When Silence Becomes Survival the Psychology of Silence, The Politics of Voice, and the Imperative of Trauma-Responsive Practice for Survivors of Intimate Partner Violence in India

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ABSTRACT:

In India, silence is the most common response to ntimate partner violence (IPV): the National Family Health Survey-5 records that approximately 29% of ever-married women aged eighteen to forty-nine have experienced spousal violence, and that roughly 86% of them have never sought help from any source. This article argues that such silence is neither indifference nor mere passivity but a rational, structurally enforced, and psychologically deep phenomenon operating simultaneously at three distinct but interdependent levels. At the neurological level, sustained interpersonal trauma reorganises the brain and the body in ways that make coherent, consistent articulation difficult precisely where institutions most demand it. At the psychological level, coercive control, intermittent reinforcement, and intimate betrayal displace the survivor's own voice with a dominant, problem-saturated narrative authored by the abuser and corroborated by a patriarchal social order. At the structural level, family, community, law enforcement, and the adversarial legal process have historically enforced rather than invited disclosure. Against this layered silence, the article examines Narrative Therapy, trauma-specific Cognitive Behavioural Therapy — principally Cognitive Processing Therapy and Prolonged Exposure — and Trauma-Informed Care as complementary frameworks for restoring voice, and draws on restorative justice scholarship to argue that recovery from IPV ultimately requires the social recognition of harm. Insisting throughout on contextual translation to the intersecting realities of caste, class, religion, gender, and economic dependence, the article contends that breaking silence demands coordinated, sequential intervention at every level at which it is produced.

Keywords: intimate partner violence; trauma-informed care; narrative therapy; cognitive processing therapy; coercive control; complex PTSD; restorative justice; voice and silence; India.

I. Introduction

In India, silence is the most common response to intimate partner violence. The National Family Health Survey-5 (NFHS-5), conducted between 2019 and 2021 across 636,699 households, found that approximately 29% of ever-married women aged eighteen to forty-nine had experienced spousal violence.[1] Of these, approximately 86% had never sought help from any source.[2] These figures are not the product of indifference. They are the product of a silence that is rational, structurally enforced, and psychologically deep. Understanding that silence — what produces it, what it costs, and what it takes to break it — is the central concern of this article.

The dominant tendency in discussions of IPV, whether legal, social, or clinical, is to ask questions about the violence: how severe it is, how often it occurs, how it should be classified, and how it should be punished. These are necessary questions. But they proceed from an assumption that the violence is already known, already visible, already available to institutional response. In the overwhelming majority of cases in India, it is none of these things. The prior question — the question that must be answered before any legal reform or therapeutic intervention can reach the people it is designed to serve — is not why violence occurs but why it stays hidden. What is it, inside the survivor and in the society that surrounds her, that keeps the violence contained within the walls of the household, unnamed, unreported, and beyond the reach of any system that might respond to it?

This article argues that silence in IPV is not a single phenomenon but a layered one, operating at three distinct but interdependent levels. The first is neurological: trauma reorganises the brain in ways that can make articulation, consistency, and rational deliberation difficult, particularly at the moments when the legal system most demands them. The second is psychological: the chronic experience of coercive control, intermittent reinforcement, and intimate betrayal produces a reorganisation of the self in which the survivor's own voice becomes inaccessible to her, displaced by the dominant narrative that the abuser and the patriarchal social order have written in its place. The third is structural: the social institutions that surround the survivor — family, community, law enforcement, the legal process itself — have historically functioned not as invitations to speak but as enforcers of silence, treating domestic violence as a private matter that does not require, and may not deserve, public response.

The article then turns to what breaking silence requires. It examines the clinical frameworks of Narrative Therapy, developed by Michael White and David Epston, and Cognitive Behavioural Therapy (CBT) in its trauma-specific forms — principally Cognitive Processing Therapy (CPT) as developed by Patricia Resick, and Prolonged Exposure (PE) as developed by Edna Foa and colleagues — as frameworks for addressing the neurological and psychological layers of silence. It examines Trauma-Informed Care (TIC) as the ethical architecture within which this work must be conducted. And it argues that the communal dimensions of breaking silence — the act of speaking, being heard, and having harm publicly acknowledged — connect the therapeutic and the juridical in ways that matter practically, not merely philosophically. The restorative justice scholarship on storytelling and community circles is drawn upon here not to make a legal argument but to illuminate what the clinical literature itself implies: that healing from IPV requires, at some point, the social recognition of harm. Individual therapy, however excellent, cannot provide what only a community can: the public

[1] International Institute for Population Sciences (IIPS) and ICF, *National Family Health Survey (NFHS-5), 2019–21: India* Vol. I 646 (2021) [*hereinafter* NFHS-5 Report]. The domestic violence module was administered to a subsample of 72,320 women aged 18–49.

[2] *Id.* at 650. Of the 17,765 women in the domestic violence subsample who reported experiencing any form of IPV, only 2,449 — approximately 13.8% — sought help from any source, whether formal or informal. This rate has remained essentially unchanged across the three NFHS rounds of 2005–06, 2015–16, and 2019–21.

acknowledgment that the violence was real, that it was wrong, and that it matters.

The Indian context is the article's consistent frame of reference. The intersection of caste, class, religion, gender, and economic dependence in structuring Indian women's vulnerability to IPV and their access to help means that general principles require, at every stage, contextual translation. A framework derived exclusively from Western clinical literature and applied without adaptation to India is not trauma-informed. It is culturally oblivious. This article insists on the distinction.

II. Literature Review

This article sits at the intersection of five bodies of scholarship that have, for the most part, developed in isolation from one another: the neurobiology of trauma; the clinical psychology of coercive control and complex post-traumatic stress; the therapeutic literature on recovery; the framework of trauma-informed care; and the socio-legal scholarship on domestic violence and restorative justice in India. This review surveys each in turn, identifies the points at which they converge, and locates the gap that the present study seeks to address.

The empirical scale of intimate partner violence in India is established principally by the National Family Health Survey, whose successive rounds have measured both the prevalence of spousal violence and the persistently low rates of help-seeking, and by epidemiological surveillance work that situates those findings within nearly two decades of trend data.[3]

A second body of work, drawn from the neurobiology of trauma, supplies part of the explanation for that silence. Van der Kolk's account of how sustained interpersonal trauma reorganises the brain — hyperactivating the systems that detect threat while suppressing the regions that govern language and narrative — and Levine's complementary work on the somatic encoding of trauma together establish that the capacity for coherent, consistent articulation is itself a casualty of prolonged abuse.[4]

Herman's formulation of complex post-traumatic stress disorder bridges the neurological and the psychological, documenting both the alterations in self-perception that prolonged interpersonal trauma produces and the systematic misreading of those alterations by the institutions that survivors encounter.[5]

The question of why survivors remain, and remain silent, is most influentially theorised in Walker's cycle-of-abuse model and in the wider literature on coercive control and trauma bonding, which reframes a survivor's attachment to an abusive partner as a conditioned response rather than a free choice.[6]

On the therapeutic side, the narrative tradition of White and Epston offers a vocabulary — externalisation, the dominant problem-saturated story, unique outcomes, and communal witness — that maps closely onto the displacement of voice that coercive control produces.[7]

The cognitive-behavioural tradition, from Beck's foundational account of maladaptive cognition

[3]On the prevalence and distribution of intimate partner violence in India, *see* NFHS-5 Report, *supra* note 1, at 646, 650; Raksha Dandona et al., *Domestic Violence in Indian Women: Lessons from Nearly 20 Years of Surveillance*, 22 BMC Women's Health 128 (2022) (documenting IPV trends across India from 2001 to 2018 using NCRB data).

[4]Bessel A. van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (Viking Press 2014) [*hereinafter* van der Kolk, *The Body Keeps the Score*]; Peter A. Levine, *Waking the Tiger: Healing Trauma* (North Atlantic Books 1997).

[5]Judith L. Herman, *Trauma and Recovery: The Aftermath of Violence — From Domestic Abuse to Political Terror* (Basic Books 1992) [*hereinafter* Herman, *Trauma and Recovery*].

[6]Lenore E. Walker, *The Battered Woman* (Harper & Row 1979); *see also* Sujata Dasgupta, *Thinking Forward: Preventing Intimate Partner Violence*, in *Preventing Intimate Partner Violence: Interdisciplinary Perspectives* (Policy Press 2017).

[7]Michael White & David Epston, *Narrative Means to Therapeutic Ends* (Norton 1990) [*hereinafter* White & Epston, *Narrative Means*]; Michael White, *Maps of Narrative Practice* (Norton 2007) [*hereinafter* White, *Maps of Narrative Practice*].

through Resick's Cognitive Processing Therapy and Foa's Prolonged Exposure, addresses the same injury at the level of specific beliefs and avoidance behaviours, treating recovery as a problem of meaning-making and of learning to tolerate rather than evade traumatic material.[8]

Cutting across these clinical modalities is the framework of trauma-informed care articulated by SAMHSA, which is less a therapeutic technique than an ethical architecture intended to govern every institutional encounter with a survivor.[9]

A final body of scholarship concerns the communal dimension of recovery. The restorative justice literature — including feminist accountability scholarship and emerging Indian work on community circles — argues that the public recognition of harm is a distinct and irreplaceable component of healing, while cautioning that community-based processes can as readily entrench patriarchal authority as disrupt it.[10]

Underlying all of this is the Indian legal framework itself. The Protection of Women from Domestic Violence Act, 2005, marked a shift toward civil, protective relief. while the continued non-criminalisation of marital rape — formerly under the Indian Penal Code, 1860, and now under its successor the Bharatiya Nyaya Sanhita, 2023, together with the unresolved constitutional litigation surrounding it — marks the limits of the law's recognition of intimate harm.

The Research Gap

Three gaps emerge from this survey. First, the bodies of scholarship outlined above operate as largely self-contained silos: the neurobiological, clinical, therapeutic, trauma-informed-care, and socio-legal literatures are seldom integrated, with the result that no single framework explains how the silence surrounding IPV is produced simultaneously at the neurological, psychological, and structural levels, or how a response might be sequenced across them. Second, the clinical and therapeutic frameworks on which any intervention would draw are almost entirely Western in origin and are rarely translated to the intersecting realities of caste, class, religion, gender, and economic dependence that structure both the experience of IPV and access to help in India. Third, the Indian socio-legal literature on the Protection of Women from Domestic Violence Act and the marital rape exception has developed in substantial isolation from the trauma and voice scholarship, leaving unexplained the persistent distance between the remedies the law formally provides and the help that survivors actually seek.[11]

[8]Aaron T. Beck, A. John Rush, Brian F. Shaw & Gary Emery, *Cognitive Therapy of Depression* (Guilford Press 1979); Patricia A. Resick, Candice M. Monson & Kathleen M. Chard, *Cognitive Processing Therapy for PTSD: A Comprehensive Manual* (Guilford Press 2017) [*hereinafter* Resick et al., *CPT Manual*]; Edna B. Foa, Elizabeth A. Hembree & Barbara Olasov Rothbaum, *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences — Therapist Guide* (Oxford University Press 2007) [*hereinafter* Foa et al., *PE Manual*].

[9]Substance Abuse and Mental Health Services Administration (SAMHSA), *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. SMA 14-4884 (2014) [*hereinafter* SAMHSA].

[10]Reelika Sinha, *Intimate Partner Violence and Restorative Justice in India* (PhD thesis, CHRIST (Deemed to be University), Bengaluru 2024–25) [*hereinafter* Sinha, *IPV and RJ in India*]; Sarah Curtis-Fawley & Kathleen Daly, *Gendered Violence and Restorative Justice: The Views of Victim Advocates*, 11 Violence Against Women 603 (2005); Ann Russo, *Feminist Accountability: Disrupting Violence and Transforming Power* (NYU Press 2018).

[11]The Indian Penal Code, 1860, No. 45, Acts of Parliament, 1860 (India), § 375 Exception 2, now replaced by the Bharatiya Nyaya Sanhita, 2023, No. 45, Acts of Parliament, 2023 (India), § 63 Exception 2, which carries the marital rape exception forward in substantially identical terms and fixes the age threshold at eighteen years. The Indian Penal Code, 1860, the Code of Criminal Procedure, 1973, and the Indian Evidence Act, 1872 were replaced, with effect from 1 July 2024, by the Bharatiya Nyaya Sanhita, 2023, the Bharatiya Nagarik Suraksha Sanhita, 2023, No. 46, Acts of Parliament, 2023 (India), and the Bharatiya Sakshya Adhiniyam, 2023, respectively. The Protection of Women from Domestic Violence Act, 2005, No. 43, Acts of

This article addresses these gaps by proposing an integrated account of how silence is produced and a correspondingly sequenced — therapeutic and then communal — account of how it might be broken. Its distinctive contribution is not the individual clinical frameworks, which are well established, but their integration and, above all, their translation to the Indian context. The claim that silence in IPV is produced simultaneously at the neurological, psychological, and structural levels can be assembled in pieces from the existing literatures; what this article seeks to make its own is the reading of that layered silence through the specific intersections of caste, class, religion, gender, and economic dependence that govern both the experience of IPV and access to help in India.

Research Questions

Proceeding from this gap, the article is organised around four research questions:

(1) Through what mechanisms is the silence of survivors of intimate partner violence in India produced and sustained at the neurological, psychological, and structural levels, and how do those mechanisms interact?

(2) To what extent can the principal clinical and therapeutic frameworks for trauma recovery — Narrative Therapy, Cognitive Processing Therapy, Prolonged Exposure, and Trauma-Informed Care — be understood as responses to specific layers of that silence?

(3) What is required to translate these predominantly Western frameworks to the intersectional realities of caste, class, religion, gender, and economic dependence that shape IPV and help-seeking in India?

(4) How might therapeutic and communal — including restorative — responses be sequenced so that the social recognition of harm becomes possible without re-traumatising the survivor, and what does this imply for the design of legal and community institutions?

III. Methodology

This article is conceptual and doctrinal rather than empirical, and it advances its argument through two complementary methods. The first is an integrative literature review: a recognised form of inquiry that synthesises bodies of research which have developed in isolation from one another in order to generate new framing rather than merely to summarise existing findings.[12] The five literatures identified above — the neurobiology of trauma, the clinical psychology of coercive control and complex post-traumatic stress, the therapeutic literature on recovery, trauma-informed care, and the socio-legal scholarship on domestic violence and restorative justice — were selected because each supplies a distinct part of the explanation for why survivors of IPV remain silent, and because they have not previously been read against one another as a single, layered phenomenon. Within each literature, sources were chosen for their foundational status, their analytical centrality to the problem of voice and silence, and, where available, their empirical support, with priority given to peer-reviewed and primary sources over secondary restatement.

Principally the Protection of Women from Domestic Violence Act, 2005, the marital rape exception formerly in the Indian Penal Code, 1860, and now carried forward into the Bharatiya Nyaya Sanhita, 2023, and the constitutional litigation surrounding it— to establish what the

Parliament, 2005 (India), a separate civil enactment, remains in force and is unaffected by this recodification. On the constitutional challenge to the exception, see Independent Thought v. Union of India, (2017) 10 SCC 800; RIT Foundation v. Union of India, W.P.(C) 284/2015 (Delhi H.C., Division Bench, 2022); the appeals and connected petitions now pending before the Supreme Court are directed at the exception as carried forward in Section 63 of the Bharatiya Nyaya Sanhita, 2023.

[12]On the integrative literature review as a distinct research method that synthesises disparate literatures to produce new conceptual framing rather than to summarise findings, see Richard J. Torraco, *Writing Integrative Literature Reviews: Guidelines and Examples*, 4 Hum. Resource Dev. Rev. 356 (2005). On doctrinal legal method, see Terry Hutchinson & Nigel Duncan, *Defining and Describing What We Do: Doctrinal Legal Research*, 17 Deakin L. Rev. 83 (2012).

law formally provides and where its recognition of intimate harm reaches its limits. The two methods are not pursued separately but brought into contact: the clinical and neurobiological literatures are used to interrogate the assumptions about disclosure, consistency, and credibility on which the legal materials silently rely.

This design carries limitations that are best stated at the outset. The article generates no primary data of its own; its claims about the Indian context rest on existing survey evidence, principally the National Family Health Survey, and on the secondary literature, and they are therefore propositions to be tested by future empirical and field research rather than findings established here. The clinical frameworks it examines were, moreover, developed largely in Western settings, so the article's central methodological commitment is to their critical translation rather than their wholesale application — a translation for which it argues in principle but which, within the limits of a conceptual study, it cannot validate in practice.

IV. The Neurological Architecture of Silence

The first and most fundamental reason that survivors of IPV do not speak is that trauma makes speaking physiologically difficult. This is not a metaphor. Bessel van der Kolk's influential synthesis of the trauma literature argues that sustained interpersonal trauma reorganises the brain, and a convergent body of neuroimaging evidence associates post-traumatic stress with heightened reactivity in the amygdala — the brain's threat-detection centre — alongside reduced regulatory activity in the prefrontal cortex, which governs language, rational deliberation, and the organisation of experience into coherent narrative.[13] The survivor who appears inconsistent, evasive, or emotionally dysregulated when giving an account of violence is not lying or exaggerating. Her brain is doing precisely what sustained trauma has trained it to do: prioritising threat-response over language, survival over narration.

Peter Levine's work on somatic trauma extends this understanding into the body itself. Trauma is not stored solely as conscious memory. It is encoded in the physical — in muscle tension, chronic arousal states, somatic pain, and the phenomenon of dissociation. Levine describes what he calls frozen or incomplete survival responses: the body's physiological preparations for fight or flight that were suppressed at the moment of the original trauma and that remain physiologically active, generating distress and disrupting function long after the immediate danger has passed.[14] The survivor who freezes when asked to describe what happened, who cannot remember the sequence of events, who feels suddenly absent from her own body during an interview — she is not being uncooperative. She is experiencing the somatic signature of unprocessed trauma.

This neurological reality has consequences that extend far beyond the clinical encounter. It reaches into every institutional setting where survivors are expected to produce coherent, consistent, emotionally regulated accounts of violence: police stations, courtrooms, social welfare offices, and any facilitated process — restorative or otherwise — that requires the survivor to speak about what was done to her before she has had the support to do so safely. Judith Herman has argued that the symptoms of complex PTSD are routinely misread by

[13] van der Kolk, *The Body Keeps the Score*, *supra* note 4, at 21, 44–46. For peer-reviewed meta-analytic and neuroimaging support for the associated amygdala–prefrontal pattern, see *Amit Etkin & Tor D. Wager, Functional Neuroimaging of Anxiety: A Meta-Analysis of Emotional Processing in PTSD, Social Anxiety Disorder, and Specific Phobia*, 164 Am. J. Psychiatry 1476 (2007); *Lisa M. Shin, Scott L. Rauch & Roger K. Pitman, Amygdala, Medial Prefrontal Cortex, and Hippocampal Function in PTSD*, 1071 Annals N.Y. Acad. Sci. 67 (2006). The finding that ventromedial prefrontal hypoactivity accompanies amygdala hyperactivity is among the more robust in the imaging literature, though it is observed in some patient groups more than others and should not be overstated as a uniform or deterministic mechanism.

[14] Levine, *Waking the Tiger*, *supra* note 4, at 17–20, 97–99. Levine identifies the incomplete discharge of survival responses as the somatic mechanism through which trauma remains physiologically active long after the original threat has passed.

institutional actors as evidence of unreliability, manipulation, or exaggeration.[15] The survivor who presents in this way is not unreliable. She is a person whose nervous system has been reorganised by sustained harm. Any institutional response that does not build this understanding into its design — that does not, in SAMHSA's formulation, ask what happened to her rather than what is wrong with her — will reproduce, within the institutional encounter, the same silencing that the violence has already produced at home.

Why Women Stay: Trauma Bonding and the Cycle of Abuse

Silence is sustained not only by the difficulty of speaking but by the complexity of the relationship within which the violence occurs. The question that communities, police, and even clinical practitioners sometimes ask — why did she not simply leave? — reflects a fundamental ignorance of the psychological dynamics that coercive intimate relationships systematically produce.

Lenore Walker's foundational study of battered women identified the cycle of four recurring phases that characterises abusive relationships: a period of tension building; the acute incident of violence; a reconciliation phase marked by remorse, affection, and promises of change; and a period of relative calm.[16] It is the reconciliation phase that is clinically decisive. The warmth and apparent vulnerability of this phase creates intermittent reinforcement — the neurological mechanism by which unpredictable rewards produce the strongest and most persistent conditioning. Operating under conditions of intimate dependency and sustained threat, this intermittent pattern produces the phenomenon the clinical literature calls trauma bonding: an intense emotional attachment to the abuser that has the neurochemical structure of addiction.[17] A woman who returns to an abusive partner, or who withdraws a complaint after the reconciliation phase, is not irrational. She is responding to the most powerful neurological conditioning her relationship has produced. The practitioner who does not understand this will interpret her behaviour as a choice and will respond to her accordingly, compounding the institutional silence that already surrounds her.

In the Indian context, the neurological dynamics of trauma bonding intersect with social and economic structures that reinforce them at every level. Economic dependence on the marital household, the cultural expectation that women bear responsibility for preserving the family unit, the social stigma attached to separation and to the reporting of spousal violence, and the legal silences that surround certain forms of IPV — most notably most notably the non-criminalisation of marital rape, carried forward from Section 375 Exception 2 of the Indian Penal Code, 1860[18] into Exception 2 to Section 63 of

[15]Herman, *Trauma and Recovery*, *supra* note 5, at 119–122. Herman documents the systematic misreading of complex PTSD symptoms — fragmented accounts, emotional dysregulation, and inconsistency — as evidence of unreliability rather than neurological consequence.

[16]Walker, *The Battered Woman*, *supra* note 6, at 42–54. Walker's cycle of abuse model was developed from research with over 400 battered women and identifies the reconciliation phase as the source of the intermittent reinforcement that explains the persistence of survivor attachment to abusive partners.

[17]The concept of traumatic bonding originates with Donald G. Dutton & Susan L. Painter, *Traumatic Bonding: The Development of Emotional Attachments in Battered Women and Other Relationships of Intermittent Abuse*, 6 Victimology 139 (1981), and was empirically tested in Dutton & Painter, *Emotional Attachments in Abusive Relationships: A Test of Traumatic Bonding Theory*, 8 Violence & Victims 105 (1993), which identify power imbalance and intermittent abuse as its two structural preconditions; on its addictive quality, see Patrick J. Carnes, *The Betrayal Bond: Breaking Free of Exploitive Relationships* (Health Communications 1997). On the manipulation, isolation, economic control, and intermittent reinforcement that sustain these dynamics in practice, see Dasgupta, *Thinking Forward*, *supra* note 6.

[18]The Indian Penal Code, 1860, § 375 Exception 2, supra note 11, now carried forward into the Bharatiya Nyaya Sanhita, 2023, § 63 Exception 2 ("Sexual intercourse or sexual acts by a man with his own wife, the wife not being under eighteen years of

the Bharatiya Nyaya Sanhita, 2023 — together create a social environment in which silence is not merely the path of least resistance. It is the only path that does not cost the woman everything she has been told she is supposed to protect.

V. The Psychological Architecture of Silence: The Stolen Self

Beyond the neurological, there is a deeper layer of silence that is psychological in character: the systematic displacement of the survivor's own voice by the narrative that the abuser has constructed and that patriarchal social structures have endorsed. This is what Judith Herman means when she describes complex PTSD as producing, among its other effects, a profound alteration in self-perception: the survivor comes to experience herself as permanently damaged, as responsible for what was done to her, and as fundamentally different from other people who have not been marked by violence.[19] This alteration is not a side-effect of IPV. It is one of its primary mechanisms. Coercive control is designed to produce it. The abuser who tells a woman, repeatedly and systematically, that she is worthless, that she deserved it, that no one would believe her, that she has nowhere to go — is not merely being cruel. He is constructing an interior architecture of silence that will keep the violence hidden more effectively than any lock.

Michael White and David Epston's foundational work in narrative therapy names this architecture with clinical precision. They call it the dominant problem-saturated story: an identity narrative defined entirely by the abuser's voice and reinforced by social structures that corroborate it.[20] The survivor no longer recognises this narrative as external. It has become, in her experience, who she is. She does not think: the abuser has told me I am worthless. She thinks: I am worthless. She does not think: he has tried to take my voice. She thinks: I have no voice to take. This internalisation is the psychological achievement of sustained coercive control, and it is the primary obstacle to any therapeutic or juridical intervention that requires the survivor to speak on her own behalf.

Patricia Resick's clinical work in Cognitive Processing Therapy identifies the specific cognitive forms that this internalised narrative takes. She calls them stuck points: beliefs forged in the experience of trauma that prevent the survivor from processing what occurred and that maintain the PTSD symptom burden indefinitely.[21] In survivors of domestic violence, these stuck points cluster around five domains that correspond directly to what coercive control damages. Safety stuck points — I will never be safe, danger is everywhere — reflect the recalibration of threat-perception. Trust stuck points — no one can be trusted, closeness means harm — reflect the destruction of relational faith by intimate betrayal. Power and control stuck points — I am helpless, nothing I do matters — reflect the learned helplessness that coercive control is designed to produce. Esteem stuck points — I am worthless, damaged, undeserving of help — are the direct internalisation of the abuser's narrative. And intimacy stuck points — connection leads to suffering, I will always end up alone — reflect the foreclosure of relational possibility that complex trauma creates.[22]

age, is not rape"); see Independent Thought v. Union of India, supra note 11 (removing the exception only for wives below eighteen years of age, leaving adult married women unprotected); RIT Foundation v. Union of India, supra note 11 (split verdict on the constitutionality of the exception for adult wives; the appeals and connected petitions, now directed at the exception as retained in Section 63 of the Bharatiya Nyaya Sanhita, 2023, remain sub judice before the Supreme Court).

[19]Herman, *Trauma and Recovery*, *supra* note 5, at 96–122. Herman's criteria for complex PTSD include alterations in self-perception — specifically the experience of chronic shame, guilt, and the belief of being permanently damaged — as primary features of prolonged interpersonal trauma.

[20]White & Epston, *Narrative Means*, *supra* note 7, at 38–40. The concept of the dominant problem-saturated story describes the identity narrative defined by external, oppressive voices that narrative therapy seeks to externalise and contest.

[21]Resick et al., *CPT Manual*, *supra* note 8, at 49–68.

[22]Resick et al., *CPT Manual*, *supra* note 8, at 49–68. The five domains — safety, trust, power and control, esteem, and intimacy — derive from the

The practical consequence of this architecture of stuck points is that the survivor who arrives at a police station, a Protection Officer's office, or a clinical service does not arrive as a person who knows what she needs and is capable of asking for it. She arrives as a person who has been taught, through sustained systematic effort, that she does not deserve help, that no one will believe her, that speaking will make things worse, and that the violence is, in some fundamental sense, her fault. Any institutional response that does not address these stuck points — that does not create the conditions within which they can be identified, examined, and challenged — will find the survivor withdrawing, recanting, or simply not returning. Not because she does not want help. Because everything she has been taught tells her that help is not available to people like her.

VI. The Structural Architecture of Silence: Institutions That Enforce Rather Than Invite

The third layer of silence is structural. The social institutions that surround the survivor — family, community, law enforcement, the legal process — have historically functioned not as invitations to speak but as reinforcements of the domestic silence that IPV depends upon. Understanding this is as important as understanding the neurological and psychological layers, because even a survivor who has found the neurological and psychological capacity to speak will remain silent if the institutions to which she might speak are experienced as hostile, dismissive, or dangerous.

The retributive criminal justice system is, in many of its features, precisely this kind of institution. Its procedural framework — since 1 July 2024 the Bharatiya Nagarik Suraksha Sanhita, 2023, which replaced the Code of Criminal Procedure, 1973 — continues to structure the registration, investigation, and trial of sexual and domestic offences along essentially adversarial lines. The adversarial process filters the survivor's narrative through rigid legal categories that prioritise evidentiary sufficiency over experiential truth. Cross-examination — designed to challenge, fragment, and where possible discredit the account of the opposing party — replicates within the courtroom the dynamics of the abusive relationship: the demand for a consistent, controlled, emotionally neutral account from a person whose neurological state makes consistency, control, and emotional neutrality physiologically difficult. Credibility is assessed on criteria — composure, consistency, apparent reasonableness — that trauma specifically impairs. The result is that the very women whose need for institutional response is greatest are least able to meet the institutional standards by which their credibility is judged.

The Protection of Women from Domestic Violence Act, 2005 (PWDVA) was a significant legislative advance precisely because it recognised, at least implicitly, some of these limitations.[23] Its civil framework, its focus on immediate protective relief rather than criminal conviction, and its provision for a range of remedies including protection orders, residence orders, and monetary relief represent a departure from purely retributive logic. But the Act's implementation has been severely constrained by structural failures: inadequate numbers of Protection Officers, insufficient training of those who are appointed, and a pervasive institutional culture that continues to treat domestic violence as a matter for family resolution rather than legal intervention. The gap between the Act's

constructivist self-development theory of I. Lisa McCann & Laurie Anne Pearlman, *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation* (Brunner/Mazel 1990), and were incorporated into cognitive processing therapy through Patricia A. Resick & Monica K. Schnicke, *Cognitive Processing Therapy for Sexual Assault Victims*, 60 J. Consulting & Clinical Psychol. 748 (1992); they correspond directly to the relational and cognitive structures that coercive control is designed to damage.

[23] The Protection of Women from Domestic Violence Act, 2005, *supra* note 11. The Act establishes a civil framework for protective relief — including protection orders (§ 18), residence orders (§ 19), and monetary relief (§ 20) — and provides for the appointment of Protection Officers (§ 8) to assist aggrieved women in accessing its remedies.

aspirations and its implementation is itself a form of institutional silence.

Community and family — which are in many contexts the first and most accessible resources available to a survivor — have in the Indian setting often functioned as enforcers rather than disrupters of silence. The cultural expectation that women preserve the marital family, the social stigma associated with reporting spousal abuse, the economic consequences of separation in households where women lack independent income, and the authority of community elders who define the resolution of domestic disputes in terms of family honour rather than individual rights — these are not incidental features of the social landscape. They are the structural conditions within which the neurological and psychological silencing of individual survivors is sustained and amplified.

Restorative justice scholarship has identified this structural dimension of silence as both the central challenge and the central opportunity of community-based responses to IPV. The community circle, when constituted by a survivor's own community and facilitated by someone who understands the gendered dynamics of domestic violence, can transform the community from an enforcer of silence into a witness to harm.[24] The storytelling component of restorative justice — in which the survivor speaks her truth in her own words, is believed without having to prove her experience, and receives the community's condemnation of the violence rather than its pressure to maintain domestic peace — is not merely a procedural mechanism. It is a structural disruption of the conditions that produce and sustain IPV's invisibility. This is why the design of any community-based response to IPV in India matters so profoundly: the community can break silence or it can deepen it. The difference lies entirely in whether the process is designed to centre survivor safety and voice, or to centre family preservation and communal reputation.

This optimism about restorative process must, however, be qualified by the sustained feminist critique of restorative justice in cases of partner violence, which this argument takes seriously rather than sets aside. Feminist scholars have warned that restorative and informal community processes can reproduce the very power imbalance they are meant to redress: that the pressure to reconcile may be experienced as a pressure to forgive; that an apology can be deployed by a practised abuser as a further instrument of control rather than a genuine acknowledgment of harm; and that diversion to community processes may withdraw from survivors the protection and resources that the formal legal system, for all its failings, is obliged to provide.[25] These objections are not reasons to abandon the communal recognition of harm that this article argues recovery requires. They are reasons to insist on its preconditions: that any communal process be entered only after the clinical preparation described below; that survivor safety be treated as a non-negotiable threshold rather than one value to be balanced against family preservation; and that facilitation lie with practitioners trained in the dynamics of coercive control rather than with community authorities whose interest in reconciliation may be indistinguishable from the social pressure that produced the silence in the first place. The Indian community circle, the panchayat, and analogous traditions are especially exposed to these dangers,

[24]Sinha, *IPV and RJ in India*, *supra* note 10, ch. 3, ss. 2.1, 2.3 (on the storytelling component of restorative justice as a platform that ensures the survivor is no longer a nameless victim but someone with a voice to take control of her situation, and on the risk that community circles in India may be co-opted by patriarchal authority structures that prioritise family preservation over survivor safety); *see also* Curtis-Fawley & Daly, *supra* note 10, at 625; Russo, *supra* note 10.

[25]For the principal feminist critiques, see Kathleen Daly & Julie Stubbs, *Feminist Engagement with Restorative Justice*, 10 Theoretical Criminology 9 (2006); Julie Stubbs, *Beyond Apology? Domestic Violence and Critical Questions for Restorative Justice*, 7 Criminology & Crim. Just. 169 (2007); Donna Coker, *Enhancing Autonomy for Battered Women: Lessons from Navajo Peacemaking*, 47 UCLA L. Rev. 1 (1999). On the manipulative deployment of apology in particular, see Stubbs, *supra*.

and the burden of the argument here is that the sequencing and the safeguards, not the communal form itself, determine whether such processes break silence or deepen it.

VII. Narrative Therapy: Giving the Survivor Her Story Back

Against the backdrop of this layered silence, Narrative Therapy offers a therapeutic response that is precisely calibrated to its psychological architecture. The foundational principle of the approach developed by Michael White and David Epston at the Dulwich Centre in Adelaide is that the person is not the problem. The problem is the problem.[26] This principle, which White and Epston called externalisation, directly addresses the dominant problem-saturated story that coercive control has installed in the survivor's sense of herself. By treating the violence and its consequences as external to the survivor — as something that has been done to her, something that has operated upon her life from outside rather than something that defines who she is — externalisation restores the ontological distance between the person and the harm inflicted upon her. It does not minimise the harm. It refuses to let the harm constitute the person.

In the context of IPV in India, this therapeutic principle carries a political dimension that White and Epston were always careful not to suppress. The dominant problem-saturated story is not only constructed by individual abusers. It is endorsed and amplified by a patriarchal social order that tells women from childhood that their value lies in their capacity to maintain the family, that violence is the consequence of their failure to do so, and that speaking about what happens behind the domestic door is a betrayal of obligations more sacred than their own well-being. Externalisation in this context is not merely a linguistic device. It is an act of resistance against the social conditions that produce silence, because it refuses the premise that the violence and the silence that surrounds it are the survivor's responsibility to manage.

Unique Outcomes: The Evidence of a Different Story

At the heart of narrative therapy's clinical methodology is White's concept of unique outcomes: moments, events, qualities, or actions in the survivor's life that contradict the dominant abuse-defined story.[27] Every survivor, however severely traumatised, carries within her history evidence of a different self than the one the violence has tried to construct. She maintained a friendship the abuser tried to end. She protected a child from witnessing an incident of violence. She found a way to call for help when it seemed impossible. She kept herself together, day after day, under conditions designed to break her. These moments are not exceptions to the dominant story. They are the raw material of a counter-story — one that reflects a self that is capable, resourceful, and worthy of care — and the task of narrative therapy is to excavate them and help the survivor thicken them into a narrative identity that can hold against the weight of what has been done to her.

The therapist's role in this process is one of what White called a decentred but influential presence.[28] The narrative therapist does not interpret, diagnose, or categorise the survivor's experience. She creates the conditions within which the survivor can become, gradually and on her own terms, the author of her own story rather than a character in the story that abuse has written. This is a process that takes time, that must proceed at the survivor's pace, and that requires a therapeutic relationship built on

[26]White & Epston, *Narrative Means*, *supra* note 7, at 38–40. The principle that the person is not the problem — the problem is the problem — grounds the practice of externalisation that restores ontological distance between the survivor and the harm inflicted upon her.

[27]White, *Maps of Narrative Practice*, *supra* note 7, at 61–65. White's concept of unique outcomes identifies the moments, events, and actions that contradict the dominant, problem-saturated account and supply the raw material for a re-authored narrative identity.

[28]White, *Maps of Narrative Practice*, *supra* note 7, at 61–65. White describes the therapist's posture as a "decentred but influential" presence — one that creates the conditions for the survivor to author her own story rather than interpreting or diagnosing it for her.

genuine trust. It cannot be rushed, abbreviated, or delivered as a standardised protocol. In this respect, narrative therapy's clinical ethics and the trauma-informed care principles of SAMHSA are entirely aligned: both insist that the pace, direction, and depth of the work are determined by the survivor, not by the practitioner's schedule or the institution's targets.

The Role of Witness: From Private Therapy to Public Voice

White and Epston's clinical work extended beyond the individual therapeutic session into practices of communal witness: therapeutic letter-writing, in which the therapist sends the survivor a written account of the session that externalises and amplifies her counter-story; and outsider witness groups, in which carefully selected witnesses attend a therapeutic conversation and reflect back what they found meaningful, what resonated with them, and what the survivor's account told them about who she is.[29] These practices are grounded in the clinical observation that trauma thrives in silence and isolation, and that the public naming of harm — the act of having one's story received with belief and honour by people who matter — is a distinct and irreplaceable dimension of recovery that individual therapy alone cannot provide.

This clinical observation is what connects narrative therapy, at its deepest level, to the communal dimensions of breaking silence that restorative justice processes at their best can provide. The restorative circle in which a survivor speaks her truth in her own words, is believed without having to prove it, and receives the community's public condemnation of the violence — this is, clinically speaking, an outsider witness group with the additional dimension of legal accountability and formal community acknowledgment of harm. The narrative therapy session and the restorative circle are not parallel but sequential: the former prepares the survivor for the latter. A survivor who has begun, in the clinical space, to find her counter-story is a survivor who has the psychological resource to tell it in the communal space. Without that clinical preparation, the demand that the survivor speak her truth in front of the community and the perpetrator risks overwhelming rather than empowering her.

VIII. Cognitive Behavioural Therapy: Clearing the Cognitive Debris of Silence

While narrative therapy works at the level of identity and story, CBT in its trauma-specific applications works at the level of cognition: the specific stuck points that maintain PTSD symptoms and that, in the context of IPV, constitute the cognitive architecture of silence. The two approaches address different but equally essential dimensions of the same injury. Without the cognitive stabilisation that CBT provides, the survivor cannot sustain the focused, emotionally demanding work that narrative re-authoring requires. Without the narrative reconstruction that Narrative Therapy provides, CBT risks producing symptom reduction that leaves the survivor less distressed but still carrying the abuser's story as her own truth.

Aaron Beck's foundational insight — that psychological distress is maintained by identifiable patterns of maladaptive thought, and that these patterns can be systematically identified and changed — provides the clinical foundation for CPT's approach to IPV trauma.[30] Patricia Resick's central contribution in Cognitive Processing Therapy is the clinical observation that the inability to recover from trauma is not a failure of memory. It is a failure of meaning-making.[31] The survivor is not re-experiencing the violence because she cannot stop thinking about

[29]White, *Maps of Narrative Practice*, *supra* note 7, at 182–195. White's practices of outsider witness groups and therapeutic letters extend the principle of communal witness into the clinical space, connecting individual re-authoring to the communal recognition of harm that restorative processes provide.

[30]Beck et al., *Cognitive Therapy of Depression*, *supra* note 8, at 8–12.

[31]Resick et al., *CPT Manual*, *supra* note 8, at 5–8. Resick's formulation of trauma recovery as a failure of meaning-making rather than a failure of memory distinguishes CPT from exposure-only models and

it. She is re-experiencing it because she has not yet been able to make sense of it in a way that allows it to be integrated into her life story rather than continuing to erupt into the present. The stuck points are the places where meaning-making has failed: where the trauma has been either assimilated in a self-blaming way — it happened because I am the kind of person things like this happen to — or over-accommodated in a catastrophising way — the world is always dangerous and I will never be safe. Both strategies prevent accurate processing of the traumatic experience and maintain the silence by convincing the survivor, in different ways, that speaking is either pointless or dangerous.

Prolonged Exposure and the Paradox of Avoidance

Prolonged Exposure therapy, developed by Edna Foa and colleagues, addresses a paradox that is particularly relevant to the psychology of silence in IPV: the avoidance that protects the survivor from immediate distress is the very mechanism that prevents recovery.[32] By staying away from the memories, the places, the people, and the topics associated with the violence, the survivor prevents her nervous system from processing the experience and learning that she can bear the memory, that the danger has passed, and that the world is not uniformly hostile. The silence that surrounds IPV is, in part, an avoidance strategy: not speaking about the violence protects the survivor from the immediate distress of acknowledgment, but it also maintains the PTSD that avoidance is designed to escape.

The clinical implications of this are important for any programme that seeks to help survivors speak. The goal is not to compel disclosure, which would simply add institutional pressure to the existing neurological and psychological barriers. The goal is to create the conditions within which disclosure becomes possible: conditions of safety, of genuine trust, of psychological stabilisation sufficient to tolerate the distress of approaching the material, and of a clearly communicated right to withdraw at any stage without consequence. Foa and colleagues are explicit that exposure work must never proceed without extensive preparation — psychoeducation about the rationale for approaching rather than avoiding, the development of coping skills, and the construction of a therapeutic relationship of genuine trust are all prerequisites, not preliminaries.[33] The same clinical logic applies to any restorative or communal process in which a survivor is asked to speak about what was done to her. The preparation is not optional. It is the condition upon which the safety of the entire process depends.

IX. Trauma-Informed Care: The Ethics of Creating Space for Voice

The frameworks examined in this article — Narrative Therapy, CBT, Prolonged Exposure — each address specific dimensions of the silence that IPV produces. But they share a common ethical architecture without which none of them is safe to apply: the framework of Trauma-Informed Care (TIC) as articulated by the Substance Abuse and Mental Health Services Administration (SAMHSA).[34] TIC is not a therapeutic technique. It is a set of values and a structural approach to service delivery that disciplines every interaction between a practitioner and a survivor, from the first point of contact to the conclusion of engagement, regardless of the modality being used.

SAMHSA's six core principles — safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment and choice; and cultural, historical, and gender

underpins its structured engagement with the specific beliefs that trauma has forged.

[32]Foa et al., *PE Manual*, *supra* note 8, at 1–14.

[33]Foa et al., *PE Manual*, *supra* note 8, at 23–24. Foa and colleagues are explicit that exposure work must be preceded by psychoeducation about the rationale for approaching rather than avoiding, the development of coping skills, and the construction of a trusting therapeutic relationship; these are prerequisites, not preliminaries.

[34]SAMHSA, *supra* note 9, at 9. The shift from "What is wrong with you?" to "What happened to you?" is identified by SAMHSA as the foundational reorientation of trauma-informed practice.

sensitivity — define what it means, in institutional terms, to create a space in which a survivor can speak.[35] The first principle is not coincidentally called safety. A survivor cannot speak about violence in an environment that does not feel safe. Safety in this context means not only physical safety but the psychological safety of the encounter: the genuine assurance that what is disclosed will be received without judgment, that it will not be used against the survivor, that confidentiality will be maintained within its clearly communicated limits, and that the person in front of her is present and trustworthy. For a woman whose experience has taught her that intimate relationships mean danger and that the people who hold power over her use it to harm her, this kind of safety is not automatic. It must be actively constructed, and it cannot be constructed quickly.

The practical shift that TIC demands of practitioners is, at its core, a shift in the question they bring to the encounter. The question What is wrong with you? — which has historically structured both clinical and institutional responses to survivors of IPV — locates the problem within the survivor, confirms her stuck-point belief that she is damaged and deficient, and reproduces, in the professional encounter, the same silencing that the violence has already produced. The question What happened to you? — which TIC insists upon — locates the problem in the survivor's experience, acknowledges the reality of what was done to her, and creates the conditions within which she can begin, gradually and on her own terms, to speak. This question is simple in form. It is the foundation of everything else.

Intersectionality and Cultural Humility in the Indian Context

In India, trauma-informed practice must go further than SAMHSA's principles alone can take it. It must attend to the intersecting structural realities of caste, class, religion, and gender that shape not only the experience of IPV but the specific forms in which silence is produced and maintained. The NFHS-5 data demonstrated that IPV cuts across class, education level, and geographic location — shattering the widespread assumption that domestic violence is a problem of rural poverty or limited education.[36] The corollary is that the barriers to help-seeking are not uniform either. The Dalit woman in a rural district who fears that police will not take her complaint seriously, the Muslim woman in an urban neighbourhood who fears community ostracism if she reports spousal violence, the upper-caste professional woman who fears the social consequences of disclosure in a milieu that enforces silence through respectability rather than poverty — each of these women is silent, but the specific architecture of her silence is different. Culturally humble practice means approaching each survivor as the expert on her own experience and her own context, rather than applying a universal framework that flattens the structural specificity that shapes her situation.

This cultural humility is also required of the institutions and processes that seek to break silence at the communal level. The community circles of restorative justice, the panchayat traditions of community resolution, and the tribal practices of mediation and reconciliation that exist across India's diverse communities are not inherently silencing or inherently liberating. They are what they are designed to be. A restorative process that places patriarchal community elders in the role of arbiters and defines its success in terms of family preservation will deepen the silence rather than break it. A restorative process that is facilitated by trained, gender-sensitive practitioners, that centres the survivor's voice and safety, and that directs community condemnation at the violence rather than

[35]SAMHSA, *supra* note 9, at 9–10. SAMHSA's six principles are: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment and choice; and cultural, historical, and gender sensitivity.

[36]NFHS-5 Report, *supra* note 1, at 646. The survey found IPV across urban and rural settings, across education levels, and across economic categories, directly contradicting the assumption that domestic violence is confined to contexts of illiteracy or poverty. *See also* Dandona et al., *supra* note 3.

community pressure at the survivor has the potential to do what individual therapy cannot: to make the silence public, and to make the harm visible to the people whose recognition matters most to the survivor's recovery.

X. Conclusion: The Politics and Practice of Voice

The 86% of IPV survivors in India who have never sought help from any source are not, in the main, women who do not want help. They are women for whom the cost of speaking has been made, through neurological, psychological, and structural means, higher than they can bear. That calculation — the silent arithmetic of self-preservation that leads a woman to absorb violence rather than report it — is not a personal failing. It is the outcome of systems designed, whether consciously or by accumulated cultural inertia, to keep intimate partner violence hidden.

Breaking that silence requires intervention at all three levels at which it is produced. At the neurological level, it requires creating clinical conditions — safety, stabilisation, the patient construction of trust — within which the brain's capacity for language and narrative can be restored sufficiently for speech to become possible. At the psychological level, it requires the therapeutic work of externalisation and re-authoring that Narrative Therapy provides, and the cognitive restructuring that CPT and Prolonged Exposure deliver: the dismantling of the stuck points that maintain silence by convincing the survivor that she is not worth helping, that help will not come, and that speaking will only make things worse. At the structural level, it requires the redesign of institutions — clinical services, legal processes, community mechanisms — so that they become invitations to speak rather than enforcers of silence. This redesign requires, at minimum, the adoption of TIC across every institution that serves IPV survivors, the training of practitioners in the specific psychological dynamics of coercive control and complex trauma, and the kind of community education that restorative justice processes at their best can provide.

None of this is simple. None of it is quick. And none of it can be achieved by any single institution, framework, or professional discipline working in isolation. The clinician who stabilises the survivor, the facilitator who supports her storytelling, the community that bears witness to her harm, the legal system that provides the accountability and protection without which recovery cannot be sustained — these are not competing responses. They are sequential components of the single, integrated process of recovery from a violence that operates at every level of a person's life.

The NFHS-5 tells us that 29% of ever-married Indian women have experienced spousal violence.[37] It tells us that 86% of those women have never told anyone.[38] What it cannot tell us — what no survey can measure — is the cost of that silence: the accumulated weight of violence absorbed in private, the counter-stories never told, the selves diminished year by year by a harm that could not be named. The obligation of scholarship, clinical practice, and law in the face of this reality is not to design ever more refined theoretical frameworks and leave the implementation to chance. It is to build, with urgency and with care, the conditions in which survivors of intimate partner violence in India can, at last, speak.

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[37] NFHS-5 Report, *supra* note 1, at 646.

[38] *Id.* at 650.

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