a narrative of significant life events in a coherent, consistent, and chronological manner, i.e., anecdotally. PTSD theories have highlighted disorganised or fragmented narratives as characteristic to trauma memories. Issues include problems with chronology and sequence of events, fragmentation, missing 'chunks' of time, and increasing skewness towards threat representations (Brewin et al., 1996; Ehlers & Clark, 2000; Foa et al., 1995; Foa & Riggs, 1993). Treatment that is aimed at reducing trauma symptoms should result in organized memories that are reflected in trauma narratives (Foa et al., 2006, 2007). Based on these theoretical paradigms, NET identifies the reconstruction of the autobiographical memory to produce a chronological, consistent narrative of the traumatic experience as a key treatment goal (Schauer et al., 2011).

This theme reflects the broad deductive code 'narrative organisation', along with excerpts coded inductively from the testimonies. Subthemes are not mutually exclusive and there are clear overlaps between various indices of narrative organisation. Quotes that are most representative of the

subtheme are included, but a single quote may illustrate more than one index of narrative organisation.

5.4.2.1.1 *Subtheme 1: Chronology and sequencing of events*

In the analysis of the final testimonies, there was significant evidence of participants' ability to narrate events in a sequence or as having a specific chronology.

> *"I got pregnant in February. I had known that something was happening with my body. I didn't tell <name of perpetrator> but I told my parents. On 19th February, they came home. <Name of perpetrator> started abusing me in front of them. My dad was upset and hurt and he went towards <name of perpetrator>. They charged towards us. <Perpetrator> pushed me hard… yes, really hard. I fell and I lost consciousness in front of my parents."*

In the above excerpt, Maya narrates the exact sequence of a distressing event. She was able to connect various elements of the memory such as her pregnancy, the date of her parents' visit, and the key events that took place during the visit. Anna recalls the chronological sequence of the events that led up to her being coerced into the marriage.

> *"First, his mother came home by herself. We had just returned from visiting <name of place>. She talked about marriage. I told my mother immediately that I wasn't interested. The next day, she brought <name of perpetrator> to see me. As soon as I saw him, I decided that I wasn't interested."*

This event was significant to Anna's experience of abuse; she re-iterated that she 'wasn't interested' in the marriage proposal several times during this narration. While previous narrative research has viewed repetitions as a direct index of fragmentation or narrative disorganisation (Bedard-Gilligan et al., 2017; Foa et al., 1995; Halligan et al., 2003), in this analysis, they are interpreted as an indicator of emphasis. Repetitions can have multiple functions in language, including emphasising particular parts of the story (Kakava, 2001) or as a marker of deception or emotional concealment (Depaulo et al., 2003). Anna wanted to emphasise that she was coerced into a marriage which turned out to be traumatic, and this particular incident was important to that aspect of the narrative. Her ability to clearly sequence these events is interpreted as a marker of narrative organisation of a painful

memory. Sequential organisation is evocative of being a 'healthy human' in psychotherapy research (Singer & Rexhaj, 2006). This is foundational to PTSD theory, making it significant to recovery through NET.

5.4.2.1.2 *Subtheme 2: Evidence of descriptive details*

NET emphasises the importance of eliciting detailed narrative account of events for two explicit reasons: (1) to encourage activation of the fear network to aid habituation, and (2) to assist in the reconstruction of the autobiographical memory of events (Schauer et al., 2011). Capturing instances of descriptive detail or vividness has been coded as an index of narrative dis/organisation and includes a verbal account of trauma memories such as own activities, others' activities, feelings and thought processes (Halligan et al., 2003; O'Kearney & Perrott, 2006). Successful recovery would entail a detailed description of significant experiences by the participants; evidence of which was found in across testimonies. Anna provided a detailed account of events leading up to, and consisting of significant physical, sexual, and emotional abuse -

> *"On the way to the hotel, he asked me where the gold was. I told him I gave it to my mom. I told him to his face that I didn't feel safe. I didn't want to go. When we reached the hotel, I changed my clothes. I told him I was tired. He told me 'you're not going to sleep'. He told me I can't have my medication either. He ordered (alcoholic) drinks. I swallowed my medication quickly. He hit my head and he forced me to spit the tablets out. He was pressing my throat so hard that I vomited. He told me 'no sleeping tonight'".*

Anna recalls verbatim conversations, her actions, and the perpetrator's actions in vivid detail. She also demonstrates a keen ability to recall her own thought process as the events of the night unfolded. This illustrated her ability to relive the traumatic experience in narrative detail, thereby addressing a crucial NET process and goal.

Asha produced a detailed description of the experience of self-immolation as a response to severe emotional and physical abuse by her family.

> *"This was when I made the decision to commit suicide. I had hidden the matchbox a while ago. I found it in my room and set myself on fire. I remember everything very clearly. It was around 6.30 in the evening. I was in my room, wearing a violet*

'churidar' (traditional Indian clothing worn by young women). After they doused the flames, I was lying down quietly. I was in pain, but I didn't cry. I was very quiet. I could see my father's face from where I was. He was very upset and said they should let me die. He was crying a lot. When I saw him cry, I realized I had made a mistake. I saw everyone crying. I had never seen any of them cry."

She recalls the trigger and the process leading up to the self-immolation attempt. She was also able to provide a detailed description of her physical surroundings such as the time of the day and her clothing. She then moves on to discussing the reactions of others around her, providing descriptive details of *who, where* and *how* she perceived these reactions. This is a significant amount of detail and suggests Asha was able to descriptively reconstruct her memory of what transpired on the day through the therapeutic process.

5.4.2.1.3 *Subtheme 3: Evidence of coherence and structure*

Bedard-Gilligan et al. (2018) include coherence as an index of fragmentation and define it using evidence of 'how well concepts hung together logically' (p. 216). Similarly, O'Kearney & Perrott (2006) define the language domain of narrative coherence as an index of conceptual organisation. According to Sawyer (2003), coherence focuses on how well goals, actions, outcomes, topics, or event sequences are connected, regardless of their cohesiveness. Coherence is a NET treatment goal and instances of coherence and structure in the testimonies were interpreted as indices of recovery.

Vani demonstrates a high degree of coherence when she speaks about the precise moment her marriage ended, following a period of severe abuse and neglect.

"He just said, "I don't love you anymore, I don't hate you anymore. I just don't care." I fell to his feet and begged him, but he just left me there. After that, I came back to <name of place> and finally decided to give up. I withdrew the mutual consent for divorce, and I filed a case under 498A (section in the Indian Penal code criminalizing the act of cruelty by the husband or relative of the husband of a woman) *because I didn't want to give up without a fight. They have made me suffer so much. I want justice for what happened to me. They treated me inhumanely."*

Vani discusses the sequence of events that led her to file a criminal charge against her husband and his family. There is a clear progression of actions that resulted in the decision, and she clarifies her thought process behind the decision. This shows continuity (events are ordered as per their occurrence) and logical organisation (characters, places, and actions are reasonably connected). The excerpt also provides character, the orientation of time and place, a sequence of events leading to a climax with a resolution (her decision to file a criminal case) (McCabe & Peterson, 1991). It evaluates what is important, which in Vani's case is her need for justice and reprisal.

Asha, who shared the experience of being coerced into making an undesirable career choice by her mother (one of the primary perpetrators) –

> *"I wanted to study nursing. But my mother didn't let me. She forced me to start working after class 10 because she wanted me to earn money to help build our house. My friends continued to study after class 10, and I was extremely jealous of them. But now that this has happened (self-immolation attempt), my mother tells me I can study. This makes me really angry. Now I don't want to study anymore. It's too late."*

Reese et al. (2011) have proposed that a coherent personal narrative is one that goes beyond an understanding of the *when, where* and *what,* and tackles the meaning of that event to the narrator. In this excerpt, Asha demonstrates a coherent understanding of the contradiction in her mother's actions before (forcing her to discontinue her studies) and after (encouraging her to pursue her dream) the self-immolation attempt. She felt that the change of heart was disingenuous as it was linked to her decision to self-immolate. Reese et al. (2011) proposed that 'theme' is an important dimension of narrative coherence. The thematic dimension is assessed though a high point and a resolution, accompanied by affective and evaluative information. Asha's claim that it is 'too late' suggests that she has moved on from previous desires and recognises that the trauma has changed her. Her verbalisations demonstrate coherence in thought, actions, and outcomes. Finally, her admittance of anger coherently links her emotional reactions to the perceived injustices she has suffered.

5.4.2.1.4 *Subtheme 4: Narrative clarity*

Clarity refers to the overall amount of clear thoughts and ideas, and is illustrated by excerpts containing a finished description of events, people, places, and references to where, when, how, and

why (Bedard-Gilligan et al., 2018). Although not explicitly stated as a treatment outcome for NET, lower clarity has been indexed as an important feature of traumatic memories (Gray & Lombardo, 2001; Koss et al., 1996; Porter & Birt, 2001) and an index of narrative dis/organisation (Bedard-Gilligan et al., 2018).

Asha demonstrates most aspects of clarity in her narration of the events below –

> *"The next time they were in <name of city> was during Rakshabandan* (Indian festival)*. This was when the whole family got together to serve me with the divorce papers. This was in August. I just signed it and left because I was exhausted, and I didn't want to put up with them anymore. I left in September, but I decided to go back in October to try and reconcile. I don't know why, but I didn't want to lose him. Maybe it was because he was my husband, and I was emotionally attached to him. I also realise now that it was because I didn't want to be alone. I flew to <name of city> and found that he was living with a friend. Together, they ganged up against me and started to verbally abuse me. They told me to get out and threatened to call the cops. I tried to speak to his mother, but she also threatened me over the phone."*

There was clarity in her re-telling of a significantly distressing memory; being served with divorce papers. She identifies the *where* and *when* the events occurred. She also clearly identifies the main characters and describes their actions towards her. She provides explanations into *why* she signed the divorce papers and then attempted reconciliation, which illustrates clarity of thought and understanding into her own reactions. The narrative contains complete descriptions of the main elements of the incident which indicates clarity.

Gauri discusses the sequence of events that followed after her traumatic self-immolation attempt.

> *"They took me to <name of hospital>, and then to a hospital in <name of town>. The facilities were horrible. After two days, they told me to move to a different hospital in <name of city>. No one wanted to take me. Everyone was very scared. In the end, it was my son's friend and another boy who brought me all the way to <name of hospital> in <name of city> admitted me and stayed with me. I was admitted there for 2 months. I was in the Intensive Care Unit for 20 days. If it*

weren't for those boys, I wouldn't be here talking to you. God was behind them the whole time. That's why I'm alive today."

There are references and descriptions of events, places, and people's actions and Gauri shows significant clarity in detailing these incidents. She clearly identified key characters, names places of interest and also provides temporal information. She also demonstrated clarity in the meaning she ascribed to key events and actions. She talked about how those closest to her weren't willing to come to her aid at a crucial time which provides insight into her perception of what social support means to her.

Overall, the main theme of 'anecdotal reliving' was analysed using four subthemes: *chronology and sequencing, evidence of descriptive detail, coherence and structured narration, and narrative clarity.* While these features of narration tend to overlap in defining characteristics and features, they have been analysed separately and interpreted using diverse, illustrative excerpts from the testimonies to show the scope and range of the testimonies in providing evidence of change mechanisms through NET. Taken together, these subthemes present the ability of the participants to construct a clear, coherent, consistent autobiographical account of significant, DV-related life experiences.

5.4.2.2 **Theme 2: Contextual reliving**

An important characteristic of PTSD narratives is how well they are anchored to temporal and spatial contexts. Ehlers & Clark's (2000) cognitive model of PTSD suggested that trauma memories are not only poorly elaborated, but do not possess adequate context in time and place due to not being adequately integrated into the autobiographical memory system. This has been attributed to peri-traumatic data-driven processing, which focuses on sensory-perceptual representations and lacks contextualisation of encoded information (Ehlers & Clark, 2000). Adding the context of space and time (the 'cold' memory) to their narratives of cognitive, emotional, and sensory-perceptual representations of experiences ('hot' memory) is essential to the reconstruction of the narrative. A lack of spatiotemporal context in encoding trauma memories is consistent with intrusion symptoms or re-experiencing the event(s) in the present.

Holman & Silver (1998) found evidence for temporal disintegration among diversely traumatized individuals. Verb shifts from past to present have been documented when recounting emotional

experiences of peak distress (Hellawell & Brewin, 2004; Pillemer et al., 1998). O'Kearney & Perrott's (2006) review found evidence for distortions in the temporal organization of PTSD narratives.

Based on the theoretical premise that trauma memories are poorly elaborated, decontextualized and inadequately incorporated into the autobiographical memory system, references to spatiotemporal dimensions during the narration of highly arousing content are therefore considered to be critical to the inhibition of threat-related cues in the present and the production of a complete autobiographical account of one's experiences (Neuner et al., 2020).

Gauri's original account of her self-immolation attempt consisted of a two-line description following the trigger. She stated,

"I wanted to die that day, so I used kerosene. And the result is what you're seeing today <points at the burn scars>.

Over time, through exposure and narrative reliving, she managed to provide significant contextual detail during this narration -

"It was in May. I am quite sure it was on a Thursday because I weave coconut palm leaves on Thursdays. I was so angry that I left the kitchen and went into my bedroom because I didn't want anyone to see me. I remember pouring the kerosene on myself. I was in so much pain and I don't remember anything after that. I don't remember how I lit the match. But I remember I was wearing a green saree. The next thing I remember is the burning sensation on my skin. I ran into the room where my husband was sleeping. I didn't want to go outside because everybody will know what I did, and it would be humiliating. When I went to him, he splashed water all over me and that's what I remember clearly."

Gauri in peak distress during this narration; she was emotionally distraught (helplessness and anger) while also engaging in a sensory-perceptual reliving of the experience. Nonetheless, she used cold memories (such as weaving coconut palm leaves on Thursdays) to contextualise her emotional engagement with the trauma.

In one of her last sessions, Maya shared her account of emotional catharsis following over two years of chronic IPV.

"After Christmas, my family decided to take me to <name of town> for a vacation. On the third morning of our stay, I decided to take a walk by myself. I got lost in that world. I was surrounded by nature. It was breath-taking. The trees, the water - it was so calm and beautiful. I don't know why, but I cried that day. I remembered all the abuse, the violence, the betrayal of trust. But I told myself that it would be the last time I cried and that I had to move on. It was like self-motivation."

She makes references to the time of the year (*after Christmas*) and other specific temporal references (*day three of her vacation*). She further refers to the name of the place and describes the location using descriptive detail and sensory imagery. This suggests that while reliving the experience through the narrative at multiple levels of processing, she was also contextualising the event in the appropriate time and space dimension and situating it within her biography.

In NET, the life story is used to contextualise the network of cognitive, emotional, and sensory-perceptual memories by filling in the gaps through detail (Neuner et al., 2020). Situating trauma memories in the past within the larger context of the person's life is crucial, thereby addressing core PTSD symptoms. Accordingly, participants' capacity for contextualising their traumatic memories through the narrative is indicative of recovery.

5.4.2.3 **Theme 3: Associated network processing**

NET draws significantly from the associated network model of fear (Lang, 1979, 1993) which proposes that when a person is confronted with a trauma reminder, activation at one level of processing (such as sensory) will cue the activation of multiple levels of processing (such as emotional, physiological, or cognitive) (Foa & Kozak, 1986). This accounts for the hallmark PTSD symptoms of intrusions, and in extension, avoidance of internal and external reminders.

NET aims at connecting trauma memories to corresponding sequences in the autobiography by verbalising the sensations using narratives. This seeks to prevent avoidance, which has been implicated as a maladaptive coping strategy leading to more persistent and long-term psychopathology in several studies (Bryant & Harvey, 1995; Dunmore et al., 1999, 2001b; McFarlane, 1988). Therefore, successful treatment is concurrent to reducing intrusion and avoidance symptoms through the activation of the processing the fear/trauma network (Schauer et al., 2011). This process is expected to achieve habituation, which will in turn reduce the emotional impact of the sensations

and decrease physiological arousal. In this theme, instances of sensory-perceptual activation and emotional activation are analysed and interpreted as evidence of recovery.

5.4.2.3.1 *Subtheme 1: Re-experiencing the trauma using the senses*

The retrieval of the sensory-perceptual representation of an event is the crucial, final step in recalling a memory of a past event (Conway, 2001). This underlines the importance of activating trauma memories at the sensory-perceptual level, which includes visual, auditory, tactile, or olfactory information about an experience. NET therapists are directed to probe for details regarding the sensations experienced through the narrative to awaken sensory memories of the event(s) (Schauer et al., 2011).

Sensory re-experiencing was evident throughout and across testimonies of participants. Maya recalled the traumatising experience of miscarriage.

> *"At night, the pain was just unbearable. I collapsed because I couldn't bear the pain. I had to go to the washroom and push the foetus out. I actually saw it. I can never forget what I saw that night. There was so much blood. I saw it and then I had to flush it myself. After this happened <pauses> after the miscarriage, I was very depressed. I am better now, but I was very sensitive, upset all the time. I would cry a lot."*

Maya experienced significant emotional distress during this narration. She was guided to describe this experience in as much descriptive detail as possible. When doing so, she began to cry, suggesting that reliving this memory through her senses triggered an emotional reaction. PTSD networks contain unusually large and strong interconnections between various elements and individuals are more strongly primed towards the activation of the full fear/trauma network when faced with a single cue/reminder (Foa & Kozak, 1986). In this instance, Maya was reminded of a painful experience and when the sensory memories of the experience were activated, so were the emotional responses that were strongly connected to them. When asked to verbalise how she felt (then and now), she admitted that she had been very emotionally distressed during that time. She also stated that she since felt she was doing better, which could be a result of naturalistic symptom recovery over time.

Anna discussed a traumatic memory of her wedding day, before and during which time she had already been subjected to significant emotional, verbal, and economic abuse by the perpetrator and his family.

> *"During the wedding, they really humiliated us in front of everyone. The venue was horrible. It was ugly and dirty. They were abusing us in the Church in really vulgar language <covers ears>. I was terrified thinking of what I was getting into. I actually couldn't see. I couldn't see anything. I couldn't even respond to the question the priest asked me because I didn't hear him. They said he had to ask me twice, and I only responded the second time. I felt blindfolded. I was deaf. I've forgotten a lot of what happened on that day."*

Anna is recalling an experience of peritraumatic dissociation on a sensory level (Marmar et al., 1998) which has consistently been correlated strongly with subsequent PTSD (Lensvelt-Mulders et al., 2008). This excerpt is filled with details that are sensory-perceptual in nature. Records of non-verbal communication (such as the action of covering ears) suggest that she was reliving her auditory memories of the event. She went on to describe feeling temporarily 'blindfolded' and 'deaf'. She admitted to having forgotten other details of the experience, indicating poorly elaborated, fragmented memories. This is typical for memories of events that are encoded in a heightened emotional state.

Another excerpt from Anna's testimony details experiences of DV with a focus on sensory and physiological activation.

> *"He forced me to drink. And after that, he tried to force me to have sex. During this, he choked me <demonstrates on herself>. There was a lot of physical abuse. I had a lot of bruises, especially on my back because of that night. It was because he was being physically abusive with me. Forcing me, hitting me, pushing me. My face was also swollen. He tried to forcefully remove my salwar* (Indian dress worn by women), *but I didn't let him. I didn't have the strength to resist, but I didn't let him do it. He was so drunk I couldn't bear the smell. Sometimes even now, I feel like someone is choking me."*

This excerpt provides a sensory-rich coherent, yet a non-cohesive account of what happened that night. According to O'Kearney & Perrott (2006), a coherent narrative indicates logical conceptual

organisation and can be non-cohesive (a mark of additive, temporal or causal connectedness between sentences and clauses). Anna focused on a coherent narration of the sensory-perceptual representations, and while it may not be cohesive, it indicates that she was able to recall exactly what happened through re-experiencing sights (bruises, face swelling), smells (liquor on his breath) and sensations (being hit, pushed, choked). She remarked that she continued to have flashbacks of being choked, suggesting that internal or external cues activated arousal on a physiological level.

5.4.2.3.2 *Subtheme 2: Emotional engagement and processing*

Grey et al. (2001) differentiated primary emotions (fear, helplessness, and horror) as those experienced *during* the trauma from secondary emotions as those generated by retrospective cognitive appraisals of the event(s). However, during trauma exposure such as DV, more complex evaluations can take place, resulting in a range of emotions such as anger or shame (Brewin et al., 2000; Grey et al., 2001). EPT focuses on the use of prolonged exposure for the habituation of fear (Foa & Kozak, 1986; Foa & Riggs, 1993; Foa & Rothbaum, 1998), which has been extended to include a wider range of emotions for PTSD patients (Grey et al., 2002). In this study, diverse emotional experienced were shared by participants.

Asha recounted the incident when she was targeted by her family over the suicide attempt of a relative, with whom she was close. There was physical and verbal abuse involved, and while Asha primarily spoke of fear, this incident prompted her to attempt self-immolation sparked by the feelings of anger and guilt.

> *"Everybody in my family started to blame me. My mother beat me and told me that it was my fault. She humiliated me and said a lot of ugly things to me. I told them not to ask me any questions. How is it my fault? Could I have done something to stop him? No one was listening to anything I was saying. My sister's husband started questioning me. He started beating me up badly. I couldn't speak. I was trembling with fear. He asked a lot of ugly questions. He asked if I would sleep with <name of relative>. How dare he? I was furious. This was when I made the decision to commit suicide. I did this because of him."*

Asha continued to process her emotions surrounding this incident during the narration. While she verbalised her fear and anger, she also demonstrated signs of being visibly agitated. This is

significant because activating the memories of the incident led to the significant emotional and physiological engagement, which in turn led to deeper memory retrieval. She oscillated between sharing her emotional state (during the trauma as well as during the therapy session) and providing sensory-perceptual details of the incident itself. She posed questions that are rhetorical (*'how is it my fault?', 'could I have done something?', 'how dare he?')* but are indicative of the emotional turmoil she has since experienced. She also attributed her self-immolation attempt to feeling ashamed and humiliated (by her uncle) during this incident. Asha worked through a range of emotions through the narrative experience.

Gauri grew emotional when she spoke about the impact of the DV and her self-immolation attempt on her loved ones.

> *"I am upset about the fact that there is no one to care for my children, or my home <voice breaks>. I regret everything now <cries>. When I saw my mother cry at the hospital, I knew I had made a mistake. That's when I knew I wanted to live. I wanted to live for my children, my family. I should have thought about them before making this decision. I should have thought about my mother. I should be taking care of her, but she is taking care of me now. I should've controlled my anger."*

Gauri had since experienced guilt and shame over her decision, which was the result of helplessness. Subsequently, she also experienced the secondary emotions of guilt, shame, and regret. This aspect of the narrative was clearly a hot spot for Gauri, and through NET, she was able to process and verbalise both primary and secondary emotions, reportedly for the first time. According to some PTSD theories, these emotions are presumably a result of a more elaborate and cognitive appraisal of the event (Brewin et al., 1996; Ehlers & Clark, 2000).

The illustrative excerpts demonstrate the wide range of emotional experiences that can occur during and as a consequence of traumatic experiences. The testimonies reflect the ability of the participants to process difficult and painful emotions through verbal narratives and appraisal, which is considered important to recovery success (Foa & Kozak, 1986; Schauer et al., 2011).

5.4.2.4 **Theme 4: Cognitive re-structuring**

NET emphasizes the importance of cognitive re-evaluation of behaviours and patterns such as cognitive distortions, automatic thoughts, beliefs, and responses. The reinterpretation of the meaning

content of negative, fearful, or traumatic events is achieved through reprocessing them to gain completion and closure (Schauer et al., 2011). This element of NET draws significantly from Ehlers & Clark's cognitive model of PTSD (Ehlers & Clark, 2000). While Foa & Rothbaum (1998) had previously implicated the role of negative trauma appraisals in PTSD, Ehlers & Clark (2000) identified a wide range of negative appraisals which were crucial to the development and maintenance of PTSD. Grey at al. (2002) proposed that reliving is not solely concerned with achieving habitation but must be used as an opportunity to identify peritraumatic hotspots and re-structure cognitive distortions.

Cognitive processing is important not only as part of the associated trauma network discussed in the above theme, but also independently on the cognitive re-evaluation and re-processing of thoughts, beliefs, and behaviours. Grey et al. (2002) presented a stage-wise clinical intervention to guide cognitive re-structuring within reliving. They suggested that the first stage was focused on reliving moments of peak distress and their associated cognitions, while the subsequent stage was to address these cognitions outside of reliving. This is the technique endorsed by NET, and evidence of the two-stage process is presented below.

5.4.2.4.1 *Appraisals of trauma*

Negative appraisals of the trauma event and its sequelae have been implicated in the aetiology and maintenance of PTSD (Ehlers & Clark, 2000). It can lead to a sense of current threat, which in turn maintains intrusion symptoms and leads to flashbacks and re-experiencing. An example of a negative appraisal of the trauma from the first few sessions of Tara's testimony is presented below, followed by a change in perspective as exemplified from an excerpt retrieved from the final session.

In session 3, Tara was reliving the experience of her wedding day and stated the following -

"During the wedding, I didn't feel anything (good or bad). But now when I think about it, it is my death day."

She believed that the decision to get married to the perpetrator figuratively ended her life (or life as she knew it). This relatively strong negative perception of her marriage is presumably in reference to the DV she endured throughout its duration. A negative perception of one's life prospects as a result of trauma is an important factor associated with PTSD symptomatology (Ehlers & Clark, 2000). Upon the activation of the fear/trauma network and subsequent habituation to the peak distress she

experienced while reliving the details of the DV, Tara engaged in the prescribed cognitive re-evaluation of her thoughts and beliefs about her current perception of the marriage and abuse. She was living in a secure women's shelter with her son during the time of the research, was working part-time and had completely ended contact with the perpetrator and his family. Through focusing on the life she had yet to live, she re-appraised her perception of the marriage -

"The only thing I feel bad about now is financial stress. He spoiled my life, financially. He spoiled <son's name> life as well. Whatever I earn is sometimes not enough to take care of us both. My parents, my brothers help me. So, I only feel upset when I feel financial stress. Otherwise, it is very peaceful here at the shelter. I get a lot of support here. Importantly, I feel that I am not alone. This hasn't just happened to me. So many of us are here."

This reflects a more positive perception of her life and future. By focusing on practical issues such as financial stress, Tara presented a less emotional and more objective perspective of her experiences. She also talked about the importance of social support at the shelter, thereby focusing on the positive aspects of her situation. This demonstrates change achieved through the process of cognitive reappraisal of negative trauma perceptions during NET.

Tara also expressed strong fears that her son would take after his father (her perpetrator) and his worst qualities, which indicates a negative appraisal of the trauma and its sequelae. Over time, she went on to list the positive qualities that she hoped to see in him as he grew older.

"I want him to have his voice. I want him to be open and say aloud what he wants. I want him to ask for whatever he wants. I want him to have his individuality and independence. And I feel being with me, he will be more like me and not like <name of perpetrator>"

Tara was able to focus on the possibility that her son can be now raised in a positive environment beyond the abusive relationship. She re-examined the evidence (or lack thereof) underlying the belief that her son will learn negative traits from his father. In doing so, she could situate the threat in the past and overcome her negative appraisal of the trauma.

Maya credited the experiences she had endured and her perpetrator for teaching her to recognise her positive qualities.

"Whatever I am now, the credit goes to him. Everything happens for the best. This has made be very strong. I am more focused now. I used to think that was the end of my life, but I know that I am blessed now."

She perceived the DV and ensuing trauma from a purpose-based, teleological perspective (Banerjee & Bloom, 2015) in that the lessons she learned along the way had led to personal growth. During therapy, Maya made plans to migrate to a different country to start a life and career independent from her family. She attributed this unexpected opportunity for a new life to her DV experiences. Overall, using exposure techniques followed by cognitive re-structuring can help NET clients re-examine their current circumstances and re-interpret the meaning and significance of their life experiences.

5.4.2.4.2 *Self-appraisals*

Negative appraisals are considered harmful when they reflect a perception of the self as unworthy, weak or incapable of protecting oneself (Brewin & Holmes, 2003). In a meta-analysis of 135 studies, negative appraisals about the self were more strongly related to PTSD than appraisals of the world (Gómez de La Cuesta et al., 2019). Conway and colleagues developed the Self-Memory-System (SMS) model which theorized that one's sense of self (attitudes, beliefs) may change to be consistent with autobiographical knowledge (Conway & Pleydell-Pearce, 2000). This underlines the importance of defragmenting the autobiographical memories of trauma and establishing an SMS which is congruent to the adaptive knowledge of one's life story.

Anna remarked several times throughout the narrative that she felt incapable of intervening or changing the situation that coerced her into the marriage.

"I kept hoping that some issue would come up and the wedding would get cancelled. But I was forced to change my mind by my mom and sister."

In another instance, she shared -

"We started saying yes to everything, without thinking, without discussing. We just couldn't get out this no matter how many times we said we weren't interested."

Towards the end of NET, she focused on the lessons she had learnt from her experiences and how she viewed her capacity for growth.

> *"I'm happy now. I don't want to be the same person. I want to change some things about myself. These two years were very challenging, and they taught me a lot of lessons. I feel that I have regained my confidence which I lost due to the emotional abuse. I am bold enough. I have faced a lot of people, so I can face anyone now. I have a lot of inner strength. No one can influence these things."*

This reflects a departure from a sense of self that was defeated and amenable to coercion towards a more autonomous perspective on her life.

Asha had attempted to self-immolate after years of pervasive abuse from close family. She spoke about her role in changing future outcomes.

> *"The other thing is, I must control my anger. My anger is equally responsible for everything that happened to me. Yes, people will say things and do things but if I want to be happy, I need to change how I react to things, to people, what people say to me and about me."*

Ehlers and Clark (2000) introduced the critical concept of 'mental defeat', which refers to the perceived inability of the person to influence their fate. Mental defeat is implicated as a risk factor for self-appraisals of being weak and ineffective and has been consistently found to be associated with persistent PTSD (Dunmore et al., 1999; Ehlers et al., 1998, 2000). By implying that she can control reactionary responses, Asha places the locus of control on herself as opposed to the experiences that she has suffered (Rotter, 1966), which is a striking contrast to the concept of mental defeat.

Gauri also showed a change in self-appraisal from that of mental defeat to defiance and survival.

> *"I didn't do this (self-immolation attempt) with the intention of surviving it. I wanted to die that day. Everyone would always tell me that I should just die instead of tolerating my husband's abuse. But why should I die? I don't want to die. I have my family, my children to think about. I am very strong. They don't want me to succeed, but I don't need to die for them."*

Her decision to self-immolate was a suicide attempt and she perceived herself as incompetent and her life as worthless. However, the second half of the chosen excerpt shows that she no longer perceived herself in that way. She focused on what she perceives is worth living for. She also labelled herself *'strong'* like Anna, which indicates that they were capable of changing their previously held negative self-appraisals to a more positive and competent appraisal. This perspective also indicates self-compassion, which is inversely associated with negative trauma appraisals (Barlow et al., 2017)

5.4.2.4.3 *Appraisals of others*

The goal of cognitive re-structuring is to identify and evaluate one's beliefs not only about the trauma and the self but also about the world and the future (Marks et al., 1998). Negative interpretations of others have been equally implicated in the development and maintenance of PTSD symptoms by cognitive models. Most of the women had been through abusive intimate relationships. Towards the end of several testimonies, there were illuminating discussions regarding the lessons they had learnt and what they looked for in future relationships.

At the start of therapy, Anna was resolutely focused on personal ambition and career growth and denounced the possibility of a relationship in the future. She stated – *"I just want to be with my parents. Marriage is over in my life."* This indicates an overtly negative appraisal of prospective partners in future relationships based on past trauma of abuse, similar to the early perspectives of several other participants. However, towards the end of therapy, Anna showed that she had re-examined the above stance on intimate relationships.

> *"Relationships are ok, but they should not get too serious. I am open to friendship. I have to get to know the character of the person, their family background, the way he's brought up. But I need some time. I need a break. In the end, I know my future will be good."*

While it doesn't indicate a complete overhaul of negative thoughts, it shows a change in her perspective of relationships/marriage. She also shared the lessons she has learned, which demonstrates increased competence in making an informed and conscious choice of partner in the future. Finally, she demonstrated a positive outlook toward her future. Since this was shared in the context of relationships and marriage, Anna had presumably re-examined her previously held appraisals of relationships and what they meant in the context of her future.

Both Maya and Tara indicated that they would view the past trauma as a lesson for the future. Tara shared –

"If I ever have to get married again, I will only marry for love! I will know my partner well before I get married. The lesson I've learned is that anyone can outsmart us. So we have to really understand the person before we get married."

Similarly, Maya stressed on the importance of love and intimacy in future relationships –

"I have to heal first. I have been scared to deal with another wound. But I want to be with someone who understands the value of love and relationships."

Storytelling provides narrators with insight into their goals, intentions, and desires by allowing them to examine how they have translated their own experiences into an enduring narrative (Singer & Rexhaj, 2006). NET provided the narrators in this study an opportunity to re-examine their thought processes, beliefs, and appraisals of the trauma, the self, others, and their future.

5.4.2.5 **Theme 5: Adaptive positive memories**

This theme refers to a NET-specific element which was analysed and interpreted within the context of change and recovery and was predominantly inductive. Unlike other trauma-focused exposure therapies such as PE, NET does not focus repeatedly on exposure to only the most traumatic event(s). The lifeline session is an opportunity for the participants to create a biographical overview of highly arousing and significant moments from their life (Schauer et al., 2011). The lifeline contains both negative *and* positive life events, thereby affording the individual a comprehensive approach of narrative re-structuring. Not only is it meant to a reparative experience for individuals with fragmented episodic memory, but it allows for spatiotemporal allocation from an allocentric (observer's) perspective (Neuner et al., 2020).

The testimonies in this dataset had substantial evidence of significant positive memories along with the narrative reconstruction of traumatic memories.

5.4.2.5.1 *Perpetrator-relevant memories*

In six out of seven testimonies, the primary perpetrator was an intimate partner. Despite the abuse endured, most participants were able to recall significant positive memories spent together.

Gauri shared details of a happy marriage before the abuse became prevalent and persistent.

"We were happy for at least six years after we got married. We were financially secure too. We both worked hard, we worked together. He knew how to do everything. And me, I never refused any task. Together, we could accomplish anything. We own land and we used to farm our land together. We ate what we grew. We were happy in those days. But they are easy to forget if no one sits down to ask me about them."

Gauri often centred the narratives of her relationship abuse around positive memories. Significant positive memories of individual resilience, beneficial experiences, corrective relationships, events with positive valence, achievements, experiences of social recognition and pride, and so forth (Neuner et al., 2020, p. 311) can serve as buffers to the negative, stressful and traumatic memories of experiences. Importantly, they are a means of assembling personal resources and strengths throughout the lifespan which can be uncovered in detail and validated in the sessions (Schauer et al., 2011). At the end of the final session (testimony signing), she stated –

"This (referring to the testimony) is like my autobiography! No one is interested in hearing about my problems or my achievements. Who will care? Who will listen? But now I have a storybook that I can read anytime to remember that life has also been good to me, not just bad".

This not only demonstrates the power of the lifeline construction but also that of positive reliving in providing participants with an empathetic, validating account of their life experiences.

5.4.2.5.2 *General memories*

Participants used general positive memories that were not perpetrator- or relationship-related in their life story narration. These included positive memories from the life period *before* the abuse started, such as their childhood and adolescence. Maya who was ambitious and career-driven focused on her educational and vocational achievements.

"In school, I was a very popular student. I was extremely active and loved by everyone. I was the best student. I was into both academics and sports. I also played chess, but I don't play it anymore. The friends I made in school are my

friends till date. And during college, I studied in <name of university> and I was so focused that I topped the college!"

Maya was visibly proud of her achievements, and this is relevant to her therapeutic process because she referenced her work and career success as instrumental in helping her cope with the worst of the DV experienced. Processing important moments of personal growth and achievement alongside significant and traumatising memories can serve an adaptive resource for recovery.

In Vani's case, a loving and corrective relationship with her father served as a safeguard in the context of the severe abuse and neglect she suffered. She shared –

"He was the best dad. He was a single parent and we always had a very good relationship. I used to share everything with him about my life. We used to cook, drink Feni (local Indian liquor) *together, go on trips together. He is the only one who fought for me. I would have never survived any of it without his support."*

Vani repeatedly spoke of the support, recognition, and affection she had received from him as a resource when exposed to highly arousing hot spots. Towards the end of her testimony, she stressed upon her resilience in caring for her father as a personal strength, which she felt defined her more than her experiences of DV and neglect.

These excerpts show that verbalising and processing significant moments of positivity, strength, resilience, and achievement can mitigate the impact of negative and traumatising events on the individual's personal resources. There is evidence from this dataset to show that weaving these positive memories into their life story helped participants to look beyond the abuse and DV. As Jenny put it –

"I used to think that what happened to me defines me as a person. I couldn't see anything beyond it. This has made to see that it is only one chapter in my life story. Who knows what can happen next?"

5.4.2.6 **Theme 6: Planning for the future**

The above excerpt segues into the final, and second data-driven, inductive theme: *planning for the future*. For every participant, the last few sessions revolved around looking towards the 'coiled rope' section of their lifelines which is focused on the time yet to come. The theoretical precedent for future-

planning is that maladaptive appraisals of one's past, present, and future increase the risk of PTSD onset and maintenance symptoms (Ehlers & Clark, 2000). Research has also demonstrated that the extent to which traumatic event(s) are perceived as central to a person's life story, identity and future is significantly positively correlated with PTSD symptoms (Berntsen & Rubin, 2006, 2014). This is maladaptive and can impede recovery. Moreover '*Thinking about a future self*' emerged as a subtheme in Chapter 3 (*section 3.3.5.3*). Several survivors of DV highlighted the impact of imagining a future for themselves as a means to cope with their present realities, and this finding was reinforced in the analysis of NET, which emphasises the importance of client's post-trauma future. While NET creates an opportunity to discuss the future of participants in the final sessions using the coiled rope symbolism, the manual does not provide a specific mandate for this aspect of the narrative. In this study, at least one (and in some cases, two) sessions were dedicated to imagining and planning for the future. The objective was to facilitate reappraisal and constructive revision about one's beliefs about their future. The response was positive and encouraging in the context of recovery.

5.4.2.6.1 *Ambitions for the future self*

An important outcome of engaging in future-planning exercises with the participants was the exploration of personal ambition, potential growth, and development. These sessions had a clear goal: encouraging participants to look beyond their traumatic experiences towards a hopeful and positive future. Duxbury (2006) has emphasised the need to respect the desire of DV survivors to retain a sense of responsibility and control for their own care and future, which makes voicing these ambitions doubly important from the point of support and recovery. While some participants such as Tara took longer to engage in this thought process, others, such as Vani were eager to look beyond their traumatic experiences and share their plans for the future.

Vani proclaimed herself as *'fiercely independent'* and *'career-driven'*. She shared -

> *"I want to buy a house. I want to be a millionaire! I work very hard so that I can be financially independent, and in the past, I have had so many responsibilities. But now is my time to pamper myself. Once I buy a house, I will feel settled. I have my pets with me so there is no shortage of love in my life. I'll be happy."*

Dunmore et al. (2001) have linked the role of negative appraisals such as beliefs about being 'permanently damaged' with a sense of foreshortened future in PTSD patients. By verbalising and

processing her future ambitions in this session, Vani was able to overcome these maladaptive beliefs which are implicated in the onset and maintenance of PTSD (Ehlers & Clark, 2000; Foa et al., 1989; Foa & Riggs, 1993; Foa & Rothbaum, 1998)

Anna's comparable ability to envision a successful future path is illustrated in the following excerpt.

> *"I want to complete my social work degree. If that doesn't work out, I will look for a job in teaching. I know my future is good. I have gone through a lot, so I want to help people. I also think about studying law. I want to know the law so that I can tackle things properly."*

Anna shared multiple options for her future, which suggests that she had engaged in a detailed future-planning exercise. She also demonstrated a desire to engage in empathetic and peer-focused work, which suggests that she may be looking beyond her own traumatic experiences and threat cues to support others in similar situations.

The SMS model (Conway & Pleydell-Pearce, 2000) predicts that future goals tend to be congruent or in line with one's current symptomatology. Krans et al. (2017) found that PTSD-congruent future goals were prevalent in their sample. Current symptomatology tends to impact future goals in PTSD patients. Therefore, establishing a sense of one's future self that is unrelated to the threat of trauma and reinforces a positive sense of self can be indicative of recovery.

5.4.2.6.2 *Growth and learning for the future*

Many participants evoked a desire for growth that was beyond professional or career ambitions. This subtheme is especially valuable in the context of recovery, wherein individuals demonstrated the ability to look beyond the negative feelings they associated with the DV and related trauma and articulated the positives they were willing to take from them. Maya shared everything she wanted to take away from the experience -

> *"I want to have control over myself and my mind. I want to be able to stick to the decisions I make. I want to travel, experience new things. I want to help people. I have so much left in my life. I have to learn to live in the present and not in the past or the future."*

This excerpt is in contrast to the PTSD-related negative cognition regarding 'permanent damage' (Dunmore et al., 2001).

Tara shared snippets from her journey of growth, speaking specifically about living in the women's shelter -

> *"I learnt so many things after coming here. I learnt English; I know a little bit of Kannada* (regional Indian language). *I became used to different cultures, food habits after coming here. I work part-time here which is so good for my own growth. I take care of the shelter and the school when <name of shelter manager> is not there. I was never allowed to work before, and now I am finally able to show my independence."*

Tara chose to focus on the growth as opposed to the negative aspects of the circumstances. She looked at the shelter as an opportunity to develop her skill set and work on her personal and professional ambitions, which indicates a departure from negative emotions and distorted beliefs about her future.

5.4.2.6.3 *Planning beyond the self*

Several participants were motivated not by personal ambition for their future selves, but that of their loved ones. This is significant in the Indian socio-cultural context where society is more collectivist than individualistic (Hofstede, 1980). Collectivist cultures value interdependence over independence, the family structure is strong, and caregiving duties (filial or paternal) are profoundly important. Participants in this study demonstrated an ability to plan for a future that involved contributing to bettering the lives of their parents and/or children.

Initially, Tara struggled to visualise a plan for herself. She stated –

> *"I need to be strong and move on. I don't really know what lies in the future for me. I want to take care of <son's name>, which is the most important thing."*

Over the course of the testimony, she began to visualise her future from her son's perspective, which is valuable considering the cultural context. She shared her aspirations for her son's holistic development.

"Now I just want <son's name> to have a good education. I want him to study well and be a good person. I want him to be a good citizen. I also want him to have his voice. I want him to be open and say aloud what he wants. I don't want him to hide behind me. Except for food and studies, I want him to ask for whatever he wants. I want him to have his individuality and independence."

Tara's ambitions for her son were impacted by her trauma experiences, in that she did not want him to be like his father. Nonetheless, Tara's testimony in these final sessions indicated positive change as she was finally being able to process and verbalise her own desires.

"Once <son's name> is old enough and is settled down with a life of his own, I want to go back and settle down in <name of native state>. I want a peaceful life for myself."

Asha's mother was the primary perpetrators of emotional and verbal abuse. She expressed feelings of anger, hurt and abandonment throughout the testimony when speaking about her mother. However, by end of her testimony, she demonstrated a noticeable decrease and a gradual increase in more positive thoughts and feelings towards her mother –

Now I miss my mother a lot. I don't want to be without her. I've never been separated from her. When I first came here (women's shelter), I missed her a lot. I used to sleep next to her clothing. Although she scolds me a lot, there is a lot of love. I want to be with her always."

Many proponents of forgiveness models in psychotherapy have argued that forgiveness does not mean that the survivor is denying or excusing the offender of any wrongdoing or denying or ignoring their own feelings of pain (Enright & Fitzgibbons, 2000; Freedman & Enright, 2017). Instead, North (1987) argues that forgiveness requires a recognition of the wrongdoer's actions and it typically involves a conscious effort on the part of the one wronged to improve themselves in relation to the wrongdoer. The excerpt above shows evidence of Asha's acknowledgement that while she had faced abuse, she was also loved and that she wants to move on from the feelings of hurt, resentment and justice-seeking. Freedman & Enright (2017) reviewed studies using forgiveness therapy with survivors of abuse and found it to be an effective way of restoring psychological health. It could be that through

NET, Asha was able to process and resolve negative emotions and resentment and look towards building a more positive relationship with her mother in the future. Her self-immolation attempt had deeply impacted her parents both emotionally and financially. She spoke about wanting to support them in the future -

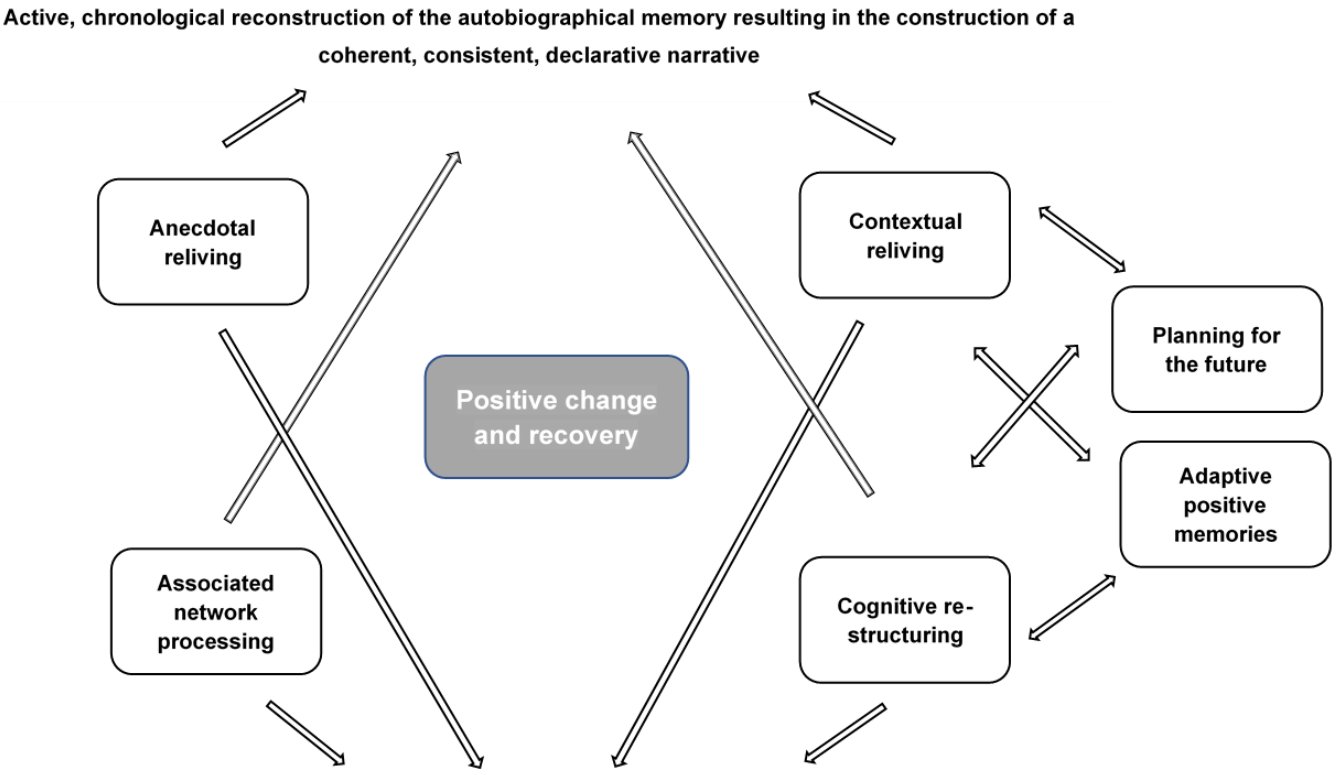
> *"I want to heal as soon as possible so that I can go back home to my parents. I want to start working again so that I can take care of them. I want to contribute financially to the family."*

Asha demonstrated the paradoxical ability to extend mercy and goodwill towards those who were not merciful to her, which is proposed as the foundation of forgiveness therapy (Freedman & Enright, 2017). This allows her to move on and envision a future that is not trauma-congruent or trauma-dependent. While NET does not target the specific paradigmatic assumptions of forgiveness models, it could be an inadvertent outcome for some participants as they use narratives to experience a validation of their anger and other emotions to subsequently moving on from them (Reed & Enright, 2006).

5.4.3 A framework of recovery: NET

The framework of recovery is a product of the TA of final testimonies and a major contribution of this thesis. Figure 5-2 illustrates how the various themes and subthemes operate to achieve the two main objectives of NET: a) active, chronological reconstruction of the autobiographical memory resulting in the construction of a coherent, consistent, declarative narratives, and b) the activation of the fear/trauma structure and subsequent habituation of the emotional, cognitive, and sensory-perceptual responses. While these individual processes are presented as main themes, the framework depicts how they are not mutually exclusive in effecting change and do not operate independently of each other. Instead, they work in tandem and influence each other in various ways. Most importantly, the framework of recovery demonstrates that other factors which do not have a theoretical underpinning interact with the psychological processes of change in the journey towards recovery.

Figure 5-2 NET: Framework of recovery



The processes of anecdotal and contextual reliving collaboratively underlie the first objective of developing a consistent, coherent, and chronological narrative of life experiences. The testimonies provided evidence that these processes worked together to realise this objective. Anecdotal reliving signifies how participants developed clarity, structure, coherence, chronology, and detailed descriptions in their reliving of traumatic experiences; all of which have been cited as indicators of an organised autobiographical narrative. Similarly, the narratives often provided clear references to spatial and temporal elements of traumatic experiences when participants were developing an organised narrative. This is primarily because trauma memories are largely 'decontextualised' and requires a biographical timeline approach to mitigate the mutual excitatory power of the fear/trauma network. Anna demonstrates how she reconstructed the events of a trauma memory by through anecdotal and contextual reliving below -

"AA: The next morning, I guess it was a Tuesday, I told him I was very hungry and that I wanted breakfast... he refused. I had severe body pain because of all the

beatings. I had a headache as well. He told me – "no crying, no telling your parents anything". He went out to buy brandy while I stayed in the hotel room.

SR: Were you able to eat when he left?

AA: Actually, no. I didn't eat the whole day that day. I'm remembering now."

Through NET, participants were able to defragment their autobiographical memories of traumatic experiences, while situating them in the appropriate spatiotemporal context of their lives.

In this manner, the contextualisation of trauma memories is equally connected to the second objective of NET which is to activate the fear/trauma network and enable habituation of trauma responses. While the spatiotemporal context is aimed at inhibiting the associations between various 'hot' memories by reinforcing connections to *time* and *place,* the process of activating the fear/trauma network is key to achieving habituation. There was evidence of sensory re-experiencing and emotional engagement to indicate within-session habituation to distressing or traumatic experiences. This was illustrated through representative quotations that showed that participants were able to activate multiple levels of processing through NET. Tara recalled –

"It was evening time. My baby was playing, and she (mother-in-law)) kicked him. She kicked him like this (demonstrates). It was so hard. He went flying right before my eyes. I was so shocked and upset. <Husband> watched this happen, and he remained quiet. I'm getting so upset remembering this now."

There was little to no evidence of physiological arousal in the testimonies. This could be due to participants predominantly reporting non-physical forms of abuse such verbal and emotional abuse, The encoding of memories in a highly emotional state (such as traumatic situations) results in the development of fear structures (Lang, 1977, 1979; Schauer et al., 2011), which are not adequately and clearly represented as *general* events in the autobiographical memory. Therefore, the process of engaging with the trauma memories at various levels of processing and subsequent habituation contributes to the reconstruction of a previously fragmented, disorganised account of the experience(s). This addresses the first objective and further demonstrates how these processes influence each other to achieve recovery.

A key element of associated network processing is that of cognitive arousal, which is presented under the larger theme of cognitive re-structuring due to its importance to the recovery process. Cognitive re-structuring is an important element of NET and can either influence or be influenced by other elements of recovery. In some instances, participants engaged in re-structuring of their thought processes or beliefs through reliving the trauma experiences anecdotally. Cognitive re-evaluations also occurred as a consequence of emotionally engaging with a previously avoided trauma memory. Jenny used the biographical lifeline to this end –

> *"In class 3, my mother was absent from our lives and my father couldn't take care of my long hair. So, he chopped it off and gave me a boy's haircut. I remember being so upset about that and crying. I feel now that I bottled up a lot of emotions during that time. Maybe that's why I don't have too many memories and whatever I do remember, they are all very hurtful memories. And maybe I was more affected by how <husband> treated me because of my past."*

At other times, activating cognitive representations of the event allowed for further breakdown and re-evaluation through the narrative process, and contributed to eventual habituation to emotional responses. In the framework, cognitive re-structuring is presented through sub-themes including appraisals of the trauma, of the self, and others. This indicates how the participants were able to develop a fresh perspective on previously held negative and maladaptive thoughts processes and beliefs that were potentially maintaining psychopathology.

Finally, this process was mutually connected to the adaptive processes of reliving positive memories and planning for the future. While the objectives of NET do not directly target these processes, there was strong evidence that they were brought about through the various elements of NET such as building a biographical lifeline and focusing on regaining dignity for a post-trauma future. Moreover, these processes appeared to have significant adaptive value as evidenced through the illustrative quotations. Maya spoke about her ability to remember positive memories of her relationship and how that helped her move on –

> *"I still feel like I can't love anyone as I love him. He has his way with me. I know I will always feel connected to him. But now there are no hard feelings. I want him*

to be happy. It's better to be separate than be in an abusive marriage. Now, I have set a lot of goals for myself, for a happy life ahead."

These processes are not separate from the others discussed in the framework, especially that of cognitive re-structuring which provided participants with an opportunity to re-evaluate their life stories and focus on the positive past and a hopeful future by adjusting basic assumptions. Similarly, contextual reliving also appeared to provide participants with the ability to situate the negative experiences in the appropriate time and place, thereby being able separate and focus on positive experiences and future aspirations that are not defined by re-experiencing the trauma. Overall, the data demonstrate that through these processes, there was an element of positive change and healing that emerged as a result of participating in NET.

In sum, the framework of recovery constitutes various interconnected process that collaboratively effect positive change and recovery for this sample. The representative quotes in the analysis show how several processes operate simultaneously, and yet are crucial to recovery in their own, meaningful way. The key implications of the framework of recovery are presented in the discussion section.

5.5 Discussion

The aim of this chapter was to utilise and examine NET with survivors of DV in south India. Statistical tests of quantitative improvement on symptom scales were augmented with a qualitative TA of NET recovery mechanisms using an idiographic approach. The final testimonies were examined for indicators of change and/or recovery using the lens of two widely-studied PTSD theoretical models – (1) EPT (Foa & Kozak, 1986; Foa & Riggs, 1993; Foa & Rothbaum, 1998), and (2) Ehler's & Clark's cognitive model (Ehlers & Clark, 2000). These models were chosen because of their relevance to the NET paradigm which draws significantly upon the key concepts, resulting in the development for its theoretical foundation. The TA resulted in a proposed framework of NET recovery, which is discussed in this section.

5.5.1 Overview of key findings

Statistically, the findings demonstrated that participants significantly improved at the post-NET assessment on PTSD and somatization symptoms. While participants improved on depression and anxiety symptoms, the mean difference in the scores was not statistically significant. These findings

are in line RCT findings where NET does not appear to improve depression outcomes as significantly as I PTSD (Lely et al., 2019; Raghuraman et al., 2020). NET is intended to target traumatic symptoms, which could explain why research has consistently demonstrated better outcomes on PTSD measures (Neuner et al., 2020; Schauer et al., 2011). Another sample-specific explanation could be that DV and IPV have been consistently linked with a relatively higher risk of depression across cultural and socioeconomic contexts (Cascardi et al., 1999), and in some studies, it was the most prevalent illness on a lifetime basis (Stein & Kennedy, 2001). Cascardi et al. (1999) also found that in their sample of DV survivors, significantly more spousal fear was associated with comorbid women and those with only PTSD, as opposed to those with depression (Cascardi et al., 1999). NET draws extensively from the fear network models (Lang, 1977, 1979) which Foa & Kozak (1986) extended to PTSD which means that NET for DV survivors might better target PTSD symptoms when compared to depression and anxiety symptoms. Overall, these findings address the first research aim, which was to understand if participants improved on the key outcome measures post-NET intervention. This is an uncontrolled study, which means that the post-intervention reduction in symptom scores cannot be attributed only to NET. The small sample size (N=07) implies inadequate statistical power to detect true intervention effects for NET through quantitative analyses. Nevertheless, the findings provide preliminary evidence of the potential benefits of NET at the individual level for DV survivors in the south Indian context. This is valuable in a setting where there is little to no anecdotal or scientific research on PTSD interventions for DV survivors (Chapter 1, *section 1.2.5.*).

Developing a framework of the components that potentially contributed to the quantitative change on symptom scales was the main aim of this study. A hybrid inductive + deductive TA was conducted to examine whether the theory-informed mechanisms of change were present in the final testimonies, while also scrutinising the data for other, inductive, context-specific themes that could potentially explain how and why participants improved in this sample. Testimonies that were co-produced by the therapist (myself) and the participants based primarily on their efforts to construct a coherent, consistent and chronological autobiographical narrative were analysed for evidence of change mechanisms.

5.5.2 Theoretical relevance of the findings

The thematic framework is illustrative of the mechanisms that underpin change and/or recovery when an individual with trauma exposure participates in NET. Both the EPT and the cognitive model have addressed the importance of alterations in memory functioning, negative appraisals, maladaptive coping strategies and cognitive beliefs in the onset and maintenance of PTSD symptoms (Brewin & Holmes, 2003). Similarly, both models agree upon the importance of reliving in the elaboration and contextualisation of the trauma memory for recovery. NET has built a treatment protocol that draws significantly from the hypotheses and findings from these models. The findings from the TA demonstrate evidence of various mechanisms that underlie the key processes effecting recovery during NET.

5.5.2.1 **Activation and habituation to the fear/trauma network**

Participants demonstrated evidence that their fear/trauma network was interconnected and primed for activation as predicted by EPT (Foa & Kozak, 1986; Foa & Riggs, 1993; Foa & Rothbaum, 1998; Lang, 1977, 1979). When cued to narrate significant life events, activation at one level of processing was sufficient and capable of activating other levels of processing. The narratives of the participants were filled with sensory details, emotional and physiological reactions, and cognitive appraisals, beliefs and thought processes that accompanied the activation at these levels. There was no evidence of under-engagement (Foa et al., 2007), purposeful or intentional avoidance or other emotional states such as dissociation that can hinder activation and habituation. A range of emotional states including primary and secondary emotions (fear, helplessness, anger) and sensory and physiological memories were discussed when reliving significant and traumatic memories. Illustrative excerpts from the testimony data confirm the presence of activation and engagement.

It was not possible to identify and measure indices within- and between-session habituation, both of which have been implicated as indicators of the modification of the fear structure (Foa & Rothbaum, 1998). This was because the unit of analysis was the final testimony, as opposed to raw therapy session data, which allows comparisons between sessions and over the course of a session using quantitative measures (Cooper et al., 2017). However, the testimonies provided an indication that the fear/trauma structure was activated through narrative reliving for a majority of the participants, allowing for its modification and eventual habituation to take place. The narrative process allowed participants to verbalise and process information at various levels of activation, which was reflected in

their efforts to construct and re-construct each session's data over the course of NET. Each session is improved upon in the next, which might indicate between-session habituation. Cooper et al., (2017) reviewed primarily quantitative studies that used a peak distress assessment to measure habituation and found strong evidence of between-session habituation. The recovery framework proposed in this study attests to these empirical findings.

5.5.2.2 **Construction of a consistent, coherent autobiographical narrative**

Based primarily on the cognitive model of PTSD (Ehlers & Clark, 2000), NET emphasises the need to reconstruct the trauma narrative by establishing chronology, filling in gaps and correcting inconsistencies. Ehlers and Clark's (2000) cognitive model of PTSD stresses the importance of appropriate details and clear understanding of events for a coherent story. Evidence of the various indices of narrative development was found in the testimonies of participants such as improved clarity and detail, introduce structure and coherence, and establish spatiotemporal context. There were only a few instances of avoidance in the early sessions for some participants, but over the course of NET, participants were able to overcome avoidance to construct an autobiographical narrative of their lives. Previous research has questioned the importance of narrative organisation in effecting recovery in PTSD (Bedard-Gilligan & Zoellner, 2012; Cooper et al., 2017; O'Kearney & Perrott, 2006). The idiographic, qualitative approach of this study can neither confirm nor deny correlations between variables and constructs (such as narrative organisation and improvement on PTSD symptoms) but it does provide evidence of the fact that previously limited, poorly detailed, and contextually devoid narratives were transformed through the course of NET for this sample. It does raise the question of whether narrative organisation and re-construction of the autobiography is *necessary* for recovery (by being a mechanism of change) or is a *product* of automatic and strategic changes in trauma memories through exposure and conscious cognitive re-appraisal, respectively.

5.5.2.3 **Other potential mechanisms and processes**

Other potential mechanisms may be active during NET in this sample. While it does not provide an explicit theoretical basis for the lifeline and reliving positive events, the NET manual discusses the importance of realizing personal resources and strengths assembled throughout the lifespan in the form of 'flowers' (Schauer et al., 2011). There was explicit evidence of the importance of reliving the full life story including positive life events, experiences, relationships, and personal achievements in this sample. The excerpts from the testimony saw the participants realising the value of positive

reliving, which helped with a present-focused perspective and revaluation of how they perceived the past trauma and the associated identity. Many participants realised that the trauma does not have to define them and that their identities could transcend it. Neuner et al. (2020) argue that this comprehensive approach of narrating re-structuring helps an individual with a trauma history to build a stable sense of identity: “I am what I remember about myself, my life, and the meaning of it” (p. 318). The context of the traumas is important for the participant to realise that the therapist is interested in the whole life, and not just their traumatic past. This is what differentiates NET from other forms of exposure therapies such as PE, and the findings from this study provide credence to the fact that rebuilding and reliving the full autobiography as opposed to only one’s traumatic events is a necessary component for recovery success.

The other finding from this study is the adaptive value of planning for the future self. PTSD theoretical models have implicated the crucial role of negative appraisals of the self, the trauma, and the world in the maintenance of symptomatology. This leads to a sense of foreshortened future (Dunmore et al., 2001; Ratcliffe et al., 2014) and has been mentioned as a symptom of PTSD in the DSM-IV-TR and DSM-V (APA, 2000, 2013) and the United Nations’ “Istanbul Protocol" (OHCHR, 2004). NET considers this to be a vital factor in recovery, in that the perception of the *Gestalt* of the course of their life allows them to be less preoccupied with their (traumatic) past and allow them to focus on how to construct a desirable, productive future (Elbert et al., 2015). This was strongly reflected in the testimonies of this sample, wherein individuals who started their narrative with a sense of foreshortened future began to explore ways and means of constructing an exciting and enticing future. This is a crucial mechanism of recovery because some participants such as Tara struggled to verbalise and process a future for themselves and were largely motivated by improving and planning for their child’s future. While this could have an adaptive value in itself, Tara was the only person whose PTSD symptoms worsened post NET. Therefore, while other mechanisms of recovery might be operating at various levels of processing, a client who is unable to visualise a future sense of self that is not defined by the traumatic past may show relatively enduring symptoms of PTSD. The findings from this study are in line with other therapy data research on NET wherein future planning was congruent to an improved quality of life (Elbert et al., 2015). Overall, the study has contributed to a better understanding of seminal PTSD theories from the perspective of psychotherapy, wherein

various elements that are considered inherent to PTSD symptom onset and recovery were explored using the NET therapeutic framework.

5.5.3 Framework of recovery: Key implications

The framework is proposed as a key resource for NET therapists, researchers, and policymakers for a variety of purposes. Firstly, the framework provides insight into the change mechanisms of NET when applied to this context/with this sample. NET therapists who aim to work with either south Indian trauma-affected populations or with DV survivors in a non-Western context could use the framework as a model to identify target therapeutic actions and inform appropriate delivery. Secondly, the framework illustrates how the theory-informed psychological processes operate in mutually influencing manner with other, context-dependent factors in the journey towards change and recovery, which places emphasis on tailoring interventions to the context/setting and looking out for *other*, culturally-specific therapy targets or actions that could contribute to change and recovery. Understanding how therapeutic processes and mechanisms work in different settings with different target populations ensures that psychological interventions can be person-centred, tailored for use in a particular setting, and optimised to achieve maximum positive benefits. In this way, it can be used to determine areas for adaptation in accordance to sociocultural setting in order to better understand and refine the process of NET to suit the context of delivery.

Researchers who are keen to contribute to the NET knowledge base and understanding could use the framework as a means of unravelling the key components of NET that work in a particular setting, for a particular target audience, thereby contributing to a *realist* understanding of the intervention. This is likely to be more useful to policymakers who develop services targeting to suit the needs of a specific population.

5.5.4 Other implications of the findings

5.5.4.1 **Research implications**

This study contributes to the growing body of literature on NET as a treatment option for diverse trauma psychopathology. It not only provides a preliminary quantitative account of symptom improvement in an under-researched population (DV survivors in south India) but also provides a thematic framework of recovery using theory-informed paradigms and full testimony data. There are currently a handful of trials measuring the efficacy of NET with victims of abuse. So far, no research

details NET being used in the Indian context, and only one other study from the South Asian context using KIDNET (a version of NET to be used with children) with Sri Lankan child refugees (Catani et al., 2009).

There was preliminary evidence of quantitative improvements for the sample immediately post-NET. The aim of this research was not to generalise the findings to larger populations through probability sampling methods, and neither is the sample considered to be representative of all DV survivors or Indian populations. Instead, I have attempted to generate research, academic and clinical interest in an understudied topic by examining it in-depth with interpretive richness. The aim was to achieve both *naturalistic generalisability* and *transferability* as defined by Smith (2018) and Tracy (2010), wherein gathering direct testimony, providing a rich description, writing accessibly and invitationally (Tracy, 2010, p. 845), and using evocative storytelling can help readers reflect and make connections to their own lives. Such types of generalisations are important for research because they provide an impetus to further investigate the experiences of diverse and subjective perspectives through multiple realities, without force-fitting the experience of *many* to *all.* Lastly, there is scope for *analytical generalisability* (Darnell et al., 2018; Smith, 2018) in this study through conceptual and theoretical generalisation. The framework of NET recovery is not fixed or immutable but can be interpreted as providing new information and fluid ideas for making sense of phenomena such as DV and recovery. In addition to the theory-informed mechanisms, data-driven themes provided deeper insight into other potential processes which could be important to recovery through NET and have not previously been explored.

There are some methodological implications. The innovative approach of qualitatively analysing raw therapy data (in the form of testimonies) has been rarely implemented in psychotherapy research (Finlay, 2014; Mallinckrodt, 2011). There is little process research on therapy data on NET that has not been published by the authors of the manual (Neuner et al., 2002, 2020). Most of the research has been quantitative, using RCT and quasi-experimental designs. By developing the protocol for a hybrid TA, this study has demonstrated the example of conducting and engaging in an accessible and relatively simple method of qualitative research with narrative/verbal therapy data (Willcox, 2017). This useful in analysing narratives in PTSD and trauma research, considering a majority of the studies that engage in process research still use primarily quantitative methods (see Cooper et al. 2017 for a review) or highly inconsistent and complex content analysis approaches that are quantitative at their core (Foa, Molnar, et al., 1995; Van Minnen et al., 2002; see O'Kearney et al. 2006 for criticisms).

Braun & Clarke (2006) argue that when used in the context of counselling and psychotherapy, TA must be underpinned by a chosen theory and theory-informed concepts, which is what makes TA *theoretically flexible* and not *atheoretical* (Clarke & Braun, 2018). In demonstrating that TA can be equally deductive as well as inductive, informed by theoretical concepts and evidence-based paradigms, this study adds to a unique understanding of using TA in psychotherapy research.

5.5.4.2 **Clinical and therapeutic implications**

Participants showed an overall, significant decrease in PTSD and somatic symptoms post-NET. There was no dissociation, excessive emotional and physiological arousal that could not be abated during the session, any subjective reports of uncontrollable distress between sessions, lack of engagement or persistent avoidance or dropouts. This was taken to mean that there was no immediate harm that was observed as a result of NET for this sample. Using an idiographic approach, this study offers new insights into how practitioners who are using NET could focus on the specific components and mechanisms that are proposed in the recovery framework. The findings from this study have contributed to re-affirming the theoretical bases of and provides clinicians and practitioners with new insights that are relevant to NET while supporting the recovery of individuals with trauma exposure.

The use of a limited sample also allowed the examination of testimonies in rich, interpretive detail. This enables generativity or the ability of research to invite readers into an experience and moves them to act upon the phenomena through that they have read (Barone & Eisner, 2012). Through *transferability*¸ there is value in presenting these findings to a clinical-practitioner audience, who might consider adopting certain elements from the findings that might be suitable to their setting or context, might draw parallels between the research findings and their own situation/practice, or may intuitively transfer the findings to their own actions. Some findings that emerged may be context-dependent and are more relevant to some cultures than others such that of forgiveness, which could be clinically relevant to similar populations or settings. According to Smith (2018), this is a legitimate form of generalisation in research that seeks to achieve inferential or case-to-case generalisation.

Overall, these findings provide clinically useful information regarding NET, trauma-focused treatment, and treatment for DV survivors which are valuable for practitioners in formulation and developing care

plan approaches. Whether this is specific to the context of the research or can be adopted, shaped, and examined in other contexts is the exciting prospect that emerges from this study.

5.5.5 Methodological issues and future directions

Some methodological issues warrant mention. Firstly, is I used opportunistic, purposeful sampling intending to access 'information-rich' cases related to the phenomenon of interest (DV) (Patton, 2002). The sample was therefore not accessed randomly from the community to increase the credibility of the results. The result was that the sample consisted of women who had already either made or consented to the decision to seek help/support and were actively dealing with their abusive and violent experiences with formal support. One of the core symptoms of PTSD is avoidance, and although participants did demonstrate the highest mean score on the avoidance subscale of the IES-R (M = 23.71, SD = 6.26), there was little to no evidence of avoidant behaviours during NET across the sample. This could be culture-related, in that healing occurs in communal and social spaces in collectivist societies such as India which promote interdependence and social cohesion (Chadda & Deb, 2013). Alternatively, these individuals could already have chosen to, or been coerced into telling their stories multiple times, albeit in an unstructured manner or a non-therapeutic setting. Whether the repeated re-telling of their traumatic experiences to gatekeepers, social workers, law enforcement and judicial officers and others involved in their legal and social care could have made them more primed to benefit from the NET process is unknown. This could also explain the lack of therapeutic (and not self-reported) avoidance and may have impacted certain patterns of recovery in the framework such as narrative and contextual reliving, and emotional engagement. However, the participation of charities in providing access to samples was necessary both from an ethical and a practical perspective. Informed consent is mandatory for participation in most forms of trauma therapy including NET. Therefore, a lack of avoidance owing to a willingness to participate and relive traumatic experiences might be characteristic of NET sessions in any clinical or research setting.

The study was uncontrolled, in that there was no control group of participants who did not receive NET. The lack of a control group means that post-intervention improvements in symptom scores cannot be attributed solely to NET. The study was also not able to control for the impact of other life stressors or changes such as the of filing legal charges, participating in divorce proceedings or any positive experiences that had direct relevance to their ongoing situation. One participant was granted a divorce by the family court during NET which could have improved her emotional state and

therefore, symptom scores post-intervention. Most importantly, social support (familial, peer, or community) emerged as a significant and recurring theme throughout the data, in line with the findings from Chapter 3. However, the effects of social support are independent of NET but must be considered as operating *outside* the therapeutic process. Social support is extremely significant to the lived experiences of abuse, DV and coping, so it is difficult to determine how much of an independent role it plays in recovery.

Longitudinal data was not collected to measure sustained symptom improvements. Participants completed self-report measures at baseline (pre-test) and immediately after NET (post-test). Most women were living in women's shelters at the time of the research, and charities did not permit direct or continued contact between myself and the participants. It was not possible to personally contact any of the participants for a follow-up, and the charities were unable to guarantee or facilitate longer contact. While the participants did show an aggregated improvement in symptom severity at post-test, these improvements need not have sustained over time. Most NET RCTs are longitudinal and collect outcome data at 3-, 6-, 9-, or 12-months post-intervention. Several studies have demonstrated sustained changes at follow-up, which is an important clinical consideration (Lely et al., 2019; Raghuraman et al., 2020; Robjant & Fazel, 2010). However, one RCT with traumatised firefighters demonstrated that symptom improvements were not maintained at follow-up and symptom scores increased due to unprecedented exposure to trauma (rescue operations during floods) after the intervention was completed (Alghamdi et al., 2015). In the current study, all the participants reported a future risk of DV exposure. In failing to collect data at repeated stages over time, this study cannot offer any recommendations regarding NET's treatment effect or subsequent harm or distress over time for this sample. The plausible impact of future risk of traumatisation on sustained symptom recovery could not be explored. This has important clinical implications for trauma populations who are at an increased risk of future exposure to trauma, such as chronic DV victims and survivors.

Due to this being a PhD project, I was solely responsible for both delivering therapy as well as coding the testimony data in the first instance. I maintained a clear audit trail of the coding and analysis on NVivo which was accessible to my supervisor at every stage. However, I could have been influenced by my experience of delivering therapy and co-producing the testimonies with the participants. There is the possibility of confirmation bias while coding the testimonies, which is where I was looking to validate a specific theme based on my perception of how the therapeutic process progressed,

whether participants recovered or not, and other therapy-related factors. Previous studies that have analysed trauma narratives have used trained, blind coders who were not informed about the study hypothesis, treatment modality or treatment response (Bedard-Gilligan et al., 2018; Halligan et al., 2003). However, these studies had a strict coding protocol and did not expect the coders to engage reflexively and actively with the data. When it comes to TA, Braun & Clarke (2019) have argued that themes are not expected to be situated 'in' the data, awaiting retrieval according to a pre-existing analytic framework. Instead, themes must be generated through thoughtful engagement with the data and the analytic process. The focus was not on accurate and reliable coding or achieving consensus between coders. This study differs from the aforementioned ones in that both the data and the analysis were co-constructed by the researcher and the 'researched', which would imply that the analysis in coder-specific. This is one of the strengths of the qualitative approach, and therefore, it is as yet unclear if using a second, blind coder would have improved or diminished the quality of this research.

Most of the interpretations drawn from the data as evidence for change and recovery are based on the therapist's (my) observations. While the use of illustrative quotes is meant to evidence and support the conclusions drawn from the analysis of testimonies, another therapist/researcher might have made different observations and arrived at distinct conclusions regarding the indicators of recovery. Therapist effects are a well-documented variable in affecting psychotherapy outcomes (Crits-Christoph et al., 1991; Luborsky et al., 1997; McKay et al., 2006), and when considered along with the role of researcher subjectivity, can lead to variability in data interpretation. While this is not a limitation, it is worth acknowledging that the developed framework is not intended to be generalisable, but flexibly transferable to other populations, contexts, and settings.

In the future, the validity of the recovery framework could be evaluated using coding schemes, content analyses, or statistical designs using multilevel modelling to determine predictors of symptom change nested within individuals. Processes or mechanisms of change that do not reflect in the testimony data of this sample but may emerge in different contexts, settings or samples can also be explored using the innovative hybrid TA approach of therapy data. The value of 'testifying', which NET argues is relevant to treatment success did not definitively emerge as a mechanism of recovery in this sample. However, given that it has been attested to in other studies (Cienfuegos & Monelli, 1983; Onyut et al., 2004), it may not be relevant in this setting or trauma population, but could be valuable in

others. By providing an example of using raw, therapy data to develop a framework of recovery that is both theory and data-informed, this study provides direction for future research into mechanisms of recovery.

Future research could analyse raw therapy transcripts as opposed to the final testimonies. While the testimonies provide comprehensive insight into how narratives transform and become indices of recovery, using transcript data could do so from a worm's eye view. Analysing transcripts can also demonstrate the gradual process of recovery from each session to the next and may also make it easier to measure mechanisms and processes such as within- and between-session habituation or narrative change.

It is also worth exploring how NET differs from other therapeutic models that use exposure-based techniques such as PE therapy (Foa et al., 2007). This study proposes the life story element that uses positive and contextual reliving, and future-focused narratives as crucial to recovery. Future research may investigate and establish whether the lifeline element does add additional value, or whether NET falls short due to the lack of emphasis on repeated reliving which facilitates the measurement of within- and between-session change.

Finally, in providing preliminary evidence that NET can potentially be useful as a treatment of PTSD in DV survivors in the south Indian context, this study provides direction for future research using designs that use longitudinal designs or can establish cause-effect relationships such as RCTs. This is especially useful in the Indian setting as NET was developed for use in low-resource contexts and has shown to be effective when disseminated by trained, non-professional and non-medical staff or laypersons (Jacob et al., 2014; Neuner et al., 2008). Given the high prevalence and risk of DV in India, compounded by the lack of research into efficacious treatment protocol, NET can address the large treatment gap in India for the mental health consequences of DV.

5.6 Conclusion

To conclude, this study aimed to utilise and examine NET in the novel south Indian setting with an under-researched population: DV survivors. Seven women who identified as victims or survivors of DV were recruited and administered NET. A paired sample *t*-test revealed statistically significant improvements on PTSD and somatic symptom severity, and non-significant improvements on depression and anxiety symptom severity immediately post-NET. An idiographic approach was used

to facilitate a rich, interpretive, and detailed understanding of the ‘active ingredients’ of NET and develop a theory-informed framework of recovery. Evidence in the form of quotations and excerpts from direct testimonies were gathered to develop the framework using the tenets of PTSD models. Emotional engagement, sensory and physiological activation, habituation, construction of a clear, coherent, and detailed anecdotal narrative, and contextualising and elaborating the autobiographical life story were all found to evident, useful, and beneficial in the process of recovery. Inductive analysis of the data also uncovered the adaptive value of reliving significant, positive memories to build resilience and resources, and that of planning for a hopeful future. Overall, the study contributed to a deeper understanding of the NET process and recovery mechanisms to address the knowledge and research gap in this area. The preliminary quantitative data on symptom improvements provide an impetus for deeper investigation of NET with DV survivors and south Asian populations.

6 General Discussion

In this thesis, I explored the in-depth, lived experiences of DV primarily among south Indian adult women, the psychological consequences of exposure to DV with a focus on PTSD, and their response to NET. A primarily idiographic approach was used to address these research aims, which consisted of using small-n samples, qualitative data, and analytic techniques to derive rich, detailed and context-relevant findings. Quantitative data and analyses were used to contextualise and augment the findings and their interpretation from a research and practical standpoint.

The first study used five in-depth, semi-structured interviews to gain a deep and meaningful understanding of how women experienced DV, how it impacted their lives, mental health and identity, and their personal coping resources and strategies. IPA was used to analyse the data from the interviews with a focus on the socio-cultural context (south Indian, urban setting) of the research. The second study presented the results from a meta-analysis of RCTs investigating NET efficacy across trauma populations and cross-cultural settings through calculating pooled intervention effects and appraising the quality of the evidence base to inform clinical practice. In the third study, NET was administered to seven south Indian women who reported exposure to diverse DV experiences. The focus was on developing a framework of recovery based on the theoretical and paradigmatic bases of NET. Change mechanisms were both deductively and inductively identified using a hybrid TA, thereby providing an idiographic perspective to the NET process and mechanisms of change. The findings from this thesis have clinical and research implications for DV and PTSD, specifically in India, and contribute to the growing body of knowledge and research into NET.

The key findings and recommendations from this research are presented briefly below, and will be examined in depth in the following sections.

1. The findings demonstrate mixed evidence of the presence of PTSD symptoms as conceptualised in the DSM among this sample of south Indian survivors of DV. In line with cross-cultural PTSD research, there was strong evidence of participants' experience of somatic symptoms in the context of DV. This further strengthens the need to carefully consider culture and context in the experience of mental illness such as PTSD in non-Western samples.

2. The challenges with disclosure of DV and help-seeking are highlighted against a backdrop of the socio-cultural and systemic determinants of DV experience in this setting. The stronghold of the family system on the private lives of women, as well as the patriarchal notion of a woman's lack of agency and independence are some of the key factors that disadvantage and disempower women in abusive relationships.
3. There is a clear reliance on informal support networks and the non-profit organisations when disclosure and help-seeking does occur. Formal screening in primary care settings is largely underdeveloped in this context, and issues with law enforcement as a support network were highlighted.
4. There is a dearth of research into interventions to support DV survivors who experience adverse psychological reactions and poor mental health. This research highlights a clear need for a care pathway that requires a coordinated effort by health and social care systems to support the needs of DV survivors.
5. The NET evidence base is encouraging in its effectiveness in treating symptoms of PTSD across diverse trauma populations and cultural contexts. However, due to high heterogeneity estimates and moderate to high risk of bias across individual RCTs, caution is recommended when using this evidence to inform clinical guidelines for PTSD treatment.
6. NET proved effective in reducing PTSD, depression, and anxiety symptoms immediately post-treatment used with a south Indian sample of female DV survivors, but the small sample size and uncontrolled trial condition prevent extrapolation of these findings to the larger cultural or trauma context.
7. A framework of recovery was developed, which attested to several of the proposed theoretically-informed mechanisms of PTSD recovery when NET was administered in this context. Further, this research uncovered the influence of positive reliving and future-focused thinking as key mechanisms of recovery for this sample. Recovery was also reinforced positively by strong formal and informal support networks, and hindered by the lack thereof.
8. The framework of recovery demonstrates the need to consider context-relevant mechanisms of recovery when an intervention like NET is administered. This could facilitate more feasible and acceptable adaptations of NET which and strengthen its effectiveness in diverse trauma populations and settings

9. Following from the findings from the framework, NET was discussed through the framework of the Contextual Model of Psychotherapy. The Contextual Model argues that recovery depends on factors beyond the 'specific' therapy effects, and considers the importance of common factors such as a positive therapeutic relationship as fundamental to recovery from mental illness. The model also highlights the importance of taking culture and context into account when designing and administering psychotherapy in diverse settings. The framework of recovery through NET attests to this argumentation.
10. Indian scholars and academics have long since argued that community-based interventions that are culturally informed and relevant are necessary when treating traumatised populations. The framework of recovery, when considered from the perspective of the Contextual Model offers further credibility to this reasoning, and highlights the crucial need for adapting interventions such as NET to the local context to improve its utility and effectiveness.

6.1 Implications for DV research: South Indian context

There is a dearth of detailed, rich data analysed using qualitative methods on DV in India. In a review of DV literature, Kalokhe *et al.* (2017) found that physical abuse has been disproportionately researched in India relative to other forms of DV. By including a diverse group of survivors who reported a wide range of DV experiences, this research addresses a significant knowledge gap in Indian DV literature. Kalokhe et al. (2017) also highlighted the need for qualitative studies to gain a deeper understanding of DV that augments the findings from quantitative studies. This work makes a relevant contribution to the literature on DV in India by exploring the nature of DV and lived experiences from the perspective of victims and survivors using IPA (Chapter 3) and their responses to treatment targeting mental health consequences of DV such as PTSD, depression, and anxiety using TA (Chapter 5). In this section, findings from these two qualitative studies will be collated to provide a rich, nuanced, and deep understanding of DV in the south Indian socio-cultural context.

Note: 'Chapter 3' will be used to indicate the IPA study on lived experiences of DV and 'Chapter 5' will be used to indicate the TA study on the NET recovery framework.

6.1.1 Psychopathological consequences of DV

6.1.1.1 **Core PTSD symptoms**

Women with self-reported exposure to DV were recruited from charities in the qualitative studies in Chapters 3 and 5. One of the main objectives was to better understand the experience of DV and its psychopathological manifestations such as PTSD.

The nosological validity of PTSD has been questioned in non-Western populations; specifically, in India (Rajkumar et al., 2013; Tharyan, 2005). This research does not attempt to validate the construct of PTSD, but to gain insight into how the symptoms have manifested in a sample of south Indian, female, DV survivors.

The PTSD assessment tool used in this research was the IES-R (Weiss & Marmar, 1997a) as it is the most predominantly used PTSD assessment measure in Indian studies and has been validated on south Indian samples. IES-R follows the three-cluster symptom classification of DSM-IV-TR (APA, 2000) as opposed to the four-symptom cluster of DSM-V (APA, 2013). Hence, the findings are presented according to DSM-IV-TR's classification of symptoms.

Intrusion symptoms/re-experiencing

A high degree of intrusion symptoms was reported by the participants in both studies that measured baseline symptoms of PTSD using the IES-R (Chapters 3 and 5). In Chapter 3, participants reported the highest average score on intrusion symptoms when compared to the other subscales of avoidance and hyperarousal. An inspection of the interview transcripts from Chapter 3 did not reveal strong evidence of re-experiencing or intrusion symptoms in the narrative content that corroborates with the high scores on the IES-R. It did not emerge as a significant theme in the analysis of the interviews either. In Chapter 5, the mean baseline score on the IES-R was the second-highest for the NET recipients (after avoidance). One of the core treatment outcomes of NET is the reduction of intrusion symptoms by spatiotemporally contextualising the traumatic memories while modifying and inhibiting the activation of the fear/trauma network to cues and reminders. Similar to Chapter 3, there was a lack of substantial evidence that participants experienced frequent intrusion symptoms such as flashbacks or other re-experiencing symptoms over the course of NET. However, there was evidence of the processes of contextual reliving and habituation throughout NET as well as evidence of cognitive re-evaluation and re-structuring of negative appraisals of the trauma from an analysis of the

testimonies. These processes have been found to target and reduce intrusion symptoms and subsequently contribute to recovery (Dunmore et al., 2001; Ehlers & Clark, 2000; Schauer et al., 2011). They form an integral aspect of the recovery framework that was developed in Chapter 5. However, evidence of these processes that are considered important to recovery does not imply the presence of significant baseline intrusion symptoms. Studies on PTSD in India conducted on refugees and survivors of natural disasters have found the prevalence of intrusion symptoms in their samples (Bhushan & Kumar, 2012; Rajkumar et al., 2015; Suar et al., 2014; Terheggen et al., 2001). One Indian study found that women with experience of IPV reported intrusive recollections, flashbacks, and distressing dreams among other symptoms using self-report measures (Chandra et al., 2009) which was replicated in this research. However, the analyses of the narratives do not reflect the presence of intrusion symptoms. There are no qualitative studies that have used non-self-report measures such as narratives to investigate the presence of individual PTSD symptoms among DV survivors in India. Overall, the findings do not conclusively provide evidence of the manifestation of intrusion symptoms in this sample.

Avoidance symptoms

The 'memory reports' of the participants showed some degree of avoidance in reliving particularly graphic or emotional content. It is not possible to comment on whether this avoidance is a symptom of PTSD, or whether it was due to the lack of rapport with the researcher (myself). The engagement with participants in Chapter 3 (IPA) was for research purposes and I had to establish rapport and build trust within a single interview. This is challenging when the phenomenon under study is highly sensitive (DV), and the participants belong to a vulnerable population (victims and survivors). The mean baseline score on the avoidance subscale of the IES-R in Chapter 3 was relatively low when compared to the intrusion and hyperarousal subscales. The instances of avoidance found in the interview content could be attributed to the lack of an opportunity to build trust and rapport with participants. Since once of the hallmark symptoms of PTSD is avoidance (APA, 2013), this is an important methodological consideration when researching sensitive topics such as DV using qualitative research methods (where the data is dependent on participants' engagement).

In Chapter 5, the element of avoidance was further investigated in the narratives that emerged from NET. The baseline scores for the avoidance subscale of the IES-5 in this sample was higher than both the hyperarousal and intrusion subscales. Participants from this study presented more strongly

with symptoms of avoidance at baseline when compared to the participants from the IPA study in Chapter 3. There was no evidence of avoidance in the narratives or during NET, which indicates the lack of therapeutic avoidance in this sample. In this study, I had the opportunity to establish trust, rapport, and a therapeutic relationship with the participants over the course of several sessions. Therefore, the lack of therapeutic avoidance suggests that instances of avoidance found in the IPA study may be attributable more to the one-session nature of the interview, and less to the nature of PTSD symptomatology of the participants. However, in Chapter 5, the lack of therapeutic avoidance in the narrative content contradicts the self-reported avoidance on the IES-R subscale. This may be related to the fact that these individuals had already demonstrated help-seeking behaviour in having accessed social care and support, had previously narrated their experiences to social workers, and had provided informed consent to participate in the study. The lack of avoidance symptoms in non-Western samples such as India has been previously reported among survivors of natural disasters (Rajkumar et al., 2015). Alternatively, while a few studies have found evidence of avoidance symptoms (Mehta et al., 2005; Suar et al., 2014; Terheggen et al., 2001), none of these studies has been conducted on DV survivors who have sought the support of social care services. The findings from this research indicate that in two samples of DV survivors, there is a lack of consensus between self-reported symptoms of avoidance and evidence for avoidant symptoms in narrative content. Future research using clinical diagnostic interviews of PTSD could provide more information regarding the nature and manifestation of avoidance symptoms in these samples.

Hyperarousal symptoms

In both studies, participants reported the lowest mean baseline score on the hyperarousal subscale of IES-R when compared to the other subscales. A few studies on Indian samples have identified the presence of hyperarousal symptoms in their study (Chadda & Malhotra, 2006; Mehta et al., 2005; Suar et al., 2014). Only a handful of references to hyperarousal symptoms were found in the narrative content in both studies. In Chapter 3, Vinny shared the following when she was recounting a distressing memory - *"I am feeling dizzy as I am talking to you now, I am not able to bear it, my mouth is going dry".* In Chapter 5, Anna was narrating an episode of physical abuse that involved her being choked by the perpetrator and shared – *"even now, I feel like someone is choking me."*

Beyond these instances, the narrative content did not reflect any enduring physiological distress being reported by the participants when reliving traumatic memories. This may not have been the first time

they had recounted their traumatic experiences of DV. They were all assigned caseworkers by the charity and were receiving ongoing practical, social, and legal support at the time of recruitment. Repeating re-telling of their life stories and experiences of DV, albeit in an unstructured manner, may have had the unintentional therapeutic effect of habituation. This in turn could reduce the activation of the fear/trauma network at the physiological level over time. This could account for the lack of evidence of marked alterations in arousal and reactivity during NET.

This is the first study among DV survivors in India that uses analyses of in-depth narratives to augment the findings from self-report scores on PTSD assessment measures. The analyses of the interviews and testimonies do not fully reflect the assessment scores at baseline. This raises the question of whether these assessment measures are accurately capturing the experience of mental health consequences among DV survivors in India. It is important to design PTSD research that uses in-depth clinical and research interviews from an idiographic perspective. These findings will have long-term implications for the management of the mental health outcomes of DV exposure in a setting where there is scarcely any data or knowledge of interventions tailored to meet the needs of DV survivors.

6.1.1.2 **Somatic symptoms**

The manifestation of somatic symptoms in non-Western, post-trauma populations has been raised by critics who have questioned the cross-cultural validity of the PTSD construct (Escobar, 1995; Hinton et al., 2011; Marsella et al., 2004). The experience of psychiatric symptoms is believed to be embedded in culturally-rooted systems of meaning and discursive practices (Kirmayer, 2005). Mumford et al. (1991) argued that somatic symptoms frequently often replaced the hallmark PTSD symptoms in non-Western populations of India, China, and Africa. This is reflected in the measurement of somatic symptoms in addition to PTSD, depression, and anxiety disorders by a large majority of Indian studies conducted on individuals with trauma exposure. Many studies have highlighted the relevance of somatic symptoms as a crucial aspect of post-trauma psychopathology (Contractor et al., 2014; Crescenzi et al., 2002; Kar et al., 2007; Mushtaq et al., 2016; Sachs et al., 2008; Terheggen et al., 2001; Vijayakumar et al., 2006; Viswanath et al., 2013; Yaswi & Haque, 2008). The samples in these studies include both adult and child populations and range from post-disaster survivors, to refugees and survivors of torture and armed conflict.

Specifically, Indian women with experience of DV/IPV have been found to manifest somatic complaints among other psychological symptoms (Varma et al., 2007; Vizcarra et al., 2004b). A plausible explanation is that when physical or sexual abuse is present, there is a greater likelihood of survivors showing physical or physiological symptoms (Chandra et al., 2009). In this study, several participants had endured long-term physical violence. In cases where the abuse was ongoing, somatic complaints such as stomach-ache and body pain could be attributed to being recently punched and kicked in the stomach. Physiological symptoms may also be a consequence of emotional abuse. Some women complained of loss of energy and exhaustion which could be attributed to being the sole caregiver for children and the sole breadwinner for the family due to emotional abuse and neglect perpetrated by the partner.

Previous research with DV survivors has demonstrated that somatic symptoms are significantly associated with IPV (Varma et al., 2007; Vizcarra et al., 2004). The presence of somatic symptoms in the narratives of the interviewees in Chapter 3 emerged as a sub-theme of the women's responses to DV (*section 3.3.2.2*.). Complaints ranged from breathlessness, dizziness, exhaustion, and loss of energy to fever, stomach pain, vomiting, sleeplessness, and changes in appetite. These findings, when considered in the context of previous research on PTSD and somatisation prompted the use of a culturally valid somatic symptoms inventory (BSI) as an outcome of interest in the TA study in Chapter 5. The mean baseline score of the participants on the BSI was 28.29, which crosses the threshold for case-ness. At the individual level, five out of seven participants crossed this threshold at baseline. Taken together, these results suggest that the participants in this sample reported a range of somatic symptoms at baseline in addition to PTSD, depression, and anxiety symptoms. There was a statistically significant difference in BSI scores for this sample between pre- and post-intervention time points. Although an uncontrolled design was used, the results are encouraging concerning NET's treatment effect on somatic symptoms and is discussed in detail in Chapter 6, *section 6.3.*

Varma et al. (2007) argued that in the Indian context, the manifestation of somatic symptoms in otherwise healthy young women reflects the presence of depressive symptoms in a relatively socially desirable manner. The stigma attached to DV, mental health disorders and poor mental health literacy in India complicates the issue of identifying poor mental health as a legitimate concern when DV is present (Dias & Patel, 2009; Gururaj et al., 2016). This leads to identifying psychological symptoms in favour of somatic symptoms (Bhugra & Mastrogianni, 2004; Rao et al., 2007). The findings from the

IPA study in Chapter 3 demonstrated the disproportionate influence of traditional and rigid societal norms that perpetuate stigma and discrimination against survivors of gender-based violence in this setting. Women in both studies reported attempts to dissociate from their experience of, and responses to the DV experienced. These findings replicate the qualitative findings of Kaur & Garg (2010), who discovered that a 'culture of silence' (p. 249) prevailed around the issue of DV in India.

Some Indian PTSD researchers have explained the presence of somatic symptoms as an expression of general distress (Kar et al., 2007; Terheggen et al., 2001). Psychosomatic manifestations of poor mental health may be seen in a socio-cultural setting that does not typically identify or verbalise emotional distress in the same way Western populations do. In the IPA study in Chapter 3, Annie reported that she developed a fever during a distressing episode of physical abuse and sexual coercion. When asked to verbalise her emotions about this incident during the interview, she responded simply with – *"I was not happy. I didn't feel good about it".* It was clear that the episode was part of significantly traumatic memory, but Annie was unable to verbalise the extent of her emotional distress during the interview. Instead, she recalled developing a fever, which is a symptom of physical ill-health. In their discussion of Western assessment tools to measure somatic symptoms, Wig & Verma (1973) highlighted the importance of language in the identification of psychological symptoms across cultures. The diversity in the semantics of emotions suggests that cultures across the world do not possess similar vocabulary for expressing emotions (Mumford, 1996). Leff (1973) has questioned the accessibility or availability of a particular experience (such as the experience of emotion) when one does not possess the words to define it due to their cultural background. The interview and testimony content showed a lack of sophistication in the vocabulary when talking about emotional or psychological states. Participants used relatively simplistic language to identify emotional states such as 'happy', 'angry', and 'sad', as opposed to using vocabulary that denotes a spectrum of emotions. This was observed in both English and in local language interviews which means that the limited vocabulary for emotional expression could not be attributed to lack of language skills, but their use of sophisticated vocabulary. On the contrary, physiological illness or physical ill-health are well-understood concepts. In cultures that have not yet achieved parity between physical ill health and poor mental health, there is a higher scope of the presence of somatic expressions of underlying emotional distress. This is an important consideration for primary care and welfare services who are often tasked with screening for DV and its psychological consequences in survivors.

6.1.2 Implications for the rehabilitation of DV survivors

6.1.2.1 **Screening for DV**

International guidelines such as WHO have called for improving the health systems response for DV survivors by recommending screening for DV and abuse when women present with mental health disorders or when assessing conditions that may be caused or complicated by DV (such as substance abuse, unexplained medical symptoms, chronic pain, and traumatic injury) (WHO, 2013). Due to the lack of an effective public health system in India, there is no evidence for the implementation of these guidelines.

None of the participants in Chapter 3 had accessed medical or psychiatric help at the first instance, despite the high reporting of somatic and physical symptoms. A report by ICRW (2000) demonstrated that healthcare settings in India are seldom the point of first contact for DV survivors and that hospitals rarely documented any DV-related information in women's medical records. Decker (2013) found that while less than 5% of perinatal women residing in low-income communities in India were screened for DV in healthcare settings, over 67% reported that they would be willing to disclose abuse *if* they had been screened. None of the participants in this research had been referred by the healthcare system after being screened for abuse, and similar to Decker's (2013), most of them had sought informal sources of support first. In some cases, participants had been referred to the charity by the police, who served as the survivors' first point of contact. This trend is reflected in the ICRW report, which found that state and non-governmental organisations were a critical entry point for women who struggled to access police, hospital or legal support (ICRW, 2000).

In this research, DV had been recognised and reported, and help was sought by all participants. An analysis of the 2015-16 NHFS data of 66,013 women found a prevalence of only 13.5% in terms of help-seeking behaviours among women facing spousal violence (Krishnamoorthy et al., 2020). Another study on psychiatric patients in India found that 60% of the respondents did not disclose experiences of sexual abuse or seek help (Chandra et al., 2003). A low level of awareness about formal support services for DV survivors is a significant factor, along with fear of divorce, escalated violence, and societal repercussions (Decker et al., 2013). This is the only known study on the barriers to help-seeking behaviour among DV survivors in India and reflects a global scarcity of research into barriers to DV disclosure and help-seeking behaviours (Oram et al., 2017). As a result,

there is little insight into the shortcomings of health systems and community services and how best they can mobilise to address the needs of survivors most adequately.

6.1.2.2 **Rehabilitation services**

The literature review revealed a notable research and treatment gap for psychological and mental health conditions for DV survivors. The diversity linked to the victim's racial, cultural, or socioeconomic background when developing rehabilitation services for DV survivors has been highlighted (Krishnan et al., 2012; Sharma, 2001). The use of qualitative methods allowed for a culture-specific exploration of the social determinants of DV, which can better inform clinical practice and support service development for DV survivors.

6.1.2.2.1 *Social determinants of DV*

6.1.2.2.1.1 The feminist perspective

The *battered women's* movement in the 1970s aimed at raising awareness about DV and its management in the USA, which involved redefining DV as a criminal act (Houston, 2014). Feminist scholars rejected the psychological perspective of DV as an interplay of personality and relationship dysfunction and argued for the predominance of social factors and social change as central to understanding and tackling DV (Houston, 2014). They theorised that gender inequality was the predominant social factor in the perpetration and experience of DV and not multiple social factors as proposed by family violence theorists (Fernandez, 1997; Houston, 2014). Women are predominantly considered victims or survivors; as opposed to agents or perpetrators of violence (Radford & Russell, 1994). There is considerable evidence from various contexts to back this contention (Campbell, 1992; Counts et al., 2019; Hester, 2013; Levinson, 1988).

The findings from Chapter 3 can be interpreted through the lens of the feminist theory. While there was evidence in some narratives about the two-way perpetration of abuse, the instances were limited and consisted primarily of verbal abuse perpetrated by the woman in self-defence or retaliation to male-perpetrated violence (Gangoli & Rew, 2011). There was no evidence for physical violence, sexual coercion or other forms of coercive control perpetrated by the women against their male partners. Participants also reported experiencing coercive control (sexual and emotional), dependency on their male partners for financial and domestic sustenance, a lack of control over their circumstances and feelings of loss and helplessness among other factors that demonstrate a clear

gender divide between men and women in this setting. They had all accessed legal/formal and informal social support, but there were no reported incidents of the perpetrators/male partners seeking any form of recourse, aid, or support at any time.

According to feminist theory, the male domination of resources, and institutionalised gender norms (such as marriage, decision-making, property ownership, or educational access) and other forms of inequalities between men and women in heterosexual relationships underlie the perpetuation of violence against women (Counts et al., 2019; Fernandez, 1997; Levinson, 1988). DV researchers in India have written extensively about the predominantly patrilineal and patriarchal systems and structures in India which enable and perpetuate violence against women (Ahmed-Ghosh, 2004; Charak & Koot, 2014; Ghosh, 2013; Kimuna et al., 2013; Krishnaraj, 2007; Panchanadeswaran & Koverola, 2005; Sharma & Gupta, 2004; Tichy et al., 2009; Visaria, 2000). This is reflected in the participants' appraisals of the DV and their inability to leave the abusive relationship or marital home in this research. Some participants had normalised the experience of DV and abuse for years before seeking help. This was related to both stigma and shame linked to victimisation, as well as unrealistic optimism and expectations of relationships. The inability to leave abusive relationships was also linked to internalised and normalised gender-biased notions of male superiority and financial or emotional dependence on men. These experiences indicate that women are relegated (or relegate themselves) to a subordinate position within the relationship and within the larger society, which sets the context for the legitimisation and normalisation of DV.

There is also a strong element of entrapment in the narratives of women in both Chapters 3 and 5, which was linked to experiences of coercion, manipulation, and control by the partner. This sense of entrapment was not only associated with enduring long-term abuse, but also with women feeling coerced into a relationship or a marriage by the male partner, their families, or societal norms around the 'marriageable age' for women and sexually active, unmarried women. This results in a perceived sense of entrapment and dependency that is unique to the woman's experience of victimising and DV (Fernandez, 1997), and was corroborated by the narratives of survivors in this research.

On the whole, there is support for the feminist perspective that gender inequality is a key social determinant of DV in this setting. This is a crucial to the development of services to support DV survivors in that it provides an understanding of how women perceive heterosexual relationships, their

role as a female partner, and why they endure long-term DV or continue to stay in the abusive relationships.

6.1.2.2.1.2 Multiple social factors

While the findings discussed above lend credence to feminist theories of DV, the gendered perspective proposed by feminist scholars has its limitations (Counts et al., 2019; Levinson, 1988). Feminist scholars view that experience of women survivors of DV as universal and homogeneous, which research and anecdotal accounts have challenged (Fernandez, 1997). Further, the focus in this perspective is only on the (male) perpetrator and the (female) victim, which places gender hierarchy and male dominance as the primary social constructs to understanding DV, while discounting the role of other social factors (Heise, 1998). The collection of essays of DV against women across diverse cultures by Counts et al. (1992) implicated the participation of other family members such as mothers-in-law (MILs) in Iranian, Indo-Fijian, Taiwanese, and Indian cultures. The evidence of violence perpetrated by women against women has been documented in India various forms, such as the violence perpetrated by MILs and sisters-in-law (Babu & Kar, 2009; Fernandez, 1997; Gangoli & Rew, 2011; Kaur & Garg, 2010; Krishnan et al., 2012; Panchanadeswaran & Koverola, 2005). This is substantiated by the findings from this research. A majority of the participants from both studies revealed the role of non-partner perpetrators (MILs, fathers-in-law, and siblings-in-law). This experience could be distinctive to patrilineal societies such as India, where a majority of male progeny continue to live with their parents and unmarried siblings even after marriage (Kalokhe et al., 2017). Most women in this research reported having lived with their in-laws or husband's relatives after marriage, and in many cases, their husband's home was the setting where the DV occurred. MILs (and in some cases, the fathers- and sisters-in-law) played a significant role in the perpetration of abuse at various stages of the relationship. Their role involved coercing the participants into abusive relationships/marriage, perpetrating acts of physical and emotional violence, and economic manipulation and abuse of the participants.

Collectivistic societies like India value family cohesion, cooperation, solidarity, and conformity. According to Fernandez's (1997) older women in India (such as the MILs) assume the position of generational superiors in the family, and the 'responsibility' of younger women (such as the daughter-

in-law) is relegated to them. This is interpreted through Hooks' (2015) interlocking system of domination, where various levels of social hierarchies operate simultaneously. Hooks refers to the complexity and diversity of the female experience and their relationship to power and domination by acknowledging the impact of not just sexism, but also racism and class exploitation in determining the nature of their identity, status, and circumstance. This perspective looks beyond the gendered perspective of feminist theory, by considering the 'multiple forces or hierarchies that oppress women' (Fernandez, 1997, p. 437). In India, these constitute intergenerational hierarchies and the resulting cross-cutting loyalties experienced by older women; solidarity with her fellow woman (the daughter-in-law), versus solidarity with the son, family and/or their class caste interests among other divided interests (Fernandez, 1997). The interlocking systems of domination align with Heise's (1998) integrated, social-ecological theory which has emphasized the interplay of a host of personal, situational (relationship, family, and community), and socio-cultural factors in predicting and determining women's risk of DV and their responses to it. Heise (1989) criticised the single factor explanation of feminism and recommended the adoption of a more widespread framework for conceptualising DV at various levels of the social ecology. For instance, the recurring role of family and extended social circles in influencing how women perceived and reacted to their abuse, their decisions to disclose abuse, leave an abusive relationship, and seek help and support was uncovered. Secondly, the stigma surrounding DV and mental health issues in India is known to contribute to under-detection and underreporting of abuse, which significantly hinders identification, prevention and rehabilitation of survivors (Chandra et al., 2003; Oram et al., 2017). Survivors shared accounts of how they managed their experiences of DV within the home, with varying lengths of time passed before help was offered or sought. There is a wealth of data on the social construction of shame and stigma surrounding experiences of gender-based violence in India (Babu & Kar, 2009; Barn & Kumari, 2015; Kermode et al., 2007; Ragavan et al., 2015; Sharma & Gupta, 2004; Shidhaye & Kermode, 2013), and this research contributes insight into how they may impact mental and physical health outcomes for survivors in the long-term. Finally, participants in this research outlined their concerns of being financially dependent on their partners and the impact an eventual separation or divorce would have on their children as reasons for non-disclosure or staying with their abusive partners. Several participants reported feeling trapped in the abusive relationship due to the lack of financial security and independence or lack of spending or decision-making power. Moreover, when

women had dependent children, they reported feelings of guilt, shame, and a sense of obligation towards their children or other family members as reasons for non-disclosure. Some women were concerned about their children's future prospects being affected by their status as a DV victim/survivor, while others felt that they had to cover for the perpetrator to protect their children from societal stigma and shame. Previous research has identified these factors to be important social determinants in the decision of survivors to leave abusive relationships versus enduring them (Rose et al., 2011). While more urban women are seeking employment and financial independence within relationships, a large majority of women in the country are still relegated to childbearing and caregiving roles within the family. These findings are in line with previous research conducted on DV survivors in India (Kimuna et al., 2013; Pankajakshan et al., 2020; Ragavan et al., 2015; Rao et al., 2012; Tichy et al., 2009), and have serious implications for DV service development and rehabilitation efforts. As Oram (2017) has pointed out, mental health professionals must consider the 'strategic risk-benefit analysis' that survivors may employ in making decisions about disclosure or separation, which indicates agency as opposed to the notion of inaction and victimhood.

It is crucial to look beyond the factors of gender and patriarchy while disregarding the multidimensional nature of DV experiences that operate at different levels of the social ecology, especially within the family structure. Krishnan et al. (2012) identified a lack of family-focused and empowerment-based approaches to mitigating DV in south Asian cultural contexts, such as India. They argued that efforts targeting only the victim could be ineffective if the broader context of their life was not conducive to mitigation and change. It is also important to consider situational factors such as dependency and need for companionship, perceptions of filial or parental duties, and socio-cultural factors such as stigma and discrimination in the aetiology and rehabilitation of DV. Interventions that consider the complex interplay of the various social-ecological factors that underlie the experience of DV are needed for the effective prevention, mitigation, and rehabilitation of DV.

6.2 Implications for NET

By examining the implementation of NET, an individual, trauma-focused intervention, this research makes a much-needed contribution to addressing the research and knowledge gap on providing targeted mental health support and treatment for DV survivors in India.

So far, published DV intervention research in India has focused disproportionately on the prevention and mitigation of DV and its perpetration, and less on the mental health and psychological outcomes for the survivor. One study which reported the effects of a cognitive-behavioural intervention for IPV focused primarily on the reduction of IPV perpetration (i.e., on the male perpetrator) with a secondary focus on improving the mental health outcomes of women (Satyanarayana et al., 2016). Krishnan et al. (2012) tested the acceptability and feasibility of an empowerment-base, integrated approach to mitigating DV but did not include measures of mental health or psychological symptoms as outcomes in their study. Magar (2003) discussed an empowerment approach to gender-based violence which uses an informal *women's court* to hold perpetrators accountable for the abuse, while also providing counselling services for women. They argued that this integrated empowerment framework uses indigenous conflict-resolution techniques and maintains traditional, culturally-sensitive, and community-based intervention protocol. The previous sections on the social determinants of DV discussed the importance of developing socio-ecological, culturally-informed empowerment-based interventions for DV. However, the well-established association between DV exposure and poor mental health outcomes for women (Oram et al., 2017) equally emphasise the importance of specifically targeting the psychological consequences of DV when developing rehabilitation services. A key aim of this thesis was to examine the implementation and utility of NET to address the psychological needs of DV survivors in India.

6.2.1 An evaluation of the NET evidence-base

Chapter 4 presented the findings from the most up-to-date, comprehensive meta-analysis of NET efficacy, and addressed some limitations of the Lely et al.'s (2019) meta-analysis by including a larger data-set, analysing differing follow-up time points appropriately, and investigating potential heterogeneity between trials through sub-group analyses. In this review of 24 trials, NET was found to significantly alleviate PTSD symptoms at mid-term (6-7 month follow-up), and long-term (9-12 month follow-up) time points. These findings support Neuner et al.'s (2020) contention that the most pronounced improvements for NET are generally observed at the long-term follow-up, which they interpreted as evidence of its long-term sustainability. The meta-analysis also showed that depression symptoms were significantly lower for NET participants only at the mid-term time point. Lely et al. (2019) also found that NET was not as effective in treating depression symptoms as PTSD, which is

an expected outcome since NET is based primarily on the theoretical paradigms of PTSD and its treatment protocols.

In line with Lely et al. (2019), significant methodological weaknesses were found in the trials included in this study, which impact the interpretation of the pooled intervention estimate as an indicator of NET efficacy. A majority of the studies were underpowered, which raises the question of whether the evidence base is subject to small study effects (Sterne et al., 2000). One of the reasons is the selective reporting or publishing only the most favourable outcomes. There were some instances of a high risk of reporting bias in the included trials, and several instances of unclear risk of bias, which suggests that the pooled intervention effect might be impacted by small study effects.

The quality of the trials was determined primarily using the Cochrane Risk of Bias tool (Higgins et al., 2011). The estimates in this analysis were more conservative when compared to Lely et al. (2019) and led to a relatively cautious interpretation of the pooled intervention effect estimates. High risk of performance bias and a relatively high risk of detection bias was found, along with significant issues related to the measurement of outcomes. There was a largely unclear risk of bias with regard to allocation concealment, and relatively unclear bias with regard to selection bias.

High heterogeneity estimates were found within most of the analyses conducted. Trials included diverse trauma populations across cross-cultural contexts in their analyses. High levels of clinical heterogeneity have been known to cause small study effects; wherein smaller studies may have included a selection of participants to effect a favourable outcome (Schwarzer et al., 2015). Other potential sources of heterogeneity include the use of adapted versions of NET such as FORNET and brief NET, and a range of control groups ranging from active, bonafide treatments to waitlist controls (WLC).

Most of the studies used WLC in the control condition. *Section 4.4.2.* in Chapter 4 elucidated the methodological concerns of using WLC which makes it difficult to determine is NET is superior to other active, trauma-focused interventions such as TF-CBT, CPT, and EMDR in treating symptoms of PTSD. Meta-analytic findings of trauma-focused therapies have shown that the use of active control groups was associated with a smaller effect size than the use of passive controls (such as WLC) (Lambert & Alhassoon, 2015). The use of WLC also raises the issue of whether we can consider NET as an efficacious treatment protocol when compared with what is essentially a ‘no-treatment’

condition. Normal processing that takes place as a result of the time elapsed since exposure to trauma, a positive change in circumstances, social and community-based support, and other factors unrelated to therapeutic engagement could contribute to better outcomes at post-intervention. When NET is compared with WLC, it is unclear whether the 'specific' ingredients in NET have contributed to better outcomes for participants in these trials, or whether the post-intervention effects could be attributed to normal processing that is unrelated or not produced as a result of the NET process itself. There is an urgent need to measure the efficacy of NET against other empirically supported trauma treatments to better understand its individual and unique capacity to alleviate PTSD and related psychopathology.

6.2.2 Specific effects versus general effects

A related issue is a debate between 'specific effects' and 'placebo or general effects', more generally known as common factors. Wampold (2001) has argued that common factors such as the therapeutic relationship, creation of expectations, attention, and remoralisation constitute a core aspect of an intervention, making it difficult to disentangle and differentiate what contributes to better outcomes. The success of NET is contingent on building rapport and developing a trusting, empathetic relationship between the therapist and the client. The development of the therapeutic alliance was facilitated by the initial sessions of securing informed consent, psychoeducation and building the lifeline in this research. The psychoeducation and lifeline sessions also provided participants with the opportunity to outline their therapeutic expectations as to what they hoped to gain through NET. The analysis of the testimonies revealed the vital importance of the lifeline session in effecting positive change through remoralisation and regaining dignity. Therefore, it can be argued that these aspects of NET are better explained from the common factors perspective as opposed to specific effects that are unique to NET.

The important benefits of common factors are further revealed by the studies that show uniform efficacy of diverse psychotherapy, and by studies that show variance in outcomes based largely on therapist factors (Wampold & Imel, 2015). Luborsky et al. (2002) found a nonsignificant effect size between the efficacy of different psychotherapies based on a meta-synthesis of 17 meta-analyses; a finding which replicates that of Grissom (1996) and Wampold (1997). These analyses cast doubt on the contention that specific ingredients that are drawn from a particular theoretical approach are the main sources of psychotherapeutic effects. There are no known studies investigating therapist factors

in the implementation of NET and use of a single therapist (myself) in this research did not provide an opportunity for deeper exploration of this issue. In the following section, the relevance of a common factors model to NET is presented the context of the findings from this research.

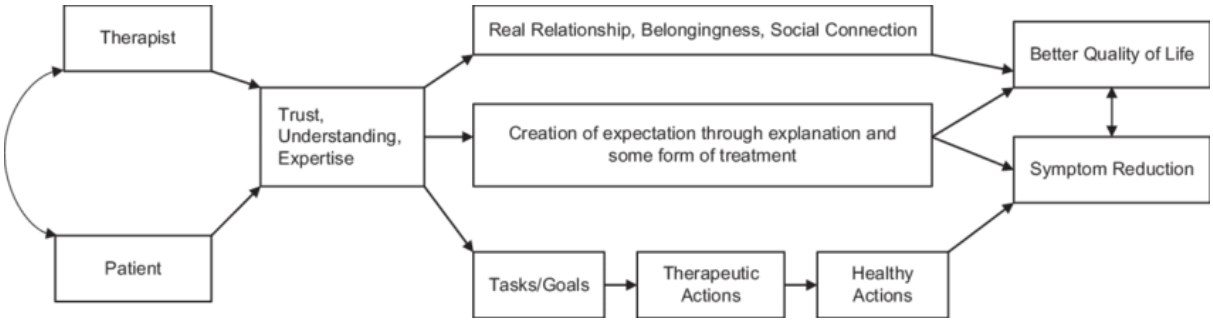
6.2.3 NET: Through the lens of the Contextual Model of Psychotherapy

Clinical researchers have questioned the necessity of specific intervention components for effecting successful treatment outcomes for specific diagnoses or conditions (Messer & Wampold, 2002) and specifically, PTSD (Gerger et al., 2014; Wampold et al., 2010). This approach to psychotherapy, which is thought to be based on the medical model of psychotherapy (Messer & Wampold, 2002; Wampold & Imel, 2015) is challenged by the common factors approach or the 'contextual approach' (Frank & Frank, 1991; Wampold, 2001).

According to one of the many common factors approaches, namely, the Contextual Model (Wampold, 2001; Wampold & Imel, 2015), the benefits of psychotherapy are accrued through social processes, and the therapeutic relationship is a core element of psychotherapeutic effectiveness. This model (Figure 6-1) is meant to account for the effectiveness of all bonafide psychotherapies and posits three pathways to change that are built on a bond of trust, understanding and expertise.

The first pathway is based on the 'real' relationship between the therapist and the client and the social connectedness that it brings. The second pathway is through the creation of expectations through explanations and treatment actions. The third pathway to recovery is a result of carrying out treatment actions. Collectively, these pathways are believed to lead to a better quality of life and symptom reduction.

Figure 6-3 Contextual Model (adapted from Wampold & Imel, 2015)



Proponents of the Contextual Model of psychotherapy have argued that common factors are incidental, which means that certain elements of therapy such as the therapeutic relationship are

common to all (or most) treatments and underlie their uniform efficacy. When applied to the study of NET, it raises an important question of how NET differs from psychotherapeutic models that it is based on such as cognitive-behavioural and exposure treatments. NET incorporates all the core elements of the Contextual Model within the treatment protocol. The informed consent and psychoeducation sessions are focused on building trust and rapport with the client, which helps establish the therapeutic relationship. According to the Contextual Model, this real relationship is therapeutic in and of itself, to some extent. The findings from the qualitative analyses of Chapters 3 and 5 emphasized the importance of social support and welfare services in rehabilitating survivors. In some cases, the participants had already established a trusting, real relationship with their social workers and acknowledged the positive impact of this relationship in their healing process. Therefore, it could be said that according to tents of the Contextual Model, their healing began before they participated in this research, and thereby NET. Wampold & Imel (2015) have argued that first and foremost, psychotherapy provides the clients with an opportunity to form a human connection with caring, empathetic individuals. NET emphasizes the importance of the therapist's empathetic and accepting attitude as a key component of the therapeutic relationship (Neuner et al., 2020). From my reflections of administering NET to DV survivors, I found that the empathetic and accepting attitude is especially important in the case of clients who have impoverished or chaotic social relationships.

The psychoeducation session directs the therapist to explain the therapeutic procedure in detail including elements of imaginative exposure and habituation and narration. This process helps with creating expectations for treatment outcomes, which are not necessarily based on the scientific validity of the theory but on the 'acceptance of the explanation for the disorder and the therapeutic actions that consistent with the explanation' (Wampold & Imel, 2015, p. 59). None of the individuals who participated in the NET study had been seeking any form of psychotherapeutic support before the study. This could be for the lack of opportunity or access. Therefore, the anticipation of healing and recovery through the creation of expectations and instilling of hope in the first few sessions is thought to be an ameliorative process in itself, much like the placebo effect in medical research (Frank & Frank, 1991; Wampold & Imel, 2015). All the participants who consented to participate did so with eagerness and anticipation, and the lack of treatment dropouts suggests that NET provides ample opportunity for recovery to be realised through this pathway.

The treatment actions are targeted at symptom reduction, remoralisation, improving the client's well-being and regaining dignity and purpose (Schauer et al., 2011). These 'specific ingredients' were the subject of enquiry in Chapter 5: the development of a framework of recovery (Figure 5-2). The findings from this analysis uncovered evidence for specific elements such as anecdotal reliving, contextual reliving, habituation, and cognitive re-structuring in the final testimonies of the participants. These elements are largely based on the theoretical understanding of PTSD and are built into NET as vital processes of recovery. Additionally, the recovery framework also found evidence for two processes that seem to be relevant to recovery in this sample/in this context or setting. These include the benefit of reliving positive memories and the exercise of planning for the future. NET's focus on the entire life story of the client creates an opportunity for these processes to take place. Importantly, the qualitative analysis of the testimonies revealed that these processes had adaptive value for the participants. This understanding of change mechanisms, presented in the framework of recovery through NET, highlights the importance of *other* factors that do not emerge out of a theoretical understanding of PTSD and related concepts, but as a product of the context/setting.

According to Barlow (2004), potent psychotherapies contain 'specific psychological procedures targeted at the psychopathology at hand' (p. 873), which goes above and beyond the common factors. In the case of NET, the framework of recovery provides credibility to the importance of rooting psychotherapeutic interventions in scientific and theoretical knowledge. In addition to common factors, the specific psychological procedures that were found to be important to treatment success include the activation of the fear/trauma network through anecdotal reliving, habituation through emotional processing, and reconstruction of the autobiographical memory through contextual reliving and cognitive-re-structuring. NET is based on scientific explanations for PTSD which proponents of the medical model would argue are the core ameliorative elements *necessary* and *sufficient* for treatment success. However, the other pathways proposed by Contextual Model as being crucial to recovery success such as therapeutic alliance and expectations are inherently built into NET, and NET cannot be administered in complete adherence to the treatment manual in the absence of these elements. When NET is interpreted through the Contextual Model, the specific ingredients that are built into NET based on their scientific credence are *not sufficient* in and of themselves to effect recovery. The operation of the three pathways proposed by the Contextual Model contribute in tandem to recovery success, and the specific treatment actions (third pathway) constitute only one of three pathways that

lead to change and recovery. The framework also proposes processes do not have a clear theoretical or scientific orientation but are crucial to recovery in this sample that such as the adaptive value of positive memories and planning for the future. These findings further challenge the universality of the medical model which places the theoretically-derived, therapeutic actions as the 'potent' part of psychotherapy (Barlow, 2004). Finally, the analysis of the NET testimonies uncovered the importance of social support in the healing process; an element which operated 'outside' the therapeutic relationship and practice. Almost all the participants spoke extensively of the alleviating impact of practical and social support in their ability to cope with their trauma experience(s). This was highlighted in the discussion of Chapter 5 (see *section 5.5.4*.), in support of the findings from the IPA of lived experiences of DV in Chapter 3. This further emboldens the importance of social connectedness as an element of the first pathway to recovery; and suggests that recovery cannot take place in its absence.

The Contextual Model values the specific effects of psychotherapy, but as a health-promoting, salubrious exercise and not as an activity that targets the remediation of a deficit (Wampold & Imel, 2015). This model provides a novel means of understanding the adaptive value of trauma-focused interventions such as NET and underlines the importance of common factors in addition to the theory-informed specific effects. Based on this understanding of NET, it is highly recommended that practitioners who choose to use individual-focused treatments such as NET must not solely rely on their specific effects, but that they must expend an equal amount of time and resources on constructing a coherent treatment plan that the therapist believes in and provide a convincing rationale to clients (Messer & Wampold, 2002).

Lastly, the Contextual Model argues that the medical model of psychotherapy has consistently ignored the effect of culture and context in the practice of healing, in favour of treatment based on scientific discovery and universal biological processes (Wampold & Imel, 2015). Wampold & Imel (2015) quote Mays & Albee's (1992; as cited in Wampold & Imel, 2015) review of a 100 years of American psychotherapy to support their argument that members of minority ethnic groups do not constitute major users of Westernised psychotherapies. This reflects the position of several Indian clinicians and researchers who have advocated for the use of traditional, indigenous, and community-based healing practices that are culturally and contextually sensitive (Busby, 1999; Chandra et al., 2009; S. Kumar et al., 2005; Math et al., 2008; Tharyan, 2005; Lakshmi Vijayakumar et al., 2006;

Vizcarra et al., 2004). Messer & Wampold (2002) cautioned against studying either specific or general effects independently of the healing context and atmosphere in which they occur and recommended the need to consider 'cultural capital' (p. 774) along with institutional and legal facets when developing interventions for DV and its aftermaths.

The findings from the IPA in Chapter 3 demonstrated the complex interplay of social and cultural contextual factors in determining the lived experiences of abuse. These factors might have an impact on the response to treatment as well. The strict use of manualised NET for diverse trauma populations does not consider the multiplicity of trauma experiences for different types of exposure. Zang et al. (2014) adapted NET to suit the needs of Chinese earthquake survivors based on the findings from their previous research which showed that successful governmental rehabilitation efforts and the lack of a perpetrator rendered the final testimony irrelevant to survivors (Zang et al., 2013). The adapted version was tailored to suit the needs of earthquake survivors in a particular cultural context and was found to show comparable efficacy in treating PTSD and related symptoms (Zang et al., 2014). Prioritising specific treatment effects over contextual factors may diminish the quality of evidence for NET efficacy, which has thus far involved strictly applying the treatment protocol in diverse settings with a range of trauma samples without culturally sensitive adaptations to suit local, indigenous needs.

In India, the few studies examining the utility of culturally sensitive interventions show encouraging results, but the outcomes do not address the key, individual, psychological needs of survivors (Krishnan et al., 2012; Magar, 2003). The findings from this research strongly recommend that a comprehensive middle ground must be reached. There is an urgent need for adapting and building empirically supported treatments such as NET into empowerment-based programmes so that these services can go beyond prevention and mitigation of DV and alleviates the psychological distress and mental health suffering of survivors.

This is especially relevant since psychotherapeutic support still does not emerge as the first-line treatment for women who manifest poor mental health as a result of interpersonal problems and DV in India. In their study on depressed women seeking support at a premier psychiatric facility in south India (NIMHANS), Rao, Horton and Raguram (2012) found that women were predominantly prescribed pharmacological treatment. This is significant because psychiatric illness was most strongly correlated with DV and structural violence among participants in this study. Psychosocial

interventions such as TF-CBT, CPT, and EMDR are the first-line treatments for PTSD, which is among the most highly reported mental health conditions associated with DV. NICE also recommends NET as a first-line treatment for PTSD, and it is recommended as a second-line treatment for PTSD by other guidelines (American Psychological Association, 2017; VA/DoD, 2017; ISTSS, 2018; NICE, 2018). This is not an argument for merely transplanting interventions developed using Western expertise for Western populations without consideration of context and culture. It is, however, an argument for rigorously and scientifically tailoring evidence-based treatments (such as NET) through a Contextual Model approach and building these treatments into empowerment-based approaches to rehabilitation with due consideration to the socio-cultural context factors of DV.

6.3 Methodological considerations and future research

Some methodological issues warrant consideration. The NET manual recommends the use of structured interviews by experts as mandatory for pre-treatment diagnostics and cautions against the reliance on self-report instruments to determine eligibility for NET (a PTSD diagnosis) (Schauer et al., 2011). Due to the lack of both time and resources and the requirement of undertaking the intended research within the PhD duration, I could not use structured interviews to diagnose PTSD. Schauer et al. (2011) recognise that establishing a clear psychiatric history and diagnosing PTSD using a structured interview requires extensive theoretical and practical training and skills. This was not feasible within the scope of this thesis, as a result of which I chose to use self-report assessment measures. Similarly, several RCTs of NET efficacy have used self-report assessments to measure PTSD symptoms (Raghuraman et al., 2020). Self-report measures could be prone to both overreporting or underreporting of symptoms and may not reflect the findings derived from clinical interviews.

The manual recommends the Post-Traumatic Diagnostic Scale (PDS) as an option for a self-report assessment to measure the frequency and occurrence of PTSD symptoms. I could not find a record of the PSD being used, translated, or validated for use in Indian samples. There is a paucity of scientifically valid and reliable research tools and instruments developed specifically for Indian samples. Consequently, I chose to use assessment measures such as the IES-R and HADS to measure symptoms of PTSD, depression, and anxiety as they have previously been validated for use in south Indian populations. The appropriate, scientific procedures for translation were undertaken to

ensure reliability and construct validity. Future research with NET in this setting must use structured interviews to diagnose PTSD to establish eligibility and measure baseline outcomes or undertake a validation of the recommended self-report measures to ensure treatment manual adherence.

Purposeful, opportunistic sampling was used to maximise information power while keeping pragmatic considerations in mind. This meant that the sample was limited to those participants who I was given access to. The intention was to maximise information power and access information-rich participants. Due to the sensitive nature of the research, the pool of potential participants who were able and willing to participate was limited. While data saturation was not intended, some perspectives may have been excluded as a result of opportunistic sampling. Similarly, every effort was made to access a demographically diverse sample (age, educational background, socio-economic status) to ensure maximum representation of perspective and lived experience. However, due to the constraints of time and access, such diversity could not be entirely achieved.

There was significant diversity in the nature and forms of abuse reported by the final sample in both qualitative studies. This ranged from physical and sexual violence to emotional abuse and neglect. While this may be considered a strength in terms of widespread representation of voices and perspectives, the range of DV and abuse endured by the participants may have been too heterogeneous to justify their inclusion within the same study. The lived experiences, the manifestation of pathology, and response to treatment may be different for a survivor dealing with coercive control when compared to someone facing severe, long-term neglect and destitution. Survivors of physical violence may manifest more physiological and somatic symptoms when compared to women dealing with pervasive emotional or economic abuse. The participants in both studies reported a wide range of DV experiences which were overlapping in some ways, but markedly dissimilar in others. Future research may benefit from undertaking targeted analyses of specific forms of abuse or violence which can have significant implications for the development of distinct recovery and rehabilitation services.

A related issue is that I relied on self-reported experience (extent and severity) of DV and abuse. All the women who participated in this research had been referred to or had voluntarily sought help from the social care based on their *subjective* experiences of DV. The research design did not include a standardised tool or assessment to *objectively* measure the extent or severity of experiences of abuse and violence such as the Composite Abuse Scale (Hegarty et al., 1999, 2005). Firstly, the

experiences of the women and the meaning they make of these experiences was the key focus of the analysis. This means that subjectivity was not viewed as a methodological limitation but as a strength. Moreover, this constituted an effort to reflect 'real' clinical or practical settings as much as possible, wherein women generally tend to self-report their experiences of DV when seeking help. It is important to build support, treatment, and rehabilitation services for *anyone* who presents with exposure to DV experiences, regardless of an objective measurement of such exposure. Lastly, the sampling approach was opportunistic, in that it was driven by pragmatic considerations as much as it was purposive. Access to information-rich participants would have been limited had participants been excluded based on an objective measure of the severity of trauma exposure.

For the framework of recovery study in Chapter 5, I was primarily responsible for data collection and analysis of the testimonies. Data collection comprised of measuring baseline and post-intervention outcomes, as well as administering NET to the participants. In retrospect, my knowledge of the theory and process of NET and my experience of delivering NET and engaging with the participants in a collaborative, therapeutic process could have bilaterally impacted each other. This means that it was not possible for my analysis of the testimonies for indicators of change and recovery to occur exclusive of my personal reflections on the therapeutic process, my perception of each participant's trauma and recovery journey, and my own experiences of facilitating this journey. The analytic process was a reflective, dynamic process, which precludes the resulting framework of recovery from being truly objective and scientifically valid. Instead, the framework only provides an understanding of recovery through NET for *this particular sample* with *me as the therapist*. A different researcher may make contrasting observations and arrive at distinct interpretations of the data if they had not been part of the therapeutic process and measurement of outcomes. While I conducted the primary analysis of the data, the audit trail on NVivo software allowed my supervisors to examine the analytic process, make observations and contribute to the interpretation of data. However, my primary observations and development of the analysis indicate that I am intrinsically entwined into the findings that emerge from the analysis and the resulting framework. However, this research was undertaken within the limitations that come with a PhD project, and thus, this is highlighted as a methodological issue for consideration.

My involvement in every stage of the research process also increases the likelihood of social desirability bias in the self-reporting of outcomes post-intervention. The process of NET is contingent

on building a trusting, empathetic therapeutic relationship between the therapist (me) and the client (the participant). Informal feedback provided by participants suggested that the therapeutic process had been a positive experience for them, largely due to the 'real' relationship, safe space, and social connectedness that it afforded them. They also were aware of the nature of the research in that they would have to complete the same self-report assessments after the treatment ended to measure the change in symptom levels. Therefore, their perception of me/their relationship with me might have prompted them to respond favourably on the assessments post-intervention and may not reflect a true improvement on the chosen outcomes. As I was unable to secure the resources required to undertake blind outcome assessments, this is highlighted as a potential limitation of the research design.

This research sheds light only on those experiences that have allowed themselves to be voiced and shared. The issue of DV suffers greatly from nondisclosure and under-reporting for a variety of reasons already discussed in previous sections. This research only includes the responses and experiences of women who have recognised their abuse and those who have actively sought help and consented to participate in NET. This is a general issue when researching DV in cultures where there is pervasive stigma, shame, and guilt associated with DV along with poor mental health literacy. While there is no immediate or reasonable solution for this issue, clinical research must take active steps towards screening and identifying DV survivors in the community and build awareness-raising services in addition to recovery and rehabilitation services to ensure address the wide knowledge and research gaps that currently exist.

There are other implications for future research that have emerged from this research. Firstly, there is a significant knowledge gap in understanding the lived experience of DV in India, with a focus on its specific mental health consequences, barriers and challenges to help-seeking, the role of healthcare services in screening and rehabilitation, and understanding the social determinants of enduring long-term abuse. This research has provided a preliminary understanding of these issues and has identified crucial knowledge gaps that future qualitative research can address. Significantly, this research highlighted the dearth of survivor-focused, mental health and psychotherapeutic service research in India. Addressing the challenges of balancing the use of empirically supported treatments alongside local, indigenous and community healing practices is an area that requires crucial research interest. the focus on empowerment-based treatment approaches that endorse the inclusion of the survivors' wider network into rehabilitation programmes must also reflect on the importance of

incorporating trauma-focused treatments that target the specific psychosocial needs of the survivor. There has been little emphasis on improving the mental health outcomes of DV survivors in India, due to the twofold blow of stigma surrounding issues of DV and mental health. Acknowledging and investigating the impact of these issues on the health and wellbeing of survivors is crucial to addressing India's wide-ranging public health issues. If empirically supported treatments such as CBT, CPT, EMDR, and NET are being used in clinical practice, the feasibility, acceptability, efficacy, and effectiveness of such treatments must be documented through research and published for dissemination.

In terms of psychopathology, this research has highlighted the inconsistencies between self-reported symptoms of PTSD and narrative accounts of psychological ill-health. The construct of PTSD must be explored through a mix of quantitative and qualitative research using representative samples to advance our understanding of how trauma exposure manifests through psychopathology in this socio-cultural setting. This knowledge will be crucial when planning mental health and welfare services for affected populations in a setting with a high risk of various forms of diverse trauma exposure. A related issue that must be addressed is the development or validation of culturally and linguistically sensitive, valid, and reliable assessment measures for use in this setting. The poor understanding of the PTSD construct in India my be intrinsically linked to our inability to appropriately measure symptom manifestations. These efforts will also significantly homogenise PTSD research in India and allow for crucial comparative analyses to be made.

This research uses innovative methodology; a theory-informed TA to better understand mechanisms and processes of recovery through NET. The overreliance on RCTs and other quantitative analyses to measure change through psychotherapy, and specifically NET, has been highlighted through the findings from the meta-analysis of NET efficacy. While this is not solely intended as a criticism of either RCTs or NET, it highlights the importance of augmenting RCT research with complementary, idiographic designs to further practice-based evidence. Process research based on therapy data is heavily under-researched and undocumented but provides a multitude of accessible possibilities for clinical psychology research to link theory and practice in a meaningful way. The development of a framework of recovery provides an impetus for future researchers using NET or other psychotherapies to analyse and understand what exactly goes on in therapy sessions using raw therapy data (Finlay, 2014). This area of research has serious clinical and logistical implications; as

Mallinckrodt (2011) note, “there is probably no area of research that poses more practical problems than studies of actual client interactions with actual counsellors” (p. 711). Aimed at naturalistic generalisability and transferability, the intention is that the NET framework of recovery will encourage future researchers to develop their own culturally and contextually relevant recovery frameworks to better understand specific and general effects of NET in alleviating PTSD and related psychopathology. This will make a significant and meaningful contribution to its growing body of knowledge and will make it more accessible to researchers and practitioners from different settings to apply it in their individual contexts.

Finally, this research discusses the importance of viewing empirically supported interventions through the lens of common factors models and challenging the medical model of psychotherapy. NET offers a range of possibilities to further the field of common factors research, as demonstrated in this research. These efforts will vastly improve the transferability and adaptability of NET to diverse settings, thereby improving the access of vulnerable individuals in need of psychotherapeutic support in low-resource contexts with a high risk of trauma exposure.

6.4 Reflexivity

Section 2.7 in Chapter 2 discussed the reflexivity informing the design of the research. Analytic and interpretative reflexivity was an inherent and irrevocable element of undertaking the qualitative research in line with the critical realist epistemological approach of this thesis.

Firstly, I have become aware of how important the issue of safeguarding vulnerable populations is; in general and to me, as a clinical researcher. Mental health and rights-based advocacy in India is faced with significant challenges, and when combined with the issues of gender and violence, I am more acutely aware now than I was when I embarked on this research of how much work there is to be done. Through engaging with first-person accounts of lived experiences of violence, discrimination, and stigmatisation, I have become more vocal about issues that I believe are as political as they are social. As I write this, India is grappling with significant social, communal, and political turmoil, and the ones who are and will continue to suffer are the already marginalised and disadvantaged. Identifying as a woman in India is no easy feat, and while the forms of abuse and discrimination may be diverse and wide-ranging, they transcend class, caste, and other forms of social hierarchies. However, I continue to acknowledge my unfailing privilege when compared with millions of others who suffer

grave injustices as a consequence of gender-based violence in India. This very privilege has provided me with access to educational and professional opportunities that allow me to research and write about these issues today.

I discussed why I chose to undertake my PhD research on these topics in Chapter 2 (*section 2.7*). Four years later, the conviction in my choice of subject is stronger. While much has been written and said about the stigma and discrimination surrounding issues of mental health and DV in India, I was surprised at the honesty and candidness demonstrated by the participants when sharing their experiences. Most of the participants were facing significant emotional distress and had undergone severely painful and traumatic experiences. Regardless, their willingness to engage with me was reflective of their need for social connectedness, understanding and empathy. There are two important considerations to reflect upon. In terms of context, the women who were accessed for participation were all currently seeking support from a charity, which indicated their willingness to recognise and label their experiences as atypical and in extension, as abuse. They had consciously sought help to improve their circumstances and embark on a journey towards recovery and rehabilitation. In reflection, this is an important aspect of researching vulnerable populations and sensitive topics.

The other consideration draws upon my role as the researcher. As a young, south Indian woman, I am aware of my *insider* status (Le Gallais, 2008). The insider researcher is a member of the 'in-group' and has access to the group's past and present histories. The mean age of the participants in the two qualitative studies was 33 years and 36.4 years. At the time of data collection, I was 28 years old, which roughly places me within a similar age demographic. I also speak the local language and am accustomed to the local culture, traditions, and practices inherent to this setting. The shared experience of being an Indian woman engendered a sense of collective identity between myself and the participants. Regardless of one's educational background, level of literacy, socioeconomic or class status, or religious identity, women in India are duly aware of their historically marginalised status. Some of us are more affected by this status than others, but the knowledge of our shared history as violent and oppressed is hard to be ignorant of. Therefore, my demographic identity was a tremendous advantage in being able to access the views, perspectives, and life stories of the participants. In a majority of the cases, I was instantly greeted as one of their own, and there was a sense of ease and comfort from the early stages of the interview or therapeutic process.

This is not to say that accessing sensitive data during the interviews in Chapter 3 or building a trusting therapeutic relationship for the administration of NET in Chapter 5 was an effortless process. While insider status and shared identity are valuable tools in reflective qualitative research, they are not limitless. My educational status was a palpable source of divergence, as was my lack of experience with the phenomenon under study; DV. While these factors were not explicitly made aware, the understanding that we were differentiated by these aspects was implicit. I have worked hard to develop the sensitivity required to work with vulnerable and disadvantaged populations through years of professional employment in non-governmental and not-for-profit organisations. This includes learning local dialects to improve my communication skills, dressing mindfully to reflect cultural sensitivity, and reading and educating myself about social issues that are not part of my identity. Throughout the data collection and therapeutic processes, I strived to conduct myself with the empathy and willingness to listen to create an opportunity for trust and rapport to develop. As I was unclear of the participants' prior experiences of dealing with healthcare professionals, clinicians and researchers, I tried to seem approachable and non-intimidating but focusing more on building a relationship with them, and less on my background and expertise.

In listening to the stories and experiences of the participants, I became acutely aware of my sheltered upbringing. I realised that there are not only conceptual and putative distinctions but also practical differences between my experiences of gender-based discrimination and those of the participants. My experiences were restricted to isolated instances of stalking, harassment, bullying, and discrimination and I personally don't believe they had had a long-term impact on my mental health or well-being. As expected, this position was starkly different from those of the participants. As time went on, I had to make more of an effort to minimise this barrier between myself and the participants to not assume an *outsider* position. To report authentically about the experiences of the participants, I began to read more on the political and social issues of gender and violence in India. This helped significantly with my own meaning-making process as I sifted through the data and began my initial analyses.

The analysis of the findings from the IPA study underlined the need for participatory research in this field going forward. The importance of recognising and exploiting the expertise of lived experience and value of co-producing research in collaboration with participants was made more apparent through this experience. This is especially vital when research is intended to inform and make recommendations to improve clinical practice and welfare service development. Enlisting the views

and experiences of service users as part of a shared-decision making process helps create recovery-focused mental health services (Liz et al., 2014). This approach challenges the position that the researcher is the expert and values the experiential knowledge of participants in improving knowledge of complex phenomena.

My role as the therapist when administering NET to the participants in Chapter 5 was significant in terms of reflexive research practice. The importance of therapist factors in effecting recovery has demonstrated through research (Bergin, 1997; Luborsky et al., 1997; Messer & Wampold, 2002). During NET, the goal is to aid the development of a narrative that would be ameliorative for the participant in terms of symptom reduction and enhancing well-being. The participant is the narrator, but a key element of NET is the role of the therapist in co-constructing the participant's life story to aid the process of habitation and reconstruction of the autobiographical memory systems. This is done through compassionate understanding, active listening, therapeutic alliance, and unequivocal positive regard and encouragement (Neuner et al., 2020). During NET, the therapist aids the client in engaging deeply with their emotions, thoughts, sensations, and feelings of bodily arousal. Asking closed questions, being directive and making suggestions about emotions, cognitions, physiological arousal and meaning content are all important aspects of the therapist's role (Neuner et al., 2020). This meant that during the NET study, I was actively switching between the role of therapist and researcher. This process was as exhausting, as it was exhilarating. I was writing reflective field notes to aid analysis throughout the sessions while also attempting to aid the participant in their journey to recovery through co-construction of their narratives.

Between sessions, I transcribed the session verbatim in the participant's own words to aid habituation. When developing the narrative transcripts, I was aware of my own conceptualisations and understanding of what was being said by the participants in the sessions. I had to be keenly conscious of my predisposition to complete unfinished thoughts or sentences, filling missing gaps or creating coherence in thought and narratives through my understanding of context, and my developing understanding of the participant's experiences. This was a process that came quite naturally to me, and I had to make a deliberate effort to allow the narrative clarity, detail, coherence, and structure to emerge naturalistically and collaboratively during NET sessions.

Finally, the NET therapist plays a crucial role in aiding the client's interpretation of the meaning of their experiences in the context of their lives. This is done through knowledge of NET theory,

principles, and key elements as well as the therapist's interpretation and meaning-making process of the client's experiences. As in IPA, this involves the double hermeneutic wherein the analysis is rooted in my interpretation of the participant's interpretation of their experiences. I embarked on the analysis during the sessions using the session case notes, while simultaneously co-constructing the participant's life stories throughout the sessions. Unlike one-session interviews, it is natural to become invested in the life stories and meaning-making process over time. The crux of NET is based on storytelling; the participants were remarkable storytellers, and I found myself developing a keen interest in their life stories. Although some sessions contained distressing content, I found that my alternate role as the researcher kept me busy and grounded, thereby preventing me from emotionally engaging with the participants' experiences.

Overall, the NET study demonstrated to me the importance of being able to relate to the client in a meaningful way. My ability to communicate fluently with the participants and my *insider status* based on shared demographic and experiential identities contributed significantly to developing a positive therapeutic alliance. Undertaking the same research with the help of native language interpreters in an unfamiliar socio-cultural context and setting would likely pose a set of challenges that could impact the outcomes of both therapy and research. This is a critical point of reflection when designing and executing participatory research into therapeutic processes and outcomes in cross-cultural contexts.

Overall, undertaking this research has made me realise my political ideologies and shaped my career aspirations. I believe that I am a more well-rounded, informed, and sensitive clinical researcher and academic as a result of my engagement with this topic of study. My educational and professional background is in psychology and mental health, but I have come to appreciate the wider issues around socio-political justice, rights-based activism, and policy innovation during my studies. I have a stronger and deeper conviction in my beliefs and world views and feel better prepared to advocate for issues that are meaningful to me. I continue to remain focused on the safeguarding, empowerment, and rehabilitation of vulnerable populations with a focus on women from disadvantaged, low-resource contexts.

6.5 Conclusion

This research provides vital insight into the lived experiences of DV among south Indian women survivors, with a focus on the psychopathological consequences of exposure to various forms of DV

and abuse. The findings from the IPA study demonstrated that the social and structural disempowerment of women in the Indian context exacerbates the vulnerable position of DV survivors and hinder help-seeking and disclosure of abuse. Women endure long-term abuse for a variety of reasons including but not restricted to financial dependency and coercion, shame and societal stigma, and guilt. These findings contributed to understanding the social determinants of DV in this socio-cultural context. They were explored through the lens of feminist theory, socio-ecological theory, and the theory of interlocking systems of domination, which suggest multiple social factors contribute to the experience and perpetration of DV in this context. These include, but are not restricted to gender inequalities, male-dominated, patriarchal systems, social class and intergenerational hierarchies, and societal stigma surrounding the issue of DV. A deeper understanding of these issues has far-reaching implications for the development of culturally sensitive, ecologically valid, acceptable rehabilitation services for DV survivors in India.

There are crucial knowledge and research gaps in the treatment of mental health conditions resulting from abuse in this socio-cultural context. An important focus of this thesis was on evaluating the evidence base of NET using meta-analytic techniques. An analysis of the evidence base for NET shows that it significantly alleviates symptoms of PTSD over time, but the quality of evidence was low-to-moderate. Trials were underpowered and highly heterogeneous, and caution is recommended when interpreting pooled intervention effects. The need for qualitative, idiographic studies to supplement the findings from RCTs was highlighted as an important source of information regarding the efficacy of psychotherapy.

To subvert the overreliance on nomothetic RCT designs in understanding psychotherapeutic effects, NET was administered to a group of DV survivors in south India to gain an in-depth understanding of recovery mechanisms. Using a theory-informed TA, a framework of recovery through NET was developed. The framework highlighted how the main aims of NET such as activation and habituation to trauma memories and the re-construction of the autobiographical memories were achieved through a range of interconnected, vital processes. These included the importance of developing a narrative through anecdotal reliving, attributing time and space context to trauma memories, activating multiple levels of processing, and cognitive re-evaluation of thoughts and beliefs. The analysis also uncovered the importance of reliving positive memories and planning for the future as vital for recovery. The theoretical and methodological implications of these findings were discussed, with a focus on

undertaking process research in psychotherapy to augment efficacy data from RCTs, and inform 'real-world', clinical settings more appropriately.

Finally, NET was analysed through the lens of the Contextual Model of psychotherapy, which proposes the importance of common factors as important to effecting recovery and argues against the reliance of specific factors that are considered unique to therapeutic models. There are important implications from this research for the development of culturally sensitive recovery and rehabilitation services for DV survivors. There is a need to strategically plan empowerment-based programmes that consider indigenous cultural practices and the social and community context of DV. At the same time, addressing the mental health needs of survivors through individual, trauma-focused treatments is important.

This research has contributed to a better understanding of NET and its benefits for treating trauma populations in diverse settings. It has also addressed crucial research and knowledge gaps in the understanding of DV and its psychopathological consequences in the south Indian socio-cultural context. Together, these findings have made vital recommendations for improving rehabilitation and recovery service development for survivors DV and abuse in this setting, with an aim for naturalistic generalisation and transferability to other settings and cultural contexts.

References

Adenauer, H., Catani, C., Gola, H., Keil, J., Ruf, M., Schauer, M., & Neuner, F. (2011). Narrative exposure therapy for PTSD increases top-down processing of aversive stimuli--evidence from a randomized controlled treatment trial. *BMC Neuroscience*, *12*(1), 127.

Ahmed-Ghosh, H. (2004). Chattels of Society: Domestic Violence in India. *Violence Against Women*, *10*(1), 94–118.

Ahuja, R. C., Bangdiwala, S., Bhambal, S. S., Jain, D., Jeyaseelan, L., Kumar, S., Lakshman, M., Mitra, M. K., Nair, M. K. C., Pillai, R., Peedicayal, A., Sadowski, L., Suresh, S., & Upadhyaya, A. K. (2000). *Domestic Violence in India: A Summary Report of a Multi-Site Household Survey*.

Ainsworth, M. D. S. (2014). *Patterns of attachment : a psychological study of the strange situation* (M. D. S. Ainsworth (Ed.)) [Book]. Psychology Press.

Alghamdi, M., Hunt, N., & Thomas, S. (2015). The effectiveness of Narrative Exposure Therapy with traumatised firefighters in Saudi Arabia: A randomized controlled study. *Behaviour Research and Therapy*, *66*, 64–71.

AlHadethe, A., Hunt, N., Al-Qaysi, G., & Thomas, S. (2015). Randomised Controlled Study Comparing Two Psychological Therapies for Posttraumatic Stress Disorder (PTSD): Emotional Freedom Techniques (EFT) vs. Narrative Exposure Therapy (NET). *Journal of Traumatic Stress Disorders & Treatment*, *04*(04).

Allen, M. (2011). Violence and voice: Using a feminist constructivist grounded theory to explore women's resistance to abuse. *Qualitative Research*, *11*(1), 23–45.]

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders (3rd ed.)* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders (3rd ed., rev.)* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)* (4th ed.). American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th*

ed., text rev.) (p. 943). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. American Psychiatric Association.

American Psychological Association (APA). (2017). *Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD)*. https://www.apa.org/ptsd-guideline/ptsd.pdf

American Psychological Association (APA). (2019). *Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts*.

Andrews, B., Brewin, C. R., & Rose, S. (2003). Gender, social support, and PTSD in victims of violent crime. *Journal of Traumatic Stress*, *16*(4), 421–427.

Ashworth, P. (2008). Conceptual Foundations of Qualitative Psychology. In J. A. Smith (Ed.), *Qualitative psychology: a practical guide to research methods* (pp. 4–25). SAGE Publications: London, England.

Asukai, N., Kato, H., Kawamura, N., Kim, Y., Yamamoto, K., Kishimoto, J., Miyake, Y., & Nishizono-Maher, A. (2002). Reliability and validity of the Japanese-language version of the Impact of Event Scale-Revised (IES-R-J): Four studies of different traumatic events. *Journal of Nervous and Mental Disease*, *190*(3), 175–182.

Audrey, S., Holliday, J., Parry-Langdon, N., & Campbell, R. (2006). Meeting the challenges of implementing process evaluation within randomized controlled trials: The example of ASSIST (A Stop Smoking in Schools Trial). *Health Education Research*, *21*(3), 366–377.

Babu, B. V., & Kar, S. K. (2009). Domestic violence against women in eastern India: A population-based study on prevalence and related issues. *BMC Public Health*, *9*(1), 129.

Bandura, A. (1997). *Self-efficacy: The exercise of control. - PsycNET*. Freeman. https://psycnet.apa.org/record/1997-08589-000

Banerjee, K., & Bloom, P. (2015). “Everything Happens for a Reason”: Children’s Beliefs About Purpose in Life Events. *Child Development*, *86*(2), 503–518.

Barlow, D. H. (2004). Psychological treatments. *American Psychologist*, *59*(9), 869–878.

Barn, R., & Kumari, V. (2015). Understanding Complainant Credibility in Rape Appeals: A Case Study

of High Court Judgments and Judges' Perspectives in India. *British Journal of Criminology*, *55*(3), 435–453.

Barnett, O. W. (2000). Why Battered Women Do Not Leave, Part 1: External Inhibiting Factors Within Society. *Trauma, Violence, & Abuse*, *1*(4), 343–372.

Barone, T., & Eisner, E. W. (2012). Arts based research. In *Arts Based Research*.

BBC News. (2013). *Is Indian storytelling a dying art?* BBC News. https://www.bbc.com/news/world-asia-india-21651933

Beck, A., Steer, R., & Brown, G. (1996). *Manual for the beck depression inventory-II*.

Beck, J. G., Grant, D. M. M., Read, J. P., Clapp, J. D., Coffey, S. F., Miller, L. M., & Palyo, S. A. (2008). The Impact of Event Scale-Revised: Psychometric properties in a sample of motor vehicle accident survivors. *Journal of Anxiety Disorders*, *22*(2), 187–198.

Becker, C. B., & Zayfert, C. (2001). Integrating DBT-Based Techniques and Concepts to Facilitate Exposure Treatment for PTSD. *Cognitive and Behavioral Practice*, *8*, 107–122.

Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy*, *42*(3), 277–292.

Bedard-Gilligan, M., & Zoellner, L. A. (2012). Dissociation and memory fragmentation in post-traumatic stress disorder: An evaluation of the dissociative encoding hypothesis. In *Memory* (Vol. 20, Issue 3, pp. 277–299).

Bedard-Gilligan, M., Zoellner, L. A., & Feeny, N. C. (2017). Is Trauma Memory Special? Trauma Narrative Fragmentation in PTSD. *Clinical Psychological Science*, *5*(2), 212–225.

Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: a meta-analysis of direct comparisons. *Clinical Psychology Review*, *28*(5), 746–758.

Bergin, A. E. (1997). Neglect of the therapist and the human dimensions of change: A commentary. In *Clinical Psychology: Science and Practice* (Vol. 4, Issue 1, pp. 83–89).

Berntsen, D., & Rubin, D. C. (2006). The centrality of event scale: A measure of integrating a trauma into one's identity and its relation to post-traumatic stress disorder symptoms. *Behaviour*

Research and Therapy, *44*(2), 219–231.

Berntsen, D., & Rubin, D. C. (2014). Involuntary memories and dissociative amnesia: Assessing key assumptions in posttraumatic stress disorder research. *Clinical Psychological Science*, *2*(2), 174–186.

Bewley, S., & Welch, J. (Eds.). (2014a). *ABC of domestic and sexual violence*. John Wiley & Sons.

Bewley, S., & Welch, J. (2014b). *ABC of domestic and sexual violence*. John Wiley & Sons.

Bhat, R. M., & Rangaiah, B. (2015). Exposure to Armed Conflict and Prevalence of Posttraumatic Stress Symptoms among Young Adults in Kashmir, India. *Journal of Aggression, Maltreatment and Trauma*, *24*(7), 740–752.

Bhugra, D., & Mastrogianni, A. (2004). Globalisation and mental disorders: Overview with relation to depression. *British Journal of Psychiatry*, *184*(JAN.), 10–20.

Bhushan, B., & Kumar, J. S. (2012). A study of posttraumatic stress and growth in tsunami relief volunteers. *Journal of Loss and Trauma*, *17*(2), 113–124.

Bhushan, B., & Sathya Kumar, J. (2007). Emotional distress and posttraumatic stress in children surviving the 2004 tsunami. *Journal of Loss and Trauma*, *12*(3), 245–257.

Bichescu, D., Neuner, F., Schauer, M., & Elbert, T. (2007). Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression. *Behaviour Research and Therapy*, *45*(9), 2212–2220.

Bienvenu, O. J., Friedman, L. A., Colantuoni, E., Dinglas, V. D., Sepulveda, K. A., Mendez-Tellez, P., Shanholz, C., Pronovost, P. J., & Needham, D. M. (2018). Psychiatric symptoms after acute respiratory distress syndrome: a 5-year longitudinal study. *Intensive Care Medicine*, *44*(1), 38–47.

Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, *13*(2).

Bjelland, I., Dahl, A. A., Haug, T. T., & Neckelmann, D. (2002). The validity of the Hospital Anxiety and Depression Scale: An updated literature review. *Journal of Psychosomatic Research*, *52*(2),

69–77.

Blaikie, N. W. H. (1991). A critique of the use of triangulation in social research. *Quality and Quantity*, *25*(2), 115–136.

Blankenship, D. M. (2017). Five Efficacious Treatments for Posttraumatic Stress Disorder: An Empirical Review. *Journal of Mental Health Counseling*, *39*(4), 275–288.

Bloom, D. E., & Reddy, P. H. (1986). Age patterns of women at marriage, cohabitation, and first birth in India. *Demography*, *23*(4), 509–523.

Borah, E. V. (2015, January). Military Behavioral Health Providers' Attitudes and Use of Evidence-Based Treatments for PTSD. *18th Annual Conference of the Society for Social Work and Research:*

Bowlby, J. (1969). *Attachment and loss.* (E. Institute of Psycho-analysis (London (Ed.)) [Book]. Hogarth Press.

Boyatzis, R. E. (1998). *Transforming qualitative information : thematic analysis and code development* [Book]. Sage Publications.

Bracken, P., Giller, J. E., & Summerfield, D. (1997). Rethinking Mental Health Work with Survivors of Wartime Violence and Refugees. *Journal of Refugee Studies*, *10*(4), 431–442.

Bracken, P. J. (2001). Post-modernity and post-traumatic stress disorder. *Social Science & Medicine*, *53*, 733–743.

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta- analysis of psychotherapy for PTSD. In *American Journal of Psychiatry* (Vol. 162, pp. 214–227).

Bradley, T. (2011). Religion and Gender in the Developing World. In Religion and Gender in the Developing World (2nd ed.). I. B. Tauris.

Brady, K. T. (1997). Posttraumatic stress disorder and comorbidity: Recognizing the many faces of PTSD. *Journal of Clinical Psychiatry*, *58*(SUPPL. 9), 12–15.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. In *Qualitative Research in*

Sport, Exercise and Health (Vol. 11, Issue 4, pp. 589–597).

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2018). Thematic analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health and social sciences.* Springer.

Breslau, N. (2002). Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *47*(10), 923–929.

Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, *48*(3), 216–222.

Brewin, C. R., Andrews, B., & Rose, S. (2000). Fear, helplessness, and horror in posttraumatic stress disorder: Investigating DSM-IV criterion A2 in victims of violent crime. *Journal of Traumatic Stress*, *13*(3), 499–509.

Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review*, *103*(4), 670–686.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review*, *23*(3), 339–376.

Brislin, R. W. (1970). Back-translation for cross-cultural research. *Journal of Cross-Cultural Psychology*, *1*(3), 185–216.

Brislin, R. W. (1973). *Cross-cultural research methods* (W. J. Lonner & R. M. Thorndike (Eds.)) [Book]. Wiley.

Bryant, R. A., & Harvey, A. G. (1995). Avoidant coping style and post-traumatic stress following motor vehicle accidents. *Behaviour Research and Therapy*, *33*(6), 631–635.

Bryman, A., & Bell, E. (2003). Breaking down the quantitative/qualitative divide. In *Business Research Methods*. Oxford University Press.

Busby, C. (1999). Agency, power and personhood: Discourses of gender and violence in a fishing community in south India. *Critique of Anthropology*, *19*(3), 227–248.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-

behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*(1), 17–31.

Buunk, B. P., Oldersma, F. L., & De Dreu, C. K. W. (2001). Enhancing satisfaction through downward comparison: The role of relational discontent and individual differences in social comparison orientation. *Journal of Experimental Social Psychology*, *37*(6), 452–467.

Cahill, S. E., & Foa, E. B. (2004). A Glass Half Empty or Half Full? Where We Are and Directions for Future Research in the Treatment of PTSD. *Advances in the Treatment of Posttraumatic Stress Disorder: Cognitive-Behavioral Perspectives.*, 267–313.

Campbell, J. C. (1992). Wife-Battering: Cultural contexts versus western social sciences. In *Sanctions and Sanctuary: Cultural Perspectives on the Beating of Wives* (pp. 229–249). Taylor and Francis.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, *359*(9314), 1331–1336.

Candel, I., & Merckelbach, H. (2004). *Peritraumatic Dissociation as a Predictor of Post-traumatic Stress Disorder: A Critical Review*.

Cascardi, M., & O'Leary, K. D. (1992). Depressive symptomatology, self-esteem, and self-blame in battered women. *Journal of Family Violence*, *7*(4), 249–259.

Cascardi, M., O'Leary, K. D., & Schlee, K. A. (1999). Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *Journal of Family Violence*, *14*(3), 227–249.

Catani, C., Mahendran, K., Ruf, M., Schauer, E., Elbert, T., & Neuner, F. (2009). Treating children traumatized by war and Tsunami: A comparison between exposure therapy and meditation-relaxation in North-East Sri Lanka. *BMC Psychiatry*, *9*(1), 22.

Chadda, R. K., & Malhotra, A. (2006). An experience of provision of psychiatric services in the earthquake-affected area of Kashmir. *International Psychiatry*, *3*(3), 3–5.

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. In *Indian Journal of Psychiatry* (Vol. 55, Issue SPEC. SUPPL., p. S299). Wolters Kluwer -- Medknow Publications.

Chadda, R. K, Malhotra, A., Kaw, N., Singh, J., & Sethi, H. (2007). Mental health problems following the 2005 earthquake in Kashmir: Findings of community-run clinics. In *Prehospital and Disaster Medicine* (Vol. 22, Issue 6, pp. 541–545).

Chan, K. S., Aronson Friedman, L., Bienvenu, O. J., Dinglas, V. D., Cuthbertson, B. H., Porter, R., Jones, C., Hopkins, R. O., & Needham, D. M. (2016). Distribution-based estimates of minimal important difference for hospital anxiety and depression scale and impact of event scale-revised in survivors of acute respiratory failure. *General Hospital Psychiatry*, *42*, 32–35.

Chandra, P. S., Deepthivarma, S., Carey, M. P., Carey, K. B., & Shalinianant, M. P. (2003). A Cry from the Darkness: Women with Severe Mental Illness in India Reveal Their Experiences with Sexual Coercion. *Psychiatry*, *66*(4), 323–334.

Chandra, P. S., Satyanarayana, V. A., & Carey, M. P. (2009). Women reporting intimate partner violence in India: Associations with PTSD and depressive symptoms. *Archives of Women's Mental Health*, *12*(4), 203–209.

Chapman, A., & Monk, C. (2015). Domestic Violence Awareness. *American Journal of Psychiatry*, *172*(10), 944–945.

Charak, R., & Koot, H. M. (2014). Abuse and neglect in adolescents of Jammu, india: The role of gender, family structure, and parental education. *Journal of Anxiety Disorders*, *28*(6), 590–598.

Childress, S. (2013). A meta-summary of qualitative findings on the lived experience among culturally diverse domestic violence survivors. *Issues in Mental Health Nursing*, *34*(9), 693–705.

Chowdhary, N., & Patel, V. (2008). The effect of spousal violence on women's health: Findings from the Stree Arogya Shodh in Goa, India. *Journal of Postgraduate Medicine*, *54*(4), 306–312.

Cienfuegos, A. J., & Monelli, C. (1983). The testimonhy of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry*, *53*(1), 43–51.

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling and Psychotherapy Research*, *18*(2), 107–110.

Clohessy, S., & Ehlers, A. (1999). PTSD symptoms, response to intrusive memories and coping in ambulance service workers. *The British Journal of Clinical Psychology / the British Psychological Society*, *38 (Pt 3)*, 251–265.

Cloitre, M. (2009). Effective psychotherapies for posttraumatic stress disorder: A review and critique. In *CNS Spectr* (Vol. 14, Issue 1).

Cloitre, M., Stolbach, B. C., Herman, J. L., Van Der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex ptsd: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, *22*(5), 399–408.

Cochrane Library. (2019). *Risk of Bias 2 (RoB 2) tool | Cochrane Methods*. https://methods.cochrane.org/risk-bias-2

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, *20*(1), 37–46.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). Treating trauma and traumatic grief in children and adolescents. In *Treating trauma and traumatic grief in children and adolescents.* Guilford Press.

Coid, J., Petruckevitch, A., Chung, W. S., Richardson, J., Moorey, S., & Feder, G. (2003). Abusive experiences and psychiatric morbidity in women primary care attenders. *British Journal of Psychiatry*, *183*(OCT.), 332–339.

Condino, V., Tanzilli, A., Speranza, A. M., & Lingiardi, V. (2016). Therapeutic interventions in intimate partner violence: an overview. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *19*(2).

Contractor, A. A., Mehta, P., Tiamiyu, M. F., Hovey, J. D., Geers, A. L., Charak, R., Tamburrino, M. B., & Elhai, J. D. (2014). Relations between PTSD and distress dimensions in an Indian child/adolescent sample following the 2008 Mumbai terrorist attacks. *Journal of Abnormal Child Psychology*, *42*(6), 925–935.

Conway, M. A. (2001). Sensory-perceptual episodic memory and its context: Autobiographical memory. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *356*(1413), 1375–1384.

Conway, M. A., & Pleydell-Pearce, C. W. (2000). The construction of autobiographical memories in the self-memory system. *Psychological Review*, *107*(2), 261–288.

Cook, J. M., Schnurr, P. P., & Foa, E. B. (2004). Bridging the gap between posttraumatic stress

disorder research and clinical practice: The example of exposure therapy. In *Psychotherapy* (Vol. 41, Issue 4, pp. 374–387).

Cooper, A. A., Clifton, E. G., & Feeny, N. C. (2017). An empirical review of potential mediators and mechanisms of prolonged exposure therapy. In *Clinical Psychology Review* (Vol. 56, pp. 106–121). Elsevier Inc.

Counts, D. A., Brown, J. K., & Campbell, J. C. (2019). Sanctions and sanctuary: Cultural perspectives on the beating of wives. In *Sanctions and Sanctuary: Cultural Perspectives on the Beating of Wives*. Taylor and Francis.

Coyne, I. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing*, *26*(3), 623–630.

Crabtree, B., & Miller, W. (1999). A template approach to text analysis: Developing and using codebooks. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed., pp. 163–177). Sage Publications.

Creamer, M., Bell, R., & Failla, S. (2003). Psychometric properties of the Impact of Event Scale - Revised. *Behaviour Research and Therapy*, *41*(12), 1489–1496.

Crescenzi, A., Ketzer, E., Van Ommeren, M., Phuntsok, K., Komproe, I., & de Jong, J. T. V. M. (2002). Effect of political imprisonment and trauma history on recent tibetan refugees in india. *Journal of Traumatic Stress*, *15*(5), 369–375.

Creswell, J. W., Fetters, M. D., & Ivankova, Nataliya, V. (2004). Designing a mixed methods study in primary care. *Annals of Family Medicine*, *2*(1), 7–12.

Crime in India 2013. (2013). http://ncrb.nic.in/StatPublications/CII/CII2013/Statistics-2013.pdf

Crits-Christoph, P., Baranackie, K., Kurcias, J., Beck, A., Carroll, K., Perry, K., Luborsky, L., Mclellan, A., Woody, G., Thompson, L., Gallagher, D., & Zitrin, C. (1991). Meta-analysis of therapist effects in psychotherapy outcome studies. *Psychotherapy Research*, *1*(2), 81–91.

Crombach, A., & Elbert, T. (2015). Controlling Offensive Behavior Using Narrative Exposure Therapy. *Clinical Psychological Science*, *3*(2), 270–282.

Crombach, A., & Siehl, S. (2018). Impact and cultural acceptance of the Narrative Exposure Therapy

in the aftermath of a natural disaster in Burundi. *BMC Psychiatry*, *18*(1), 233.

Meichenbaum, D. (1975). A self-instructional approach to stress management: A proposal for stress inoculation training. In C. Spielberger & I. Sarason (Eds.), *Stress and Anxiety in Modern Life*. Winston.

Dar, K. A., Iqbal, N., Prakash, A., & Paul, M. A. (2018). PTSD and depression in adult survivors of flood fury in Kashmir: The payoffs of social support. *Psychiatry Research*, *261*(January), 449–455.

Darnell, S. C., Chawansky, M., Marchesseault, D., Holmes, M., & Hayhurst, L. (2018). The State of Play: Critical sociological insights into recent 'Sport for Development and Peace' research. *International Review for the Sociology of Sport*, *53*(2), 133–151.

Deaton, A., & Cartwright, N. (2018). Understanding and misunderstanding randomized controlled trials. *Social Science and Medicine*, *210*, 2–21.

Decker, M. R., Nair, S., Saggurti, N., Sabri, B., Jethva, M., Raj, A., Donta, B., & Silverman, J. G. (2013). Violence-related coping, help-seeking and health care-based intervention preferences among perinatal women in Mumbai, India. *Journal of Interpersonal Violence*, *28*(9), 1924–1947.

Department of Veterans Affairs and Department of Defense (VA/DoD). (2017). Management of posttraumatic stress disorder and acute stress disorder. In *Department of Veterans Affairs and Department of Defense (VA/DoD)* (Vol. 1).

Depaulo, B. M., Lindsay, J. J., Malone, B. E., Muhlenbruck, L., Charlton, K., & Cooper, H. (2003). Cues to deception. *Psychological Bulletin, 129(1),* 74-118.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science*, *19*(1), 1–15.

Descilo, T., Vedamurtachar, A., Gerbarg, P. L., Nagaraja, D., Gangadhar, B. N., Damodaran, B., Adelson, B., Braslow, L. H., Marcus, S., & Brown, R. P. (2010). Effects of a yoga breath intervention alone and in combination with an exposure therapy for post-traumatic stress disorder and depression in survivors of the 2004 South-East Asia tsunami. *Acta Psychiatrica Scandinavica*, *121*(4), 289–300.

Devilly, G. J., & McFarlane, A. C. (2009). When wait lists are not feasible, nothing is a thing that does

not need to be done. *Journal of Consulting and Clinical Psychology*, *77*(6), 1159–1168.

Dias, A., & Patel, V. (2009). Closing the treatment gap for dementia in India. *Indian Journal of Psychiatry*, *51 Suppl 1*(Suppl1), S93-7.

Dickersin, K., Chan, S., Chalmersx, T. C., Sacks, H. S., & Smith, H. (1987). Publication bias and clinical trials. *Controlled Clinical Trials*, *8*(4), 343–353.

Doshi, P., Dickersin, K., Healy, D., Vedula, S. S., & Jefferson, T. (2013). Restoring invisible and abandoned trials: A call for people to publish the findings. *BMJ (Online)*, *346*(7913).

Dunmore, E., Clark, D. M., & Ehlers, A. (1999). Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy*, *37*(9), 809–829.

Dunmore, E., Clark, D. M., & Ehlers, A. (2001). A prospective investigation of the role of cognitive factors in persistent Posttraumatic Stress Disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy*, *39*(9), 1063–1084.

Duxbury, F. (2006). Recognising domestic violence in clinical practice using the diagnoses of posttraumatic stress disorder, depression and low self-esteem. *British Journal of General Practice*, *56*(525), 294–300.

Dyson, T., & Moore, M. (1983). On kinship structure, female autonomy, and demographic behavior in India. Population & Development Review, 9(1), 35–60.

Egger, M., Davey Smith, G., Schneider, M., & Minder, C. (1997). Bias in meta-analysis detected by a simple, graphical test. *BMJ (Clinical Research Ed.)*, *315*(7109), 629–634.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345.

Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., Fennell, M., Herbert, C., & Mayou, R. (2003). A randomized controlled trial of cognitive therapy, a self-help booklet, and repeated assessments as early interventions for posttraumatic stress disorder. *Archives of General Psychiatry*, *60*(10), 1024–1032.

Ehlers, A., Clark1, D. M., Dunmore, E., Jaycox, L., Meadows, E., & Foa, E. B. (1998). Predicting

response to exposure treatment in PTSD: the role of mental defeat and alienation. In *Journal of Traumatic Stress* (Vol. 11, Issue 3).

Ehlers, A., Maercker, A., & Boos, A. (2000). Posttraumatic stress disorder following political imprisonment: The role of mental defeat, alienation, and perceived permanent change. *Journal of Abnormal Psychology*, *109*(1), 45–55.

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. *Social Science & Medicine (1982)*, *33*(6), 673–680.

Elbert, T., Schauer, M., & Neuner, F. (2015). Evidence based treatments for trauma-related psychological disorders. *Evidence Based Treatments for Trauma-Related Psychological Disorders*, *October 2017*.

Enright, R. D., & Fitzgibbons, R. P. (2000). *Helping clients forgive: An empirical guide for resolving anger and restoring hope*. *American Psychological Association.*

Epstein, J., Santo, R. M., & Guillemin, F. (2015). A review of guidelines for cross-cultural adaptation of questionnaires could not bring out a consensus. *Journal of Clinical Epidemiology*, *68*(4), 435–441.

Ertl, V., Pfeiffer, A., Schauer, E., Elbert, T., & Neuner, F. (2011). Community-implemented trauma therapy for former child soldiers in Northern Uganda: A randomized controlled trial. *JAMA - Journal of the American Medical Association*, *306*(5), 503–512.

Escobar, J. I. (1995). Transcultural aspects of dissociative and somatoform disorders. *Psychiatric Clinics of North America*, *18*(3), 555–569.

Evans, M. A., & Feder, G. S. (2016). Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support. Health Expectations, 19(1), 62–73.

Fensterheim, H., & Raw, S. D. (1996). Psychotherapy research is not psychotherapy practice. *Clinical Psychology: Science and Practice*, *3*(2), 168–171.

Fernandez, M. (1997). Domestic violence by extended family members in India: Interplay of gender and generation. *Journal of Interpersonal Violence*, *12*(3), 433–455.

Festinger, L. (1954). A Theory of Social Comparison Processes. *Human Relations*, *7*(2), 117–140.

Finlay, L. (2002a). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*(2), 209–230.

Finlay, L. (2002b). “Outing” the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531–545.

Finlay, L. (2014). Qualitative methodologies. In A. Vossler & N. Moller (Eds.), In *The counselling & psychotherapy research trainee handbook*. SAGE.

Foa, E. B. (1997). Psychological processes related to recovery from a trauma and an effective treatment for PTSD. In *Psychobiology of posttraumatic stress disorder.* (pp. 410–424). New York Academy of Sciences.

Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment*, *9*(4), 445–451.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences. New York: Oxford University Press.

Foa, E. B., Huppert, J. D., & Cahill, S. P. (2006). Emotional processing theory: An update. In *Pathological anxiety: Emotional processing in etiology and treatment.* (pp. 3–24). The Guilford Press.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear. exposure to corrective information. In *Psychological Bulletin* (Vol. 99, Issue 1, pp. 20–35).

Foa, E. B., & Meadows, E. A. (1997). Psychosocial treatments for posttraumatic stress disorder: A critical review. *Annual Review of Psychology*, *48*(1), 449–480.

Foa, E. B., Molnar, C., & Cashman, L. (1995). Change in rape narratives during exposure therapy for posttraumatic stress disorder. *Journal of Traumatic Stress*, *8*(4), 675–690.

Foa, E. B., & Riggs, D. S. (1993). Post-traumatic stress disorder in rape victims. In John M. Oldham, Michelle B. Riba, & Allan Tasman (Eds.), *American Psychiatric Press Review of Psychiatry* (Vol. 12, pp. 273–303). American Psychiatric Association Publishing.

Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress*, *6*(4), 459–473.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape : cognitive-behavioral therapy for PTSD*. Guilford Press.

Foa, E. B., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. In *Journal of Consulting and Clinical Psychology* (Vol. 59, Issue 5, pp. 715–723). American Psychological Association.

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualizations of post-traumatic stress disorder. *Behavior Therapy*, *20*(2), 155–176.

Foa, E. B., & Tolin, D. F. (2000). Comparison of the PTSD Symptom Scale-Interview Version and the Clinician-Administered PTSD Scale. *Journal of Traumatic Stress*, *13*(2), 181–191.

Follingstad, D. R., Hause, E. S., Rutledge, L. L., & Polek, D. S. (1992). Effects of battered women's early responses on later abuse patterns. *Violence and Victims*, *7*(2), 109–128.

Foran, H. M., & O'Leary, K. D. (2008). Alcohol and intimate partner violence: A meta-analytic review. *Clinical Psychology Review*, *28*(7), 1222–1234.

Foster, J. K., & Jelicic, M. (1999). *Debates in psychology.Memory: Systems, process, or function?* (J. K. Foster & M. Jelicic (Eds.)). Oxford University Press.

Fraley, R. C., & Shaver, P. R. (2000). Adult Romantic Attachment: Theoretical Developments, Emerging Controversies, and Unanswered Questions. Review of General Psychology, 4(2), 132–154.

Franco, A., Malhotra, N., & Simonovits, G. (2014). Publication bias in the social sciences: Unlocking the file drawer. *Science*, *345*(6203), 1502–1505.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Johns Hopkins University Press.

Frans, O., Rimmö, P. A., Åber, L., & Fredrikson, M. (2005). Trauma exposure and post-traumatic

stress disorder in the general population. *Acta Psychiatrica Scandinavica*, *111*(4), 291–290.

Freedman, S., & Enright, R. D. (2017). The use of forgiveness therapy with female survivors of abuse. *Journal of Womens Health Care*, *06*(03).

Friedman, M. J., Resick, P. A., Bryant, R. A., Strain, J., Horowitz, M., & Spiegel, D. (2011). Classification of trauma and stressor-related disorders in DSM-5. In *Depression and Anxiety* (Vol. 28, Issue 9, pp. 737–749).

Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help seeking: Implications for intervention. Violence Against Women, 11(3), 290–310.

Furukawa, T. A., Noma, H., Caldwell, D. M., Honyashiki, M., Shinohara, K., Imai, H., Chen, P., Hunot, V., & Churchill, R. (2014). Waiting list may be a nocebo condition in psychotherapy trials: A contribution from network meta-analysis. *Acta Psychiatrica Scandinavica*, *130*(3), 181–192.

Gangoli, G., & Rew, M. (2011). Mothers-in-law against daughters-in-law: Domestic violence and legal discourses around mother-in-law violence against daughters-in-law in India. *Women's Studies International Forum*, *34*(5), 420–429.

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*, *2*, 1260–1269.

García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., Montoya, O., Bhate-Deosthali, P., Kilonzo, N., & Watts, C. (2015). Addressing violence against women: A call to action. *The Lancet*, *385*(9978), 1685–1695.

Gerger, H., Munder, T., & Barth, J. (2014). Specific and nonspecific psychological interventions for PTSD symptoms: A meta-analysis with problem complexity as a moderator. *Journal of Clinical Psychology*, *70*(7), 601–615.

Ghosh, B. (2013). How does the legal framework protect victims of dowry and domestic violence in India? A critical review. *Aggression and Violent Behavior*, *18*(4), 409–416.

Gibbons, F. X., & Buunk, B. P. (1999). Individual differences in social comparison: Development of a scale of social comparison orientation. Journal of Personality and Social Psychology, 76(1), 129–142.

Gilmoor, A. R., Adithy, A., & Regeer, B. (2019). The cross-cultural validity of post-traumatic stress disorder and post-traumatic stress symptoms in the Indian context: A systematic search and review. In *Frontiers in Psychiatry* (Vol. 10, Issue July, p. 439). Frontiers.

Goldfried, M. R. (2015). On Possible Consequences of National Institute of Mental Health Funding for Psychotherapy Research and Training. *Professional Psychology: Research and Practice, 47*(1), 77–83.

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, *14*(2), 99–132.

Gómez de La Cuesta, G., Schweizer, S., Diehle, J., Young, J., & Meiser-Stedman, R. (2019). The relationship between maladaptive appraisals and posttraumatic stress disorder: a meta-analysis. In *European Journal of Psychotraumatology* (Vol. 10, Issue 1, p. 1620084). Taylor and Francis Ltd.

Gough, B. (2016). Reflexivity in qualitative psychological research. *Journal of Positive Psychology*. 12(3), 311–312.

Gray, M. J., & Lombardo, T. W. (2001). Complexity of trauma narratives as an index of fragmented memory in PTSD: A critical analysis. *Applied Cognitive Psychology*, *15*(7 Special Issue), 171–186.

Grey, N., Holmes, E., & Brewin, C. R. (2001). Peritraumatic emotional “hot spots” in memory. *Behavioural and Cognitive Psychotherapy*, *29*(3), 367–372.

Grey, N., Young, K., & Holmes, E. (2002). Empirically grounded clinical interventions section: Cognitive re-structuring within reliving: A treatment for peritraumatic emotional “hotspots” in posttraumatic stress disorder. *Behavioural and Cognitive Psychotherapy*, *30*(1), 37–56.

Griffin, A., & May, V. (2011). Narrative Analysis and Interpretative Phenomenologial Analysis. In C. Seale (Ed.), *Researching Society and Culture* (3rd ed., p. 183). SAGE Publications: London, England.

Grissom, R. J. (1996). The magical number .7 ± .2: Meta-meta-analysis of the probability of superior outcome in comparisons involving therapy, placebo, and control. *Journal of Consulting and Clinical Psychology*, *64*(5), 973–982.

Guolo, A., & Varin, C. (2017). Random-effects meta-analysis: The number of studies matters. *Statistical Methods in Medical Research*, *26*(3), 1500–1518.

Gururaj, G., Varghese, M., Benegal, V., Rao, G. N., Pathak, K., Singh, L. K., Mehta, R. Y., Ram, D., Mid, S. T., Kokane, A., RK, L. S., S, C. B., Sharma, P., Ramasubramanian, C., Dalal, P. K., Saha, P. K., Deuri, S. P., Giri, A. K., Kavishvar, A. B., … NMHS collaborators group. (2016). *National Mental Health Survey of India, 2015-2016: Prevalance, pattern and outcomes* (Vol. 129).

Gwozdziewycz, N., & Mehl-Madrona, L. (2013). Meta-Analysis of the Use of Narrative Exposure Therapy for the Effects of Trauma Among Refugee Populations. *The Permanente Journal*, *17*(1), 70–76.

Hackett, S., McWhirter, P. T., & Lesher, S. (2016). The Therapeutic Efficacy of Domestic Violence Victim Interventions. Trauma, Violence, and Abuse, 17(2), 123–132.

Hakmiller, K. L. (1966). Threat as a determinant of downward comparison. *Journal of Experimental Social Psychology*, *1*(SUPPL. 1), 32–39.

Halligan, S. L., Michael, T., Clark, D. M., & Ehlers, A. (2003). Posttraumatic stress disorder following assault: The role of cognitive processing, trauma memory, and appraisals. *Journal of Consulting and Clinical Psychology*, *71*(3), 419–431.

Halvorsen, J. Ø., & Stenmark, H. (2010). Narrative exposure therapy for posttraumatic stress disorder in tortured refugees: a preliminary uncontrolled trial. *Scandinavian Journal of Psychology*, *51*(6), 495–502.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry*, *23*, 56–62.

Hamilton, M. (1967). Development of a rating scale for primary depressive illness. *British Journal of Social and Clinical Psychology*, *6*(4), 278–296.

Hamner, M. B., Robert, S., & Frueh, B. C. (2004). Treatment-resistant posttraumatic stress disorder: Strategies for intervention. *CNS Spectrums*, *9*(10), 740–752.

Handsel, V. A. (2007). *Psychological variables in battered women's stay/leave decisions: risk-taking, perceived control, and optimistic bias*. University of North Carolina.

Hartsock, N. (1990). Foucault on power: A theory for women? In L. Nicholson (Ed.), *Feminism/Postmodernism*. Routledge.

Harvey, A. G., & Bryant, R. A. (1999). A qualitative investigation of the organization of traumatic memories. *British Journal of Clinical Psychology*, *38*(4), 401–405.

Harvey, A. G., Bryant, R. A., & Tarrier, N. (2003). Cognitive behaviour therapy for posttraumatic stress disorder. In *Clinical Psychology Review* (Vol. 23, Issue 3, pp. 501–522).

Hasan, Z. (2010). Gender, religion and democratic politics in India. *Third World Quarterly*, *31*(6), 939–954.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *52*(3), 511–524.

Hecker, T., Hermenau, K., Crombach, A., & Elbert, T. (2015). Treating traumatized offenders and veterans by means of narrative exposure therapy. *Frontiers in Psychiatry*, *6*(Jun), 80.

Hegarty, K., Bush, R., & Sheehan, M. (2005). The Composite Abuse Scale: Further development and assessment of reliability and validity of a multidimensional partner abuse measure in clinical settings. *Violence and Victims*, *20*(5), 529–547.

Hegarty, K., Sheehan, M., & Schonfeld, C. (1999). A multidimensional definition of partner abuse: Development and preliminary validation of the composite abuse scale. *Journal of Family Violence*, *14*(4), 399–415.

Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Woman*, *4*(3), 262–290.

Hellawell, S. J., & Brewin, C. R. (2004). A comparison of flashbacks and ordinary autobiographical memories of trauma: Content and language. *Behaviour Research and Therapy*, *42*(1), 1–12.

Helzer, J. E., Robins, L. N., & McEvoy, L. (1987). Post-Traumatic Stress Disorder in the general population: Findings from an epidemiological catchment area study. *The New England Journal of Medicine*, 1630–1634.

Hensel-Dittmann, D., Schauer, M., Ruf, M., Catani, C., Odenwald, M., Elbert, T., & Neuner, F. (2011). Treatment of traumatized victims of war and torture: A randomized controlled comparison of

narrative exposure therapy and stress inoculation training. *Psychotherapy and Psychosomatics*, *80*(6), 345–352.

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review*, *27*(3), 11–28.

Herman, J. (1997). *Trauma and Recovery: The Aftermath of Violence - From Domestic Abuse to Political Terror* (Vol. 53, Issue 9).

Herman, J. L. (1992). *Trauma and Recovery: The Aftermath of Violence*. Basic Books.

Hermenau, K., Hecker, T., Schaal, S., Maedl, A., & Elbert, T. (2013). Addressing post-traumatic stress and aggression by means of narrative exposure: A randomized controlled trial with ex-combatants in the eastern DRC. *Journal of Aggression, Maltreatment & Trauma*, *22*(8), 916–934.

Hester, M. (2013). Who does what to whom? Gender and domestic violence perpetrators in English police records. *European Journal of Criminology*, *10*(5), 623–637.

Higgins, J., & Green, S. (2011). Cochrane Handbook for Systematic Reviews of Interventions | Cochrane Training. In J. Higgins & S. Green (Eds.), *The Cochrane Collaboration*. https://training.cochrane.org/handbook

Higgins, J. P. T., Altman, D. G., Gøtzsche, P. C., Jüni, P., Moher, D., Oxman, A. D., Savović, J., Schulz, K. F., Weeks, L., & Sterne, J. A. C. (2011). The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. *BMJ (Online)*, *343*(7829).

Higgins, J. P., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M., & Welch, V. (2019). *Cochrane Handbook for Systematic Reviews of Interventions version 6.0 (updated July 2019)*. Cochrane, 2020. Available from www.training.cochrane.org/handbook.

Hijazi, A. M., Lumley, M. A., Ziadni, M. S., Haddad, L., Rapport, L. J., & Arnetz, B. B. (2014). Brief narrative exposure therapy for posttraumatic stress in iraqi refugees: A preliminary randomized clinical trial. *Journal of Traumatic Stress*, *27*, 314–322.

Hinsberger, M., Holtzhausen, L., Sommer, J., Kaminer, D., Elbert, T., Seedat, S., Augsburger, M., Schauer, M., & Weierstall, R. (2019). Long-term effects of psychotherapy in a context of continuous community and gang violence: Changes in aggressive attitude in high-risk South

African adolescents. *Behavioural and Cognitive Psychotherapy*, 48(1), 1–13.

Hinsberger, M., Holtzhausen, L., Sommer, J., Kaminer, D., Elbert, T., Seedat, S., Wilker, S., Crombach, A., & Weierstall, R. (2016). Feasibility and effectiveness of Narrative Exposure Therapy and Cognitive Behavioral Therapy in a context of psychological trauma : Theory, research, practice and policy. *Psychological Trauma: Theory, Research, Practice, and Policy*, *December*. https://doi.org/10.1037/tra0000197

Hinsberger, M., Holtzhausen, L., Sommer, J., Kaminer, D., Elbert, T., Seedat, S., Wilker, S., Crombach, A., & Weierstall, R. (2017). Feasibility and effectiveness of narrative exposure therapy and cognitive behavioral therapy in a context of ongoing violence in South Africa. *Psychological Trauma: Theory, Research, Practice, and Policy, 9(3),* 282-291.

Hinton, D. E., Lewis-Fernandez Lewis-Fernández, R., & Lewis-Fernández, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *Depression and Anxiety*, *28*(9), 783–801.

Hofstede, G. (1980). *Culture's Consequences: International Differences in Work-Related Values* (Vol. 5). SAGE Publications.

Holman, A., & Silver, R. C. (1998). Getting "stuck" in the past: temporal orientation and coping with trauma. *Journal of Personality and Social Psychology*, *74*(5), 1146–1163.

Home Affairs. (2018). *Domestic Abuse - Home Affairs Committee - House of Commons*. Home Affairs. https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/1015/101503.htm#_idTextAnchor000

hooks, b. (2015). *Talking Back: Thinking Feminist, Thinking Black*. Routledge. New York.

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine*, *41*(3), 209–218.

Houston, C. (2014). How feminist theory became (criminal) law: Tracing the path to mandatory criminal intervention in domestic violence cases. In *Michigan Journal of Gender and Law* (Vol. 21, Issue 217).

Howard, L. M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R., & Feder, G. (2013).

Domestic violence and severe psychiatric disorders: Prevalence and interventions. *Psychological Medicine*, *40(6*), 881-893.

Hughes, M., & Jones, L. (2000). Women, domestic violence, and posttraumatic stress disorder (PTSD). *Family Therapy*, *27*(3), 125.

Humphreys, C., & Thiara, R. (2003). Mental Health and Domestic Violence: "I Call it Symptoms of Abuse." *British Journal of Social Work*, *33*(2), 209–226.

Hurst, S., Arulogun, O. S., Owolabi, M. O., Akinyemi, R., Uvere, E., Warth, S., & Ovbiagele, B. (2015). Pretesting qualitative data collection procedures to facilitate methodological adherence and team building in Nigeria. *International Journal of Qualitative Methods*, *14*(2015), 53–64.

India Overview. (2019). The World Bank. https://www.worldbank.org/en/country/india/overview

Indian Council of Medical Research. (2000). *ICMR centre for advanced research on health consequences of earthquake disaster (Marathwada, 1993) with special reference to mental health.* Report submitted to ICMR, Pune, Maharashtra Institute of Mental Health. 2000.

International Center for Research on Women. (2000). *Domestic Violence in India: A Summary Report of Four Records Studies*. https://www.icrw.org/wp-content/uploads/2016/10/Domestic-Violence-in-India-2-A-Summary-Report-of-Four-Records-Studies.pdf

International Institute for Population Sciences. (2017). *National Family Health Survey (NFHS-4) 2015-16*. http://www.rchiips.org/nfhs

International Institute for Population Sciences, & Macro International. (1999). *National Family Health Survey (NFHS-2) 1998-1999*. http://www.nfhsindia.org

International Society for Traumatic Stress Studies (ISTSS). (2018). *Posttraumatic Stress Disorder Prevention and Treatment Guidelines Methodology and Recommendations*. http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_PreventionTreatmentGuidelines_FNL.pdf.aspx

Ishikawa, M., Yamamoto, N., Yamanaka, G., Suwa, K., Nakajima, S., Hozo, R., Norboo, T., Okumiya, K., Matsubayashi, K., & Otsuka, K. (2012). Disaster-related psychiatric disorders among survivors of flooding in Ladakh, India. *The International Journal of Social Psychiatry*, *59*(5), 468–473.

ITRHD. (2017). *Oral Traditions, Myths & Legends of India An ITRHD Publication*. www.itrhd.com

Jacob, N., Neuner, F., Maedl, A., Schaal, S., & Elbert, T. (2014). Dissemination of psychotherapy for trauma spectrum disorders in postconflict settings: A randomized controlled trial in Rwanda. *Psychotherapy and Psychosomatics*, *83*(6), 354–363.

Jain, D., Sanon, S., Sadowski, L., & Hunter, W. (2004). Violence against women in India: evidence from rural Maharashtra, India. *Rural Remote Health*, *4*(4). 304.

John, P. B., Russell, S., & Russell, P. S. S. (2007). The prevalence of posttraumatic stress disorder among children and adolescents affected by tsunami disaster in Tamil Nadu. *Disaster Management & Response: DMR : An Official Publication of the Emergency Nurses Association*, *5*, 3–7.

Johnson, D. M., Zlotnick, C., & Perez, S. (2011). Cognitive behavioral treatment of ptsd in residents of battered women's shelters: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *79*(4), 542–551.

Jones, D. S., & Podolsky, S. H. (2015). The history and fate of the gold standard. In *The Lancet* (Vol. 385, Issue 9977, 1502–1503). Lancet Publishing Group.

Jones, E. E., & Davis, K. E. (1965). From acts to dispositions the attribution process in person perception. *Advances in Experimental Social Psychology*, *2*(C), 219–266.

Jones, E., Vermaas, R. H., McCartney, H., Beech, C., Palmer, I., Hyams, K., & Wessely, S. (2003). Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *The British Journal of Psychiatry*, *182*(2), 158-163.

Jones, L., Hughes, M., & Unterstaller, U. (2001). Post-Traumatic Stress Disorder (PTSD) in victims of domestic violence: A review of the research. *Trauma, Violence, & Abuse*, *2*(2), 99–119.

Joshipura, M. K. (2008). Trauma Care in India: Current Scenario. *World Journal of Surgery*, *32*(8), 1613–1617.

Kakava, C. (2001). Discourse and conflict. In D. Schiffrin, D. Tannen, & H. E. Hamilton (Eds.), *The handbook of discourse analysis* (pp. 651–670). Blackwell.

Kalokhe, A., del Rio, C., Dunkle, K., Stephenson, R., Metheny, N., Paranjape, A., & Sahay, S. (2017).

Domestic violence against women in India: A systematic review of a decade of quantitative studies. *Global Public Health*, *12*(4), 498–513.

Kar, N, Jagadisha, M., Psychiatry, N. M.-K. J. of, & 2001, U. (2001). Post-traumatic stress disorder in children following disaster. *Kerala Journal of Psychiatry*, *16*(2), 7–14.

Kar, N. (2011). Cognitive behavioral therapy for the treatment of post-traumatic stress disorder: A review. In *Neuropsychiatric Disease and Treatment* (Vol. 7, Issue 1, pp. 167–181). Dove Press.

Kar, N., Krishnaraaj, R., & Rameshraj, K. (2014). Long-term mental health outcomes following the 2004 Asian tsunami disaster. *Disaster Health*, *2*(1), 35–45.

Kar, N., Mohapatra, P. K., Nayak, K. C., Pattanaik, P., Swain, S. P., & Kar, H. C. (2007). Post-traumatic stress disorder in children and adolescents one year after a super-cyclone in Orissa, India: exploring cross-cultural validity and vulnerability factors. *BMC Psychiatry*, *7*, 8. https://doi.org/10.1186/1471-244X-7-8

Kar, N., Sharma, P., Murali, N., & Mehrotra, S. (2004). Mental health consequences of the trauma of super-cyclone 1999 in orissa. *Indian Journal of Psychiatry*, *46*(3), 228–22837.

Kardiner, A. (1941). The traumatic neuroses of war. In *National Research Council* (Vol. 369, Issue 1). Hoeber.

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.

Kawamura, N., Kim, Y., & Asukai, N. (2001). Suppression of cellular immunity in men with a past history of posttraumatic stress disorder. *American Journal of Psychiatry*, *158*(3), 484–486.

Kaysen, D., Resick, P. A., & Wise, D. (2003). Living in danger: The impact of chronic traumatization and the traumatic context on posttraumatic stress disorder. *Trauma, Violence & Abuse*, *4*(3), 247–264.

Kayser, K., Wind, L., & Shankar, R. A. (2008). Disaster relief within a collectivistic context: Supporting resilience after the tsunami in South India. *Journal of Social Service Research*, *34*(3), 87–98.

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. In *Annual Review of Clinical Psychology* (Vol. 3, pp. 1–27).

Kelley, H. H. (1967). Attribution theory in social psychology. -. In *Nebraska Symposium on Motivation* (Vol. 15, pp. 192–238).

Kermode, M., Herrman, H., Arole, R., White, J., Premkumar, R., & Patel, V. (2007). Empowerment of women and mental health promotion: A qualitative study in rural Maharashtra, India. *BMC Public Health*, *7*, 225.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic Stress Disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, *52*(12), 1048–1060.

Kidder, L. H., & Fine, M. (1987). Qualitative and quantitative methods: When stories converge. *New Directions for Program Evaluation*, *1987*(35), 57–75.

Kimuna, S. R., Djamba, Y. K., Ciciurkaite, G., & Cherukuri, S. (2013). Domestic violence in India: insights from the 2005-2006 national family health survey. *Journal of Interpersonal Violence*, *28*(4), 773–807.

Kirmayer, L. J. (2005). Culture, Context and Experience in Psychiatric Diagnosis. *Psychopathology*, *38*(4), 192–196.

Köbach, A., Schaal, S., Hecker, T., & Elbert, T. (2017). Psychotherapeutic intervention in the demobilization process: Addressing combat-related mental injuries with narrative exposure in a first and second dissemination stage. *Clinical Psychology and Psychotherapy*, *24*(4), 807–825.

Kornblit, A. L. (1994). Domestic violence-An emerging health issue. *Social Science and Medicine*, *39*(9), 1181–1188.

Koss, M. P., Figueredo, A. J., Bell, I., Tharan, M., & Tromp, S. (1996). Traumatic memory characteristics: A cross-validated mediational model of response to rape among employed women. *Journal of Abnormal Psychology*, *105*(3), 421–432.

Krans, J., Peeters, M., Näring, G., Brown, A. D., Bree, J. de, & B, A. van M. (2017). Examining temporal alterations in Social Anxiety Disorder and Posttraumatic Stress Disorder: The relation between autobiographical memory, future goals, and current self-views. *Journal of Anxiety Disorders*, Dec;52, 34-42

Krishnamoorthy, Y., Ganesh, K., & Vijayakumar, K. (2020). Physical, emotional and sexual violence

faced by spouses in India: evidence on determinants and help-seeking behaviour from a nationally representative survey. *Journal of Epidemiology and Community Health, 74(9),* 732-740

Krishnan, S., Subbiah, K., Khanum, S., Chandra, P. S., & Padian, N. S. (2012). An intergenerational women's empowerment intervention to mitigate domestic violence: results of a pilot study in Bengaluru, India. *Violence Against Women, 18(3),* 346–370.

Krishnaraj, M. (2007, November). Understanding violence against women. *Economic & Political Weekly*, *42*(44), 90–91.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., Lozano, R. et al. (2002). *World report on violence and health /* edited by Etienne G. Krug ... [et al.]. World Health Organization. https://apps.who.int/iris/handle/10665/42495

Kubany, E. S., Hill, E. E., & Owens, J. A. (2003). Cognitive trauma therapy for battered women with PTSD: preliminary findings. Journal of Traumatic Stress, 16(1), 81–91.

Kubany, E. S., Hill, E. E., Owens, J. A., Iannce-Spencer, C., McCaig, M. A., Tremayne, K. J., & Williams, P. L. (2004). Cognitive Trauma Therapy for Battered Women with PTSD (CTT-BW). Journal of Consulting and Clinical Psychology, 72(1), 3–18.

Kumar, M. S., Murhekar, M. V., Hutin, Y., Subramanian, T., Ramachandran, V., & Gupte, M. D. (2007a). Prevalence of posttraumatic stress disorder in a coastal fishing village in Tamil Nadu, India, after the December 2004 tsunami. *American Journal of Public Health*, *97*(1), 99–101.

Kumar, M. S., Murhekar, M. V, Hutin, Y., Subramanian, T., Ramachandran, V., & Gupte, M. D. (2007b). Prevalence of posttraumatic stress disorder in a coastal fishing village in Tamil Nadu, India, after the December 2004 tsunami. *American Journal of Public Health*, *97*(1), 99–101.

Kumar, S., Jeyaseelan, L., Suresh, S., & Ahuja, R. C. (2005). Domestic violence and its mental health correlates in Indian women. *Br J Psychiatry*, *187*, 62–67.

Lambert, J. E., & Alhassoon, O. M. (2015). Trauma-focused therapy for refugees: Meta-analytic findings. *Journal of Counseling Psychology*, *62*(1), 28–37.

Landenburger, K. (1989). A process of entrapment in and recovery from an abusive relationship. *Issues in Mental Health Nursing*, *10*(3–4), 209–227.

Lang, P. J. (1977). Imagery in therapy: an information processing analysis of fear. *Behavior Therapy*, *8*(5), 862–886.

Lang, P. J. (1979). A Bio-Informational Theory of Emotional Imagery. *Psychophysiology*, *16*(6), 495–512.

Lang, P. J. (1993). The network model of emotion: Motivational connections. In R. Wyer & T. Scrull (Eds.), *Advances in Social Cognition, Volume Vi - Google Books*. Lawrence Earlbaum Associate.

Lawrence, E., Orengo-Aguayo, R., Langer, A., & Brock, R. L. (2012). The Impact and Consequences of Partner Abuse on Partners. *Partner Abuse*, *3*(4), 406–428.

Le Gallais, T. (2008). Wherever I go there I am: reflections on reflexivity and the research stance. *Reflective Practice*, *9*(2), 145–155.

Leff, J. P. (1973). Culture and the differentiation of emotional states. *British Journal of Psychiatry*, *122*(574), 299–306.

Lelaurain, S., Graziani, P., & Monaco, G. Lo. (2017). Intimate partner violence and help-seeking: A systematic review and social psychological tracks for future research. European Psychologist, 22(4), 263–281.

Lely, J. C.G., Knipscheer, J. W., Moerbeek, M., Ter Heide, F. J. J., Van Den Bout, J., & Kleber, R. J. (2019). Randomised controlled trial comparing narrative exposure therapy with present-centred therapy for older patients with post-traumatic stress disorder. *British Journal of Psychiatry*, *214*(6), 369–377.

Lely, Jeannette C.G., Smid, G. E., Jongedijk, R. A., Knipscheer, J. W., & Kleber, R. J. (2019). The effectiveness of narrative exposure therapy: a review, meta-analysis and meta-regression analysis. *European Journal of Psychotraumatology*, *10*(1), 1550344.

Lensvelt-Mulders, G., van der Hart, O., van Ochten, J. M., van Son, M. J. M., Steele, K., & Breeman, L. (2008). Relations among peritraumatic dissociation and posttraumatic stress: A meta-analysis. In *Clinical Psychology Review* (Vol. 28, Issue 7, pp. 1138–1151). Clin Psychol Rev.

Levinson, D. (1988). Family Violence in Cross-Cultural Perspective. In *Handbook of Family Violence* (pp. 435–455). Springer US.

Lilly, M. M., Pole, N., Best, S. R., Metzler, T., & Marmar, C. R. (2009). Gender and PTSD: What can we learn from female police officers? *Journal of Anxiety Disorders*, *23*(6), 767–774.

Lin, K., Sun, I. Y., Liu, J., & Chen, X. (2018). Chinese Women's Experience of Intimate Partner Violence: Exploring Factors Affecting Various Types of IPV. Violence Against Women, 24(1), 66–84.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.

Lipsky, S., Field, C. A., Caetano, R., Larkin, G. L., & Fredon, J. (2001). Posttraumatic stress disorder symptomatology and comorbid depressive symptoms among abused women referred from emergency department care. *Violence and Victims*, *20*(December), 645–659.

Liz, W., Rachel, P., & Julie, R. (2014). Creating a recovery focused workforce: supporting staff well-being and valuing the expertise of lived experience. *Mental Health and Social Inclusion*, *18*(3), 133–141.

Lombard, N., & McMillan, L. (2013). *Violence against women : current theory and practice in domestic abuse, sexual violence, and exploitation*. Jessica Kingsley Publishers.

Luborsky, L., McLellan, A. T., Diguer, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. In *Clinical Psychology: Science and Practice, 4(1),* 53–65.

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., Seligman, D. A., & Krause, E. D. (2002). The Dodo bird verdict is alive and well - Mostly. *Clinical Psychology: Science and Practice*, *9*(1), 2–12.

Ma, L. (2012). Some philosophical considerations in using mixed methods in library and information science research. *Journal of the American Society for Information Science and Technology*, *63*(9), 1859–1867. https://doi.org/10.1002/asi

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*(1), 1–20.

Maertens, A. (2013). Social norms and aspirations: Age of marriage and education in rural india. *World Development*, *47*, 1–15.

Magar, V. (2003). Empowerment approaches to gender-based violence: Women's courts in Delhi slums. *Women's Studies International Forum*, *26*(6), 509–523.

Mallinckrodt, B. (2011). Addressing the Decline in Counseling and Supervision Process and Outcome Research in the Journal of Counseling Psychology. *The Counseling Psychologist*, *39*(5), 701–714.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760.

Maneesriwongul, W., & Dixon, J. K. (2004). Instrument translation process: A methods review. *Journal of Advanced Nursing*, *48(2),* 175–186)

Manor, J. (1996). "Ethnicity" and politics in India. In *International Affairs (Royal Institute of International Affairs 1944-)* (Vol. 72, Issue 3).

Marks, I., Lovell, K., Noshirvani, H., Livanou, M., & Thrasher, S. (1998). Treatment of posttraumatic stress disorder by exposure and/or cognitive re-structuring: A Controlled Study. *Archives of General Psychiatry*, *55*(4), 317–325.

Marmar, C. R., Weiss, D. S., & Metzler, T. (1998). Peritraumatic dissociation and posttraumatic stress disorder. In D. J. Bremner & C. R. Marmar (Eds.), *Trauma, memory, and dissociation* (pp. 229–252). American Psychiatric Press.

Marsella, A. J., Friedman, M. J., & Spain, E. H. (2004). Ethnocultural aspects of PTSD: An overview of issues and research directions. In *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications.* (pp. 105–129). American Psychological Association.

Martin, A. J., Berenson, K. R., Griffing, S., Sage, R. E., Madry, L., Bingham, L. E., & Primm, B. J. (2000). The process of leaving an abusive relationship: The role of risk assessments and decision-certainty. *Journal of Family Violence*, *15*(2), 109–122.

Math, S. B., Tandon, S., Girimaji, S. C., Benegal, V., Kumar, U., Hamza, A., Jangam, K., & Nagaraja, D. (2008). Psychological impact of the tsunami on children and adolescents from the andaman and nicobar islands. *Primary Care Companion to the Journal of Clinical Psychiatry*, *10*(1), 31–37.

Matheson, F. I., Daoud, N., Hamilton-Wright, S., Borenstein, H., Pedersen, C., & O'Campo, P. (2015).

Where Did She Go? The Transformation of Self-Esteem, Self-Identity, and Mental Well-Being among Women Who Have Experienced Intimate Partner Violence. *Women's Health Issues*, *25*(5), 561–569.

Maxwell, J. A., & Mittapalli, K. (2012). Realism as a stance for mixed methods research. In *A Realist Approach for Qualitative Research* (pp. 145–166). SAGE.

McCabe, A., & Peterson, C. (1991). *Developing a narrative structure*. Erlbaum.

McEvoy, P., & Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, *11*(1), 66–78.

McFarlane, A. C. (1988). The longitudinal course of posttraumatic morbidity: The range of outcomes and their predictors. In *Journal of Nervous and Mental Disease* (Vol. 176, Issue 1, pp. 30–39). Lippincott Williams & Wilkins.

McKay, K. M., Imel, Z. E., & Wampold, B. E. (2006). Psychiatrist effects in the psychopharmacological treatment of depression. *Journal of Affective Disorders*, *92*(2–3), 287–290.

McPherson, J. (2012). Does narrative exposure therapy reduce ptsd in survivors of mass violence? In *Research on Social Work Practice* (Vol. 22, Issue 1, pp. 29–42). SAGE Publications.

Mehta, K., Vankar, G., & Patel, V. (2005). Validity of the construct of post-traumatic stress disorder in a low-income country: Interview study of women in Gujarat, India. *British Journal of Psychiatry*, *187*(DEC.), 585–586.

Messer, S. B., & Wampold, B. E. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. In *Clinical Psychology: Science and Practice* (Vol. 9, Issue 1, pp. 21–25).

Micale, M. S. (1990). Charcot and the idea of hysteria in the male: Gender, mental science, and medical diagnosis in late nineteenth-century France. *Medical History*, *34*(4), 363–411.

Mohd Razali, N., & Bee Wah, Y. (2011). Power comparisons of Shapiro-Wilk, Kolmogorov-Smirnov, Lilliefors and Anderson-Darling tests. In *Journal of Statistical Modeling and Analytics* (Vol. 2, Issue 1).

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., Altman, D., Antes, G., Atkins, D., Barbour, V.,

Barrowman, N., Berlin, J. A., Clark, J., Clarke, M., Cook, D., D'Amico, R., Deeks, J. J., Devereaux, P. J., Dickersin, K., Egger, M., Ernst, E., … Tugwell, P. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine, 6(7),* e1000097.

Mohr, D. C., Spring, B., Freedland, K. E., Beckner, V., Arean, P., Hollon, S. D., Ockene, J., & Kaplan, R. (2009). The selection and design of control conditions for randomized controlled trials of psychological interventions. *Psychotherapy and Psychosomatics*. https://doi.org/10.1159/000228248

Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *74*(5), 898–907.

Morath, J., Gola, H., Sommershof, A., Hamuni, G., Kolassa, S., Catani, C., Adenauer, H., Ruf-Leuschner, M., Schauer, M., Elbert, T., Groettrup, M., & Kolassa, I.-T. (2014). The effect of trauma-focused therapy on the altered T cell distribution in individuals with PTSD: Evidence from a randomized controlled trial. *Journal of Psychiatric Research*, *54*, 1–10.

Morath, J., Moreno-Villanueva, M., Hamuni, G., Kolassa, S., Ruf-Leuschner, M., Schauer, M., Elbert, T., Bürkle, A., & Kolassa, I.-T. (2014). Effects of psychotherapy on DNA strand break accumulation originating from traumatic stress. *Psychotherapy and Psychosomatics*, *83*(5), 289–297.

Mørkved, N., Hartmann, K., Aarsheim, L. M., Holen, D., Milde, A. M., Bomyea, J., & Thorp, S. R. (2014). A comparison of narrative exposure therapy and prolonged exposure therapy for PTSD. *Clinical Psychology Review*, 34(6), 453–467.

Mortl, K., & Gelo, O. C. G. (2015). Qualitative methods in psychotherapy process research. In O. C. G. Gelo, B. Rieken, & A. Pritz (Eds.), *Psychotherapy Research: Foundations, Process, and Outcome* (Issue December, pp. 1–639).

Mumford, D. B. (1996). Somatic symptoms and psychological distress in the Iliad of Homer. *Journal of Psychosomatic Research*, *41*(2), 139–148.

Mumford, D. B., Bavington, J. T., Bhatnagar, K. S., Hussain, Y., Mirza, S., & Naraghi, M. M. (1991).

The Bradford Somatic Inventory. A multi-ethnic inventory of somatic symptoms reported by anxious and depressed patients in Britain and the Indo-Pakistan subcontinent. *British Journal of Psychiatry*, *158*(MAR.), 379–386.

Mundt, A. P., Wünsche, P., Heinz, A., & Pross, C. (2014). Evaluating interventions for posttraumatic stress disorder in low and middle income countries: Narrative exposure therapy. *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, *12*(2), 250–266.

Munet-Vilaró, F., & Egan, M. (1990). Reliability Issues of the Family Environment Scale For Cross-Cultural Research. *Nursing Research*, *39*(4), 244–247.

Murnen, S. K., Wright, C., & Kaluzny, G. (2002). If “boys will be boys,” then girls will be victims? A meta-analytic review of the research that relates masculine ideology to sexual aggression. *Sex Roles*, *46(11–12),* 359–375.

Murray, J., Ehlers, A., & Mayou, R. A. (2002). Dissociation and post-traumatic stress disorder: Two prospective studies of road traffic accident survivors [Article]. *British Journal of Psychiatry*, *180*(APR.), 363–368.

Mushtaq, R., Shah, T., & Mushtaq, S. (2016). Post-traumatic Stress Disorder (PTSD) in Children of conflict region of Kashmir (India): A Review. *Journal of Clinical and Diagnostic Research*, *10(1),* VE01–VE03.

Myhill, A. (2015). Measuring Coercive Control: What Can We Learn From National Population Surveys? *Violence Against Women*, *21*(3), 355–375.

Najavits, L. M. (2015). The problem of dropout from "gold standard" PTSD therapies. *F1000prime Reports*, *7*, 43.

National Institute for Health and Care Excellence (NICE). (2011). *Overview | Common mental health problems: identification and pathways to care | Guidance | NICE*. NICE. https://www.nice.org.uk/guidance/cg123

National Institute for Health and Care Excellence (NICE). (2018). *Recommendations | Post-traumatic stress disorder | Guidance | NICE*. NICE. https://www.nice.org.uk/guidance/ng116/chapter/Recommendations

Neuner, F., & Elbert, T. (2007). The mental health disaster in conflict settings: Can scientific research

help? In *BMC Public Health* (Vol. 7, Issue 1, p. 275). BioMed Central.

Neuner, F., Elbert, T., & Schauer, M. (2020). Narrative exposure therapy for PTSD. In L. F. Bufka, C. V. Wright, & R. W. Halfond (Eds.), *Casebook to the APA Clinical Practice Guideline for the treatment of PTSD.* (pp. 187–205). American Psychological Association.

Neuner, F., Kurreck, S., Ruf, M., Odenwald, M., Elbert, T., & Schauer, M. (2010). Can asylum-seekers with posttraumatic stress disorder be successfully treated? A randomized controlled pilot study. *Cognitive Behaviour Therapy*, *38*(4), 1–11.

Neuner, F., Onyut, P. L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counsellors in an African refugee settlement: A randomised controlled trial. *Journal of Consulting and Clinical Psychology*, *76*(4), 686–694.

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology*, *72*(4), 579–587.

Neuner, F., Schauer, M., Roth, W. T., & Elbert, T. (2002). A Narrative Exposure Treatment as intervention in a Macedonia's refugee camp: a case report. *Behavioural and Cognitive Psychotherapy*, *30(2),* 205 - 209.

Newman, K. D. (1993). Giving up: Shelter experiences of battered women. *Public Health Nursing*, *10*(2), 108–113.

Nixon, R. D. V., Resick, P. A., & Nishith, P. (2004). An exploration of comorbid depression among female victims of intimate partner violence with posttraumatic stress disorder. *Journal of Affective Disorders*, *82*(2), 315–320.

North, J. (1987). Wrongdoing and forgiveness. *Philosophy*, *62*(242), 499–508.

O'Kearney, R., & Perrott, K. (2006). Trauma narratives in posttraumatic stress disorder: A review. *Journal of Traumatic Stress*, *19*(1), 81–93. https://doi.org/10.1002/jts.20099

Office of National Statistics (ONS). (2018). Domestic abuse in England and Wales: year ending March 2018. *Office of National Statistics*, *March 2018*, 4–16. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabus

einenglandandwales/yearendingmarch2018

Onyut, L. P., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., & Elbert, T. (2004). The Nakivale Camp Mental Health Project: Building local competency for psychological assistance to traumatised refugees. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict*, *2*(2), 90–107.

Onyut, L. P., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., & Elbert, T. (2005). Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement. *BMC Psychiatry*, *5*, 7.

Oram, S, Trevillion, K., Feder, G., & Howard, L. M. (2013). Prevalence of experiences of domestic violence among psychiatric patients: Systematic review. *British Journal of Psychiatry, 202(2),* 94–99.

Oram, Sian, Khalifeh, H., & Howard, L. M. (2017). Violence against women and mental health. *The Lancet Psychiatry*, *4(2),* 159–170.

Orang, T., Ayoughi, S., Moran, J. K., Ghaffari, H., Mostafavi, S., Rasoulian, M., & Elbert, T. (2018). The efficacy of narrative exposure therapy in a sample of Iranian women exposed to ongoing intimate partner violence—A randomized controlled trial. *Clinical Psychology and Psychotherapy*, *25*(6), 827–841.

Overstreet, N. M., & Quinn, D. M. (2013). The Intimate Partner Violence Stigmatization Model and Barriers to Help Seeking. Basic and Applied Social Psychology, 35(1), 109–122.

Pabst, A., Schauer, M., Bernhardt, K., Ruf-Leuschner, M., Goder, R., Elbert, T., Rosentraeger, R., Robjant, K., Aldenhoff, J., & Seeck-Hirschner, M. (2014). Evaluation of Narrative Exposure Therapy (NET) for borderline personality disorder with comorbid posttraumatic stress disorder. *Clinical Neuropsychiatry: Journal of Treatment Evaluation*, *11*(3), 108–117.

Palmer, R. E. (1969). *Hermeneutics (Studies in Phenomenology and Existential Philosophy)*.

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

Panda, A., & Gupta, R. K. (2004). Mapping Cultural Diversity within India: A Meta-analysis of Some

Recent Studies. Global Business Review, 5(1), 27–49.

Pankajakshan, V. I., Remadevi, S., Vidhukumar, K., Shah Navas, P. M., Anilkumar, T. V., & Subha, N. (2020). Domestic violence as a risk factor for attempted suicide in married women. *Journal of Interpersonal Violence*, *35*(23–24), 5753–5771.

Patel, N., Kellezi, B., & Williams, A. (2014). Psychological , social and welfare interventions for psychological health and well-being of torture survivors. *Cochrane Library*, *11*.

Patel, V., Kirkwood, B. R., Pednekar, S., Pereira, B., Barros, P., Fernandes, J., Datta, J., Pai, R., Weiss, H., & Mabey, D. (2006). Gender disadvantage and reproductive health risk factors for common mental disorders in women: A community survey in India. *Archives of General Psychiatry*, *63*(4), 404–413.

Patel, V., Xiao, S., Chen, H., Hanna, F., Jotheeswaran, A. T., Luo, D., Parikh, R., Sharma, E., Usmani, S., Yu, Y., Druss, B. G., & Saxena, S. (2016). The magnitude of and health system responses to the mental health treatment gap in adults in India and China. *The Lancet*, *388(10063),* 3074–3084.

Patterson, B., Boyle, M. H., Kivlenieks, M., & Van Ameringen, M. (2016). The use of waitlists as control conditions in anxiety disorders research. *Journal of Psychiatric Research*, *83*, 112–120.

Patton, M. Q. (2002). *Qualitative research & evaluation methods: Integrating theory and practice*. SAGE Publications.

Perilla, J. L., Norris, F. H., & Lavizzo, E. A. (2002). Ethnicity, Culture, and Disaster Response: Identifying and Explaining Ethnic Differences in PTSD Six Months After Hurricane Andrew. *Journal of Social and Clinical Psychology*, *21*(1), 20–45.

Persons, J. B., & Silberschatz, G. (1998). Are results of randomized controlled trials useful to psychotherapists? *Journal of Consulting and Clinical Psychology*, *66*(1), 126–135.

Peter van der Veer. (1994). *Religious Nationalism: Hindus and Muslims in India*. University of California Press.

Piccirillo, M. L., & Rodebaugh, T. L. (2019). Foundations of idiographic methods in psychology and applications for psychotherapy. *Clinical Psychology Review*, *71*, 90–100.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne Psychological Journal*, *20*(1), 7-14.

Pillai, L., Mehta, S. G., & Chaudhari, B. L. (2016). Post-Traumatic Stress Disorder (PTSD): Indian Perspective. In *Comprehensive Guide to Post-Traumatic Stress Disorders* (pp. 1617–1635). Springer International Publishing.

Pillemer, D. B., Desrochers, A. B., & Ebanks, C. M. (1998). Remembering the Past in the Present: Verb Tense Shifts in Autobiographical Memory Narratives. In C. P. Thompson, D. J. Herrmann, D. Bruce, J. D. Read, D. G. Payne, & M. P. Toglia (Eds.), *Autobiographical memory: Theoretical and applied perspectives.* (pp. 145–162). Lawrence Erlbaum Associates.

Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system: Policy and practice implications. *Trauma, Violence, and Abuse*, *8*(2), 226–239.

Porter, S., & Birt, A. R. (2001). Is Traumatic Memory Special? A Comparison of Traumatic Memory Characteristics with Memory for Other Emotional Life Experiences. *Applied Cognitive Psychology*, *15*(7), S101–S117.

Powers, M. B., Halpern, J. M., Ferenschak, M. P., Gillihan, S. J., & Foa, E. B. (2010). A meta-analytic review of prolonged exposure for posttraumatic stress disorder. In *Clinical Psychology Review* (Vol. 30, Issue 6, pp. 635–641).

Pyszczynski, T., & Greenberg, J. (1987). Self-Regulatory Perseveration and the Depressive Self-Focusing Style: A Self-Awareness Theory of Reactive Depression. *Psychological Bulletin*, *102*(1), 122–138.

QSR International. (2012). *NVivo qualitative data analysis software | QSR International*. https://www.qsrinternational.com/nvivo/home

Radford, J., & Russell, D. (1994). Femicide: The Politics of Woman Killing. *Australian & New Zealand Journal of Criminology*, *27*(2), 210–211.

Ragavan, M. I., Iyengar, K., & Wurtz, R. M. (2014). Physical intimate partner violence in northern India. *Qualitative Health Research*, *24*(4), 457–473.

Ragavan, M. I., Iyengar, K., & Wurtz, R. (2015). Perceptions of Options Available for Victims of Physical Intimate Partner Violence in Northern India. *Violence Against Women*, *21*(5), 652–675. https://doi.org/10.1177/1077801215573332

Raghuraman, S., Stuttard, N., & Hunt, N. (2020). Evaluating Narrative Exposure Therapy for Posttraumatic Stress Disorder and Depression Symptoms: A Meta-Analysis of the Evidence-base. *Clinical Psychology & Psychotherapy*. 11(JUN).

Rajkumar, A. P., Mohan, T. S. P., & Tharyan, P. (2013). Lessons from the 2004 Asian tsunami: Epidemiological and nosological debates in the diagnosis of post-traumatic stress disorder in non-Western post-disaster communities. *International Journal of Social Psychiatry*, *59*(2), 123–129.

Rajkumar, A. P., Premkumar, T. S., & Tharyan, P. (2008). Coping with the Asian tsunami: Perspectives from Tamil Nadu, India on the determinants of resilience in the face of adversity. *Social Science and Medicine*, *67*(5), 844–

Rajkumar, A. P, Mohan, T. S., & Tharyan, P. (2015). Lessons from the 2004 Asian tsunami: Nature, prevalence and determinants of prolonged grief disorder among tsunami survivors in South Indian coastal villages. *International Journal of Social Psychiatry*, *61*(7), 645–652.

Ramsay, J., Rutterford, C., Gregory, A., Dunne, D., Eldridge, S., Sharp, D., & Feder, G. (2012). Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. *The British Journal of General Practice : The Journal of the Royal College of General Practitioners*, *62*(602), e647-55.

Rao, D., Young, M., & Raguram, R. (2007). Culture, somatization, and psychological distress: Symptom presentation in South Indian patients from a public psychiatric hospital. *Psychopathology*, *40*(5), 349–355.

Rao, D., Horton, R., & Raguram, R. (2012). Gender inequality and structural violence among depressed women in South India. *Social Psychiatry and Psychiatric Epidemiology*, *47*(12), 1967–1975.

Rao, K. (2006). Psychosocial support in disaster-affected communities. *International Review of Psychiatry*, *18*(6), 501–505.

Rasmussen, D. J. (2013). Victimization and PTSD in an Indian youth sample from Pune City. *Open Journal of Epidemiology*, *03*(01), 12–19.

Ratcliffe, M., Ruddell, M., & Smith, B. (2014). What is a “sense of foreshortened future?” A phenomenological study of trauma, trust, and time. *Frontiers in Psychology*, *5*(SEP), 1026.

Ratna Kapur, & Brenda Cossman. (1996). *Subversive Sites: Feminist Engagements with Law in India Google Books*. Sage Publications.

Rauch, S. A. M., Eftekhari, A., & Ruzek, J. I. (2012). Review of exposure therapy: A gold standard for PTSD treatment. *Journal of Rehabilitation Research and Development*, *49*(5), 679–688.

Reed, G. L., & Enright, R. D. (2006). The effects of forgiveness therapy on depression, anxiety, and posttraumatic stress for women after spousal emotional abuse. *Journal of Consulting and Clinical Psychology*, *74*(5), 920–929.

Reese, E., Haden, C. A., Baker-Ward, L., Bauer, P., Fivush, R., & Ornstein, P. A. (2011). Coherence of personal narratives across the lifespan: A multidimensional model and coding method. *Journal of Cognition and Development*, *12*(4), 424–462.

Resick, P. A., Galovski, T. E., Uhlmansiek, M. O. B., Scher, C. D., Clum, G. A., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of Cognitive Processing Therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology*, *76*(2), 243–258. https://doi.org/10.1037/0022-006X.76.2.243

Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of Cognitive-Processing Therapy with Prolonged Exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70(4),* 867-879.

Resick, P. A., Nishith, P., & Griffin, M. G. (2003). How well does cognitive-behavioral therapy treat symptoms of complex PTSD? An examination of child sexual abuse survivors within a clinical trial. *CNS Spectrums*, *8*(5), 340.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive Processing Therapy for Sexual Assault Victims. *Journal of Consulting and Clinical Psychology*, *60*(5), 748–756. https://doi.org/10.1037/0022-006X.60.5.748

Review Manager (RevMan) (5.3). (2014). The Nordic Cochrane Centre, The Cochrane Collaboration. https://community.cochrane.org/help/tools-and-software/revman-5

Richard G. Tedeschi, Jane Shakespeare-Finch, Kanako Taku, & Lawrence G. Calhoun. (2018). *Posttraumatic Growth: Theory, Research, and Applications*. Routledge.

Richardson, W. S., Wilson, M. C., Nishikawa, J., & Hayward, R. S. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP journal club,123(3),* A12-3

Risjord, M., Moloney, M., & Dunbar, S. (2001). Methodological triangulation in nursing research. *Philosophy of the Social Sciences*, *31*(1), 40–59.

Robinson, G. E. (2003). Violence against women in North America. In *Archives of Women's Mental Health* (Vol. 6, Issue 3, pp. 185–191). Springer-Verlag.

Robjant, K., & Fazel, M. (2010). The emerging evidence for Narrative Exposure Therapy: A review. *Clinical Psychology Review*, *30*(8), 1030–1039.

Robjant, K., Roberts, J., & Katona, C. (2017). Treating posttraumatic stress disorder in female victims of trafficking using Narrative Exposure Therapy: A retrospective audit. *Frontiers in Psychiatry*, *8*, 63.

Roland, M., & Torgerson, D. J. (1998). Understanding controlled trials. What are pragmatic trials? In *British Medical Journal* (Vol. 316, Issue 7127, pp. 285–289). British Medical Journal Publishing Group.

Barlow, M. R., Goldsmith Turow, R. E., & Gerhart, J. (2017). Trauma appraisals, emotion regulation difficulties, and self-compassion predict posttraumatic stress symptoms following childhood abuse. *Child Abuse & Neglect, 35,* 37-47

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *British Journal of Psychiatry*, *198*(3), 189–194.

Rosen, G. M. (2008). Posttraumatic stress disorder: Issues and controversies. John Wiley & Sons.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. In *Psychological Monographs: General and Applied* (Vol. 80, Issue 1, pp. 1–28). American

Psychological Association.

Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E., & Elbert, T. (2010). Narrative exposure therapy for 7- to 16-year-olds: a randomized controlled trial with traumatized refugee children. *Journal of Traumatic Stress*, *23*(4), 437–445.

Rusbult, C. E. (1980). Commitment and satisfaction in romantic associations: A test of the investment model. *Journal of Experimental Social Psychology*, *16*(2), 172–186.

Russell, S., Subramanian, B., & Russell, P. S. S. (2004). Psychometric properties of Tamil version of Impact of Event Scale for adolescents. *International Journal of Disaster Medicine*, *2*(4), 148–151.

Sachs, E., Rosenfeld, B., Lhewa, D., Rasmussen, A., & Keller, A. (2008). Entering Exile: Trauma, Mental Health, and Coping Among Tibetan Refugees Arriving in Dharamsala, India. *Journal of Traumatic Stress*, *21*(2), 199–208.

Satyanarayana, V. A., Nattala, P., Selvam, S., Pradeep, J., Hebbani, S., Hegde, S., & Srinivasan, K. (2016). Integrated Cognitive Behavioral Intervention reduces intimate partner violence among alcohol dependent men, and improves mental health outcomes in their spouses: A clinic based randomized controlled trial from South India. *Journal of Substance Abuse Treatment*, *64*, 29–34.

Satyen, L., Rogic, A. C., & Supol, M. (2019). Intimate Partner Violence and Help-Seeking Behaviour: A Systematic Review of Cross-Cultural Differences. Journal of Immigrant and Minority Health, 21(4), 879–892.

Sawyer, K. (2003). Coherence in Discourse: Suggestions for Future Work. *Human Development*, *46*(4), 189–193.

Schaal, S., Elbert, T., & Neuner, F. (2009). Narrative Exposure Therapy versus Interpersonal Psychotherapy. *Psychotherapy and Psychosomatics*, *78*(5), 298–306.

Schauer, M., Elbert, T., Gotthardt, S., Rockstroh, B., Odenwald, M., & Neuner, F. (2006). Wiedererfahrung durch psychotherapie modifiziert geist und gehirn. *Verhaltenstherapie, 16(2),* 96–103.

Schauer, M., Elbert, T., & Neuner, F. (2011). *Narrative exposure therapy : a short-term treatment for traumatic stress disorders* (2nd ed.). Hogrefe. https://us.hogrefe.com/shop/narrative-exposure-

therapy-67506.html

Schauer, M., Neuner, F., & Elbert, T. (2005). *Narrative Exposure Therapy*. Hogrefe Publishing. https://doi.org/10.1016/B978-0-08-097086-8.21058-1

Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., Tendick, V., & Gray, S. H. (2008). Nonresponse and dropout rates in outcome studies on PTSD: review and methodological considerations. *Psychiatry*, *71*(2), 134–168.

Schwarzer, G., Carpenter, J. R., & Rücker, G. (2015). *Small-Study Effects in Meta-Analysis* (pp. 107–141). Springer, Cham.

Sedgwick, P. (2013). Meta-analyses: how to read a funnel plot. *BMJ*, *346*, f1342.

Seethalakshmi, R., Dhavale, H. S., Gawande, S., & Dewan, M. (2006). Psychiatric morbidity following motor vehicle crashes: A pilot study from India. *Journal of Psychiatric Practice*, *12*(6), 415–418.

Seide, S. E., Röver, C., & Friede, T. (2019). Likelihood-based random-effects meta-analysis with few studies: Empirical and simulation studies. *BMC Medical Research Methodology*, *19*(1), 16.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist*, *50*(12), 965–974.

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). Experimental and quasi-experimental designs for generalized causal inference. Houghton, Mifflin and Company.

Shah, S. (2013). Holistic approach to community in crisis. *Psychiatric Clinics of North America*, *36*(3), 403–416.

Shapiro, F, & Solomon, R. (2010). Eye movement desensitization and reprocessing. *In The Corsini encyclopedia of psychology* (pp. 1–3). Hoboken: Wiley

Shapiro, F. (1989). Efficacy of the Eye Movement Desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, *2*(2), 199–223. https://doi.org/10.1002/jts.2490020207

Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures, 2nd ed. Guilford Press.

Shapiro, M. B. (1961). The single case in fundamental clinical psychological research. *British Journal*

of Medical Psychology, *34*(3–4), 255–262.

Shapiro, M. B. (1966). The single case in clinical-psychological research. *Journal of General Psychology*, *74*(1), 3–23.

Sharan, P., Chaudhary, G., Kavathekar, S. A., & Saxena, S. (1996). Preliminary report of psychiatric disorders in survivors of a severe earthquake. *American Journal of Psychiatry*, *April*, 556–558.

Sharma, B. R., & Gupta, M. (2004). Gender based violence in india: A never-ending phenomenon. *Journal of International Women's Studies*, *6*(1), 114–123.

Shaver, P. R., & Hazan, C. (1988). A biased overview of the study of love. *Journal of Social and Personal Relationships*, *5*(4), 473–501.

Shean, G. (2014). Limitations of Randomized Control Designs in Psychotherapy Research. *Advances in Psychiatry*, *2014*, 1–5.

Sheehan, D. V, Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *The Journal of Clinical Psychiatry*, *59 Suppl 2*, 22-33;quiz 34-57.

Shidhaye, R., & Kermode, M. (2013). Stigma and discrimination as a barrier to mental health service utilization in India. *International Health*, *5*(1), 6–8.

Shidhaye, R., & Patel, V. (2010). Association of socio-economic, gender and health factors with common mental disorders in women: A population-based study of 5703 married rural women in India. *International Journal of Epidemiology*, *39*(6), 1510–1521.

Shoeb, M., Weinstein, H., & Mollica, R. (2007). The Harvard Trauma Questionnaire: Adapting a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Iraqi refugees. *International Journal of Social Psychiatry*, *53*(5), 447–463.

Shoib, S., Mushtaq, R., Jeelani, S., Ahmad, J., Dar, M. M., & Shah, T. (2014). Recent trends in the sociodemographic, clinical profile and psychiatric comorbidity associated with posttraumatic stress disorder: A study from Kashmir, India. *Journal of Clinical and Diagnostic Research*, *8*(4), 1–05.

Shore, J. H., Vollmer, W. M., & Tatum, E. H. (1989). Community patterns of posttraumatic stress disorders. *The Journal of Nervous and Mental Disease*, *177*(11), 681–685.

Simpson, J. A., & Rholes, W. S. (2010). Attachment and relationships: Milestones and future directions. Journal of Social and Personal Relationships, 27(2), 173–180.

Singal, A. G., Higgins, P. D. R., & Waljee, A. K. (2014). A primer on effectiveness and efficacy trials. *Clinical and Translational Gastroenterology*, *5*(1), e45.

Singer, J. A., & Rexhaj, B. (2006). Narrative coherence and psychotherapy: A commentary. *Journal of Constructivist Psychology*, *19*(2), 209–217.

Singh, G. (2004). State and religious diversity: reflections on post- 1947 India. *Totalitarian Movements and Political Religions*, *5*(2), 205–225.

Singh, A., Chokhandre, P., Singh, A. K., Barker, K. M., Kumar, K., McDougal, L., James, K. S., & Raj, A. (2021). Development of the India Patriarchy Index: Validation and Testing of Temporal and Spatial Patterning. Social Indicators Research 2021, 1–27.

Sinha, J. B. P., Vohra, N., Singhal, R. B. N., & Ushashree, S. (2002). Collectivism and Individualism in India: Intentions and Behaviour. In Mimeograph. (pp. 27–51). Springer, New Delhi.

Skinner, B. F. (1966). Operant Behaviour. In W. K. Honig (Ed.), *Operant behavior: Areas of research and application* (pp. 12–32). Appleton-Century-Crofts.

Smith, B. (2018). Generalizability in qualitative research: misunderstandings, opportunities and recommendations for the sport and exercise sciences. *Qualitative Research in Sport, Exercise and Health*, *10*(1), 137–149.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11(2),* 261–271.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE Publications.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (2nd ed., pp. 53–80).

Solomon, S. D., & Johnson, D. M. (2002). Psychosocial treatment of posttraumatic stress disorder: A

practice friendly review of outcome research. *Journal of Clinical Psychology*, *58*(8), 947–959.

Spitzer, R. L., Kroenke, K., & Williams, J. B. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. Primary care evaluation of mental disorders. Patient Health Questionnaire. *JAMA*, *282*(18), 1737–1744.

Squire, L. R. (1994). Declarative and nondeclarative memory: Multiple brain systems supporting learning and memory. In *Memory systems 1994.* (pp. 203–231). The MIT Press.

Steil, R., & Ehlers, A. (2000). Dysfunctional meaning of posttraumatic intrusions in chronic PTSD. *Behaviour Research and Therapy*, *38*(6), 537–558.

Stein, M. B., & Kennedy, C. (2001). Major depressive and post-traumatic stress disorder comorbidity in female victims of intimate partner violence. *Journal of Affective Disorders*, *66*(2–3), 133–138.

Steinert, C., Stadter, K., Stark, R., & Leichsenring, F. (2017). The effects of waiting for treatment: A meta-analysis of waitlist control groups in randomized controlled trials for social anxiety disorder. *Clinical Psychology & Psychotherapy*, *24*(3), 649–660.

Stenmark, H., Catani, C., Neuner, F., Elbert, T., & Holen, A. (2013). Treating PTSD in refugees and asylum seekers within the general health care system: A randomized controlled multicentre study. *Behaviour Research and Therapy*, *51*(10), 641–647.

Stern, A. F. (2014). The Hospital Anxiety and Depression Scale. In *Occupational Medicine* (Vol. 64, Issue 5, pp. 393–394).

Sterne, J. A. C., Gavaghan, D., & Egger, M. (2000). Publication and related bias in meta-analysis: Power of statistical tests and prevalence in the literature. *Journal of Clinical Epidemiology*, *53*(11), 1119–1129.

Sterne, J. A. C., Savović, J., Page, M. J., Elbers, R. G., Blencowe, N. S., Boutron, I., Cates, C. J., Cheng, H. Y., Corbett, M. S., Eldridge, S. M., Emberson, J. R., Hernán, M. A., Hopewell, S., Hróbjartsson, A., Junqueira, D. R., Jüni, P., Kirkham, J. J., Lasserson, T., Li, T., … Higgins, J. P. T. (2019). RoB 2: A revised tool for assessing risk of bias in randomised trials. *The BMJ*, *366*.

Suar, D., Das, N., & Hota, L. B. (2010). Social Indicators Affecting Post-Tsunami Trauma of Survivors. *Journal of Health Management*, *12*(4), 483–500.

Suar, D., Das, S. S., & Alat, P. (2014). Bereavement, postdisaster trauma, and behavioral changes in tsunami survivors. *Death Studies*, *39*(4), 226–233.

Suls, J., & Wheeler, L. (2000). *Handbook of Social Comparison: Theory and Research* (J. Suls & L. Wheeler (Eds.)). Springer US.

Summerfield D. (1999). A critique of seven assumptions behind psychological trauma programmes in war affected areas. *Social Science Medicine*, *48(10)*, 1449–1462.

Surís, A., Link-Malcolm, J., Chard, K., Ahn, C., & North, C. (2013). A randomized clinical trial of Cognitive Processing Therapy for veterans with PTSD related to military sexual trauma. *Journal of Traumatic Stress*, *26*(1), 28–37.

Szabo, Y. Z., Warnecke, A. J., Newton, T. L., & Valentine, J. C. (2017). Rumination and posttraumatic stress symptoms in trauma-exposed adults: a systematic review and meta-analysis. *Anxiety, Stress, & Coping* , *30*(4), 396–414.

Taylor, S. E., & Brown, J. D. (1988). Illusion and Well-Being: A social psychological perspective on mental health. *Psychological Bulletin*, *103*(2), 193–210.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic Growth : Conceptual foundations and empirical evidence. *Psychological Inquiry*, *15*(1), 1–18.

Telles, S., Singh, N., Joshi, M., & Balkrishna, A. (2010). Post traumatic stress symptoms and heart rate variability in Bihar flood survivors following yoga: A randomized controlled study. *BMC Psychiatry*, 2(*10),* 18.

Terheggen, M. A., Stroebe, M. S., & Kleber, R. J. (2001). Western conceptualizations and eastern experience: A cross-cultural study of traumatic stress reactions among Tibetan refugees in India. *Journal of Traumatic Stress*, *14*(2), 391–403.

Tharyan, P. (2005). Traumatic bereavement and the Asian tsunami: perspectives from Tamil Nadu, India. *Bereavement Care*, *24*(2), 23–26.

The British Psychological Society. (2014). *Code of Human Research Ethics*. The British Psychological Society.

The British Psychological Society. (2018). Code of Ethics and Conduct Guidance. In *The British*

Pyscological Society Guidelines (Issue January).

The Hindu. (2016). India's religions by numbers - The Hindu. The Hindu. https://www.thehindu.com/news/national/religious-communities-census-2011-what-the-numbers-say/article7582284.ece

Thomas, B. C., Devi, N., Sarita, G. P., Rita, K., Ramdas, K., Hussain, B. M., Rejnish, R., & Pandey, M. (2005). Reliability & validity of the Malayalam hospital anxiety & depression scale (HADS) in cancer patients. *Indian Journal of Medical Research*, *122*(5), 395–399.

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

Tolin, D. F., & Foa, E. B. (2008). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Trauma: Theory, Research, Practice, and Policy*, *S*(1), 37–85.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357.

Tracy, S. J. (2010). *Qualitative Inquiry Qualitative Quality: Eight "'Big-Tent'" Criteria for Excellent Qualitative Research*. *Qualitative Inquiry, 16(10),* 837-851.

Trevillion, K., Oram, S., Feder, G., & Howard, L. M. (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. *PLoS ONE*, *7*(12), e51740.

Tulving, Endel. (1972). Episodic and semantic memory. In E. Tulving & W. Donaldson (Eds.), *Organization of memory* (pp. 381–403). Academic Press.

Tulving, Endel. (2001). Episodic memory and common sense: How far apart? *Philosophical Transactions of the Royal Society of London. Series B: Biological Sciences*, *356*(1413), 1505–1515.

Turner, R. M., Bird, S. M., & Higgins, J. P. T. (2013). The Impact of study size on meta-analyses: Examination of underpowered studies in Cochrane reviews. *PLoS ONE*, *8*(3), e59202.

Ullman, S. E., & Filipas, H. H. (2001). Predictors of PTSD symptom severity and social reactions in sexual assault victims. *Journal of Traumatic Stress*, *14*(2), 369–389.

Undavalli, C., Das, P., Dutt, T., Bhoi, S., & Kashyap, R. (2014). PTSD in post-road traffic accident patients requiring hospitalization in Indian subcontinent: A review on magnitude of the problem and management guidelines. *Journal of Emergencies, Trauma, and Shock*, *7*(4), 327–331.

UN Office of the High Commissioner for Human Rights (OHCHR). (2004). *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol"),* HR/P/PT/8/Rev.1, https://www.refworld.org/docid/4638aca62.html.

United Nations. (1994). *Declaration on the Elimination of Violence against Women* (p. Resolution No. A/RES/48/104).

United Nations. (2006). *Ending violence against women: From words to action, Study of the Secretary-General*. https://www.unwomen.org/-/media/headquarters/media/publications/un/en/englishstudy.pdf?la=en&vs=954

Van Der Hart, O., Van, J., Hospital, O., Sengelmann, H., Metropolitan, K. S., & Associates, P. (2008). Relations among peritraumatic dissociation and posttraumatic stress: A critical review. *Journal of Trauma & Dissociation, 9(4),* 481-505.

Van der Kolk, B. A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress*, *8*(4), 505–525.

Van der Kolk, B. A., Herron, N., & Hostetler, A. (1994). The history of trauma in psychiatry. *Psychiatric Clinics of North America*, *17*(3), 583–600.

Van Minnen, A., Wessel, I., Dijkstra, T., & Roelofs, K. (2002). Changes in PTSD patients' narratives during prolonged exposure therapy: A replication and extension. *Journal of Traumatic Stress*, *15*(3), 255–258.

Van Minnen, A., Zoellner, L. A., Harned, M. S., & Mills, K. (2015). Changes in comorbid conditions after prolonged exposure for ptsd: A literature review. *Current Psychiatry Reports, 17(3),* 549.

Varma, D., Chandra, P. S., & Thomas, T. (2007). Intimate partner violence and sexual coercion among pregnant women in India: Relationship with depression and post traumatic stress

disorder. *Journal of Affective Disorders*, *102*(1–3), 227–235.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, *18*(1), 148.

Velotti, P., Beomonte Zobel, S., Rogier, G., & Tambelli, R. (2018). Exploring Relationships: A Systematic Review on Intimate Partner Violence and Attachment. Frontiers in Psychology, 0(JUL), 1166.

Vijayakumar, L. (2016). Suicide Among Refugees – A Mockery of Humanity. *Crisis*, *37*(1), 1–4.

Vijayakumar, L., Kannan, G. K., & Daniel, S. J. (2006). Mental health status in children exposed to tsunami. *International Review of Psychiatry*, *18*(6), 507–513.

Vijayakumar, L, Thara, R., John, S., & Chellappa, S. (2006). Psychosocial interventions after tsunami in Tamil Nadu, India. *Int Rev Psychiatry*, *18*(3), 225–231.

Vijayakumar, L., Kannan, G. K., Ganesh Kumar, B., & Devarajan, P. (2006). Do all children need intervention after exposure to tsunami? *International Review of Psychiatry (Abingdon, England)*, *18*(December), 515–522.

Visaria, L. (2000). Violence against Women: A Field Study. *Economic and Political Weekly*, *35*(20), 1742–1751.

Viswanath, B., Maroky, A. S., Math, S. B., John, J. P., Cherian, A. V, Girimaji, S. C., Benegal, V., Hamza, A., & Chaturvedi, S. K. (2013). Gender differences in the psychological impact of tsunami. *The International Journal of Social Psychiatry*, *59*(2), 130–136.

Vizcarra, B., Hassan, F., Hunter, W. M., Muñoz, S. R., Ramiro, L., & De Paula, C. S. (2004a). Partner violence as a risk factor for mental health among women from communities in the Philippines, Egypt, Chile, and India. *Injury Control and Safety Promotion*, *11*(2), 125–129.

Walker, L. E. (1979). *The battered woman* [Book]. Harper.

Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research*, *7*(1), 21–43.

Wampold, B. E. (2001). Contextualizing psychotherapy as a healing practice: Culture, history, and

methods. *Applied and Preventive Psychology*, *10*(2), 69–86.

Wampold, B. E., & Imel, Z. E. (2015). The great psychotherapy debate: The evidence for what makes psychotherapy work: Second edition. In *Routledge*.

Wampold, B. E., Imel, Z. E., Laska, K. M., Benish, S., Miller, S. D., Flűckiger, C., Re, A. C. Del, Baardseth, T. P., & Budge, S. (2010). Determining what works in the treatment of PTSD. *Clinical Psychology Review, 30(8),* 923-933.

Weatherhead, S. (2011). Narrative Analysis: An often overlooked approach. *Clinical Psychology Forum*, 218, 47-52

Weathers, F. W., & Keane, T. M. (2007). The criterion a problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress, 20(2)*, 107–121.

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). The PTSD Checklist (PCL): Reliablity, validity, and diagnostic utility. *9th Annual Conference of the ISTSS*.

Websdale, N. (1995). Rural Woman Abuse: The Voices of Kentucky Women. *Violence Against Women*, *1*(4), 309–338.

Weinstein, N. D. (1980). Unrealistic optimism about future life events. *Journal of Personality and Social Psychology*, *39*(5), 806–820.

Weiss, D. S., & Marmar, C. R. (1997a). The Impact of Event Scale—Revised. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). Guilford Press.

Weiss, D. S., & Marmar, C. R. (1997b). The Impact of Events Scale-Revised. In John P Wilson & Keane (Eds.), *Assessing Psychological Trauma and PTSD* (pp. 339–441). Guilford Press.

Weiss, K. G. (2009). “Boys will be boys” and other gendered accounts an exploration of victims’ excuses and justifications for unwanted sexual contact and coercion. *Violence Against Women*, *15*(7).

Werner, O., & Campbell, D. . (1970). Translating, Working through Interpreters, and the Problem of Decentering. In , American Museum of Natural History, New York, - . In R. Naroll & R. Cohen (Eds.), *A Handbook of Method in Cultural Anthropology* (pp. 398–420). Natural History Press.

Wessells, M. (1999). Culture, power, and community: intercultural approaches to psychosocial assistance and healing. In. In K. Nader, N. Dubrow, & B. H. Stamm (Eds.), *Honoring differences : cultural issues in the treatment of trauma and loss* (pp. 267–282). Brunner/Mazel.

Wig, N. N., & Verma, S. K. (1973). A cross-cultural study of psychiatric patients on Cornell Medical Index. *Indian Journal of Psychiatry*, *15*, 363–366.

Wikipedia. (, October). *Bangalore*. Wikipedia.

Wilkinson, S. (1988). The role of reflexivity in feminist psychology. *Women's Studies International Forum*, *11*(5), 493–502.

Willcox, R. S. (2017). *An attachment theory-informed thematic analysis of bereaved families' narratives*. University of the West of England.

Willig, C. (2001). Introducing qualitative research in psychology: Adventures in theory and method. *Qualitative Research*, *2nd*(7), 217.

Wolbert Burgess, A., & Lytle Holmstrom, L. (1974). Rape trauma syndrome. *American Journal of Psychiatry*, *131*(9), 981–986.

World Health Organization. (1997). *Violence against women Definition and scope of the problem. World Report on Violence and Health*. World Health Organization.

World Health Organization. (2013). *Responding to Intimate Partner Violence and Sexual Violence Against Women.* World Health Organization.

World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* World Health Organization. https://apps.who.int/iris/handle/10665/85239

World Health Organization. (1990). *Composite International Diagnostic Interview (CIDI)*. www.who.int

World Health Organization. (1993). *The ICD-10 classification of mental and behavioural disorders*. World Health Organization.

Wuest, J., & Merritt-Gray, M. (1999). Not going back: Sustaining the separation in the process of leaving abusive relationships. *Violence Against Women*, *5*(2), 110–133.

Yaswi, A., & Haque, A. (2008). Prevalance of PTSD symptoms and depression and level of coping

among the victims of the Kashmir conflict. *Journal of Loss and Trauma*, *13*(5), 471–480.

Young, A. (1995). *The harmony of illusions: inventing post traumatic stress disorder*. Princeton University Press.

Zang, Y., Cox, T., & Hunt, N. (2013). A randomised controlled pilot study - the effectiveness of narrative exposure therapy with adult survivors of the Sichuan earthquake. *BMC Psychiatry*, *13:41*.

Zang, Y., Hunt, N., & Cox, T. (2014). Adapting narrative exposure therapy for Chinese earthquake survivors: a pilot randomised controlled feasibility study. *BMC Psychiatry*, *14*(1), 262.

Zigmond, A. S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, *67*(6), 361–370.

Appendix A. Ethics Approval

Contents:

- Ethics approval letter
- Participant Information Sheet (Study 1)
- Participant Information Sheet (Study 3)
- Consent Form
- Charity Invite Letters
- Participant Invite Letters

Appendix A1: Ethics approval letter

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
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27 June 2018

Ms Shruti Raghuraman
PhD Student - Clinical Psychology
c/o Dr Nigel Hunt, Associate Professor
Room B14, Yang Fujia Building
Centre for Forensic & Family Psychology,
Division of Psychiatry and Applied Psychology
Jubilee Campus, Wollaton Road
University of Nottingham
NG8 1BB

Dear Ms Raghuraman

Ethics Reference No: 103-1704 – **please always quote**	
Study Title: Trauma and PTSD in primary and secondary abuse survivors in India: Evaluating the efficacy of Narrative Exposure Therapy in the Indian Sociocultural Context	
Chief Investigator/Supervisor: Dr Nigel Hunt, Associate Professor, Centre for Forensic & Family Psychology, Division of Psychiatry and Applied Psychology.	
Lead Investigators/student: Ms Shruti Raghuraman, PhD Student - Clinical Psychology, Division of Psychiatry and Applied Psychology.	
Type of Study: qualitative, PhD project, overseas & UK, pilot	
Proposed Start Date: 05/2017	**Proposed End Date:** 30/09/2019 28 mths
No of Subjects: 10-50+	**Age:** 18+years
School: Medicine	

Thank you for notifying the Committee of amendment no 1: 04.06.2018 as detailed and the following revised documents were received:

Notice of Amendment form dated 04.06.2018
Appendix I - Updated participant information sheet (following GDPR guidelines)
Appendix II - Updated informed consent forms
Appendix III - Gatekeeper invite letter
Appendix IV - Participant invite letter

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix A2. Participant Information Sheet (Study 1)

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences
School of Medicine
Division of Psychiatry and Applied Psychology
Yang Fujia Building
Wollaton Road, NG8 1Bb
Nottingham

Dr Nigel Hunt
Associate Professor
Division of Psychiatry and Applied Psychology
School of Medicine
University of Nottingham
nigel.hunt@nottingham.ac.uk

Ms Shruti Raghuraman
PhD Candidate, Clinical Psychology
Division of Psychiatry and Applied Psychology
School of Medicine
University of Nottingham
shruti.raghuraman@nottingham.ac.uk

Study Title: Study Title: *Trauma and PTSD in primary abuse survivors in India: Examining Narrative Exposure Therapy in the Indian Socio-cultural Context*

PARTICIPANT INFORMATION SHEET

Research Ethics Reference: 103-1704
Version 2.0 Date: 04.06.2018

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. We will go through the information sheet with you and answer any questions you have. Please take time to read this carefully and discuss it with others if you wish. Ask us anything that is not clear.

What is the purpose of the research?

The purpose of this study is to explore grief and distress among individuals who have experienced some form of traumatic stress in the recent past, such as abuse or violence.

Why have I been invited to take part?

You are being invited to take part because you identify as a survivor of traumatic abuse or violence.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. We will describe the study and go through this information sheet with you to answer any questions you may have. If you agree to participate, we will ask you to sign a consent form and will give you a copy to keep. However, you would still be free to withdraw from the study at any time, without giving a reason and without any negative consequences, by advising the researchers of this decision. This would not affect your legal rights.

What will happen to me if I take part?

If you choose to participate, you will be asked to take part in a one-on-one interview with a researcher and asked to speak about your life like a story, starting from your childhood, to the time of the traumatic incident(s) took place, to your current state of mind. You will be asked to discuss in detail your thoughts, feelings and beliefs, which may be challenging and emotionally overwhelming at times.

The sessions will take place in a convenient place for you, preferably a private area (eg office or room in your home), where you will not be disturbed. The sessions will be recorded by the researcher, who will read out their notes from each session back to you at the beginning of the next session. You will be given a chance to clarify/change information as you see fit.

You will also be requested to fill out some short questionnaires before and after the interviews take place. The content of the sessions will only be seen by the main researcher. All information will be anonymised, and any analyses will not reveal your identity. If you say something you wish to withdraw just say so.

If you are still happy to take part, then you will then be asked to sign a consent form.

Are there any risks in taking part?

There are no known risks to taking part in this study.

You will be given an opportunity to share your difficult and traumatic experiences with a trained professional in a structured manner. This may cause temporary distress, as the focus is on the way you feel, the emotions you experienced, how you acted, and how these events impacted on your life relationships. Apart from taking up some of your time, there are no other foreseeable disadvantages to your participation in this study.

If there is a significant problem arising from your participation in the sessions, you will be provided with guidance regarding where to obtain help.

Will my time/travel costs be reimbursed?

Participants will not receive an inconvenience allowance to participate in the study. We will reimburse travel costs, but the sessions will be arranged in a location convenient for you, so you are not expected to incur significant travel costs.

What happens to the data provided?

We will follow ethical and legal practice and all information about you will be handled in confidence. No one outside the project will be aware of any information that you provide.

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data and records will be stored for a minimum of 7 years after publication or public release of the work of the research.

We would like your permission to use anonymised data in future studies, and to share data with other researchers (e.g. in online databases) both inside and outside the European Union. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study at any time without giving any reason and without your legal rights being affected. If you choose to withdraw, you can request for your data to be withdrawn from being included in the final publication/report before it is fully anonymised. Your data will be destroyed along with any personal information you have provided.

Who will know that I am taking part in this research?

All information collected about you during this research would be kept strictly confidential. All such data are kept on firewall and password-protected computers and any paper information (such as your consent form, contact details and any research questionnaires) would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

With your consent, we will keep your personal information on a secure database in order to contact you for future studies.

What will happen to the results of the research?

Once the data collection is completed the resultant transcripts will be analysed, a report will be prepared. The research will be written up as a thesis. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access. Further, a journal article prepared and submitted for publication in an appropriate peer-reviewed journal. You can obtain a copy of the by contacting the lead researcher. The report will be completed a year of the completion of the interview stage.

We would like your permission to use fully anonymised direct quotes in research publications. Quotations used within the report will not be identifiable as you or any other individual. If you have used names these will be changed.

Who has reviewed this study?

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee (Reference number: FMHS 103-1704).

Who is organising and funding the research?

This research is being organised by Dr Nigel Hunt, Associate Professor, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham. This study has not been funded by any internal/external agencies.

What if something goes wrong?

If you have a concern about any aspect of this project, please speak to the researcher Ms Shruti Raghuraman who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how he/she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, Faculty PVC Office, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Contact Details

If you would like to discuss the research with someone before or after, please contact:

Shruti Raghuraman
Division of Psychiatry and Applied Psychology
School of Medicine
B14, Yang Fujia Building
Wollaton Rd., NG8 1BB
Email: shruti.raghuraman@nottingham.ac.uk
Tele: +44-7387368244

Appendix A3. Participant Information Sheet (Study 3)

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences
School of Medicine
Division of Psychiatry and Applied Psychology
Yang Fujia Building
Wollaton Road, NG8 1Bb
Nottingham

Dr Nigel Hunt
Associate Professor
Division of Psychiatry and Applied Psychology
School of Medicine
University of Nottingham
nigel.hunt@nottingham.ac.uk

Ms Shruti Raghuraman
PhD Candidate, Clinical Psychology
Division of Psychiatry and Applied Psychology
School of Medicine
University of Nottingham
shruti.raghuraman@nottingham.ac.uk

Study Title: ***Trauma and PTSD in primary abuse survivors in India: Examining Narrative Exposure Therapy in the Indian Socio-cultural Context***

PARTICIPANT INFORMATION SHEET

Research Ethics Reference: 103-1704
Version 2.0 Date: 04.06.2018

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. One of our team will go through the information sheet with you and answer any questions you have. Please take time to read this carefully and discuss it with others if you wish. Ask us anything that is not clear.

What is the purpose of the research?

The purpose of this study is to explore grief and distress among individuals who have experienced abuse or violence and provide therapeutic relief by using a tried and tested rehabilitation technique known as Narrative Exposure Therapy.

Why have I been invited to take part?

You are being invited to take part because you identify as a survivor of traumatic abuse or violence.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. We will describe the study and go through this information sheet with you to answer any questions you may have. If you agree to participate, we will ask you to sign a consent form and will give you a copy to keep. However, you would still be free to withdraw from the study at any time, without giving a reason and without any negative consequences, by advising the researchers of this decision. This would not affect your legal rights.

What will happen to me if I take part?

The study uses a narrative approach called Narrative Exposure Therapy (NET), wherein individuals are encouraged to explain their experiences, what it means to them, along with their thoughts and feelings with a member of the research team in a series of structured sessions. The aim of this exercise is to reduce survivors' psychological distress over time and help them cope with their experiences by facing the traumatic event and overcoming the fear associated with it. By gauging participants' response to NET, authors of the study will be able to make recommendations for post-diagnostic support and intervention for survivors of traumatic stress in India.

If you choose to participate, you will be asked to participate in a series of sessions with a trained professional, each of which may last anywhere between 30 to 180 minutes. The number of sessions will depend on each participant's individual story, but it is likely that there will be no more than 8 sessions.

After the initial session where you will be provided with information on the process of NET, why it is important and how you are expected to benefit from it. In the subsequent sessions, you will be encouraged to speak about your life like a story, starting from your childhood, to the time of the traumatic incident(s) took place, to your current state of mind. You will be asked to discuss in detail your thoughts, feelings and beliefs, which may be challenging and emotionally overwhelming at times.

The sessions will take place in a convenient place for you, preferably a private area (eg office or room in your home), where you will not be disturbed. The sessions will be recorded by the researcher, who will read out their notes from each session back to you at the beginning of the next session. You will be given a chance to clarify/change information as you see fit. At the end of the sessions, you will be requested to sign off on the written testimony.

You will also be requested to fill out some short questionnaires before and after the interviews take place. Your convenience will be of paramount importance when we contact you after the interviews to fill out the questionnaires. This may either happen in person, or over the phone.

The content of the sessions will only be seen by the main researcher. All information will be anonymised, and any analyses will not reveal your identity. If you say something you wish to withdraw just say so.

If you are still happy to take part, then you will then be asked to sign a consent form.

What is the procedure that is being tested?

Narrative Exposure Therapy (NET) is a short, manualised therapy which was developed for the rehabilitation of victims of organized violence and related trauma. It can be delivered by non-mental health professionals who have undergone training to do so.

The aim of NET is to provide care and rehabilitation to those who have been faced with adversity or traumatic stress in a short span of time. This is done through the process of exposing the participant

to the details of memories of the traumatic event(s) in order to help them build a consistent narrative that is rooted in context.

NET has been tested across a range of socio-cultural and geographical settings and has been found to work better than other forms of therapy in reducing psychological distress. Participants have also been found to be more responsive to NET when compared to other techniques, which often see high drop-out rates.

Are there any risks in taking part?

There are no known risks to taking part in this study.

You will be given an opportunity to share your difficult and traumatic experiences with a trained professional in a structured manner. This may cause temporary distress, as the focus is on the way you feel, the emotions you experienced, how you acted, and how these events impacted on your life relationships. Apart from taking up some of your time, there are no other foreseeable disadvantages to your participation in this study.

If there is a significant problem arising from your participation in the sessions, you will be provided with guidance regarding where to obtain help.

Are there any benefits in taking part?

NET is aimed at reducing the level of psychological distress you are currently experiencing as result of the negative events that have taken place in your life. At the end of the sessions, it is expected that you will feel more capable of coping with these events and will experience lower levels of distress when faced with thoughts or reminders about the event(s).

Will my time/travel costs be reimbursed?

Participants will not receive an inconvenience allowance to participate in the study. We will be reimburse travel costs, but the sessions will be arranged in a location convenient for you, so you are not expected to incur significant travel costs.

What happens to the data provided?

We will follow ethical and legal practice and all information about you will be handled in confidence. No one outside the project will be aware of any information that you provide.

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data and records will be stored for a minimum of 7 years after publication or public release of the work of the research.

We would like your permission to use anonymised data in future studies, and to share data with other researchers (e.g. in online databases) both inside and outside the European Union. All personal

information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study at any time without giving any reason and without your legal rights being affected. If you choose to withdraw, you can request for your data to be withdrawn from being included in the final publication/report before it is fully anonymised. Your data will be destroyed along with any personal information you have provided.

Who will know that I am taking part in this research?

All information collected about you during this research would be kept strictly confidential. All such data are kept on firewall and password-protected computers and any paper information (such as your consent form, contact details and any research questionnaires) would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

With your consent, we will keep your personal information on a secure database in order to contact you for future studies.

Anything you say during your NET sessions will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the appropriate persons (social worker/health-care worker in charge)

What will happen to the results of the research?

Once the data collection is completed the resultant transcripts will be analysed, a report will be prepared. The research will be written up as a thesis. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access. Further, a journal article prepared and submitted for publication in an appropriate peer-reviewed journal. You can obtain a copy of the by contacting the lead researcher. The report will be completed a year of the completion of the interview stage.

We would like your permission to use fully anonymised direct quotes in research publications. Quotations used within the report will not be identifiable as you or any other individual. If you have used names these will be changed.

Who has reviewed this study?

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee (Reference number: FMHS 103-1704).

Who is organising and funding the research?

This research is being organised by Dr Nigel Hunt, Associate Professor, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham. This study has not been funded by any internal/external agencies.

What if something goes wrong?

If you have a concern about any aspect of this project, please speak to the researcher Ms Shruti Raghuraman who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how he/she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, Faculty PVC Office, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Contact Details

If you would like to discuss the research with someone before or after, please contact:

Shruti Raghuraman
Division of Psychiatry and Applied Psychology
School of Medicine
B14, Yang Fujia Building
Wollaton Rd., NG8 1BB
Email: shruti.raghuraman@nottingham.ac.uk
Tele: +44-7387368244

Appendix A4: Consent form

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences
School of Medicine
Division of Psychiatry and Applied Psychology
Yang Fujia Building
Wollaton Road, NG8 1BB
Nottingham

CONSENT FORM

Study Title: Trauma and PTSD in primary abuse survivors in India: Examining Narrative Exposure Therapy in the Indian Socio-cultural Context

REC ref: FMHS 103-1704

Name of Researchers:

Dr Nigel Hunt
Associate Professor
Division of Psychiatry and Applied Psychology
School of Medicine
University of Nottingham
nigel.hunt@nottingham.ac.uk

Ms Shruti Raghuraman
PhD Candidate, Clinical Psychology
Division of Psychiatry and Applied Psychology
School of Medicine
University of Nottingham
shruti.raghuraman@nottingham.ac.uk

Participant Code:

1. I confirm that I have read and understand the information sheet version number 2.0: dated 04.06.2018 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. However the data collected so far cannot be erased and may still be used in the final report. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I agree that the information collected about me can be stored by the above research team at the University of Nottingham and used to support other research in the future and may be shared anonymously with other researchers (approved by an Ethics Committee). ☐
6. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended and then destroyed. ☐
7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Appendix A5: Charity invite letters

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Division of Psychiatry and Applied Psychology
School of Medicine

The University of Nottingham
Nottingham
NG8 1BB
t: +44 (0)7387368244
e: shruti.raghuraman@nottingham.ac.uk

To whom it may concern

Respected colleague,

Thank you for your interest in this project. My name is Shruti and I am a doctoral student in Clinical Psychology at the University of Nottingham.

My PhD project is aimed at exploring the psychosocial impact and rehabilitation of abuse and gendered violence in women. Abuse can be physical, emotional and/or sexual, and can have a lasting impact on a person's mental health and wellbeing. Those that undergo trauma due to abuse or violence may develop symptoms of psychological disorders such as Post-Traumatic Stress Disorder (PTSD), depression, anxiety or even physiological complaints related to trauma. I propose to interview women who identify as victims or survivors of gender-based violence in a one-on-one, in-depth interview that will last anywhere between 30-120 minutes.

My supervisor, Dr Nigel Hunt has over 20 years of experience working with trauma survivors. He is keen on understanding trauma interventions that focus on using narratives. Dr Hunt has significant research experience across a number of cultural settings, including research with Bosnian civilians and refugees, Chinese earthquake survivors, widowed women in India, firefighters in Saudi Arabia, civilians in Iraq, and those affected by communism in Eastern Europe. I will undertake this research under his supervision.

I am seeking your cooperation in this effort, in the hope that you will see the potential for a collaboration. I am looking to gain access to participants for this project. The benefit of participation is two-fold –

a) Contribution towards a better understanding of trauma, PTSD, abuse and gendered violence

b) Support in coping with psychological distress that may result from experiences of abuse

Participation is voluntary, and there will be no monetary compensation available.

If you know of women who are trauma survivors, and have faced abuse or violence in the last 5 years and will be willing to participate, please do hand over the attached Participant Invitation pamphlet to them.

Many thanks for your time.

Best regards,

Shruti Raghuraman
Graduate Student | Clinical Psychology
Division of Psychiatry & Applied Psychology
School of Medicine
University of Nottingham
Nottingham, NG7 2UH

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Division of Psychiatry and Applied Psychology
School of Medicine

The University of Nottingham
Nottingham
NG8 1BB
t: +44 (0)7387368244
e: shruti.raghuraman@nottingham.ac.uk

To whom it may concern

Respected colleague,

Thank you for your interest in this project. My name is Shruti and I am a doctoral student in Clinical Psychology at the University of Nottingham.

My PhD project is aimed at exploring the psychosocial impact and rehabilitation of abuse and gendered violence in women. Abuse can be physical, emotional and/or sexual, and can have a lasting impact on a person's mental health and wellbeing. Those that undergo trauma due to abuse or violence may develop symptoms of psychological disorders such as Post-Traumatic Stress Disorder (PTSD), depression, anxiety or even physiological complaints related to trauma.

I propose to examine a short-form trauma rehabilitation technique called Narrative Exposure Therapy (NET) in reducing psychological distress in survivors of abuse. NET has been found to widely successful in relieving symptoms of PTSD and related trauma psychopathology. However, there are no documented accounts of its efficacy in rehabilitating trauma psychopathology in survivors of domestic abuse and/or sexual and physical violence in India. Due to the increasing prevalence of gendered violence around the world, exploring cost and time effective ways to support survivors is crucial.

My supervisor, Dr Nigel Hunt has over 20 years of experience working with trauma survivors. He is keen on understanding trauma interventions that focus on using narratives. Dr Hunt has significant research experience across a number of cultural settings, including research with Bosnian civilians and refugees, Chinese earthquake survivors, widowed women in India, firefighters in Saudi Arabia, civilians in Iraq, and those affected by communism in Eastern Europe. I will undertake this research under his supervision.

I am seeking your cooperation in this effort, in the hope that you will see the potential for a collaboration. I am looking to gain access to participants for this project. The benefit of participation is two-fold –

a) Contribution towards a better understanding of trauma, PTSD, abuse and gendered violence

b) Support in coping with psychological distress that may result from experiences of abuse

Participation is voluntary, and there will be no monetary compensation available.

If you know of women who are trauma survivors, and have faced abuse or violence in the last 5 years and will be willing to participate, please do hand over the attached Participant Invitation pamphlet to them.

Many thanks for your time.

Best regards,

Shruti Raghuraman
Graduate Student | Clinical Psychology
Division of Psychiatry & Applied Psychology
School of Medicine
University of Nottingham
Nottingham, NG7 2UH

Appendix A6: Participant invite letters

The University of Nottingham

UNITED KINGDOM · CHINA · MALAYSIA

Division of Psychiatry and Applied Psychology
School of Medicine

The University of Nottingham
Nottingham
NG8 1BB
t: +44 (0)7387368244
e: shruti.raghuraman@nottingham.ac.uk

To whom it may concern

Dear Sir/Madam,

My name is Shruti Raghuraman and I am a graduate student in the School of Medicine, University of Nottingham. I am interested in finding out more about the impact of abuse and violence on an individual's mental health. I am also trying to find the most effective way of helping individuals who have undergone such experiences to manage their symptoms better, and cope with their negative emotions.

As someone who has undergone a traumatic experience, I would like to take some of your time to ask you some questions. I understand that it may be difficult for you to talk about the negative aspects of your life, but what and how much you want to say is completely up to you. Your contributions to this research project can go a long way in helping you, and others who have undergone similar experiences.

If you choose to take part, you will be be asked to participate in a one-on-one interview with me at a time and place convenient for you. During the interview, you will be speaking with an interviewer and will be asked to share as much as you can about your life experiences; the good and the bad, and how you cope with these experiences. Whatever you say will be completely confidential.

By agreeing to participate in this research, the personal benefit is that you may gain relief by speaking about your experiences with a trained professional. You will also be contributing towards a better understanding of the psychological impact of abuse and violence on women survivors.

I understand that you may find it difficult to talk about your personal experiences with someone you do not know very well. I want to let you know that those who you will be speaking to are suitably trained to undertake research of this nature, and will adapt the interviews and programmes to suit your individual needs and preferences.

Participation is completely voluntary, and you are under no obligation to be involved in this project. If you choose to take part, please note that your contributions will be treated with complete confidentiality. For more information, please read the attached Participant Information Sheet carefully. If you are willing to participate, please do let us know by signing on the dotted line below, with your full name, phone number and address. Please make sure to hand it over to the person who sent you this invitation. You will receive a phone-call from someone on the research team in the near future to schedule the next session. You will be able to clarify any doubts, questions or concerns you may have in detail over the phone or in person.

Thank you for your time.

Best regards,

Shruti Raghuraman
Graduate Student | Clinical Psychology
Division of Psychiatry & Applied Psychology
School of Medicine
University of Nottingham
Nottingham, NG8 1BB

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

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School of Medicine

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t: +44 (0)7387368244
e: shruti.raghuraman@nottingham.ac.uk

To whom it may concern

Dear Sir/Madam,

My name is Shruti Raghuraman and I am a graduate student in the School of Medicine, University of Nottingham. I am interested in finding out more about the impact of abuse and violence on an individual's mental health. I am also trying to find the most effective way of helping individuals who have undergone such experiences to manage their symptoms better, and cope with their negative emotions.

If you choose to take part, you will be enrolled into a short, structured program called Narrative Exposure Therapy (NET) that is aimed at helping you cope with any distress you may be facing at the moment. The programme will have approximately 6 sessions, each lasting about 90 minutes each. During these sessions, you will be speaking with an interviewer and will be asked to share as much as you can about your life experiences; the good and the bad, and how you cope with these experiences. Whatever you say will be completely confidential.

By agreeing to participate in this research, the personal benefit is that through your engagement in the NET program, you will receive help and support to deal feelings of fear, upset, grief or other emotional distress that you may be experiencing. NET has been used in a lot of different settings and has helped thousands of people cope with their difficulties worldwide. You could be one of those who gain relief by participating in the program. You will also be contributing towards a better understanding of the psychological impact of abuse and violence on women survivors. You will also help us find out whether certain therapeutic techniques such as NET are effective in helping women overcome and cope with these experiences in a meaningful way.

I understand that you may find it difficult to talk about your personal experiences with someone you do not know very well. I want to let you know that those who you will be speaking to are suitably trained to undertake research of this nature, and will adapt the interviews and programmes to suit your individual needs and preferences.

Participation is completely voluntary, and you are under no obligation to be involved in this project. If you choose to take part, please note that your contributions will be treated with complete confidentiality. For more information, please read the attached Participant Information Sheet carefully. If you are willing to participate, please do let us know by signing on the dotted line below, with your full name, phone number and address. Please make sure to hand it over to the person who sent you this invitation. You will receive a phone-call from someone on the research team in the near future to schedule the next session. You will be able to clarify any doubts, questions or concerns you may have in detail over the phone or in person.

Thank you for your time.

Best regards,

Shruti Raghuraman
Graduate Student | Clinical Psychology
Division of Psychiatry & Applied Psychology
School of Medicine
University of Nottingham
Nottingham, NG8 1BB

Appendix B: Assessment measures

Appendix B1: Impact of Events Scale – Revised

IMPACT OF EVENTS SCALE-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to _____ _____(event) that occurred on _____(date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total IES-R Score:_____

INT: 1, 2, 3, 6, 9, 14, 16, 20
AVD: 5, 7, 8, 11, 12, 13, 17, 22
HYP: 4, 10, 15, 18, 19, 21

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson, & T.M. Keane (Eds.) *Assessing psychological trauma and PTSD: a practitioner's handbook* (2nd ed., pp. 168-189). New York: Guilford Press.

AETR2N 22 1/13/2012

Revised Impact of Event Scale (22 questions):

The revised version of the Impact of Event Scale (IES-r) has seven additional questions and a scoring range of 0 to 88.

On this test, scores that exceed 24 can be quite meaningful. High scores have the following associations.

Score (IES-r) **Consequence**

24 or more	PTSD is a clinical concern.[6] Those with scores this high who do not have full PTSD will have partial PTSD or at least some of the symptoms.
33 and above	This represents the best cutoff for a probable diagnosis of PTSD.[7]
37 or more	**This is high enough to suppress your immune system's functioning** (even 10 years after an impact event).[8]

The IES-R is very helpful in measuring the affect of routine life stress, everyday traumas and acute stress

References:

1. Horowitz, M. Wilner, N. & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. Psychosomatic Medicine, 41, 209-218.
2. Weiss, D.S., & Marmar, C.R. (1997). The Impact of Event Scale-Revised. In J.P. Wilson & T.M. Keane (Eds.), Assessing Psychological Trauma and PTSD (pp.399-411). New York: Guilford.
3. Hutchins, E. & Devilly, G.J. (2005). Impact of Events Scale. Victim's Web Site. http://www.swin.edu.au/victims/resources/assessment/ptsd/ies.html
4. Coffey, S.F. & Berglind, G. (2006). Screening for PTSD in motor vehicle accident survivors using PSS-SR and IES. Journal of Traumatic Stress. 19 (1): 119-128.
5. Neal, L.A., Walter, B., Rollins, J., et al. (1994). Convergent Validity of Measures of Post-Traumatic Stress Disorder in a Mixed Military and Civilian Population. Journal of Traumatic Stress. 7 (3): 447-455.
6. Asukai, N. Kato, H. et al. (2002). Reliability and validity of the Japanese-language version of the Impact of event scale-revised (IES-R-J). Journal of Nervous and Mental Disease. 190 (3): 175-182.
7. Creamer, M. Bell, R. & Falilla, S. (2002). Psychometric properties of the Impact of Event Scale-Revised. Behaviour Research and Therapy. 41: 1489-1496.
8. Kawamura, N. Yoshiharu, K. & Nozomu, A. (2001) Suppression of Cellular Immunity in Men with a Past History of Post Traumatic Stress Disorder. American Journal of Psychiatry. 158: 484-486

Appendix B2: Hospital Anxiety and Depression Scale

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:
Total score: Depression (D) _____ Anxiety (A) _____
0-7 = Normal
8-10 = Borderline abnormal (borderline case)
11-21 = Abnormal (case)

Appendix B3: Bradford Somatic Inventory

B.S.I. 2-1

BRADFORD SOMATIC INVENTORY

NAME _____ SEX ____ AGE___ ___ ___ STUDY No_____

We should like to know if you have had any body symptoms over the past month.
Please answer all the questions simply by ticking the appropriate box.
Remember that we want to know about *the past month,* not symptoms you have had before that.
It is important that you try to answer all the questions.
Thank you very much for your co-operation.

	" *During the past month* .... "	Absent	Present on LESS than 15 days in past month	Present on MORE than 15 days in past month
1	Have you had severe headaches ?	☐	☐	☐
2	Have you had fluttering or a feeling of something moving in your stomach ?	☐	☐	☐
3	Have you had pain or tension in your neck and shoulders ?	☐	☐	☐
4	Has your skin been burning or itching all over ?	☐	☐	☐
5	Have you had a feeling of constriction of your head, as if it was being gripped tightly from outside ?	☐	☐	☐
6	Have you felt pain in the chest or heart ?	☐	☐	☐
7	Has your mouth or throat felt dry ?	☐	☐	☐
8	Has there been darkness or mist in front of your eyes?	☐	☐	☐
9	Have you felt a burning sensation in your stomach ?	☐	☐	☐
10	Have you felt a lack of energy (weakness) much of the time ?	☐	☐	☐
11	Has your head felt hot or burning ?	☐	☐	☐
12	Have you been sweating a lot ?	☐	☐	☐
13	Have you felt as if there was pressure or tightness on your chest or heart ?	☐	☐	☐
14	Have you been suffering ache or discomfort in the abdomen ?	☐	☐	☐
15	Has there been a choking sensation in your throat ?	☐	☐	☐
16	Have your hands or feet had pins and needles or gone numb?	☐	☐	☐
17	Have you felt aches or pains all over the body ?	☐	☐	☐
18	Have you had a feeling of heat inside your body ?	☐	☐	☐

continued overleaf ....

	" *During the past month* .... "	Absent	Present on LESS than 15 days in past month	Present on MORE than 15 days in past month
19	Have you been aware of palpitations (heart pounding)?	☐	☐	☐
20	Have you felt pain or burning in your eyes ?	☐	☐	☐
21	Have you suffered from indigestion ?	☐	☐	☐
22	Have you been trembling or shaking ?	☐	☐	☐
23	Have you been passing urine more frequently ?	☐	☐	☐
24	Have you been having low back trouble ?	☐	☐	☐
25	Has your stomach felt swollen or bloated ?	☐	☐	☐
26	Has your head felt heavy ?	☐	☐	☐
27	Have you been feeling tired, even when you are not working?	☐	☐	☐
28	Have you been getting pain in your legs ?	☐	☐	☐
29	Have you been feeling sick in the stomach (nausea)?	☐	☐	☐
30	Have you had a feeling of pressure inside your head, as if your head was going to burst ?	☐	☐	☐
31	Have you had difficulty in breathing, even when resting?	☐	☐	☐
32	Have you felt tingling (pins and needles) all over the body?	☐	☐	☐
33	Have you been troubled by constipation ?	☐	☐	☐
34	Have you wanted to open your bowels (go to the toilet) more often than usual ?	☐	☐	☐
35	Have your palms been sweating a lot ?	☐	☐	☐
36	Have you had difficulty in swallowing, as if there was a lump in your throat ?	☐	☐	☐
37	Have you been feeling giddy or dizzy ?	☐	☐	☐
38	Have you had a bitter taste in your mouth ?	☐	☐	☐
39	Has your whole body felt heavy ?	☐	☐	☐
40	Have you had a burning sensation when passing urine?	☐	☐	☐
41	Have you been hearing a buzzing noise in your ears or head?	☐	☐	☐
42	Has your heart felt weak or sinking ?	☐	☐	☐
43	Have you suffered from excessive wind (gas) or belching ?	☐	☐	☐
44	Have your hands or feet felt cold ?	☐	☐	☐

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Appendix B4: Sociodemographic form

Please fill in these details honestly. If you have any questions regarding the form, please do not hesitate to ask the researchers present. The questionnaire is brief and should take less than 5 minutes to complete.

PART A

1. Name:

2. Date of Birth (MM/DD/YYYY):

3. Gender
   [ ] Male [ ] Female [ ] Other

4. Marital Status
   [ ] Single [ ] Married [ ] Separated [ ] Divorced

5. a) Number of dependents
   [ ] 0-2 [ ] 3-6 [ ] 6-10 [ ] > 10

   b) Please specify age and relationship with dependents:

6. Please indicate your level of education -
   [ ] No formal schooling [ ] Upto 4th Standard [ ] Upto 6th Standard
   [ ] Upto 8th Standard [ ] Upto 10th Standard [ ] Upto 12th Standard
   [ ] Undergraduate [ ] Postgraduate [ ] Other: _____

7. Do you work for pay outside the home?
   [ ] Yes [ ] No

b) If yes, please tick the box that best applies to you –
   [ ] Working full time [ ] Working part time
   [ ] Looking for employment [ ] Not looking for employment
   [ ] Disabled or retired [ ] Student

8. What is your total combined family income for the past 12 months (in rupees), before taxes, from all sources? Please estimate if you are not sure.

   [ ] Less than 1000 [ ] 1000-5000 [ ] 5000-10,000

[ ] 10,000-20,000 [ ] 20,000-40,000 [ ] 40,000-60,000

[ ] 60000-80000 [ ] 80,000-1 lakh [ ] 1 lakh - 1.5 lakhs

[ ] Above 2 lakhs

PART B

1. Please indicate the type of abuse you have experienced (you may tick more than 1 option) -

   [ ] Physical abuse (e.g. being slapped, beaten, kicked, punched, burnt, manhandled)

   [ ] Sexual abuse (e.g. indecent behaviour, molestation, rape, genital mutilation)

   [ ] Verbal abuse (e.g. indecency or use of filthy language, name-calling)

   [ ] Social (e.g. humiliation in the presence of others)

   [ ] Emotional (e.g. deprivation of love, affection, care, concern or sympathy)

   [ ] Financial (e.g. deprivation of financial means required for daily sustenance or taking away your assets/earnings)

   [ ] Intellectual (e.g. lack of involvement in decision-making, denial of your right to education, career)

2. Is your abuse ongoing?

   [ ] Yes [ ] No

3. If no, is there a risk of abuse in the future?

   [ ] Yes [ ] No

4. Can you name the offender(s)?

   a) _____
   b) _____
   c) _____
   d) _____
   e) _____

5. Approximate date(s) when the incident(s) took place:

   a) _____
   b) _____
   c) _____
   d) _____
   e) _____

6. Location of incident(s)

   a) _____
   b) _____

c) _____

d) _____

e) _____

7. Please indicate informal support that you have received following the incident(s):

[ ] Close Family (specify) [ ] Friends [ ] Relatives

[ ] Peer groups [ ] Others

8. a) Have you accessed formal support?

[ ] Yes [ ] No

b) If yes, please specify:

[ ] Inpatient psychiatric services [ ] Outpatient psychiatric services

[ ] Formal counselling and therapy [ ] Other:

9. Please indicate your level of satisfaction with the formal support you have received.

[ ] Very happy [ ] Happy [ ] Neutral

[ ] Not happy [ ] Very unhappy [ ] Not applicable

10. Have you accessed legal/judicial support?

[ ] Yes [ ] No

11. If yes, please specify.

Thank you for your time.

Appendix C. IPA Interview Schedule

This is an interview of your life story, and I am interested in hearing about key events in your life. You can share whatever you feel is significant from your past, your present, and what you see in your future. Please share as much or as little as you'd like but know that anything you say will be strictly confidential and will in no way impact the care and support you are currently receiving. We are interested in hearing about the events that have led you to seek help here, how they have affected you, and how you have coped with them. I will ask you some questions and may stop you at times to ask for clarity or detail, but feel free to share your thoughts as honestly and candidly as possible. This may take around 30 minutes to one hour. If you need breaks or would like to stop at any time, please let me know.

1. I'd like to begin by asking about your childhood.
    a. Please tell me about yourself (Probe: identity and self-concept)
    b. What are some of the key events that took place during this time? (Probe: Negative and positive events, key figures/characters)
2. Could you tell me about the event(s) that brought you here? (Probe: Time, duration, key characters)
3. Would you be able to share how you felt when this happened?
    a. Can you talk about your emotional state during or after these experiences took place? (Probes for detail or clarity)
4. How are you feeling now that you are remembering and recalling these events to me? (Probe: emotional, sensory, physiological, and cognitive responses)
5. Can you tell me about your present circumstances? (Probe: status of abuse, practical circumstances)
6. Do you think there have been any changes in your life during or after you experienced these event(s)? (Probe for details)
7. How do you see yourself in the present situation? (Probe: identity and identity change)
8. What has been the impact of undergoing these experience(s) on you, or those around you?
9. Can you tell me how you have managed these experiences and their impact?
    a. What/who has made a difference in your life during this period?
    b. How do you feel about this? (coping techniques, support, or lack thereof)
10. How do you currently see your future?
    a. Has your view of your future changed at any point? If so, how?
11. Would you like to share any other thoughts that you feel are important to you?
12. Other foci to be decided with the interviewee.

Thank you for your time.

Appendix D: Participant Debrief Document

Project Title: Treating posttraumatic stress disorder using Narrative Exposure Therapy: A study of domestic violence survivors in south India

Ethics reference No: 103-1704

Name of Investigators: Dr Nigel Hunt and Shruti Raghuraman

Thank you for taking part in this research study. Due to the sensitive nature of the topics discussed, you may experience some distress either during or after the sessions. Please contact your caseworker immediately in this case. If you are unable to do so, or require additional support, we have complied a list of resources and helplines that you can access. You can also contact the researcher for further information about the research or access to resources and we will do our best to help you. *Email:* shruti.raghuraman@nottingham.ac.uk

NATIONAL HELPLINES

Domestic Abuse National Helpline (24/7)

181

Women's Helpline (24/7)

1091/1291

National Commission for Women (NCW)

011-26942369, 011-26944754

Vandravela Foundation (24/7)

1860 2662 345/1800-233-3330

BANGALORE

NIMHANS

080-46110007

Vimochana

080-25492781/82/83

CHENNAI

Dhwani Crisis Hotline (24/7)

044-43111143/1800 102 7282

SNEHA (24/7)

044-2460050/044-2460060

Appendix E: COREQ 32-item Checklist

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	68
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	Title Page
Occupation	3	What was their occupation at the time of the study?	Title Page
Gender	4	Was the researcher male or female?	63
Experience and training	5	What experience or training did the researcher have?	
Relationship with Participants:			
Relationship established	6	Was a relationship established prior to study commencement?	61
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	61-62
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	63-65
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	67
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	68
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	61
Sample size	12	How many participants were in the study?	68
Non-participation	13	How many people refused to participate or dropped out? Reasons?	NA
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	70
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	70
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	69
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	70
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	NA
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	71
Field notes	20	Were field notes made during and/or after the inter view or focus group?	70
Duration	21	What was the duration of the inter views or focus group?	71
Data saturation	22	Was data saturation discussed?	217
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	71

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	71
Description of the coding tree	25	Did authors provide a description of the coding tree?	--
Derivation of themes	26	Were themes identified in advance or derived from the data?	71
Software	27	What software, if applicable, was used to manage the data?	71
Participant checking	28	Did participants provide feedback on the findings?	71
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	75-98
Data and findings consistent	30	Was there consistency between the data presented and the findings?	73-98
Clarity of major themes	31	Were major themes clearly presented in the findings?	75-97
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	75-79

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix F: PRISMA Checklist

PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	107
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	107
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	109
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	No protocol exists
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	108-110
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	108-109
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	109
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	110
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	110-111
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	109-110
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	111
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	112
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	112

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	111

Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	112
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	113
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	114-119
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	121-125
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	125-130
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	125-130
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	121
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	131-133
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	134-142
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	137-139
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	139-142
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	5

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097