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Using a Continuous Traumatic Stress Framework to Examine Ongoing Adversity Among Indian Women from Slums: A Mixed-Methods Exploration

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Gender-based violence (GBV) is pervasive among Indian women. Although posttraumatic stress disorder (PTSD) is a psychological outcome of GBV, it might not accurately capture the experiences of Indian women from slums, who face continued stressors (i.e., ongoing adversity). Continuous traumatic stress (CTS) is a framework used to characterize experiences of ongoing adversity. This mixed-method study investigated the applicability of the CTS framework for characterizing ongoing adversity and the psychological impacts of ongoing adversity among GBV-exposed Indian women from slums. Indian women from slums ($N = 100$) completed all study measures; a subset ($n = 47$) completed qualitative interviews analyzed using deductive coding and thematic analysis to identify core CTS characteristics. To examine the impact of ongoing adversity on participants' psychological symptom severity in the full sample, we performed an ANCOVA on PTSD symptom severity and an ANOVA on anxiety and depression symptom severity. Interviewed participants described the context of stressor conditions as pervasive, reported stressor conditions existed in the present or future rather than the past, had difficulty discriminating between real versus imagined threat, and demonstrated absent external protective systems. Results indicated that ongoing adversity was associated with significantly more severe PTSD, $F(1, 96) = 9.86$, $p < .001$; anxiety, $F(1, 98) = 20.31$, $p < .001$; and depression, $F(1, 98) = 25.24$, $p < .001$. The CTS framework is valuable for characterizing ongoing adversity and its related mental health impacts among GBV-exposed Indian women from slums. Assessment and intervention in slum communities must account for ongoing adversity.

Gender-based violence (GBV) is a significant public health and human rights concern that includes physical, sexual, and psychological violence against women across the lifespan (Garcia-Moreno et al., 2005). In India, where GBV is pervasive, it is associated with adverse mental health outcomes, including posttraumatic stress disorder (PTSD), depression, and anxiety (Chandra et al., 2009). However, PTSD might not fully describe the context and experiences of individuals who experience ongoing adversity, such as Indian women from slums, which includes continued exposure to traumatic and nontraumatic stressors and is associated with a high risk of future trauma exposure (Sabri & Campbell, 2015). Instead, continuous traumatic stress (CTS) is a framework that describes stressor conditions to more accurately characterize contexts of ongoing adversity (Straker & the Sanctuaries Counselling Team, 1987). While the CTS framework evolved for use in conflict settings, it can be applied to similar contexts (Kira et al., 2008; Stevens et al., 2013). The present mixed-method study examined the applicability of the CTS framework and the effect of ongoing adversity on PTSD, anxiety, and depressive symptom severity in a sample of Indian women from slums.

According to a recent systematic review, 41% percent of Indian women report lifetime GBV (Kalokhe et al., 2017), and up to 84% of women report lifetime GBV in some Indian states (Priya et al., 2014). Sexual and physical forms of GBV comprise rape, attempted rape, sexual abuse, exploitation, domestic violence, marital rape, trafficking, and female genital mutilation (World Health Organization, 2020). Psychological forms of GBV include economic abuse or depriving a woman of control over her finances (P. Vyas, 2006) and emotional abuse, such as threats, coercion, and marginalization (Heise et al., 2002).

Complex interactions between sociocultural, situational, and individual factors have been shown to maintain GBV (Heise et al., 2002; Leonardsson & San Sebastian, 2017). Sociocultural factors, such as preference for male children, viewing marriage as a permanent institution, and dominance of in-laws; situational variables, including dowry-related coercion, arranged marriages that limit personal freedom, and

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living in joint families; and individual norms that stipulate a strict code of conduct and fixed gender roles for married women are important determinants of GBV (Kalokhe et al., 2017; Sharma & Pathak, 2015). As Indian family structures often adhere to a joint family system wherein the bride lives with her husband's family, GBV also includes family violence perpetrated by one's in-laws (Rew et al., 2013).

Although GBV cuts across demographic groups, Indian women from lower castes, who are typically less educated and are of lower socioeconomic status, are disproportionately affected by GBV, as they have less agency to leave abusive marriages (Babu & Kar, 2009; Dalal & Lindqvist, 2012). For instance, the rates of GBV among women in urban slums range from 21% to 87%, which is often higher than the rates found in the general population (Begum et al., 2015; Shrivastava & Shrivastava, 2013). Slum communities, defined as high-density areas of congested tenements in unhygienic environments that lack adequate infrastructure (India Census, 2011), are often associated with other, nontraumatic adversities as well. Examples include home destruction by the government, lack of sanitation and potable water, electricity shortages, and rat infestations (Subbaraman et al., 2012). For individuals living in these slum contexts, such poverty-related strain and the resulting daily stressors likely elevate continuous stress levels from experiences of GBV.

Previous research has demonstrated associations between GBV and many adverse mental health outcomes, including suicidality, anxiety, depression, and, most notably, PTSD (Rees et al., 2011). The PTSD diagnosis is gaining nascent acceptance in India (Mehta et al., 2005), but most studies of trauma-exposed populations have focused on youth or disaster survivors (Gilmoor et al., 2019). Despite the high rates of GBV, only two studies of which we are aware have examined PTSD among Indian GBV survivors (Chandra et al., 2009; Varma et al., 2007). Both studies were somewhat limited in their assessment of stressor conditions (e.g., trauma context and event characteristics) and related distress. Neither situated GBV in the taxonomy of traumatic stress as a Type III trauma. Type III trauma, which refers to continuous trauma or ongoing adversity, has more severe effects on mental and physical health than other trauma types that are typically situated in the past (Kaminer et al., 2018; Kira et al., 2008, 2013). Further, PTSD has considerable cross-cultural variability (Hinton & Lewis-Fernández, 2011), and researchers should account for the contextual norms and perspectives that shape Indian women's experiences of GBV when constructing culturally relevant understandings of their traumatic stressor conditions and related distress.

How the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) defines Criterion A trauma is problematic (Brewin et al., 2009; Holmes et al., 2016), as what constitutes "traumatic" is also culturally variable. For example, GBV in India frequently includes economic and emotional abuse, but these forms of abuse do not meet the Criterion A trauma thresholds. However, economic abuse can be life-threatening for a GBV survivor who lives in abject poverty and depends on her husband for food and housing security. Emotional abuse in the form of chronic experiences of marginalization, such as gender discrimination, can lead to significant and ongoing stress (e.g., Kira et al., 2015), which is heightened in patriarchal cultures that privilege male rights over women's or other genders' rights. In addition to the threat of future violence, women living in slums also face continuous stress resulting from nontraumatic stressors, such as poverty-related strain (Sinha et al., 2012; Subbaraman et al., 2014). Therefore, ongoing adversity layered onto traumatic events is not well captured by the narrow Criterion A definition.

Finally, reactions to GBV may not stem from the past for Indian women from slums because the stressor conditions—staying married to an abuser—might remain the same, as marriage is culturally regarded as a permanent institution (Rew et al., 2013). Moreover, living in conditions of ongoing adversity can be associated with distressing emotional (e.g., fear, worry) and behavioral (e.g., hypervigilance, avoidance) impacts. However, characterizing these psychological reactions as pathological and as PTSD symptoms may be inaccurate for these contexts. These reactions might be normative, adaptive, and, in some cases, protective. For example, intrusive thoughts might present as future-related concerns, and avoidance might protect against real current and future threat (Diamond et al., 2013). Trauma paradigms that broaden the field's understanding of stressor conditions are needed in India to explain both reactions: the impairing psychological effects of past traumatic events and adaptive reactions to present and potential future trauma exposure.

The CTS framework captures the complex context and experiences of individuals living in conditions of ongoing adversity (Straker & the Sanctuaries Counselling Team, 1987). Four relevant characteristics of CTS delineate this framework from PTSD criteria related to Type I (i.e., acute, unexpected, single-incident traumatic events) and Type II trauma (i.e., complex trauma typically experienced during early stages of development and often in the context of interpersonal relationships; Eagle & Kaminer, 2013). First, in the context of CTS, stressor conditions are prolonged, and danger is indirect, sporadic, and pervasive (Kira et al., 2013). Ongoing adversity is associated with no clear onset or duration. In contrast, PTSD criteria stipulate that symptoms represent a prolonged stress response that continues at least 1 month after events that occurred in the past. Whereas CTS manifests in families and is exacerbated by communities and societies, PTSD stressor conditions occur in the context of specific individuals, relationships, and events. Second, the temporal location of stressor conditions in CTS is focused on present and future rather than past traumatic experiences. This results in a preoccupation with safety, which is adaptive as opposed to the pathological form of hypervigilance seen in concomitant PTSD. Third, discriminating between real and perceived threat is challenging. Therefore, CTS involves anticipatory anxiety, which often serves to determine

realistic future trauma exposure rather than perceived threat. Fourth, CTS is defined by the absence or failure of external protective systems that perpetuate ongoing stressor conditions. Although systemic forces likely shape PTSD, traditional PTSD paradigms do not explicitly account for the absence of these protective systems.

In this way, the CTS framework describes the conditions of Type III trauma, which is the most severe trauma type compared to Types I and II, which typically encompass experiences that have occurred in the past (Kira et al., 2008). In contrast, CTS can present itself in various contexts and through different pathways. Although CTS has primarily been examined in settings of ongoing political and civil conflict (e.g., Straker, 2013), perceptions and experiences of ongoing adversity in the context of Indian women living in slums, facing daily stressors and pervasive GBV, are potentially similar in some ways. Therefore, CTS is a broader, socially and contextually relevant framework to consider (Stevens et al., 2013).

Although PTSD symptoms might also be prevalent in the context of CTS, CTS is associated with broader-ranging reactions that are sometimes more distressing when compared to PTSD. In a recent systematic review of trauma-exposed adult civilian populations from Southern Israel, the authors found higher rates of probable psychopathology and more psychological distress among individuals exposed to ongoing adversity compared to their counterparts who did not experience such ongoing stressors (Greene et al., 2018). Moreover, fear reactions to ongoing adversity have been found to be more chronic and associated with higher levels of impairment compared to symptoms associated with PTSD (Nuttman-Shwartz & Shoval-Zuckerman, 2016). In addition to PTSD, reactions to CTS also include depression, anxiety, suicidality, sleep problems, and somatization (Greene et al., 2018). However, these reactions vary in presentation, severity, and impairment. Some research has suggested that reactions to ongoing adversity are normative and appropriate (e.g. Diamond et al., 2013; Hecker et al., 2017); other studies have shown that these reactions are abnormal, maladaptive, and cause increased impairment (Itzhaky et al., 2017). Regardless, CTS is a complex and circular phenomenon that combines past, present, and future experiences, thus offering new insight into stress reactions in the context of ongoing adversity (Nuttman-Shwartz & Shoval-Zuckerman, 2016). Indian women exposed to GBV experience stressors similar to the characteristics of CTS, as GBV is often ongoing and layered with socioeconomic stressors from living in poverty and gender-based discrimination. However, a CTS lens has not been employed to examine GBV in India.

The present study aimed to fill this gap in two ways. First, using a deductive qualitative approach, we examined the applicability of the CTS framework in describing stressor conditions in the context of Indian women from slums exposed to GBV. Second, we investigated whether ongoing adversity was associated with higher levels of PTSD, anxiety, and depressive symptom severity.

Method

Participants

Participants ($N = 112$) were recruited through referral sampling from a nongovernmental organization (NGO) called CORO for Literacy, which provides social programming, educational outreach, legal aid, and supportive counseling in slum communities in Bombay. Employees, who were also community members, referred participants they knew were exposed or suspected were exposed to lifetime GBV. Adult women who consented to the study procedures and endorsed at least one lifetime traumatic event were eligible. Data were collected in two waves; the first wave ($n = 47$) included a qualitative interview and symptom screening, whereas the second wave ($n = 65$) included only symptom screening. In the full sample, 100 women endorsed a Criterion A traumatic event as well as GBV and were able to complete the symptom screening measures. Qualitative interviews from 47 women and screening data from 100 women who endorsed GBV were included in the final analyses.

Procedure

The study procedures were ethically approved by the Institutional Review Board at the University of Tulsa and members of the partnering organization, CORO for Literacy. All interviews were conducted by the second author, who is a bilingual and bicultural woman trained in conducting clinical assessments and was enrolled in a clinical psychology doctoral program during data collection. All participants were administered written and verbal informed consent in Hindi. Consenting participants were asked permission to audio-record interviews; all women consented to being audio-recorded. Interviews were strictly confidential unless participants disclosed an imminent risk of harm. In such cases, the safety protocol was to inform the field supervisor. However, this protocol was never used. All participants who endorsed lifetime or current suicidal ideation were administered verbal safety plans and provided resources for supportive and legal counseling. Interviews were conducted in private spaces, and 85% of the participants elected to be interviewed in their homes. Breaches to privacy were managed by interrupting the interview and only resuming if and when privacy was restored. The average interview length was 1 hr.

Measures

Demographic Characteristics

A short form used to collect demographic data was developed to assess participant age, place of origin, ethnicity/caste, religion, marital status, educational attainment, and monthly income.

Ethnographic Clinical Interview

A qualitative semistructured interview was developed using prompts from the Explanatory Model Interview Catalogue used in India (Raguram & Weiss, 1997). This interview was

Table 1
Sample Demographic Characteristics, Clinical Variables, and Trauma-Related Variables

	Overall sample ($N = 100$)				Endorsed ongoing adversity ($n = 57$)				Did not endorse ongoing adversity ($n = 43$)			
Variable	*M*	*SD*	*n*	%	*M*	*SD*	*n*	%	*M*	*SD*	*n*	%
Demographic characteristics												
Age (years)	34.05	9.58			33	10.65			35.44	7.87		
Primary education (years)	6.99	3.72			7.16	3.44			6.77	4.1		
Place of origin												
City			68	68.0			47	82.5			21	48.8
Village			32	32.0			10	17.5			22	51.2
Religion												
Dalit/Buddhist[a]			44	44.0			27	47.4			17	39.5
Hindu			37	37.0			18	31.6			19	44.2
Muslim			18	18.0			11	19.3			7	16.3
Christian			1	1.0			1	1.8			–	
Clinical characteristics												
PTSD symptoms (PCL-5)	29.93	16.98			34.77	15.62			23.51	16.75		
Anxiety symptoms (GAD-7)	8.87	6.39			11.14	6.1			5.79	5.48		
Depressive symptoms (PHQ-9)	10.72	6.68			13.33	6.12			7.26	5.81		
Trauma history[b]												
Interpersonal physical violence			96	96.0			56	98.2			40	93.0
Sexual violence			37	37.0			28	49.1			9	20.9
Family-related and emotional violence			81	81.0			51	89.5			30	69.8
Physical and mass trauma			70	70.0			37	64.9			33	76.7
Bereavement or loss			78	78.0			48	84.2			30	69.8

Note. PTSD = posttraumatic stress disorder; PCL-5 = PTSD Checklist for *DSM*-IV; GAD-7 = Generalized Anxiety Disorder–7 scale; PHQ-9 = Patient Health Questionnaire–9.
[a]The term Dalit, an ethnoreligious identity, is an umbrella term adopted by communities that were previously considered "untouchables" (e.g., tribal communities) in an effort to push back against centuries of caste-based oppression by dominant caste Hindus. Dalits identify as practicing Buddhism. [b]Traumatic event endorsement was not mutually exclusive. Trauma history and traumatic experiences were assessed using an adapted version of the Harvard Trauma Questionnaire (HTQ) developed for this study. HTQ items were consolidated into broader categories of (a) interpersonal physical violence (e.g., having been hit, beaten, or kicked), (b) sexual violence (e.g., forced sex), (c) family-related and emotional violence (e.g., called derogatory names for being a woman), (d) physical and mass trauma (e.g., serious accident), and (5) bereavement or loss (e.g., forced separation from a child).

selected for adaptation as it explores participants' subjective explanatory models of distress. It is designed to elicit the (a) nature of the distress, (b) causes of the distress, and (c) help-seeking or coping associated with the distress. Sample questions included, "What kinds of problems do you experience?," "What do you think causes these problems?," and "How do you cope?"

Lifetime and Current Trauma Exposure

The Harvard Trauma Questionnaire (HTQ; Mollica et al., 1992) was linguistically and culturally adapted for the present study (available upon request). Adaptations included assessing potentially traumatic events relevant to India (see Table 1 for trauma exposure categories). These events were used to screen participants into the study. This measure also elicited whether participants experienced ongoing stressors. Finally, this measure was adapted to examine the severity of PTSD symptoms and test a novel "idioms of distress" scale. As only PTSD symptoms were used in the current analyses, they are described herein.

Ongoing Stressors

The adapted HTQ was used to examine ongoing stressors (i.e., ongoing adversity) via a single item answered as either "yes" (1) or "no" (0) such that participants who endorsed any ongoing stressors were grouped separately from those who reported no ongoing stressors. If a participant reported ongoing stressors, she was asked for examples, and these were recorded verbatim.

PTSD Symptoms

The Posttraumatic Stress Disorder Checklist for *DSM-5* (PCL-5; Weathers et al., 2013) is a 20-item, self-report measure that was used to assess PTSD symptom severity based on the criteria in the *DSM-5*. Each symptom is rated for severity on a 5-point Likert scale ranging from 0 to 4, with total scores

ranging from 0 to 80. As the PCL-5 has not been validated in India, this measure was translated and back-translated for the present study until two subject-matter experts agreed on item translation. All participants were asked to anchor their symptom reports on the PCL-5 to their most stressful traumatic event. Psychometric analyses from data collected revealed good internal consistency reliability in the present sample, Cronbach's $\alpha = .88$.

Anxiety Symptoms

The seven-item Generalized Anxiety Disorders–7 scale (GAD-7; Spitzer et al., 2006), was used to assess the presence and severity of anxiety, including generalized anxiety, panic, and social anxiety. The GAD-7 has been validated in India (Kochhar et al., 2007). Respondents rate items on a scale of 0 (*not at all*) to 3 (*nearly every day*) with regard to symptom frequency in the past 2 weeks, with total scores ranging from 0 to 21 (Spitzer et al., 2006). In the present sample, the GAD-7 demonstrated good internal consistency, Cronbach's $\alpha = .84$.

Depressive Symptoms

The nine-item Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) was used to assess the presence and severity of current depressive symptoms; the scale has been validated for use in India (Kochhar et al., 2007). This questionnaire queries symptoms of depression the respondent has experienced in the past 2 weeks, with response options ranging from 0 (*not at all*) to 3 (*nearly every day*) and total scores ranging from 0 to 27. In the present sample, the PHQ-9 demonstrated adequate internal consistency, Cronbach's $\alpha = .78$.

Data Analysis

Regarding the first study aim, all interviews were transcribed from Hindi to English by a bilingual translator and checked for accuracy by the last author. Data were analyzed and coded by both authors, who are Indian, female, bilingual, and doctoral-level students and researchers in clinical psychology. First, we used a deductive positivist approach to inquiry to examine the applicability and utility of the CTS framework in the sample. All interviews were open-coded for the four overarching CTS themes by the first author using the NVivo qualitative coding program (QSR, 2000). To verify reliability, the second author audited 15% of the interviews via independent coding. Second, to remain close to the data, we used an inductive interpretive approach to map subthemes that contextualized the CTS framework in the present sample. To achieve this, we conducted a thematic analysis, and emergent subthemes within each of the four overarching CTS themes were identified. We coconstructed a thematic structure (Braun & Clarke, 2019), resolving discrepancies by discussion to reach a consensus. Audit trails were used to track the evolution of the study and coding decisions (Carcary, 2009).

Regarding the second study aim, we first examined whether any demographic covariates emerged as significantly associated with PTSD, anxiety, and depressive symptom severity. Although no demographic variables were associated with anxiety and depression, age and income were significantly correlated with PTSD symptom severity (see Supplementary Table S1). Therefore, we conducted an ANCOVA using ongoing adversity as the independent variable, age and income as covariates, and PTSD as the dependent variable. Next, we conducted two ANOVAs using ongoing adversity as the independent variable and anxiety and depression as the dependent variables, respectively. A convergent parallel design was used to triangulate the qualitative and quantitative results to examine the context and impact of ongoing adversity in this sample.

Results

Participant Characteristics

Demographic information, clinical characteristics, and variables related to trauma exposure are presented in Table 1. Most participants were unemployed (58.0%) and married (79.0%). In addition to Criterion A trauma exposure and GBV, which were endorsed by all womenin the study, 57.0% percent endorsed current ongoing adversity, including traumatic (e.g., marital rape) and nontraumatic stressors (e.g., poverty-related strain and daily hassles). Ongoing stressors were related to GBV (e.g., partner abandonment, physical and emotional abuse by partner, etc.) and/or other forms of adversity (e.g., physical ailments). The most commonly endorsed potentially traumatic events were being hit or kicked (86%), witnessing violence (65%), and sudden loss of a loved one (64%). On the HTQ, participants endorsed having experienced a median of eight potentially traumatic events. There were no significant group differences based on demographic variables.

Applicability of the CTS framework

With regard to the first study aim, the results of qualitative analyses indicated evidence of all four themes of the CTS framework (see Supplementary Table S2). Subthemes that emerged are delineated in Table 2.

Context of Stressor Conditions

Ongoing Traumatic Stressors. Participants reported physical abuse as pervasive and normalized. The women grew up in households where corporal punishment was used to enforce discipline and then married into families that were physically abusive. One woman said, "He used to fight a lot…he used to threaten to attack me with a knife." Verbal arguments, husbands' alcohol use, or instigation by one's in-laws were common precipitants. Participants discussed sexual abuse perpetrated by husbands, family members, trusted professionals (e.g., doctors), and, more rarely, strangers. Participants were afraid to disclose sexual abuse, including marital rape, for fear of not

Table 2
Subthemes Related to Each of the Four Core Themes of the Continuous Traumatic Stress Theory, as Reported by Gender-Based Violence–Exposed Indian Women From Slums

Theme	Example
Context of the stressor conditions	
Ongoing traumatic stressors	"This [physical and sexual abuse] happened with me every day—I'm a woman and I couldn't tolerate this everyday…I couldn't tolerate having, like, sex daily…there was hardly any food in my stomach and he used to make me do these things at such a time and I felt that I was becoming very *kamjor* [i.e., weak]."
Ongoing non-traumatic stressors	"My first husband did not allow me to go to work like other women. He was not working, but he would not let me to work hard and earn a living. My in-laws wouldn't allow me in their home—my husband was not earning so I had no right to be there…I used to eat, drink, and stay outside. I had no share in that house, nothing. I had two kids and I used to sleep with them on the footpath."
Cycle of hoping for change and coming to terms with current situation	"If you leave one man, your reputation is ruined…and what happens if the other man turns out to be worse than the first one? So why don't we try and repair the relationship we are already in. If we bear a little, there is a possibility that he might improve."
Temporal location of the stressor conditions	
Constant fear regarding future stress and traumatization	"My husband did drugs and he used to beat me a lot when he was under the influence…because of this, I thought, 'What if he does something?' as in, something bad might happen. Due to his violence, something could have happened to the child."
Altering current behavior to prevent future stress and traumatization	"If I stay at home, there will be fights, but if I go to work, then I won't think about home… If I spend less time at home there won't be many fights. I can do my household chores after getting back from work, go to bed, go back to work in the morning, so the fights will reduce."
Concerns about children or other family members increased future stress	"If something happens and my husband hits my son… then he might kill himself because he understands things now. I once complained to [my husband] that my son wasn't listening to me, and my husband started hitting him, and my son just went on the rail tracks outside …there was a train passing by… [My son] said that if we don't like him, he will die.… If we ever fight, [my husband] just gets after the kids."
Discriminating between real and perceived or imagined threat	
Unpredictable and unreliable behavior of perpetrators caused ongoing stress	"He listens for some time, but later, he goes back to his old ways. The kids say that their father was okay for half an hour and wonder what happened in the next half hour.… for 5 minutes he will be nice, yes…and looks for an excuse to create a scene."
Invalidation of trauma led to doubting their own reality	"When my brother-in-law's wife saw me in the morning with my face swollen due to crying through the night and my hair disheveled, she asked me what had happened. I told her what happened throughout the night, but my husband said that he hadn't done anything. Instead, I was the one who had hit him… couldn't she see it? "
The collective informs the individual's perception	"Men feel that women are like footwear. It's like this…that's why they do these things [like beatings and extramarital affairs]. If men felt that women are their equals, they wouldn't do this. If you beat the other person, it hurts less, and if you beat yourself, it hurts more."
Absence of external protective systems	
Absence or failure of the usual systems of law and order	"If I had approached the cops or an organization, for how long would they punish him? Two to 3 months or a year, not more than that. When he comes back, he will come back to me only, and when he comes back to me, he'll start doing *zulm* [i.e., ill-treatment/injustice] because the house is in his name."

(*Continued*)

Table 2
(Continued)

Theme	Example
Impacts on help-seeking	"Even now my mother doesn't care about me much, and that's why my in-laws take advantage and do whatever they please with me because I can't do anything. I have a brother, but he too doesn't care…. I had talked to [a friend] once, and she said that this problem is between husband and wife and she won't intervene. This happened 2 or 3 times, and after that, I have stopped leaving the house, and I think no matter what happens, it's better to stay home."
Barriers to help-seeking	"A woman's biggest strength or best quality is that if there is anything that you think is going to be revealed—try keeping it to yourself for as long as possible."

being believed or to keep family peace (see Table 2). One participant said,

> When he tried to force himself on me and clasped my hand, I couldn't scream. I can't say anything because he would tell me to do whatever I could do because I am his thing and no one else has a right over it and he can do whatever he wants.

Another participant stated "men always force you on every occasion. They don't want anything, but they want a woman in their bed at night." The expectation of sexual fulfillment when husbands desired sex was perceived as a women's role.

Ongoing Nontraumatic Stressors. Traumatic events often co-occurred with long-term nontraumatic stressors (e.g., emotional abuse, daily hassles). Participants described emotional abuse through their husbands' suspicions. One woman said,

> He would have dirty suspicions. He told me that you are working here and there and coming back so late – this is what his suspicion was about, and I used to feel very *bura* [i.e., bad]. And if the fights escalated, he would start to hit me.

Participants lived in restrictive environments with limited agency (see Table 2). Family members reportedly imposed rules and dictated whom the women could marry, how they behaved, and if they could work. One participant said, "My mother-in-law was old-fashioned….she was strict, and the rules were that the daughters-in-law could not venture out much…she had total control." Disobeying gender role expectations led to verbal abuse, deprivation of food, and neglect. One participant said, "I received a few stitches, and I was admitted to hospital, but [my husband] didn't even bother to check on me." The effect of such marginalization was described as such: "If someone slaps you, the mark will fade away, but if you say some words to someone, it stays on the *dil* [i.e., heart]. For me, that's the worst." Participants also expressed near-constant financial stress about losing access to food and shelter. Participants' plight of living in poverty was compounded by husbands who did not financially provide and who neglected their wives' needs. Participants reported instances of starving for days and paying rent late. One participant said, "I am *majboor* [i.e., helpless] and I have no money. I have nothing. I have to borrow money to run the household… [My husband] says that as long as his parents are alive, he won't give me a single penny." As husbands were usually the breadwinners, participants had little financial leverage. This contributed to a constant state of stress regarding their children's futures.

Cycle of Hoping for Change and Coming to Terms with Current Situation. Participants were dissatisfied with their circumstances but typically did not exit marriages. They even harbored hope that their husbands would change. One participant stated:

> I feel that if I speak to him nicely, he might like it and that might probably make him improve—it doesn't work. His *dimaag* [i.e., brain] is just like that…I burn from within, thinking what is this tension every day? I feel that I should just suddenly just leave and go …. I have to tolerate this for my kids. That's why I can't leave."

Participants did not view leaving their marriage as a viable option due to individual, cultural, and societal factors. One participant said, "It's better to die with your husband for the rest of your life." These feelings of helplessness were amplified by concerns about their children's future. This cycle of hoping circumstances would change, realizing that they will not, and continuing to stay in unhappy and abusive marriages made participants feel stuck and helpless (see Table 2).

Temporal Location of Stressor Conditions

Constant Fear Regarding Future Stress and Traumatization. A key theme that emerged was the constant state of fear regarding future stress and traumatization. One participant said, "I feel *kharab* [i.e., bad]. Meaning if I have to go someplace suddenly/urgently—I feel total *darr* [fear] that I haven't taken his permission and left, and he will shout at me." Participants were preparing for future arguments and violence. Similarly, abandonment by one's husband was a major stressor. One participant said, "I thought where I would go if my husband leaves me, and that caused me a lot of tension." The dependence on husbands for daily survival needs (i.e., food and housing security) kept participants trapped in abusive marriages.

Altering Current Behavior to Prevent Future Stress and Traumatization. Participants changed their behaviors to prevent future adversity (see Table 2). The women avoided activities that led to arguments by keeping quiet or ensuring everything was to their husbands' liking. One participant explained, "See, if I sit quietly and tolerate it then we don't have a fight. If I retort or give it back to him word for word then there is a fight. This is how it happens."

Concerns About Children or Other Family Members Increased Future Stress. Participants' fears about the future were exacerbated by responsibility regarding their children such that the women ignored safety concerns (see Table 2). One participant said, "Again and again I have this *dar* [fear] that my husband might leave me. I have two boys, and where could I go if he left me. This is the tension." This quote highlights how participants with children had more challenges in leaving abusive marriages.

Discriminating Between Real and Imagined Threat

Associations Between Ongoing Stress and Perpetrators' Unpredictable and Unreliable Behavior. Participants reported that the perpetrators' unpredictable behavior caused ongoing stress. Husbands would treat participants well and claim that they had changed but revert to the cycle of violence shortly after. These dynamics caused anticipatory fear (see Table 2). Participants expressed a gap between their expectations before marriage and the contrast in reality. This caused shock, disappointment, and ongoing stress. One participant expressed, "because he used to always talk about it but I thought that he is just talking about it and he would never raise his hand. All night [I was] crying."

Invalidation of Trauma Leads to Doubting One's Own Reality. Participants expressed invalidation by family, friends, and their community even when the abuse was evident. One participant said, "My uncle and aunt arranged this marriage, they think that my husband is right…Everyone has seen [the abuse], and [they know] that he is wrong, but my uncle and aunt still side with him." This culture of invalidation often allowed the husband and his family to manipulate the narrative and cast participants as if they were overreacting. Participants also dealt with others questioning whether their problems were "real" threats. This pervasive denial and invalidation led participants to doubt their own realities (see Table 2).

The Collective Informs the Individual's Perception of Stressors. Overarching collective and cultural narratives informed participants' appraisal of their stressors. Violence was normalized as it was ubiquitous in the community. Participants reported receiving implicit messages about how their role as women in Indian society was linked to the oppression they faced (see Table 2). They saw violence as a regrettable, but normal, occurrence. As one woman stated, "Everybody was going through this." This societal normalization of ongoing adversity blurred the lines between what was perceived as a real versus an imagined threat.

Absence of External Protective Systems

Absence or Failure of the Usual Systems of Law and Order. Participants reported a failure of law and order in protecting them from GBV. They described the police discouraging official complaints, blaming the participant, and partaking in "moral policing." Participants expressed mistrust of the police and reluctance to approach them (see Table 2). One participant said, "No, I did not go to the police because I knew that even if I went to the cops, nothing would come out of it." Participants reported positive experiences with lawyers, who intervened in cases of partner abandonment. Participants also found NGO workers and doctors to be supportive.

Impacts on Help-Seeking. Due, in part, to the absence of external protection, participants relied on social and family support systems. However, participants reported ambivalence about the perceived helpfulness of these support systems. For example, participants described negative experiences when approaching their in-laws. Common responses were denial, invalidation, and minimization of ongoing adversity. A participant who needed support regarding her husband's extra-marital affair stated, "[My sister-in-law] said that he is just chatting with her on the mobile. It's not as if he is sleeping with her. He comes back to you every day to sleep with you." When participants looked to their natal families for help, parents expressed that their daughters were now "someone else's responsibility." Essentially, perceptions regarding to whom women "belong" influenced how family members responded to calls for help (see Table 2). Participants also spoke of positive experiences of seeking help from family. In such cases, parents were advocates for their daughter's well-being. Parents counseled their daughters to leave abusive husbands and sometimes provided emotional and financial support. One participant said, "My brother… used to tell me that if your husband beats you, you shouldn't go anyplace else, but come here." Participants also found relief in sometimes disclosing problems to other women. A participant noted, "I feel relieved when I talk to them."

Barriers to Help-Seeking. Ambivalent help-seeking experiences coupled with cultural values regarding help-seeking impacted participants' willingness to seek help. Consequently, participants usually described external supports as absent. Participants had a high threshold for determining when it was time to seek help and only did so when the GBV was intolerable. One participant said, "It was only when it became too much to bear did I tell my father. I used to tolerate everything." Participants were more likely to seek help for culturally permissible problems, such as suicidality and partner abandonment, versus emotional abuse, sexual violence, or ongoing adversity.

Participants valued problem-solving on their own with the help of inner strength and resources. One participant said, "No matter what happens I keep *himmat* [courage] in my *dil* [heart] and handle things on my own." Respectability politics were invoked to retain privacy. One participant said, "If you go and tell everybody, you'll lose *izzat* [social/familial honor]—and that's why we don't talk about this to anybody."

Participants also made a delineation that adversities perpetrated by family members were "inside matters," so seeking help from "outsiders" was not acceptable. Privacy was also reinforced by the participants' fear of negative evaluation from the community. Finally, participants equated socioeconomic status and social capital to their agency. One participant said, "Who will take care of me if I have a fight and come to my mother's house? My mother is a domestic help [maid], my father is working with the Municipal Corporation."

Association of Ongoing Adversity with PTSD, Anxiety, and Depression

An ANCOVA was conducted to examine the effects of ongoing adversity on PTSD symptom severity while controlling for age and monthly income. The results suggested that participants who reported ongoing adversity indicated significantly higher PTSD symptom levels, $F(1, 96) = 9.86$, $p < .001$, compared to their counterparts who did not report ongoing adversity (see Table 1). These differences accounted for 9.3% of the variance in observed PTSD severity. Two one-way ANOVAs were conducted to test whether participants who endorsed ongoing adversity had higher levels of anxiety and depressive symptom severity. The results indicated that participants who reported ongoing adversity had significantly more severe anxiety, $F(1, 98) = 20.31$, $p < .001$, and depressive symptoms, $F(1, 98) = 25.24$, $p < .001$ (see Table 1). These differences accounted for 17.3% and 20.5% of the observed variance in anxiety and depressive symptom severity, respectively.

Discussion

The present study used a mixed-methods approach to examine CTS stressor condition characteristics and psychological symptom severity among Indian women living in slums and facing ongoing adversity. We found evidence for the four core characteristics of the CTS framework. First, the context of the stressor conditions was described as ongoing such that stressors were contiguous with the past and future. The stressor conditions included physical, sexual, and psychological abuse, usually perpetrated by husbands and in-laws. These conditions were layered by daily hassles, interpersonal conflict, and poverty-related strain. Second, the temporal location of stressor conditions was not always located in the past, which led to a preoccupation regarding current and future safety. Notably, women reported intense fears that their husbands would abandon them. As many women described absolute financial dependence on their husbands, abandonment represented a threat to survival. Participants' responsibility to their children led them to tolerate oppression, avoid provocation, and endure violence. These first two characteristics of the CTS framework align with studies from India, which have documented that abuse is often inflicted by multiple perpetrators and economic abuse is rampant (Kalaiyarasi, 2015; Kalokhe et al., 2017; P. Vyas, 2006). Third, the difficulty distinguishing real versus perceived threats manifested as women reporting anticipatory anxiety over realistic future threats. The inconsistency of their husbands' behavior caused ongoing stress. As violence was commonplace and normalized in the community, women feared judgment and doubted their reality. Similar findings have emerged from other studies conducted in India, where it is common for women to be ostracized when they disclose GBV (Panda & Agarwal, 2005). Finally, stressor conditions were shown to thrive in the absence of external protective systems. Most women reported unhelpful encounters with the police. The police were described as meddling in family affairs and discouraging complaints, which led to mistrust. Women relied more on social support systems and institutes but reported ambivalent experiences with help-seeking. In line with previous literature on barriers to GBV disclosure, women only sought help when the perceived need was high (e.g., when they were suicidal) or their circumstances became intolerable (Vranda et al., 2018). A study of 19,125 Indian women revealed that only 23.7% of women experiencing GBV ever sought help, and only 1% sought institutional help (Leonardsson & San Sebastian, 2017). The severity and multiplicity of the forms of violence predicted help-seeking. The present qualitative findings reflect the same and augment the literature by exploring cultural values and stigma as barriers to help-seeking.

The CTS framework combines past, current, and future perceptions and experiences of ongoing adversity, thereby highlighting its cyclic nature (Nuttman-Shwartz & Shoval-Zuckerman, 2016). Several factors were shown to perpetuate ongoing adversity in a continuous cycle in the present study. For example, women's family values, undergirded by concern for their children, caused them to stay in abusive marriages. Women invoked the cultural concept of *majboori* (i.e., helplessness due to dependence) as a contributor to CTS. As economic empowerment mitigates the effects of GBV (S. Vyas & Watts, 2009), the present findings confirm the role of economic abuse in maintaining the CTS cycle. Women also reported an intense fear of societal judgment and respectability politics; this prevented help-seeking behaviors and contributed to the CTS cycle. Strict gender roles that dictate what women "should" do are common cultural assumptions in India (Kumar, 2013) and were implicated in systematic forms of social oppression (e.g., family members and police advocating for women to return to their abusive husbands), thereby maintaining the CTS cycle. Finally, these gender roles were internalized and led to women experiencing ambivalence, guilt, and shame that kept them in abusive marriages as documented elsewhere (Tichy et al., 2009). Although our findings are consistent with the literature, previous studies have not examined these factors through a broader trauma lens, such as CTS, or explored them as a cycle.

Regarding the second study aim, we found that women who reported ongoing adversity endorsed significantly higher levels of PTSD, anxiety, and depressive symptom severity even after accounting for relevant covariates. Our findings align with those reported in a systematic review in which the authors also found elevated levels of PTSD, anxiety, and depression among

individuals who reported ongoing adversity compared to those whose stressors were in the past (Greene et al., 2018). These results suggest a higher degree of mental health needs for this population. However, elevated PTSD symptom severity, in particular, must be interpreted with several caveats. It is possible that participants conflated adaptive vigilance with hypervigilance, which may be overendorsed in communities with frequent adversities (Subbaraman et al., 2012). Compared to when the stressor conditions are in the past, the present findings demonstrated higher levels of symptom severity among women who reported current ongoing adversity. However, future researchers should conduct more nuanced analyses of the cumulative amount, frequency, and severity of ongoing adversity.

The present study revealed that the stressor conditions and social context of CTS is relevant in Indian slums. Further, it described the related psychological effects under conditions of ongoing adversity. These findings can inform prevention and intervention efforts for Indian women living in slums who are exposed to pervasive GBV. For example, the findings align with social interventions that disrupt conditions of ongoing adversity such as the culture of GBV in India (Go et al., 2003). Relatedly, individual interventions, such as clinical treatments, that target the psychological impacts of GBV are needed but currently lacking. Although depression treatments exist in India (Patel et al., 2014) and reduce depressive symptoms among women exposed to GBV (Patel et al., 2019), interventions for GBV survivors that target PTSD and anxiety do not exist (Gilmoor et al., 2019). This gap suggests a need for culturally adapted interventions, such as culturally adapted CBT (Hinton & Patel, 2017) or transdiagnostic protocols (Weiss et al., 2015).

The present findings can inform assessment and intervention efforts in Indian slums in three ways. First, assessment of trauma-related distress should be broader than PTSD assessment, as PTSD presumes past trauma, which is not relevant for this population. Ideally, assessment should include a range of trauma-related problems, including—but not limited to—sleep pathology, comorbid anxiety and mood disorders, and idioms of distress. Second, this setting calls for interventions that promote safety and stabilization. One way to actualize this goal is by weaving case management and safety planning into clinical care to enhance the practical utility of an intervention in this setting (Kelly et al., 2010). Finally, given that ongoing adversity elevates symptom profiles, the thresholds for clinical change must be scrutinized and revised. For instance, a 12-point reduction on the PCL-5 is the threshold used in traditional trauma-focused therapies that assume that traumatic stressors have already occurred and are in the past. Such a threshold may not apply to women in these settings given their ongoing exposure to adversity. The indices for clinical change across diagnoses and quality of life must be reshaped to be culturally and contextually appropriate.

The present study was limited in certain ways. First, we examined CTS stressor condition characteristics through secondary data analyses from interviews collected at one time point; future studies should examine CTS as a primary question and across time to verify the course and outcome of stressor conditions. Second, we examined common psychological responses to trauma exposure, but idioms of distress may be more relevant to examine in cross-cultural settings (Hinton & Lewis-Fernández, 2011). Third, we assessed ongoing adversity using a one-item screening tool. However, the symptom severity for all disorders was markedly elevated in women who reported ongoing adversity despite the use of a limited screening tool, suggesting that it may be an efficient way to differentiate high-risk groups.

Overall, the present study challenges "post"-trauma paradigms in two ways. First, the CTS framework conceptualizes stressor conditions as continuous, which is more accurate for this population and setting. Second, psychological symptom severity was predictably higher for women who reported ongoing adversity, but these symptoms may not be traditionally pathological or dysfunctional given that stressor conditions are current rather than in the past. Altogether, the present study was the first of which we are aware to integrate the CTS framework with GBV and demonstrate its applicability in understanding the experiences of GBV survivors in Indian slums. The findings shed light on unique contextual and cultural considerations in this setting. In addition, these findings apply to the ongoing epidemic of GBV worldwide in that GBV is often perpetrated as an ongoing Type III traumatic event (e.g., domestic violence). Therefore, the clinical implications of assessment and intervention with regard to ongoing adversity may highlight new directions in other cultural settings. To our knowledge, our study was one of few to apply the CTS framework outside conflict settings and, thus, represents a theory-driven approach to expanding trauma assessment and treatment in similar communities worldwide.

Open Practices Statement

The study reported in this article was not formally preregistered. Neither the data nor the materials have been made available on a permanent third-party archive. Requests for the data or materials should be sent via email to the corresponding author at anushka.patel@ucsf.edu.

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