Domestic Abuse in the UK Sri Lankan Tamil Community: Understanding Shame

Phoebe Neville

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Clinical Psychology

May 2022

Abstract

Introduction: Shame resulting from domestic abuse can have wide-reaching negative consequences for victim-survivors. Shame has been theorised as a transcultural, transdiagnostic, embodied emotion, the experience of which differs according to the norms and expectations of groups. More therefore needs to be understood on behalf of mental health services about the group-specific experiences of shame, to be able to provide targeted support for victim-survivors. No studies have previously examined the shame-experiences of Sri Lankan Tamil victim-survivors. Tamil culture holds honour and shame as key values, and understand health through a holistic, social determinants model, which fits with a shame-focussed approach to therapeutic care. Understanding shame may therefore be important to developing culturally-appropriate therapeutic care for Tamil victim-survivors.

Methods: Semi-structured interviews were conducted with first-generation Sri Lankan Tamil victim-survivors of domestic abuse. Data were analysed using reflexive Thematic Analysis.

Results: Shame was shaped by criticism, victim-blaming, betrayal, and control. Shame experiences included fear and pain of external judgement, mothering guilt, degradation of sexual abuse, and feeling vulnerable and exposed. It also included protecting others from shame.

Conclusion: Shame can be a powerful experience for Sri Lankan Tamil victim-survivors of domestic abuse, with negative implications for wellbeing, relationships and escaping abuse. Tamil victim-survivors may therefore benefit from therapeutic support that reduces shame and increases dignity.

Table of Contents

List of Tables

Acknowledgements

I would like to thank firstly, and most importantly, the women who shared their stories in this research- thank you for your openness and bravery. Your resistance and resilience is beyond belief.

Secondly, thank you so much to the Tamil Community Centre, especially to the three incredible women who shaped this research, from the very beginning to the end. I couldn't have done this research without you, nor would I have tried to. Thank you for all the time and consideration you gave the project. I hope that it can be beneficial.

A huge thank you also to Dr. Kenneth Gannon and Dr. Trishna Patel for your guidance and containment. Your reassurance and support was indispensable.

Thank you to all my incredible friends and family for encouraging me and holding me together. A special thank you to Charlie, Kimaya and Summer for looking after me, and to mum for inspiring me and leading the way in fighting violence against women. Thank you to my outstanding UEL girls- you have brought me so much strength and love over the last three years.

1.0. INTRODUCTION

1.1. Overview

Shame has been found to be a common outcome of domestic abuse for victim-survivors, with consequences for wellbeing and escaping abuse (Thaggard & Montayre, 2019). Reducing shame may therefore be important for the therapeutic support of victim-survivors. Given that shame differs between groups, the group-specific shame-experiences of victim-survivors may need to be better understood to provide targeted support. This research examines the shame-experiences of Sri Lankan Tamil (SLT) victim-survivors, for whom shame may be integral to culturally-relevant therapeutic support.

To begin, I will define and give an overview of the context of each of the topics involved in the research, and explain why the areas are important subjects for study. Following a broad introduction to the topics under discussion, two scoping reviews are presented; the first exploring domestic abuse and shame in South Asian diaspora communities, and the second exploring domestic abuse in the SLT diaspora. These scoping reviews offer a clear rationale for the study's aims and research questions.

1.2. Terminology

Choosing the language for this research has been a reflective process to ensure the use of the most appropriate, least harmful terms. However, language is complex and context-dependent, so the terms I have used may also be critiqued. I have chosen the term 'victim-survivor' to describe women who have suffered abuse to acknowledge both the victim and survivor narratives. 'Domestic abuse' has been chosen as the term for interpersonal abuse because it reflects the Tamil term, and the terminology used in UK law and policy. A variety of terms will be used to describe women from the global-majority who have moved to the UK, including 'first-generation', to avoid words with negative connotations and the shortcomings of acronyms.

1.3. Domestic Abuse

In this section I define domestic abuse, outline the national and international legal frameworks and policies that speak to domestic abuse, and describe some of its consequences. I also discuss why domestic abuse research is particularly relevant now. Throughout the section I highlight the context of domestic abuse for first-generation populations, which links onto the next points about intersectionality, and the role of the patriarchy, culture, and inequality in shaping domestic abuse.

The Domestic Abuse Act 2021 defines domestic abuse as abusive behaviour by an individual towards another, who are personally connected and aged 16 or over. Abusive behaviour includes: physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, psychological, emotional or other abuse, and economic abuse (*Domestic Abuse Act*, 2021). 'Personally connected' includes those who are, have been, or have agreed to be married or in a civil partnership, in an intimate personal relationship, or in a parental relationship in relation to the same child; it also includes relatives.

Domestic abuse is often hidden and victim-survivors can face many barriers to reporting, so it can be difficult to quantify (*Domestic Abuse Act*, 2021). It was estimated by the Crime Survey for England and Wales (CSEW) that 2.3 million adults, or 5.5% of adults 16-74 years, experienced domestic abuse in the year ending March 2020, excluding data from Greater Manchester Police (Office for National Statistics, 2020a). The CSEW estimated that 1.6 million of these cases were women, and 757,000 were men (Office for National Statistics, 2020b). Women are disproportionately victim-survivors of domestic abuse, as well as being more likely than men to experience repeat victimisation, be physically injured, experience emotional and financial abuse, or be killed (Office for National Statistics, 2020c).

1.3.1. UK Policy

It is the role of the police and the Criminal Justice System (CJS) to ensure the safety and justice of victim-survivors (*Domestic Abuse Act*, 2021). The 'Code of Practice for Victims of Crimes' ('Victims' Code') in England and Wales sets out

the minimum standard of services provided to victim-survivors of crime (Ministry of Justice, 2021). Victim-survivors' rights include the right to understand and be understood, have the crime recorded without unjustified delay, and be referred to tailored support services (Ministry of Justice, 2021).

Information gathered to inform the Domestic Abuse Bill, and subsequently the Domestic Abuse Act 2021, identifies victim-survivors who moved to the UK as particularly vulnerable to domestic abuse, due to additional risk factors and barriers to escape, relating to a dependence on a partner's visa to access public services and remain in the UK (Home Office, 2020). The Destitution Domestic Violence Concession (DDVC) supports victim-survivors on some spousal visas to apply for leave to remain without the No Recourse to Public Funds (NRPF) condition, make an application for indefinite leave to remain as a victim-survivor of domestic abuse, and apply to receive public funds for up to three-months. However, the DDVC does not extend to non-spousal visas, leaving many victim-survivors without access to benefits. It is also not clear whether access to public funds for three-months is sufficient time to support victim-survivors waiting to receive indefinite leave to remain (Home Office, 2020).

1.3.2. Human Rights

Domestic abuse breaches human rights legislation, which underpins UK and international law. Domestic abuse breaches multiple rights under the European Convention on Human Rights 1950, including the right to life, the right to freedom from cruel, inhuman or degrading treatment, and the right to non-discrimination (Council of Europe, 1952). An alarming number of countries that agreed to the human rights Convention on the Elimination of all forms of Discrimination Against Women 1979 (CEDAW) entered reservations about articles relating to domestic abuse, indicating that states are especially resistant to upholding equality and justice for women in the home (Amnesty International, 2004; UN Committee on the Elimination of Discrimination against Women, 1994). According to the Declaration on the Elimination of Violence Against Women (DEVAW), an extension of the CEDAW, some groups of women, including those from the global-majority, those who moved to Western countries, and refugee women, are especially vulnerable to abuse (United Nations General Assembly, 1993).

Although human rights can be a tool for upholding equality and enforcing accountability, the concept of human rights should be considered critically. Human rights may be considered as context-bound, to account for the operations of power and oppression that function within knowledge and knowledge production (Patel, 2011).

1.3.3. Consequences of Domestic Abuse

Domestic abuse has wide-ranging, severe, and long-lasting negative consequences on the body (both physical and psychological) (Rodríguez et al., 2009) and on social and financial factors (Street & Arias, 2001). International and national guidance thus increasingly mandate for health practitioners to identify clients experiencing abuse and support them to access support (García-Moreno et al., 2014; National Institute of Health and Care Excellence, 2016).

Physical health effects include physical injuries, induced miscarriages, contracting sexually transmitted diseases, and death (World Health Organization, 2005, 2013). The impact on mental health can include high levels of stress, distress, depression, anxiety, 'Post-Traumatic Stress Disorder' (PTSD), substance abuse, and suicidality (L. Jones et al., 2001; World Health Organization, 2005, 2013). I refer to 'PTSD' within quotation marks to indicate that it is the term used by the referenced literature, and not the language I am choosing to use within this paper, due to the non-pathologising, trans-diagnostic approach of this research. Shame has also been identified as a common outcome, with consequences for mental health and help-seeking (Thaggard & Montayre, 2019). A World Health Organization (WHO) multi-country report found that women victim-survivors of domestic abuse were more likely to have contemplated and attempted suicide than non-abused women (World Health Organization, 2005).

1.3.4. COVID-19 Pandemic

Research on domestic abuse is particularly relevant in the context of the COVID-19 pandemic. During crisis periods, such as natural disasters and pandemics, domestic abuse increases, resulting from the drastic change in normalcy (Home Office, 2020; John et al., 2020; van Gelder et al., 2020).

During the pandemic, abuse was exacerbated by the national stay-at-home orders, travel restrictions, and economic lockdown; which increased couples' financial stress, as well as forced co-habitation (Sabri et al., 2020).

The COVID-19 pandemic highlighted and exacerbated existing structural inequality, disproportionately impacting women and people from the global majority (Thiara & Sumanta, 2022). As well as an increase in violence, the pandemic created additional barriers to help-seeking for minoritised and oppressed groups; these included disproportionate decommissioning of support organisations for minoritised groups and the reinforcement of hostile immigration policies.

1.4. Intersectionality

An intersectional perspective suggests that identities exist in certain times and places and should not be conflated (Yuval-Davis, 2006). Intersectionality aims to understand the multi-dimensional lived experiences of marginalised people (Crenshaw, 1989). According to an intersectional understanding, domestic abuse is shaped by intersections of inequality (Anitha, 2008; Burman et al., 2004), such that multiple and distinct identity factors create diverse experiences of abuse. Such an approach is important to consider the additional layers of oppression, discrimination, trauma and shame faced by victim-survivors from marginalised groups (Pease & Rees, 2008; Rai & Choi, 2018). The shame and trauma of interpersonal abuse are also shaped by intersectional inequality (Dillon, 1997; Herman, 1992).

1.5. Patriarchy and Structural Theories

Patriarchy is an ideology which exists in many societies, regarding gender differences in power and male domination over women (MacKinnon, 1983). According to feminist theory, patriarchal societies give men power and control over women, shaping unequal power relationships, and resulting in the undervaluing and perceived inferiority of women, as well as violence against women, as a mechanism of oppression (Dobash & Dobash, 1979; Herman,

1992; Solomon, 1992; Straka & Montminy, 2006). In other words, social structures are to blame for domestic abuse (Mason et al., 2008).

Another structural theory called inconsistency theory similarly postulates that power is distributed differently between members of a family, and if a member perceives their resources or status to be threatened, they may use abuse to compensate or counteract this (Goode, 1971). Combining these two theories, domestic abuse may be understood as a detrimental expression of the patriarchy, exacerbated in times of change (Ahmad, Riaz, et al., 2004). This can be seen in the process of migration. Migration can create new opportunities for women to enter into the workforce (Hondagneu-Sotelo, 1992), challenging traditional gender roles (Dion & Dion, 2002; Lim, 1997), but it can also create oppressive contexts that push communities and families to adopt more conservative, traditional patriarchal values (Akpinar, 1988; Anitha et al., 2009; MacLeod & Shin, 1990; Mangar, 2011). The consequential familial stress and shift in power dynamics between couples can increase domestic abuse (Narayan, 1995).

1.6. Culture

There are many definitions of ‘culture’, this research focusses on the shared values, beliefs, attitudes, norms, traditions and languages of a group, passed through generations, based on a region of origin (Das, 2008; Raj & Silverman, 2002). Cultural contexts are important to consider because they shape the meaning of behaviour and how individuals experience and react to it (Bograd, 1999).

Different cultural ideologies increase or decrease respect for women, such as through prescription to culturally-bound traditional gender roles (Raj & Silverman, 2002). Cultural endorsement of strict gender roles is associated with the disempowerment and isolation of women, forced subservience to men, and ‘self-sacrificing’ behaviours in the name of women’s duties to their families and communities. It can also facilitate cultural acceptance of the ‘disciplining’ or ‘punishment’ of women for ‘violating’ prescribed roles, in other words, victim-

blaming and excusing of domestic abuse (Bui & Morash, 1999; M. S. George & Rahangdale, 1999; Huisman, 1996; Morash et al., 2000).

While on the one hand, acknowledging the cultural factors that shape abuse validates the different experiences of women, on the other hand, there is a danger of viewing culture as a justification for abuse and as a purely negative force (Sokoloff & Dupont, 2005). Aujla (2013) argues that it is not traditions that support domestic abuse, but the power relations, inequality and control supported by some traditions.

1.6.1. Honour

Honour is a specific cultural concept which can be understood and analysed under the wider, universal umbrella of patriarchal ideologies (Baker et al., 1999; Gupte, 2013; Ilkkaracan, 2002). Honour is typically defined as believing you are worthy of respect, and it's inverse, shame, is the feeling experienced if you believe you are unworthy of respect (Gupte, 2013). Certain cultures, including many South Asian cultures, hold honour as a key value.

Honour has been widely theorised as deeply unequal, such that only men hold honour, but it is achieved and maintained through the behaviour of women (Chakraborty, 2010; Gill, 2004; Gill & Brah, 2014; Haddad et al., 2006). Thus, as it is the man's honour at stake, and his family's, men hold the responsibility to 'protect' familial women against potential disgrace, by controlling their virginity, sexuality and roles (Appiah, 2011). Tools for 'protecting honour' include domestic abuse, gender segregation, forced marriages, and endogamous marriage rules (Akpinar, 2003; Kandiyoti, 1988). Important cultural rules that women must maintain to uphold honour include getting and remaining married, and only having sexual relations with one's husband (Akpinar, 2003; Cowburn et al., 2015; Gill & Brah, 2014; Goddard, 1987; Kandiyoti, 1988; Shankar et al., 2013).

1.7. Shame

The origins of English word 'shame' relates to the Indo-European word 'kam'/'kem', which means to hide, conceal or cover up (Karlsson & Sjöberg,

2009). Shame is typically theorised as an embodied feeling, not bound by cartesian dualism, associated with external judgement and the need to protect one's self (Crozier, 1990). Shame, thus, is not an individual experience, but relational, and connects to upholding social norms and values (Tonsing & Barn, 2017). It is therefore group-specific, depending on the norms and values of a group, what is shaming in one social group may not be in another (Gilbert et al., 2004; Sznycer et al., 2016). Shame fits with a holistic and social, interconnectedness conceptualisation of distress.

Shame is a self-conscious emotion, along with guilt and humiliation (Karlsson & Sjöberg, 2009). Guilt and shame are often studied together in psychology and there is debate as to the extent of their differences and interconnectedness (Karlsson & Sjöberg, 2009). In general though, guilt relates to a person's actions which transgress norms, whereas shame relates to a global negative self-evaluation (Tangney, 1999). Shame is suggested to be a stronger emotion and more incapacitating than guilt (H. Lewis, 1971).

There is increasing interest in viewing a range of experiences through the lens of shame, particularly those linked with mental health and wellbeing, including trauma (Lee et al., 2001), inter-generational transmission of abuse (Dutton et al., 1995), poverty (Chase & Walker, 2013), minority experiences (McDermott et al., 2008) and domestic abuse (Thaggard & Montayre, 2019). There is a broad consensus that shame is significant in contemporary societies (Giddens, 1991; Lasch, 1991) and has potentially detrimental consequences (Andrews et al., 2002; Gilbert, 1998; Kaufman, 1989; Retzinger, 1998; Tangney & Dearing, 2002). For example, shame has been found to have a positive association with and predict 'PTSD' (Aakvaag et al., 2016; Andrews et al., 2000; Street & Arias, 2001). Shame and other aversive self-conscious emotions are also thought to underlie suicidal thinking (Hastings et al., 2002; Hendin, 1991; Lester, 1997). Suicide associated with shame is especially linked with perceived public exposure and judgement, as well as despair of not living up to aspirations and ideals (A. Morrison, 2011).

There are multiple psychological theories of shame, including evolutionary (Elison, 2005; Gilbert, 1989; Gilbert & McGuire, 1998; Sznycer et al., 2016),

psychoanalytic (Broucek, 1982; H. Lewis, 1971) and cognitive-attributional (M. Lewis, 1993; Tangney, 1999; Tangney & Fischer, 1995). The dominant approach within clinical psychology currently is the biopsychosocial framework.

1.7.1. Biopsychosocial Framework

According to this framework, shame is an aversive experience which developed to reduce nonconformity and promote group membership and access to reciprocating partners (Fessler, 1999; Gilbert & McGuire, 1998; Greenwald & Harder, 1998). It postulates that shame can be internal or external; internal shame relates to strong negative feelings due to negative self-perception (Cook, 1996; Gilbert, 1998, 2002b), while external shame is an experience of negative feelings from the fear of being looked down on, rejected, or harmed by others (Gilbert, 1998). The model holds an evolutionary perspective that shame was adaptive, within a primitive, preverbal, hierarchical society, but that it is now maladaptive within most modern contexts (Tangney & Salovey, 2010). Thus, the role of therapy is to reduce the experience of shame (Tangney & Dearing, 2002).

1.7.2. Cross-Culturalism of Shame

Shame is transcultural in that it is present in most cultures, but the extent to which the experience differs between groups is undetermined (Abeyasekera & Marecek, 2019). Some cross-cultural studies suggest that there are grounds for supporting a universal understanding of shame (Fontaine et al., 2002; Scherer & Wallbott, 1994). However, these studies were based on students exposed to Western cultures. It is likely that sizeable cross-cultural differences in the meaning and experiences of shame exist, given that shame is thought to be particular to time and place, shaped by a group's norms and expectations (Scherer, 1997; Shweder, 2003).

Shame may differ across groups based on the endorsement of collectivist and individualistic values (de Groot et al., 2021). In individualistic cultures shame has typically been understood as a maladaptive, unpleasant emotion resulting in psychological problems (Elster, 1999; Kaufman, 1989). In collectivist contexts shame has been more often theorised as adaptive and valued for its role in self-improvement and the endorsement of group norms (Wong & Tsai, 2007), covering a broader range of emotions (Bhawuk, 2017; Lindquist, 2004). In

foundational Hindu texts shame is understood as an important virtue, central to the development of the person, relationships, and other virtues (Bhawuk, 2017).

1.7.3. Shame and Domestic Abuse

Degradation and violation at the hands of another and the social isolation caused by abuse can evoke feelings of shame (Herman, 2011). Victim-survivors may feel shame about what happened to them and about who they are (Boon et al., 2011; Dorahy & Clearwater, 2012; Talbot, 1996), led to believe that they are in-part to blame for the abuse (Aakvaag et al., 2019).

Shame related to domestic abuse may have different foci of experience in different contexts. For example, a study in Norway found that victim-survivors labelled themselves ‘stupid’ for ‘giving in’ and ‘staying and allowing’ the abuse, which may indicate a focus on internal shame (Enander, 2010). In comparison, a study in Tanzania found that the reporting of abuse was experienced as shameful (McCleary-Sills et al., 2016), which may be a fear of judgement, or external shame. A UK study with first-generation South Asian victim-survivors found that participants experienced internal, external and reflected shame (Tonsing & Barn, 2017). Reflected shame is feeling ashamed for bringing shame upon others (Gilbert, 2002a).

Shame in the context of domestic abuse has many consequences for mental health (Beck et al., 2011), including feelings of inadequacy, unworthiness, vulnerability, powerlessness, low self-esteem and ‘PTSD’ (Alexander et al., 2005; Gilbert, 2019). Shame may also prevent help-seeking by encouraging victim-survivors to hide abuse in order to maintain social expectations, and out of fear of stigmatisation and judgement from others (Dearing & Tangney, 2011b; Gill, 2004; G. Mason & Pulvirenti, 2013; Thaggard & Montayre, 2019). Concealing abuse can wedge a divide between victim-survivors and their support systems, eroding victims’ trust in their relationships and connections, resulting in isolation and loneliness (Buchbinder & Eisikovits, 2003).

Some research indicates that effective mental health interventions for victim-survivors should focus on shame (Thaggard & Montayre, 2019; Shorey et al., 2011). Yet services lack understanding about cultural experiences of shame,

resulting in inappropriate care for minoritised victim-survivors (Gilbert et al., 2007; Sooch et al., 2006).

1.8. Migration

In 2019, the global estimate of international 'migrants' was 272 million, or 3.5% of the global population, with more than 40% of this group born in Asia (IOM, 2019). As well as moving for employment and study, South Asian populations have been particularly vulnerable to conflicts and disasters, and have had to rely on migration and mobility as important coping strategies (IOM, 2019). This includes Sri Lanka, which became one of the world's largest sources of refugees during its civil war in the 1990s, with one million internally displaced and at least 90,000 seeking refuge abroad (Beiser et al., 2011). With the Tamil minority in Sri Lanka disproportionally impacted by the country's civil war, it is likely a large proportion of these were Tamils.

Between 2005-2018, the UK was the 4th largest refugee resettlement country, and more broadly, had in 2019 a population of 9.5 million people living in the country who were born abroad (IOM, 2019). Some of the largest migrant populations in the UK are from South Asian countries (IOM, 2019), and in 2014, Sri Lankans made up the third largest number of asylum applications to the UK (1,813 applications) (Home Office, 2014). Despite steady movement from Sri Lanka to Britain over the last decades, there has been very little research about the SLT population in the UK (Aspinall, 2019; Hirsch, 2019).

1.9. Tamil Diaspora

1.9.1. Tamil Identity

The majority of SLTs practice Hinduism and speak Tamil, and of those living in Sri Lanka, largely live in the North and East of the country. In contrast, the majority population of Sri Lanka is mainly Buddhist and Sinhalese-speaking (Tambiah, 1986). An overview of the Sri Lankan context which historically victimised and politicised the SLT identity, and continues to do so, can be found in Appendix A.

SLTs are not a homogenous group, but include a multitude of identities, castes, and dialects. Brubaker (2006) argues that treating ethnicity as a bounded bloc with specific characteristics is inaccurate, and conceals as much as it reveals about the group. Despite the differences within the group, research has found that the SLT diaspora identify with a common identity, an entitlement they associate with based on their ancestry and the politicisation of their identity (Antony, 2012; Thurairajah, 2017).

1.9.2. Approach to Health

Health in the Tamil community encompasses social, physical and mental health (Pandalangat, 2011). It is based on interdependence and interconnectedness, shaped by interpersonal and social factors, including family and work, fulfilling social roles, faith, education and community (Pandalangat, 2011; Pandalangat & Kanagaratnam, 2021; Weaver, 2005). In other words, health is conceptualised as a social phenomenon influenced by social determinants (Raphael, 2009; World Health Organization, 2010). This fits with the social determinants model in which health is influenced by race, ethnicity, gender, occupation, income, social status and education (World Health Organization, 2010). According to the World Health Organization (2010), addressing the social determinants of health is pivotal in addressing health inequalities, a major equity and social justice issue. Antithetical to the holistic, collective-value perspective held by the Tamil community is the dominant Eurocentric medical model of distress, based in individualism, autonomy and cartesian dualism (Inman et al., 2001).

1.9.3. Moving to the UK

In the early 1960s, a considerable amount of the SLTs who moved to Britain were well-educated professionals, followed by a wave of students (Daniel & Thangaraj, 1995). In the early 1990s, the majority of Sri Lankans leaving the country were refugees from the North and East of the country, fleeing the LTTE (Daniel & Thangaraj, 1995). Pre-migration, many Tamils experienced abuse, loss and genocide (M. George, 2013; Somasundaram, 2007). Then, as refugees, many faced years of limbo in refugee camps or awaiting refugee status (M. George, 2013). A Toronto-based study found that SLTs had

significantly higher prevalence rates of ‘PTSD’ compared to other refugee populations (Beiser et al., 2011).

Factors shaping psychological distress post-migration included discrimination and poverty (Beiser et al., 2011), depleted support networks and resources, loss of identity, and an absence of professional help from within the community (Dasgupta, 2003). Different from some other refugee populations, SLT refugees were framed as potential terrorists, to be viewed with suspicion, by the UK government (Hirsch, 2019). Seen as illegitimate abusers of the asylum system, many SLTs have reported experiencing racism throughout their lives in the UK.

In Warren's (2021) thesis on the experiences of SLT refugees living in the UK, participants spoke about trauma, pervasive loss, a threatened sense of identity, acculturative stress and socio-political threats. In a London-based oral history project, participants reflected on the mixed experiences of leaving Sri Lanka and moving to the UK. Some participants spoke about not wanting to leave Sri Lanka and the loneliness of the UK, as well as difficulties with finding work and a social life (Mahan, 2013). Others spoke about their excitement to move, the safety it brought, and an easy transition.

1.9.4. Tamil Community in the UK and Domestic Abuse

There are no statistics on the rates of domestic abuse within the UK-based Tamil community. Research indicates that an amalgamation of ‘South Asian’ communities in the UK do not face higher prevalence of domestic abuse (Walby & Allen, 2004), but do face additional barriers to leaving abusive relationships and receiving support (Burman et al., 2004).

1.9.5. Tamil Diaspora and Shame

No studies conducted in western contexts have examined the shame-experiences of Tamil participants. However, shame developed as a major theme in several studies with Tamil refugees and the larger diaspora. For example, a UK-based study with Tamil refugees and asylum seekers identified shame as a key component of war-related trauma. Participants discussed shame about: being physically and sexually tortured in the war; having to leave Sri Lanka for their safety; moving countries and feeling like ‘a burden on

society'; their identity; and having mental health problems (Bahu, 2019). Participants also spoke about the shame of having to re-tell their stories and discuss mental-health related difficulties with others. Though diagnostic labels were deemed inappropriate, culturally-relevant practices were found to be helpful in reducing shame. Similarly, another UK-based study found that Tamil participants held negative beliefs about mental health and felt the need to hide mental health problems, due to shame of 'madness' and fears of being ostracised (Loewenthal et al., 2012).

A study exploring the psycho-social experiences of Tamil refugee men in Canada found shame to play a central role. Participants spoke about feeling ashamed for 'failing' to fulfil the masculine role of family 'protector' in the context of the war. They also spoke about 'shaming' as a social tool used to enforce gender-roles (Affleck et al., 2018). According to the participants, their wives shamed their masculinity related to their 'bread-winner' role, because of their downward social mobility in Canada. Being shamed was associated with alcoholism as well as feeling emasculated, helpless, depressed and suicidal.

Despite acknowledgement that sex and sexual abuse are particularly shameful in the Tamil community (ABNU, 2017; Loewenthal et al., 2012), no studies have examined shame in the context of domestic abuse. Weaver (2005) suggests that more needs to be understood about how shame impacts on experiences of sexual assault and trauma in Asian cultures.

1.10. Scoping Reviews

The preceding narrative review discusses the overarching fields of interest in the current study, and the main socio-political contexts and dominant theories within them. The following section focusses on shame-experiences for first-generation SLT victim-survivors, an area identified above as requiring further attention. To rationalise the need for this research within the field of clinical psychology and ensure this study is useful to psychological practice, literature that explored the topic in relation to seeking and engaging in therapy was also included. Research with practitioners is also examined. This is partly because of the limited relevant studies with victim-survivors, but also because for this

research to be useful to practitioners' practice, and subsequently for victim-survivors, it is important to understand practitioners' ideas about domestic abuse and shame.

A scoping review was conducted to examine the extent, nature and range of the literature available on the topic of interest (Arksey & O'Malley, 2005). A scoping review was chosen because of the lack of research on the topic, and hence identifying the range of literature was judged more appropriate than an in-depth assessment of a narrow range of quality assessed studies, as required in a systemic review. I then critically evaluated the broad range of scoping review papers identified to assess their quality, using the frameworks set out by Hammersley (1997) and Mays & Pope's (2000) (see sections 1.10.1.5. and 1.10.2.5.); this included considering the clarity of papers' research questions, the sampling, the appropriateness of the studies' designs, the worth or relevance of findings, the transferability of findings, and the reflexivity of the authors. Arksey & O'Malley (2005) suggest that in conjunction with a scoping review, consultation should be conducted to inform and validate findings (see section 1.13.).

Two scoping reviews were conducted, the first explores the more extensive literature on South Asian diaspora victim-survivors' experiences of abuse to provide a context for and hypotheses about the shame-experiences of SLT victim-survivors. 'South Asian' encompasses countries within the Indian-subcontinent, including Sri Lanka. The second review then looks at the limited literature on SLT diaspora experiences of abuse, which includes little to no mention of shame.

Both scoping reviews were conducted according to the stages suggested by Arksey & O'Malley (2005). Systematic searches of Academic Search Complete, PsychInfo, and CINAHL Plus were conducted via EBSCO and Scopus. In addition, Google Scholar and other open source repositories (Research Gate and Academia), government websites, and relevant charity websites were searched for reports and grey literature. The reference lists of relevant literature were also searched for publications not previously found. The search strategy,

including inclusion/exclusion criteria, can be found in Appendix B. Appendix C and D contain PRISMA diagrams charting the scoping process of each review.

1.10.1. Scoping Review One: Shame-Experiences of South Asian Victim-Survivors of Domestic Abuse in a Western Context

The scope of the reviews were defined using Booth et al.'s (2012) framework:

1. Who= South Asian women victim-survivors living in Western contexts
2. What= domestic abuse literature that focusses on shame, or through which shame developed as a theme
3. How (what is the outcome?)= contextualise and rationalise the current study within exisiting psychological literature

The following papers were identified as meeting the inclusion criteria for the scoping review:

- Anitha et al., 2009: Project report examining mental health needs and experiences of abuse and help-seeking.
    - 72 semi-structured interviews with South Asian women victim-survivors (18-50+ years old).
- Aujla, 2013: US-based Sociology Master of Arts thesis exploring challenges of reporting domestic abuse, and the types of services and support women would want.
    - Seven semi-structured interviews were conducted with South Asian women victim-survivors (26-58 years old).
- Couture-Carron, 2020: Canadian academic paper examining shame of dating and abuse in dating relationships.
    - 11 semi-structured interviews with first- and second-generation South Asian Muslim university students (18-25 years old).
- EACH, 2012: UK government report providing guidance on culturally-appropriate best practice for professionals working with South Asian women victim-survivors.
- Gilbert et al., 2004: UK-based academic paper exploring views on shame, ‘izzat’, entrapment and subordination, and the links with mental health and help seeking.
    - Three focus groups with South Asian women living in Derby (16-25 years; 26-40 years; 41+ years old).

- Gill, 2004: UK-based academic paper exploring risk factors, experiences, and reporting of domestic abuse.
    - 18 interviews with South Asian women victim-survivors (18-69 years old).
- Kallivayalil, 2007: US-based academic paper exploring how practitioners use feminist and multicultural treatment with South Asian victim-survivors.
    - Seven interviews with South Asian practitioners.
- Reavey et al., 2006: UK-based academic paper examining professionals' views on supporting South Asian victim-survivors of domestic abuse.
    - Semi-structured interviews and two focus groups with 37 professionals identifying from a range of cultural and race backgrounds.
- Sabri et al., 2018: US-based academic paper exploring risk and protective factors for domestic abuse.
    - 16 interviews and one focus group with first- and second-generation South Asians (31-48 years old).
- Sooch et al., 2006: UK-based project report on beliefs, rates and consequences of abuse, and barriers and actions towards support.
    - Quantitative and qualitative data was collected from 60 South Asian women (16-50+ years old).
- Singh & Hays, 2008: US-based academic paper examining the use of a feminist approach in group counselling with South Asian women victim-survivors.
    - The article presents a qualitative case study. Demographics of participants were not provided.
- Tonsing, 2014: Hong Kong-based academic paper examining definitions of domestic abuse and factors influencing help-seeking.
    - 14 interviews with South Asian women victim-survivors (27-39 years old).
- Tonsing & Barn, 2017: Hong Kong-based academic paper exploring shame within the context of domestic abuse and help-seeking.
    - 14 interviews with first-generation South Asian women victim-survivors (27-39 years old).

1.10.1.1. Abuse-related shame: Tonsing & Barn (2017) found that most participants experienced domestic abuse-related shame, mainly focussing on external and reflected shame. Gilbert et al.'s (2004) study identified two main types of shame, internal shame and reflected shame. Personal (internal) shame was associated with 'failing' in one's roles and losing one's identity. Reflected shame related to a failure to behave in accordance with socio-cultural rules, resulting in shame on the woman's family and community.

Participants described 'izzat' as the concept of upholding family honour and the inverse of shame (Gilbert et al., 2004). 'Izzat' was associated with women's obligation to remain married, even if there was domestic abuse in the relationship. Thus, leaving a marriage was seen as a failure and shameful. In fact, suicide was seen as less shameful on the husband's family and a preferable choice to divorce.

Shame and 'izzat' were associated with bottling things up, and not wanting to burden others, resulting in low self-esteem and poor mental health (Gilbert et al., 2004). Shame was discussed as causing rumination and not being able to forgive oneself. Women also spoke about feeling unworthy and depressed due to male oppression.

1.10.1.2. Barriers to disclosure and support: several studies identified a number of personal, structural and socio-cultural barriers to disclosure and help-seeking. Personal challenges included explaining the abuse, accessing resources, and a lack of freedom and autonomy, including financial dependence on one's spouse and in-laws (Anitha et al., 2009; Aujla, 2013; Sooch et al., 2006). Structural barriers to reporting abuse included women's unfamiliarity with their rights and with available services, immigration and legal barriers, and a fear and shame of involving external services, including the police; controlling patriarchal structures, social isolation, and a lack of community support were also identified as restricting access to help (Aujla, 2013; Gilbert et al., 2004). One way patriarchal structures and isolation prevented disclosure was by pressuring women to adopt self-blaming coping mechanisms (Aujla, 2013). Socio-cultural pressures on women to uphold cultural expectations around marriage and gender-roles relating to being a mother and a wife meant women

were shamed for leaving abusive partners and becoming single-parents (Aujla, 2013; Sooch et al., 2006; Tonsing, 2014; Tonsing & Barn, 2017). Women felt blamed for 'their' 'digressions' and shamed for voicing the problem (Gilbert et al., 2004; Sabri et al., 2018).

Some participants in Aujla's (2013) study identified shame as the most important reason for not reporting abuse and Sooch et al. (2006) found that 73% of participants experienced shame as a barrier to support. Victim-survivors, family members and the community used shame as a method to silence and deny violence in order to preserve family honour and prevent public humiliation (Sooch et al., 2006; Tonsing & Barn, 2017). In preventing help-seeking, shame protected women from becoming isolated and marginalised from, and stigmatised within, their community (Sooch et al., 2006; Tonsing, 2014; Tonsing & Barn, 2017). In Couture-Carron's (2020) study, participants identified family honour as associated with women's sexuality, making dating, pre-marital relationships, sex and pregnancy shameful. As dating is discouraged by cultural practices, women feared being blamed and shamed for dating, as well as for the abuse perpetrated against them within the forbidden relationship. Women therefore felt unable to tell their parents about the abuse and feared that disclosure would spread across the community, bringing community judgement, shame on their families, and requiring the women to stay in the relationships.

Seeking support from South Asian GPs was seen as inappropriate due to fears of judgement and confidentiality (Gilbert et al., 2004; Tonsing & Barn, 2017). Shame was also felt about involving people from outside the community (Gilbert et al., 2004; Sooch et al., 2006), for fear that the disclosure would invite racist stereotypes and shame on the community (Anitha et al., 2009; Gill, 2004). In addition, White practitioners were viewed as pushing Eurocentric values which did not align with the support required; participants feared being labelled 'mad', locating and legitimising the problem within them and hence encouraging the abuse to continue (Gilbert et al., 2004).

1.10.1.3. Experiences of services: Anitha et al. (2009) found that participants repeatedly attempted to access support services, including mental health

services, with varying degrees of success and satisfaction. The women expressed satisfaction with specialist services and support groups which they felt validated their disclosures and understood their specific needs. In contrast, many participants who accessed NHS counselling were unsatisfied, feeling that the services did not understand them, lacked knowledge about their cultural context, and were culturally inappropriate (Anitha et al., 2009; Sooch et al., 2006). Shame of domestic abuse was also discussed as preventing meaningful work through talking therapies (Anitha et al., 2009). A recommendation from Sooch et al.'s (2006) report was for bi-lingual trained counsellors with knowledge of the community to join with established voluntary community organisation to offer culturally-appropriate support.

1.10.1.4. Professionals' perspectives: professionals thought that primary concerns of victim-survivors included the shame of community judgement, financial difficulties, immigration status, lack of education, and worries about raising their children alone (Kallivayalil, 2007). Similarly Reavey et al. (2006) and a government tool-kit for practitioners suggested that healthcare professionals should acknowledge the impact of family and community on South Asian victim-survivors' emotions and needs, including considering the impact of shame, and offering support for shame (EACH, 2012). Tonsing & Barn (2017) recommended that helping professionals and services should address women's experiences of abuse, shame, and the factors that fuel shame; they also suggested offering clients more culturally-competent care. Reavey et al. (2006) suggested that, due to the stigma associated with 'mental health' in South Asian communities, shame-focussed therapy could offer a more culturally-appropriate approach to support than the use of psychiatric labels and interventions. Singh & Hays' (2008) case study using Feminist Group Counselling found that participants responded particularly well to having the opportunity to discuss coping with feelings of shame, guilt and disconnection from the community; the therapy was successful in assisting participants to externalise feelings of shame and self-blame.

1.10.1.5. Summary and critical evaluation: the literature focusses on the socio-cultural aspects of shame, including an emphasis on external and reflected shame, and how they act as barriers to support. The findings also indicate that

the medicalisation of distress (Reavey et al., 2006) and statutory mental health services do not meet the needs of South Asian women (Sooch et al., 2006). Instead, it is suggested that addressing shame may be key to culturally-relevant support (Tonsing & Barn, 2017).

In neglecting to explore internal shame and how services and systems may shape shame in relation to domestic abuse, the studies risk suggesting that 'culture' is the sole influencing factor. In Gilbert et al.'s (2004) study, even personal (internal) shame was discussed in relation to socio-cultural aspects of shame, as a 'failure' to uphold a woman's role, according to cultural and patriarchal expectations of a woman.

Aujla (2013), Gill (2004), Kallivayalil (2007) and Sabri et al. (2018) adopted a feminist approach and ecological framework to their research. This enabled the research to explore the structural and institutional factors shaping domestic abuse, as well as the cultural factors. In contrast, the papers by Couture-Carron (2020) and EACH (2012) do not appear to have a clear theoretical basis; it is possible that, as a result, the findings focussed mainly on South Asian culture in shaping domestic abuse, which risks stereotyping South Asian women and problematising South Asian culture. The funding of EACH's (2012) report by the Government Office for London may have also limited the discussion of institutional risk factors to domestic abuse.

To a degree, the findings from Aujla (2013), Gill (2004), Sabri et al. (2018), Sooch et al. (2006) and Tonsing's (2014) studies are repetitive of each other, thus limiting their development of the field. By focussing on identifying the barriers to support, instead of ways of overcoming these barriers, such studies could be critiqued for not going far enough to create meaningful change for South Asian victim-survivors. In comparison, Kallivayalil (2007) and Singh & Hays (2008) presented novel findings and clinical implications for how to provide more appropriate and effective care to South Asian victim-survivors, and reduce the institutional barriers to support. However, the lack of victim-survivor perspectives in the research and the limited service user evaluation of the group limits the utility of Singh & Hays (2008)'s findings.

The studies by Couture-Carron (2020), Gill (2004), Kallivayalil (2007), Reavey et al. (2006), Sabri et al. (2018), Singh & Hays (2008), Tonsing (2014), and Tonsing & Barn (2017) were conducted without any public involvement. Similarly, the public involvement in Aujla's (2013) study was minimal, and the level of input from the South Asian community in shaping 'Asian Women, Domestic Violence and Mental Health- A Toolkit for Health Professionals' (EACH, 2012) is unclear. Public involvement in research can be defined as research done through an active partnership between the researcher and the public, rather than research done 'to' or 'about' a group (National Institute for Health Research, 2015). Public involvement in healthcare research is recognised as important in the UK and internationally (e.g. Department of Health and Social Care, 2012; NICE, 2016; Sheldon & Harding, 2010; UN General Assembly, 1966). Along with many other reasons for public involvement, it ensures the aims of research are relevant to the needs and priorities of the community, and that different perspectives and broader interpretations of data are considered (Brett et al., 2014; Staley, 2009). Public involvement is particularly valuable in qualitative research where the aim is to gather the views and experiences of a certain group (Staley, 2009).

A lack of public involvement in the studies could reduce their worth or relevance for the South Asian community. For example, the lack of public involvement in Couture-Carron's (2020) and Gill's (2004) studies may have limited the utility of the research in creating institutional change. In comparison, Gilbert et al.'s (2004) study is likely to be relevant and useful for the community because the research question was set by a community organisation. Anitha et al. (2009) and Sooch et al.'s (2006) studies were conducted alongside community organisations and data collection was undertaken by community members, trained by the academic authors of the paper. In line with feminist and public involvement research, these projects attempted to re-dress the power imbalance between researcher and researched (Yllö, 1988). Although Aujla's (2013) study involved limited community engagement, the author belonged to the same community as the participants; as noted by the researcher, this had its own limitations.

Studies about South Asian women homogenise a large, diverse group and risk adding to a stereotyped view of a heterogenous community. Reavey et al. (2006) acknowledged this limitation to their study and justified it on the basis of practicality. However, over all, there was a lack of reflexivity and rationale provided within the scoping review papers about the participant demographics and the impact of these on the findings. This is despite reflexivity being key to the validity of qualitative research (Mays & Pope, 2000). In fact, the papers studied different populations from each other. Tonsing (2014) used a definition of South Asia that does not include Sri Lanka or Bangladesh. Tonsing (2014) and Tonsing & Barn (2017) (the same study, written into two research papers), interviewed 10 Pakistani women, two Indian women and two Nepalese women. Based on the uneven sample size and absence of multiple South Asian populations in the research, these findings could be critiqued for their limited transferability to some South Asian populations. In addition, Tonsing & Barn (2017) adopted a grounded theory approach, based mainly on the experience of Pakistani participants; the developed theory should therefore be held lightly in its relevance to South Asian victim-survivors more generally. Similarly, Aujla (2013) and Sabri et al. (2018) claimed to have reached saturation in data collection, despite a relatively small and uneven sample size that failed to capture the perspectives of multiple South Asian communities.

Anitha et al. (2009), Couture-Carron (2020), Sabri et al. (2018) and Sooch et al. (2006) recruited both first- and second-generation South Asian participants. However, no rationale for this decision was offered. In addition, no information was provided on the sample size of first- compared to second-generation participants, or the differences in data collected from these groups. The exclusion of participants who can’t speak English may have also impacted the quality of the findings of several studies, including those of Anitha et al. (2009), Sabri et al. (2018) and Sooch et al. (2006).

Sabri et al. (2018), Tonsing (2014) and Tonsing & Barn (2017) included participants living with their abusive partners, but did not offer a rationale for this decision. They also restricted their inclusion criteria to women who have experienced domestic abuse within the last two years, without offering a rationale. Gill (2004) recruited women from refuges. I suggest that such criteria

and recruitment processes were not in the participants' best interest and therefore the research did not adopt a participant-centred approach to ethics. In contrast, Aujla (2013) excluded participants still at risk of domestic abuse and Singh & Hays (2008) continually assessed participants' safety. Though this may have made the process safer and less distressing for participants, it also meant that the voices of victim-survivors trapped in abusive relationships were not heard.

A few studies used data collection methods that may have restricted their findings. In Anitha et al.'s (2009) study, the use of a quantitative approach with pre-determined choices, based on the researcher's assumptions, prevented participants from identifying shame as a mental health issue linked to domestic abuse. In the qualitative section of the research, however, participants spontaneously mentioned shame, though this was not explored further. In Sooch et al.'s (2006) study, the use of a questionnaire restricted participants' answers to a few lines or a short paragraph. Utilising a focus group methodology in Gilbert et al.'s (2004) study may have prevented participants from speaking as openly as they may have in an individual interview. In comparison, Sabri et al. (2018) used focus groups to explore topics in theory, and then individual interviews to explore participants' personal experiences of abuse. Gilbert et al.'s (2004) study may have also limited the exploration of shame by using scenarios and asking directive prompt questions about the scenarios. For example, the scenario intended at prompting the participants to discuss shame focussed on mental health, and therefore restricted the exploration of shame to the shame of mental health.

The quality of qualitative analysis varied across the studies. The findings from Anitha et al. (2009) and Sabri et al.'s (2018) studies do not reflect themes as conceptualised by Terry et al. (2017) and Braun & Clarke (2006), as an organising concept made up of a cluster of different ideas, developed through interpretation. Aujla (2013), Sabri et al. (2018) and Tonsing (2014) refer to more quantitative approaches to evaluating the creditability of research, which could be questioned in relation to their qualitative methodologies. Tools for justifying the objectivity, reliability and validity of qualitative research, such as triangulation, saturation, member-checking and generalisability undermine the

unique benefits of qualitative research by restricting quality to a positivist understandings (Varpio et al., 2017).

1.10.2. Scoping Review Two: Experiences of Tamil Victim-Survivors of Domestic Abuse in a Western Context

The scope of the review is defined in the following terms:

1. Who= SLT women victim-survivors living in Western contexts
2. What= domestic abuse literature
3. How (what is the outcome?)= contextualise and rationalise the current study within exisiting psychological literature

The following papers were identified as meeting the inclusion criteria for the scoping review:

- Mason et al., 2008: Canadian academic paper exploring explanations of domestic abuse.
    - Eight focus groups with first-generation Tamil women; two groups with women aged 18-24 (N=17), two groups with women aged 25-64 (N=16), two groups with women 65+ years (N=18), and two groups with women accessing counselling (N=12).
- Guruge et al., 2010: Canadian academic paper exploring factors contributing to domestic abuse.
    - 16 interviews with leaders in health and settlement work, six interviews with Tamil women victim-survivors, four focus groups with Tamil women, and four focus groups with Tamil men.
- Hyman et al., 2011: Canadian academic paper exploring factors contributing to domestic abuse.
    - All participants were first-generation Tamil women. Two focus groups were conducted with women aged 18-24 (N=17), two groups with women aged 25-64 (N=16), two groups with women 65+ years (N=18), and two groups with women who accessed counselling services for domestic abuse (N=12).
- Hyman & Mason, 2006: Canadian academic paper examining definitions of domestic abuse and accounts of when to ‘tolerate’ domestic abuse.
    - Two focus groups with women 18-24 years (N=17), two groups with women 25-64 years (N=16), two groups with women 65 years

old and older (N=18), and two groups with women who received services for domestic abuse. Participants were first- and second-generation Tamil women.

- Guruge et al., 2012: Canadian academic paper exploring trends in violence against women over a lifetime and its impact on health.
    - Survey data was collected from first-generation Iranian (N=30) and Tamil (N=30) participants.
- Kanagaratnam et al., 2012: Canadian academic paper examining coping with domestic abuse and help-seeking.
    - Two focus groups with women 18-24 years (N=17); two groups with women 25-64 years (N=16), two groups with women 65 years old and older (N=18), and two groups with women who received services for domestic abuse (N=12). Participants were first- and second-generation Tamil women.
- Guruge & Humphreys, 2009: Canadian academic paper exploring the barriers to accessing and using formal support services for domestic abuse.
    - 16 interviews with first-generation Tamil community leaders supporting first-generation Tamil victim-survivors.
- Pandalangat, 2011: Canada-based PhD thesis on the impact of culture and gender on mental health, health beliefs and behaviour, help-seeking and support expectations for first-generation Tamils.
    - Interviews with Tamil men (N=8) and Tamil women (N=8) who self-diagnosed as having ‘depression’, and service-providers (N=8).
- ROTA, 2014: UK-based report examining the cultural conceptualisation of mental health, unmet needs, and barriers to accessing mental health support for Tamil people in West London.
    - Two focus groups and 14 interviews with Tamil community members and volunteers.

1.10.2.1. Definitions of domestic abuse: in multiple studies, SLT victim-survivors defined domestic abuse as physical, sexual, emotional, psychological and financial (Hyman & Mason, 2006; R. Mason et al., 2008). Psychological abuse was described as men making false claims in arranged marriage negotiations,

and being threatened or criticised by their husbands' families. Women also discussed their partner's jealousy, suspicions, controlling behaviour and the verbal abuse used to shame them, such as insulting their 'purity', their appearance and their intelligence. Participants in Hyman & Mason's (2006) study identified male suspicion, accusations and emotional abuse as the most painful forms of abuse. Financial abuse included women not being allowed to work, and husbands sending money to Sri Lanka, at the detriment of their wives and children (R. Mason et al., 2008). In Guruge et al.'s (2012) study, none of the participants noted experiencing sexual abuse, which could have been due to the shame of sexual abuse.

A survey of violence against women in 'migrant' and refugee populations in Canada found that 63% of SLT participants experienced domestic abuse, a higher percentage than the other group studied (43%) (Guruge et al., 2012). The most common form of abuse identified was psychological (30%).

1.10.2.2. Factors contributing to domestic abuse: participants in Guruge et al. (2010)'s study identified pre-migration, migration and post-migration factors that contributed to domestic abuse. These included: exposure to war in Sri Lanka; anxiety and inhumane treatment during the migration process; subsequent trauma; re-negotiation of gender roles post-migration; reduced support systems in the new country; downward social mobility; and experiencing racism. In Hyman et al.'s (2011) study, participants explained that women engaged in employment post-migration, while still managing the home, and with a lack of social support, which added to familial stress, and subsequently increased abuse. The factors were explained as contributing to male stress, demoralisation, depression, and alcoholism, which were seen as reasons for their increased use of violence (Guruge et al., 2010). Identification of these explanatory factors may demonstrate excusing of men's violence against women. At a broader level, participants identified gender inequality and male domination as underlying domestic abuse (Hyman et al., 2011).

1.10.2.3. Responsibility and tolerating abuse: male perpetrators were identified as responsible for the abuse against their wives, but participants also spoke about the role of women in avoiding 'provocation' and reducing marital problems

(Hyman et al., 2011), as well as situations in which 'disciplining' women was condoned (Guruge et al., 2010). To avoid 'provocation' and shame, and maintain family harmony, women adopted coping strategies, such as ensuring they did not look too attractive (Hyman et al., 2011; Hyman & Mason, 2006). Tolerating abuse depended on complex factors, including severity, duration and 'justifiability' of abuse (Hyman & Mason, 2006). A key reason for tolerating abuse was because of the shame and reputational damage to divorced women, based on community values around marriage.

1.10.2.4. Help-seeking and therapeutic support: participants explained that only in very high-risk situations would separation be appropriate, and only when a woman has decided to escape or at crisis point should she seek help (Kanagaratnam et al., 2012; Pandalangat, 2011). Professional help was viewed as problematic because it could break-up the family, cause shame and tarnish the children's reputations (Kanagaratnam et al., 2012). Thus, women adopted coping strategies to avoid help-seeking, such as, self-blaming, relying on religion, distraction, and normalising abuse. For women who moved country, a lack of social support pushed them towards seeking help from services (Guruge & Humphreys, 2009).

Many barriers were identified which prevented women receiving appropriate care. These included a lack of familiarity with formal services, language barriers, the shame of disclosing abuse to professionals (especially sexual abuse), and concerns about confidentiality (Guruge & Humphreys, 2009; Kanagaratnam et al., 2012). Additionally, perpetrators often attended appointments with their wives to prevent help-seeking (ROTA, 2014). Shame was also mentioned but was not explored further.

Mainstream services were discussed as culturally and linguistically inappropriate, such that talking therapies did not meet their needs. Tamil and non-Tamil service-providers identified that instead of self-focussed counselling or psycho-therapy, Tamil women wanted support with practical tasks, such as employment (Guruge & Humpreys, 2009). Women understood the lack of appropriate services as discriminatory; many women spoke about the unequal treatment of visible minorities, such as not being assigned an interpreter in

crises. Research suggests the need for linguistically and culturally Tamil services (Guruge & Humphreys, 2009; Pandalangat, 2011).

According to professionals, Tamil women often presented to services as low in mood (ROTA, 2014), due to domestic abuse and spousal alcoholism (Pandalangat, 2011). Tamil service-providers in Pandalangat's (2011) study thought that non-Tamil practitioners were less able to identify domestic abuse as the cause of distress and therefore failed to offer relevant support. The interviewees suggested that instead of identifying the cause of distress, non-Tamil practitioners were more likely to diagnose the consequential symtoms ('depression'). The interviewees suggested that being mis-understood and mis-diagnosed by practitioners was detrimental to the mental health of Tamil victim-survivors.

1.10.2.5. Summary and critical evaluation: pre-migration, migration and post-migration factors were identified as putting Tamil women at high risk of domestic abuse (Guruge et al., 2010; Hyman et al., 2011). Over-arching these factors, patriarchal ideologies created scenarios in which violence against women was tolerated (Guruge et al., 2010; Hyman et al., 2011; Hyman & Mason, 2006). The literature also suggests that some experiences of seeking support from non-Tamil services were discriminatory and worsened mental health problems (Guruge & Humphreys, 2009).

Despite the findings that services do not meet the needs of Tamil victim-survivors, and that victim-blaming and self-blame are rife, no study has examined shame-experiences or shame-focussed support for Tamil victim-survivors. Instead, multiple of the studies explored similar topics, limiting the expansion and development of the field. Mason et al. (2008) and Hyman & Mason (2006) similarly explored definitions and understanding of domestic abuse in the Tamil community. Guruge et al. (2010) and Hyman et al. (2011) both explored structural, cultural and individual, pre- and post- migration factors impacting domestic abuse in the Tamil community. Guruge & Humphreys (2009) and ROTA (2014) both explored the barriers to support. In addition, Guruge et al. (2012)'s quantitative approach did not add much to the literature beyond the findings of the qualitative research.

Adding to the limited development of the field, the papers by Mason et al. (2008), Hyman et al. (2011), Hyman & Mason (2006) and Kanagaratnam et al. (2012) appear to be based on one study. The funding of the project by the Institute of Gender and Health of the Canadian Institute of Health Research is not transparent in all of the papers. Similarly, the papers by Guruge et al. (2010) and Guruge & Humphreys (2009) appear to be based on one study. To add to this, Guruge et al. (2012)'s study was also authored by researchers involved in the two forementioned studies. Yet, there is a lack of transparency about this in the papers, nor reflexivity about the implications of dominating the field based on a couple of studies (with the same participants) and the viewpoints of a handful of researchers.

Public involvement varied across the studies. On the one hand, the main study in the field, which resulted in the studies by Mason et al. (2008), Hyman et al. (2011), Hyman & Mason (2006), and Kanagaratnam et al. (2012), were developed in partnership with community organisations. ROTA's (2014) report similarly developed out of a partnership between an NHS Trust and local Tamil organisations. Engaging Tamil organisations and community members in shaping the research improved the quality of these studies, including resulting in findings with useful clinical implications, which were actioned by the community organisations. Guruge et al. (2010), Guruge et al. (2012), Guruge & Humphreys (2009), and Pandalangat's (2011) studies, on the other hand, did not involve any public involvement.

The findings from Hyman et al. (2011)'s study about the factors that shape domestic abuse are questionable, given that they are mainly based on the perspectives of Tamil women more generally, not victim-survivors specifically; also, there is a lack of consideration and reflexivity about the possible differences in perspectives between victim-survivors and other Tamil women. Similarly, in Kanagaratnam et al.'s (2012) study, the majority of the data captures how Tamil women perceive Tamil victim-survivors to cope with domestic abuse, but also includes data from Tamil victim-survivors on how they have coped with domestic abuse. The lack of differentiation between these two types of data limits the possible clinical implications of the findings. In Hyman & Mason's (2006) study, they chose to exclude the victim-survivor participants'

data from their findings on the basis that the women's options were biased by their interactions with counselling services. The appropriateness of this approach is questionable given that the paper claims to identify the responses of Tamil women to abuse, which I would argue, requires the voices of victim-survivors. In addition, Guruge & Humphreys (2009)'s study claims that Tamil victim-survivors prefer practical support to talking therapy, but this is solely based on interviews with community leaders and does not include the perspectives of victim-survivors. The research topic may therefore require further exploration with victim-survivors themselves to ensure credibility of results.

The papers by Mason et al. (2008), Hyman et al. (2011), Hyman & Mason (2006) and Kanagaratnam et al. (2012) involved recruiting SLT victim-survivors through a community partner (an organisation that the victim-survivors received counselling through). This enabled the community partners to assess the risk to women of participating and only invite women who have left the abusive relationship to take part in the study. In the paper by Hyman et al. (2011) it was explained that it was the women's counsellors from the community organisation that recruited them to the study. This could have put pressure on the women and limited their ability to voluntarily and freely consent to participation.

The study resulting in the papers by Mason et al. (2008), Hyman et al. (2011), Hyman & Mason (2006) and Kanagaratnam et al. (2012) recruited first- and second-generation SLT participants; the papers acknowledge that the majority of the participants were first-generation SLTs, but do not reflect on the impact this might have had on the findings, nor on the impact of the un-even sample size. They also conducted focus groups with different age-groups but do not consider the differences between these groups in the results. In contrast, Guruge et al. (2010), Guruge et al. (2012), Guruge & Humphreys (2009) and Pandalangat (2011) only recruited first-generation participants; this may have improved the specificity and therefore the transferability of the results. ROTA (2014)'s study does not provide adequate information about the demographics of the participants and the impact it may have had on shaping the findings, except that the majority of participants were women, which influenced the results.

The majority of the studies included both English-speaking and Tamil-speaking participants. The main study in the field used Tamil-speaking research assistants to facilitate the focus groups and then translate and transcribe the discussions into English, checking each other's translations and discussing nuances. This appears to be a stringent and high quality approach to translation. In contrast, Guruge et al. (2010) and Guruge & Humphreys' (2009) data collection was mostly conducted in English, which may have limited who could participate in the research and thus the perspectives captured in the findings.

The study resulting in papers by Mason et al. (2008), Hyman et al. (2011), Hyman & Mason (2006), and Kanagaratnam et al. (2012) conducted focus groups as the method of data collection. While this may have been the best approach for exploring the views of Tamil community members more generally, it may have limited the victim-survivor participants from sharing their views and experiences. A better approach may have been that used by Guruge et al. (2010), who conducted interviews with community leaders and with victim-survivors, and then focus groups with men and women from the community. Guruge et al. (2012) used a quantitative survey methodology, which appears to have limited the findings of the study such that many of the participants did not answer the key multiple-choice question (yes or no), asking about whether they had experienced abuse. This may suggest that a qualitative approach, which can be less directive, and create the space for participants to feel safe and heard, is a better approach for asking sensitively about domestic abuse.

The research aims and questions were not clear in the papers by Mason et al. (2008), Guruge et al. (2010), Hyman et al. (2011), Hyman & Mason (2006), Guruge et al. (2012) and Kanagaratnam et al. (2012), which creates ambiguity about the extent to which findings developed deductively or inductively. In Kanagaratnam et al. (2012)'s paper, it is not clear whether the authors set out to explore coping strategies, or whether the themes developed inductively through the interviews. In comparison, Pandalangat (2011) clearly outlines the study's aims and research questions, improving the transparency and trustworthiness of the results.

Guruge et al. (2010), Hyman et al. (2011) and Pandalangat (2011) adopted structural and ecological models of domestic abuse in their research. The papers by Guruge & Humphreys (2009), Guruge et al. (2012), Mason et al. (2008), Hyman et al. (2011), Hyman & Mason (2006), and Kanagaratnam et al. (2012) do not appear to hold a theoretical stance. Without a theoretical basis or discussion of one, the findings are shaped by the authors' assumptions without acknowledgment or reflexivity on this.

Mason et al. (2008), Hyman et al. (2011), Hyman & Mason (2006) and Guruge & Humphreys (2009) do not appear to have an epistemological stance or clear method of analysis. In the papers by Hyman et al. (2011), Hyman & Mason (2006), and Guruge & Humphreys (2009), data appears to be coded but not analysed further. Thus, the findings reflect participants' responses to interview questions with limited interpretation or analysis. In comparison, Guruge et al. (2010), Kanagaratnam et al. (2012) and Pandalangat (2011) lay out a clear epistemology and methodology for analysis; these studies' data appears to have been analysed and interpreted to develop themes, in line Terry et al. (2017) and Braun & Clarke's (2006) writing on thematic analysis. Guruge et al. (2010) used member-checking and triangulation to try to ensure trustworthiness of their results, which could undermine their qualitative approach to analysis. Guruge et al. (2012) used a correlation to explore the relationship between mental health and abuse for all participants; instead, findings may have been more enlightening if analysis involved a comparison of mental health scores between participants who experienced abuse and those who hadn't.

1.11. Summary and Research Rationale

There is some suggestion of higher rates of domestic abuse within the Tamil diaspora compared to other 'migrant' (Guruge et al., 2012), South Asian, or UK-based communities (Walby & Allen, 2004). Tamil women, different from other South Asian groups, experienced unique pre-migration, migration, and post-migration factors that affected domestic abuse (Guruge et al., 2010), and potentially shame. Migration is a risk factor for domestic abuse because it can lead to diminished social support, isolation, difficulties with accessing services, and multiple stressors (Akpinar, 2003; Guruge et al., 2010; Hondagneu-Sotelo,

1992; Rai & Choi, 2018). Higher rates of domestic abuse in the Tamil community have also been associated with experiences of war in Sri Lanka (Guruge et al., 2017; Minority Rights Group International, 2013; Usoof-Thowfeek, 2018); women who live in conflict-affected areas are more likely to experience abuse, and men who have witnessed or been part of a conflict, or experienced political violence, are more likely to abuse their partners (Gupta et al., 2009; Mannell et al., 2021).

A key difference between the two scoping reviews is the lack of discussion about shame in the Tamil literature. This is despite the suggestion that SLT women experience victim-blaming and may excuse male violence based on men's experiences of war and patriarchal hierarchies of gender. Given that shame is intrinsically related to honour-cultures, it is likely that shame is a relevant concept for SLT victim-survivors.

Given that literature indicates a culturally Tamil conceptualisation of health is holistic, interdependent, and socially determined (Pandalangat, 2011; Pandalangat & Kanagaratnam, 2021; Weaver, 2005), it has been suggested that the medicalisation of distress is antithetical to the Tamil conceptualisation (Inman et al., 2001). In addition, studies with Tamil victim-survivors indicate that statutory mental health services in western contexts do not meet their needs (Guruge & Humphreys, 2009; Pandalangat, 2011). These studies were based in Canada, but due to the lack of research with the Tamil community in the UK, could be used to extrapolate to experiences of Tamil victim-survivors in western contexts more broadly. This suggestion is supported by literature with South Asian women and victim-survivors in the UK, which has shown that NHS services do not adequately meet their needs (e.g. Anitha et al., 2009; Gilbert et al., 2004). Much of the existing domestic abuse research, however, focusses on individualistic, psychiatric diagnoses, such as 'PTSD', and diagnostic-based interventions such as Cognitive-Behavioural Therapy (CBT) (Wagers & Radatz, 2020). Thus, there is a need to study other approaches to reducing distress that better sit with cultural conceptualisations of health (Tribe, 2007).

To fit with Tamil culture's holistic understanding of health, pursuing terms that reconcile the dichotomy between mind and body, such as shame, may offer a more appropriate understanding and approach to supporting Tamil victim-

survivors than the medical model (Grønseth, 2007). In fact, shame-focussed support has been promoted as essential to developing culturally-sensitive therapies (Edge & Lemetyinen, 2019; Gilbert, 2019). Given that shame-experiences differ between groups, more needs to be understood on the part of services about group-specific experiences of shame (Gilbert et al., 2007; Sooch et al., 2006). Weaver (2005) also suggests that more needs to be understood about how shame impacts Asian victim-survivor's experiences of abuse.

The SLT population has been described as neglected in UK health research (Aspinall, 2019), and the studies that do exist examine war-trauma, but not domestic abuse. Though there is more literature about the Tamil population in Canada, SLTs may face additional challenges in the UK. The larger Tamil community and the Canadian government's inclusive approach to refugees may have led to more research and support structures to benefit the community. In contrast, an anti-'immigrant' rhetoric and hostile environment policy has long-existed in the UK, seen in the current context of Brexit and the 2021 Nationality and Borders Bill (Gardner, 2021; IOM, 2019). In addition, the government's Increasing Access to Psychological Therapies (IAPT) scheme and NICE guidelines have created a dominance of CBT in the UK, which may be harmful if imposed on a population with a different conceptualisation of distress (Fricker, 2007; Wessells & Kostelny, 2021).

Previous UK-based domestic abuse studies examined experiences of 'South Asian' or 'migrant' women. Though there may be similarities between groups, these are not homogenous blocs. Gender, patriarchy, culture, race and class shape heterogenous experiences of abuse within South Asian communities (Abraham, 2000; Ahmad, Shik, et al., 2004; Guruge, 2010; Shirwadkar, 2004). As suggested by Rai & Choi (2018), a more focussed approach is needed to increase professionals' understanding, in this case, of first-generation Tamil women, to support the development of more specific interventions that better account for different needs.

Based on Werbner's (2002) concept of a diaspora as an 'aesthetic' and 'moral' community, SLTs are 'aesthetically' part of the wider Tamil diaspora. However, on the grounds of a 'moral' community, the SLT diaspora are a distinct sub-diaspora of the wider Tamil community due to the politicisation of being Tamil in

Sri Lanka (D. Jones, 2016). Thus, this research will not study the experience of the wider Tamil diaspora. Within the SLT community, homogenising the different experiences of victim-survivors risks erasing the diversity in religion, social status, caste, (dis)ability, sexuality, and life experiences (Michael, 2021). However, due to the constraints and boundaries on this research, the heterogeneity of SLT women will be kept in mind but will not be explored in depth.

1.12. Summary of Critical Evaluations and Implications for Research

Many of the studies in the scoping reviews included a variety of sample populations, which reduced the specificity and thus transferability of the findings. Instead, this research will focus on a specific group, in order to develop a more in-depth understanding of their unique experiences and views. The studies in both scoping reviews also varied in their recruitment of women who don't speak English, and of victim-survivors still at risk of domestic abuse. Excluding non-English speakers and victim-survivors living in abusive situations from participating may reduce the perspectives captured within the findings and thus their transferability and utility. However, recruiting victim-survivors living in abusive situations risks prioritising the research over the women's safety and well-being. Therefore, to adopt a more ethical and inclusive approach, this research will exclude victim-survivors who are in abusive relationships, but not limit recruitment to women who speak English. In addition, most of the studies lacked reflexivity. This research therefore aims to develop the quality of research in the field by adopting a reflexive approach.

Some studies in the scoping reviews used data collection methods that may have restricted the findings. Thus, this research will use a more open-ended approach with the aim of fostering participants to express themselves, and developing more inductively-developed insights. The analysis of the data was also limited in many of the studies, which may have reduced the possible development of theory in the field. This research will therefore involve theory-based, interpretative analysis with the aim of developing the field's theoretical understanding of the psychological needs of victim-survivors.

There is a need for research to expand beyond the limited topics currently explored with SLT and South Asian victim-survivors (definitions of domestic abuse; risk factors for domestic abuse; barriers to support). This research will hence explore victim-survivors' experiences of abuse. This will hopefully enable the development of clinical implications that take steps towards reducing the barriers to support, instead of simply identifying them. The studies which involved public involvement in shaping the research tended to have more real-world results and benefits for the community of interest. Thus, in order to be valuable and relevant for the community, this study will be conducted 'with' and not done 'to' the community of interest.

1.13. Consultation

I consulted with several UK-based Tamil community organisations and Tamil mental health professionals, including the Tamil Community Centre (TCC), about the topic. Consent was provided to name the TCC in the research, given that they became the key research partner. It was strongly validated that domestic abuse is a major problem in the Tamil community, including the UK-based diaspora. Consultants discussed the role shame plays in preventing disclosure, leaving the relationship, and accessing support, as well as the shame around mental health. Consultants also spoke about the inappropriateness of NHS mental health services for the Tamil community, and the need for greater understanding about the community on behalf of non-Tamil professionals.

The research aims and questions developed from both the literature and the consultations. The TCC identified that useful research would help statutory therapeutic services better understand Tamil victim-survivors and support appropriate service developments.

1.14. Research Aims

The aim of the research is to further professionals' understanding of the shame-experiences of SLT women who have suffered domestic abuse, to develop the cultural competence and equality of mental health services. As highlighted by

the ‘Advancing mental health equalities strategy’ (NHS, 2020), minority ethnic groups face inequality in access to, experience of and outcomes from engaging with NHS mental health services; a relevant review of health inequalities therefore suggests that NHS services and practitioners must continue to learn about and account for particular needs of groups, to reduce inequality in health service provision (Kapadia et al., 2022). Similarly, the NICE guidelines on ‘Domestic violence and abuse: multi-agency working’ suggest continued staff training and development in issues of equality and diversity surrounding domestic abuse and minoritised groups’ experiences of health services; the guidelines specifically speak to the importance of training staff in the complexities of shame and assumptions about ethnic minority victim-survivors (NICE, 2014). In order to operationalise such guidelines and suggestions, research must continue to develop an understanding of oppressed and marginalised groups’ experiences, including the different group experiences of shame.

1.15. Research Questions

1. What shapes the experience of shame for first-generation Tamil women victim-survivors of domestic abuse?
2. How is shame experienced and expressed by first-generation Tamil women victim-survivors of domestic abuse?

2.0. METHODS

2.1. Overview

A qualitative approach, using individual interviews, was judged to be the most appropriate method to meet the aims of the research. Because of the nature of the research questions, reflexive Thematic Analysis (TA) was used for analysis.

2.2. Design

The purpose of qualitative research is to explore and contextualise people's views and experiences, shaped by their subjective perspectives and socio-cultural environments (Wilkinson et al., 2004). This is congruent with the purpose of the research, to gain an understanding and appreciation of first-generation Tamil women's experiences and views on shame, and the socio-cultural factors that influence their meaning-making. The relatively unconstrained accounts provided by participants through qualitative research (contrasting with constrained quantitative data dictated by the researcher) may elicit unexpected insights into factors not previously considered; these insights could help inform the development of therapeutic interventions.

For a qualitative approach, it is important to choose a method of data-collection that enables participants to express themselves and their views (Wilkinson et al., 2004). Individual interviews were conducted because of the potential barriers to discussing domestic abuse and shame in a group context. Semi-structured interviews allow participants to respond to open-ended questions with their personal reactions, rather than a forced choice reaction between pre-defined options, as in other forms of interviews or quantitative approaches.

Participants were offered the opportunity to conduct interviews in-person or online. The opportunity to conduct interviews in-person addressed the potential systematic exclusion of people who can't access the internet (British Psychological Society, 2021a). Conducting the interviews online enabled

individuals who may have been unable to engage due to geographical location or time-constraints the opportunity to participate.

This study was produced in collaboration with UK-based Tamil organisations and members of the Tamil community. TCC was the main research partner and helped shape the aims, design, recruitment, interviews, and analysis (see Appendix E for the Memorandum of Understanding). Due to the time and financial constraints of the project, it was not possible to conduct Participatory Action Research (PAR) or co-production to the highest degree, as outlined by Arnstein's Ladder of Participation (Arnstein, 1969). However, within the limitations, I aimed for meaningful public involvement at each stage of the research.

2.3. Participants

2.3.1. Inclusion Criteria

I hoped to recruit UK-based first-generation SLT women victim-survivors of domestic abuse. The inclusion criteria and rationale included that participants be:

- Adults (18 years+): to prevent confounding variables related to child abuse and concerns about child safeguarding.
- First-generation Tamil women living in the UK: the study focussed on domestic abuse in the context of moving from Sri Lanka to the UK, which may differ considerably from the experience of British-Tamils. It was only UK-based because of the specific UK context. Only women were asked to participate because domestic abuse is a gendered crime.
- Speakers of English and/or Tamil: many of the women supported by TCC feel more comfortable speaking Tamil.
- No longer in an abusive relationship, living in a safe environment, for at least a period of 12 months, and feel comfortable to reflect with distance on the relationship: for the participants' safety.

2.3.2. Exclusion Criteria

Participants who were currently in an abusive relationship or may have become highly distressed by participating were excluded. Women who experienced the

domestic abuse in a gay relationship were also excluded from the study due to the confounding variables.

2.3.3. Recruitment

Women who were supported by TCC and met the inclusion criteria were approached by TCC staff about the research. Keeping in mind the power dynamic between helper (TCC) and helped (women who have been abused), the voluntary-nature of the research was reiterated. Women who were approached about the research and indicated interest in participating were provided with an information sheet, as well as the opportunity to discuss further.

Recruitment took place through TCC because of the ready-availability of the research population. It also enabled careful consideration about participants, based on the knowledge of TCC staff, to reduce risk and distress. This was deemed important based on the assumption that victim-survivors experiencing 'PTSD' may be more likely to become distressed by participating in research (Griffin et al., 2003). In addition, recruiting through TCC ensured participants were offered ongoing support following the interviews.

2.3.4. Demographic Information

All participants identified as SLT women. Four participants identified as separated from their husbands, one as single, and one as widowed. Two women were between 30-40 years old, three women were between 40-50 years old, and one woman was between 50-60 years old. Two participants had lived in the UK between 5-10 years, and four participants had lived in the UK between 15-25 years.

2.4. Materials

A semi-structured interview schedule was used to guide the interviews (Appendix F). The schedule changed and developed through consultation with my supervisors from the one submitted with the original ethics application (see Appendix G for the original ethics application). The interview questions changed from being more structured, assumption-laden, and directive, towards being clearer, simplified, and open-ended, with probes and follow-up questions for

further exploration. This change reflects the research's qualitative approach using semi-structured interviews, aimed at enabling the participants to express themselves in a relatively unconstraint manner. This change to the interview schedule did not alter the areas being explored in the interviews and so continued to fit with what had been approved by the ethics committee.

2.5. Procedure

2.5.1. Consultation

A group of community members who accessed support from TCC offered a consultation to develop my understanding of the topic. The group discussed violence against women as normalised and accepted within the Tamil community due to patriarchal ideologies supported by cultural values. Shame was identified as the main factor trapping women within abusive relationships, including the shame of being a separated/divorced woman, and the shame brought on one's children by divorce. According to the consultants, separated women are not invited to community gatherings or spaces, but separated women may also avoid community spaces because of their own shame. Arranged marriage was identified as a process based on honour, insofar as a woman's parents may insist she stays in a relationship (regardless of abuse), shaping victim-survivors' experiences of abuse.

2.5.2. Pilot

A pilot interview was conducted to review the interview schedule and interview process. It was conducted with a convenience sample of one first-generation Tamil woman who recently left an abusive relationship. The participant suggested that being asked about the difficulties with sharing her story with her friends and family, and about the barriers to escaping abuse, helped her to open up about shame. The participant also suggested referring to 'psychological support' instead of 'mental health', due to the stigma.

2.5.3. Interviews

Interviews were scheduled by TCC, with myself, the participant, and translator. Due to the additional time required for translation, two-hours was allowed for each interview. In practice, the length of interviews varied from about 1 hour 30

minutes to 2 hours 30 minutes. All interviews were conducted, recorded and transcribed using Microsoft Teams. A Dictaphone was also used to record the interviews in case of technical problems.

Prior to starting each interview, I took time to get to know the participants informally to help build their trust in me. I also reassured them that they were the experts on the topic and that their input would be greatly appreciated and useful. I then explained the purpose of the research and confidentiality, and asked them to choose a pseudonym. Demographic information was collected at this stage. I also addressed the power imbalance between us, and attempted to make space to discuss any difficulties and possible adjustments to support the participants.

At the end of each interview participants were either emailed or posted a debrief sheet and a £15 voucher for their involvement. The translator was also paid for their time.

Interview recordings were transcribed using a semantic-level approach, anonymising identifying information in the process. The anonymised transcripts were then used for data analysis (see Appendix H for example transcription).

2.5.4. Translation

A Tamil translator was present for all of the interviews and the majority of the interviews were conducted in Tamil, because the women were able to express themselves most fully in their mother-tongue (Caretta, 2015). The degree to which participants also spoke in English during the interviews (as well as Tamil), varied depending on the participants' comfort with speaking English. A couple of participants spoke mostly in English. According to Edwards (2013), enabling participants to speak in their language of choice supports more detailed data. I therefore asked questions in English, which were translated into Tamil by the translator, and then the participants' responses were translated into English. The process of translation was considered and discussed regularly throughout data collection, analysis and write-up. Key to the discussions were myself, the translator, and a key TCC staff member.

The translator was a first-generation Tamil woman and TCC volunteer with experience translating. TCC chose the translator to ensure the quality and approach to translation was one they trusted. The translator had a significant influence on the research by virtue of their attempt to convey meaning from Tamil language and culture into English, and vice versa (Larkin et al., 2007). I therefore conceptualised the translator as a 'co-researcher', whose personal impact on the fieldwork was considered similarly to my own (Temple & Edwards, 2002). As the translator was a member of the Tamil community and a volunteer with TCC, it was helpful to have her understanding and perceptions of the participants' experiences, as well as my own.

Prior to the interviews, I met with the translator to explain the study and research questions, and develop the interview questions. We also discussed the concept of 'shame' cross-linguistically and culturally. Given that there are many words for 'shame' in Tamil, we agreed that the translator would use the most appropriate translation based on participants' terminology or dialect. The word 'avamaanam' was most commonly used for shame across the interviews, which in the context of domestic abuse can also mean 'disgrace', 'dishonour', or 'humiliate'. In addition, the translator and I considered and agreed on an approach to translation. We chose to give participants space to express themselves, instead of restricting their narratives by pausing them every couple of sentences to translate their responses into English. Therefore instead of verbatim translations, translations into English were summaries of participants' responses. We chose this approach because we wanted to prioritise participants' experiences of the interviews, and due to the time-limits of the interviews. The translator also adjusted my questions to make them more appropriate and understandable to the participants. Our approach is justified based on an understanding that translation is not neutral and therefore there is no one 'correct' transfer of meaning (Temple & Young, 2004). Instead cross-cultural, cross-language research is shaped by 'triple subjectivity'- that of the participant, the translator, and the researcher.

During the research process, difficulties that arose were considered and adjusted for. For example, it proved difficult to explore participants' emotions. TCC staff explained that talking about one's feelings and emotions is not

encouraged within the Tamil culture and that questions such as ‘how did that make you feel?’ may be difficult to answer. The interview questions and prompts were therefore adjusted to focus on the situational and relational context of emotions, and to notice and comment on participants’ expressions and body language.

For transcription, I transcribed the English spoken in the interview recordings. Most transcriptions are therefore the words of the translator. In a few interviews participants spoke mostly in English and so the transcriptions capture their words, as well as some translation by the translator.

2.6. Epistemological Position

I adopted a critical realist position, which postulates that there is an objective reality but that it is shaped, explained and defined by a person’s subjective experience and social context; in other words, ‘truths’ cannot be decontextualised (Willig, 2013). Critical realism sits between a positivist approach and a relativist approach. I selected a critical realist position because I understand domestic abuse and its consequences to be ‘real’, but also context-specific.

Critical realism seeks to identify the mechanisms underlying empirical phenomena (Alvesson & Skoldberg, 2009) and a person’s subjective meaning and experience (Pilgrim & Bentall, 1999). It also seeks to support the ‘emancipation of humans’ (Bhaskar, 1998); in other words, critical realist research aims to have real-world results and benefits for humans. Critical realism therefore suits the aims of the research, to explore the underlying mechanisms and subjective experiences of shame, and in doing so, inform psychological practice that better supports Tamil victim-survivors.

The approach shares with social constructionism the requirement for concepts to be examined within historical and social contexts. This is congruent with the research’s aim to explore shame within the specific historical, ethnic, gendered, social, political and economic context of first-generation Tamil women in the UK. Different from social constructionism, critical realism does not suggest reality is socially constructed, but that the theories of reality and methodological

approaches to researching reality are socially constructed (Pilgrim & Bentall, 1999). Accordingly, the dominance of CBT and 'PTSD' in domestic abuse research can be explained by the interests and assumptions of White, Eurocentric researchers, not simply the 'objective' reality or utility of these models.

Congruent with a positivist approach, critical realism acknowledges an objective reality. This research acknowledges that the social, political, cultural, gender and economic factors that underpin domestic abuse and shame exist and have real consequences, as do domestic abuse and shame. However, critical realism adopts a critical reflexive position that ensures proper consideration of historical and cultural experiences, to avoid falling into a naïve, reductionist, medical naturalism approach to realism (Pilgrim & Bentall, 1999). I therefore considered my beliefs, interests, positions and power throughout the study, in an attempt to avoid re-producing oppression within knowledge production. Pilgrim & Bentall (1999) have suggested that critical realism is helpful for exploring the reality of mental health through a cautious and critical approach.

2.7. Analytic Approach

I chose reflexive TA as the most appropriate analytic approach that fit with the study's purpose, research questions, and theoretical position. Reflexive TA is qualitative in both procedure and values, based in critical theory, and focussed on examining socially embedded patterns of meaning and their implications (Clarke & Braun, 2014). TA enables the goal of the research to investigate the patterns relating to shame for Tamil victim-survivors (Clarke & Braun, 2020). It also enables actionable outcomes and implications for practice, which is different from other qualitative approaches (Sandelowski & Leeman, 2012). TA is congruent with a critical realist approach because it is theoretically flexible, yet theory-based (Braun & Clarke, 2021b), and understands patterns and their interpretations to be informed by theory and developed by researchers (Clarke & Braun, 2020). This differs from other forms of TA and other forms of pattern-based qualitative analysis, which hold a more positivist approach that themes exist in the world and can be biased by researcher's interpretations of them (Clarke & Braun, 2020).

In line with reflexive TA, I wrote in first-person, to communicate the active and contextual process I engaged in as the researcher to develop and interpret the research (Braun & Clarke, 2021a). I analysed the data using Braun & Clarke's (2006) six phases of TA, applying an inductive and deductive approach to interrogate the data for both semantic (participants' words) and latent (underlying, theoretical concepts) meaning. An inductive approach was chosen because of the lack of existing theory and my intention to prioritise the perspectives of first-generation Tamil women in shaping the results. A deductive approach was also used because the research questions were pre-defined, based partly in existing theory. In balancing an inductive and deductive approach I hoped to keep close to the participants' words and views, while also acknowledging the hidden nature of shame and the necessity for interpretation based on theory.

I conducted the familiarising stage by reading and re-reading physical copies of the interview transcripts. While reading I underlined all interesting and powerful statements and made notes of my thoughts in the margins. During the initial reading, I realised the pertinence of participants' responses, which at times during the interviews had seemed irrelevant to my questions.

I used NVivo to code the interviews, systematically going through the transcripts (see Appendix I for example coding). I coded phrases with detailed analytical labels, and some with multiple labels. I noticed that I created very detailed codes out of fear of moving away from the data, anxious my interpretations would misrepresent the participants. After the initial coding, with a better understanding of the consistent and divergent codes across the transcripts, I re-coded using broader labels. To contextualise the data and aid analysis I referred back to my reflective interview notes throughout coding.

To develop themes I printed out the codes on chits of paper and clustered conceptually-related codes together. During this process I loosely kept in mind the research questions. I then visually mapped how the initial themes may fit together, before seeking consultation and re-conceptualising the themes. I sought consultation from members of the Tamil community on the themes to

ensure the findings were useful to the community. As TA is an iterative process, I also went back to the codes and the transcripts several time to ensure the themes continued to represent the data. Clusters of codes and links between them were worked and re-worked until they represented themes that were coherent around a central organising concept, held value, and had enough data to support them (Terry et al., 2017) (see Appendix J for thematic mapping process). On reflection, I found defining codes and themes difficult because it involved my interpretation of whether a participant was describing shame or another experience (such as guilt or low mood), and whether those feelings were related to shame for that participant or were a separate experience in themselves.

In writing the results section, I used data excerpts illustratively and analytically (Braun & Clarke, 2021a). The excerpts are presented as transcribed, not changed for spelling or grammatical errors. Excerpts are named with the pseudonym of the participant, but in most cases are the translator's words.

Reflexive TA and critical realism emphasise the subjectivity of interpretations, and that a researcher can only have a partial, situated understanding of the data (Braun & Clarke, 2021a). I hence reflected on my assumptions and power to consider and re-consider the choices I made. Below I have identified key identities and experiences relevant to the research. I have chosen not to include the translator's identities to protect their privacy.

- I am in my late 20s, heterosexual, cisgender, White, and middle-class.
- I am influenced by my parents' social justice values and my mother's work on gender-based violence.
- I was born and brought up in Colombo, Sri Lanka.
- I identify as Irish due to familial heritage.
- I hold feminist beliefs about the impact of patriarchal ideologies on society, including violence against women.
- Through my clinical psychology training I have been drawn to critical theories and a social determinant, public health, human rights approach to health.

2.8. Ethical Considerations

2.8.1. Ethical Approval

This study received ethical approval from the University of East London, with minor changes requested by the Research and Ethics Committee addressed prior to recruitment. The study complied with the British Psychological Society's (BPS') Ethics Guidelines for Internet-mediated Research (British Psychological Society, 2021a), Code of Ethics and Conduct (British Psychological Society, 2021b), Code of Human Research Ethics (British Psychological Society, 2021c).

2.8.2. Informed Consent

Participants were provided with an information sheet (Appendix K), translated into Tamil, detailing information about the study; including its aims and purpose, how it would be disseminated, confidentiality, and data protection, as well as what to expect, including example interview questions.

The participant information sheet seen in Appendix K changed slightly from the one submitted with the original ethics application, to reflect the development and increased specificity of the research questions. This change did not require an ethics amendment because it did not expand the topic of interest or alter the research methods.

Interview questions were included in the information sheet to provide participants with all the information to make an informed decision about participating. The original interview schedule (included in the ethics application) was used in the final participant information sheet, as the information sheet had already been translated into Tamil prior to the development of the final interview schedule. Given that the development to the interview questions did not impact on how the research was conducted or the topic being explored, an ethics amendment and new participant information sheet was not necessary. In qualitative interviews, each interview is unique, and the researcher must adapt and develop questions to suit each participants' knowledge and to what they feel comfortable sharing (Rubin & Rubin, 2005); thus, the questions offered in

the participation information sheet were possible questions relating to the topic of discussion, and not an exact replication of an interview.

Staff/volunteers from TCC also explained the study in Tamil and answered questions; this addressed any difficulties with the translation of the information sheet and participants' literacy. After processing the information, women who were interested in participating in the research signed a consent form (Appendix L), which was sent to me prior to further involvement. I again gathered verbal consent at the start of each interview, and encouraged participants to ask questions.

2.8.3. Confidentiality

Participants were informed that their data would be anonymised and that it would not be possible to identify them in any write-up of the research. Hence, participants were asked to choose a pseudonym, and all identifying information in the interviews was changed or deleted during transcription. The participants' ethnicity, age, relationship status, and years in the UK were collected, to contextualise the data and ensure participants met inclusion criteria. Participants were informed that this information would not be linked to their data, and only reported in general terms.

Participants' names, email addresses and home addresses were collected for the purpose of contacting them and sending the debrief sheet and voucher post-interview. This information was deleted as soon as their involvement was complete. Interview recordings and anonymised data will be deleted once the thesis has been examined and passed, and the anonymised transcripts and electronic copies of consent forms will be stored until publication of any papers based on the research. All data was stored in password-protected files, in separate folders, on my university OneDrive, to prevent the signed consent forms, interview recordings, anonymised transcripts, demographic information and personal information being linked.

2.8.4. Possible Distress

The distressing nature of a study focussed on domestic abuse and shame was carefully considered. The participant information sheet outlined potential risk, as

well as consent and withdrawal procedures. Participants were advised of the voluntary-nature of participation and encouraged to disclose only information they were comfortable sharing (Goodhand, 2000). They were also informed that they could take a break or end the interview at any point. In accordance with recommendations for interviewing survivors of rape (R. Campbell et al., 2010), I adopted feminist interviewing processes, including having a warm and validating manner, and paying attention and responding to participants' emotions (Jaggar, 1989; Oakley, 1981). A debrief sheet with information about support services was also shared following participation (Appendix M).

Distress was particularly considered in the context of online research and needing to ensure participants were able to keep themselves safe, without face-to-face support. The Ethics Guidelines for Internet-Mediated Research (British Psychological Society, 2021a) suggests that the researcher's ability to monitor and respond to participants' reactions is impeded in online research, which can create scope for additional harm to participants. Participants were therefore supported on an on-going basis by TCC, which included support from the translator during the interview, and a supportive phone call with a key TCC staff member post-interview, if required. The TCC staff member chosen as the most appropriate person to offer support had gained the women's trust through years of helping them.

2.8.5. Debrief

Space was provided to de-brief at the end of each interview. This included discussing any distress, and participants' ability to manage distress and keep themselves safe. Consistent with BPS (2014) ethical guidelines, a debrief sheet was emailed or posted to participants post-interview.

3.0. RESULTS

3.1. Overview

TA of the six semi-structured interviews resulted in four main themes (see Table 1). This chapter describes and evidences each theme and sub-theme with excerpts. For presentation in the results section, the excerpts have been edited to facilitate the reader's understanding. The words within square brackets either suggest missing words in the speaker's speech or an alternative word to improve clarity. Where additional words or repetition of words used in free-flowing speech confused the meaning of the excerpts, they were removed; this is indicated by an ellipsis within square brackets. In addition, for the excerpts that could initially be difficult for a reader to understand, I have included an explanation based on the wider conversation in the interview.

3.1.1. A Note on Shame

The themes are one possible interpretation of participants' shame, and have been chosen with the research questions in mind. It is worth noting that shame was not always identified by participants explicitly, which fits with the hidden nature of shame. To speak of shame is to induce shame, and therefore participants may have avoided doing so (Biddle, 1997). Consequently, in some cases, shame was interpreted based on the content of responses. I chose to present a range of excerpts, some clearly identifying shame, some vivid depictions of experiences, and others that illustrated my analytic understanding.

Table 1: Table of Themes and Sub-Themes

Themes	**Sub-Themes**
Blame and Betrayal	- Criticised as a Form of Abuse - Community and Familial Expectations - Control of Women
Consequences of *Being* Shamed	- Destructed Identities - Fear of Judgement
Personal Shame	- Degradation - Vulnerability - Shame of Others Knowing - Mothering Guilt
Protection Through Denial	- Protecting Family - He Isn't to Blame

3.2. Blame and Betrayal

Participants described experiences of being blamed, shamed, controlled and unsupported within multiple relationships; these experiences spanned marriages, their families and communities, and also statutory services. Victim-blaming and shame are intrinsically linked (Gill, 2004) such that being blamed for 'transgressions' of cultural and societal norms can shape victim-survivors' experiences of shame (Gilbert et al., 2004; Sabri et al., 2018). This theme identifies external factors that may have shaped and influenced participants' shame-experiences.

3.2.1. Criticised as a Form of Abuse

Participants described being blamed and insulted by their husbands, particularly related to being a 'bad' wife or from a 'bad' family. It appears that victim-blaming was intentionally used to shame women.

The excerpt below provides an example of a participant's experience of being blamed for the abuse perpetrated against her. The suggestion is that a wife's role is to be 'passive', and that 'punishment' of a woman is justified for transgressing gender-roles or showing resistance.

> *“So sometimes she will talk back, so saying [and he will say] ‘oh, because you talked back, that’s why I'm punishing you’ and she said he will pinch her really hard everywhere on the [her] […] thighs and the [her] hands and everything, he'll pinch her really, really hard” -Nisha*

Another participant spoke about being blamed for her and her husband’s ‘arguments’. The word ‘argument’ could indicate the participant’s resistance, and the consequential shaming for resisting. By phoning his parents to complain about Sarmini, her husband may have been blaming and publicly shaming her.

> *“sometimes she have [has] an argument [with him] and then he calls […] his parents […] and tell [tells] them, you know, she's fighting with me” -Sarmini*

A lack of education or knowledge and being poor were cited by several participants as targets of humiliation.

> *“he was telling her off like ‘look, I got married to a person who has no sense of education, nothing, you have zero education’” -Abi*

> *“her family came from a very poor background because there was [were] so many kids in her family. So then eventually they built themselves up to […] become better. So […] when he's better, he speak good [speaks well] about their family, but when he's […] using alcohol, he says bad things about the family.” -Rame*

Alcohol-use arose as a major context or trigger for abuse across the interviews. Many of the participants described their husbands as severely dependent on alcohol and that this shaped their experience of abuse. Rame explained that when her husband was drinking he would insult her family, but when he was sober this was not the case. Specifically, he would call her family poor. Rame replied to the insult of being called poor with defensiveness and pride in her family, possible shame-management strategies.

3.2.2. Community and Familial Expectations

Participants referred to ‘the culture’ upheld by their families and community as creating pressures and expectations around gender-roles and marriage. Participants’ descriptions of Tamil culture reflected patriarchal ideologies, which can be more explicitly reinforced by structures within honour-based and traditional communities (Aujla, 2013). These cultural and patriarchal pressures and expectations meant participants were shamed and coerced by their families and community to remain married.

The excerpt below discusses being shamed and ostracised for calling-off an abusive engagement. When a proposal was called off, Abi felt the need to hide the broken engagement because of the societal judgement of transgressing marriage norms. Despite her fiancé’s family attempting to financially abuse her family, Abi knew that the community would judge her for ending the engagement. The shame and stigma of ‘her’ ‘transgression’ meant other families were unwilling to arrange a marriage between Abi and their sons.

> *“the first proposal was stopped in the middle, so this is a big thing in our Sri Lanka […] So it's not a good thing for […] our people to get to know. So it took her a while to find another proposal” -Abi*

Participants discussed being encouraged by both their families and their husband’s families to stay in abusive relationships. This was based on the community assumption that a woman’s role is to be ‘patient’, support their husbands to change, and keep the family together. Relating back to men’s alcohol-consumption, if a wife’s role is to change and support her husband, then the perpetrator’s drunkenness and abuse may be seen as ‘evidence’ of a woman’s ‘failings’.

> *“So at the beginning they were reluctant […] for her to come out of the marriage because of the culture and everything.” -Nisha*

Nisha discussed her family’s reluctance to support her to escape her abusive husband because of the cultural expectations around marriage.

> *“the husband’s family- they were just, you know [saying], ‘these things happened’ [happen], blah blah blah- they were trying to, you know, not to break up the family.” -Sarmini*

Sarmini spoke about her parents-in-law normalising the abuse their son perpetrated against her. They did not want Sarmini to leave their son because of the cultural importance of marriage and a united family. It is likely that they also wanted to avoid the shame divorce would have on the whole family.

For Roja, her husband sent all his earnings to his own family, forcing Roja and their children into poverty. When Roja sought support from her parents, they attempted to reassure her that her husband was a ‘good family man’; they suggested that given how well he looks after his own family (his parents and siblings), he will look after Roja and their children even better. Roja understood her parents to be unwilling to help her, and instead they tried to convince her to be patient and stay with the abuser.

> *“[I] complain [complained to] my parents and my parents said ‘don't worry he [will] save some money for them own child [your own children], because he spent for the parents and sister and brother look-after [because he spends money on looking after his parents and his siblings], how he look after own child then, don’t worry’ [so you will see how well he looks after his children as well, don’t worry], they say.” -Roja*

Being shamed by the community for leaving an abusive relationship was spoken about by most participants. Sarmini spoke to the superstitions held about separated women in the community.

> *“So in Sri Lanka we have a custom like if someone is [has] come out of a marriage […], if it’s something like a celebration happening, like a marriage or something else is happening, we don't normally invite these kind [kinds] of women into that celebration, so it's quite obvious that the whole village is just […] isolating her for some reason, so […] it's not a nice feeling for that woman.” -Sarmini*

Sarmini also discussed the difference between community pressure in Sri Lanka, a tighter-knit community, compared to the UK.

> *"she thinks if she [was] in Sri Lanka […] it wouldn't have been this easy [to leave the abusive relationship], because there's [there are] people constantly giving [putting] pressure on you, you know, if you come out of the marriage […] then they will force you to into a different- in [into] another marriage" -Sarmini*

3.2.3. Control of Women

Women described being controlled by their husbands as a form of abuse, and also described having a lack of autonomy to make decisions because of parental (and parent-in-law) control. Services also played a role, such that the control of women meant they were dependent on services for support, but often felt let-down by services. Services therefore indirectly controlled women's ability to leave and recover or suffer.

Control of women as a type of abuse took many forms, including control of women's bodies, access to information and support, suspicion and surveillance. Financial control of participants by their husbands emerged as a common issue for the women.

> *"no money, no clothes, no shopping, no temple." -Abi*

Abi's husband prevented her from having money, including enough to go shopping for the family, which is typically a woman's role, according to traditional gender-roles. The excerpt highlights that control and financial abuse isolated Abi, and prevented her from engaging with the community and valued activities. Financial abuse may have also degraded her social-standing in the community such that she couldn't afford to buy new clothes to be worn to the temple.

The control of women's fertility was linked to financial control, such that participants' husbands and husbands' families prevented women having children, so that the perpetrator could continue to send money to Sri Lanka

without the expense of a child. It is possible that being prevented from having children contributed to women's sense of 'failure' and public shaming, based on the social and cultural expectations of married woman to have children.

> *"Since the time that they got married […] Abi's parents [in-law] gave [her] a contraception tablet. She [Abi] didn't even have a clue that was a contraception tablet at that time […] just basically without telling […] she [Abi's mother-in-law] just put […] the tablet in her [Abi's] mouth." -Abi*

By restricting women's access to money and independence, they were made dependent on men:

> *"he never gave any money to her so all the shopping he did, he did, so she did the cooking only" -Vathani*

> *"she's dependent on him- she doesn't have a visa, […] so he knows that she's not going to get out of the marriage and do something on her own, she can't manage on her own, and he also has that […] male macho thing […] 'I'm a man, […] I can do anything'" -Sarmini*

One participant described being controlled by her father, to being controlled by her husband. Roja blamed her experiences of abuse on being 'over-protected', or trapped, within a bubble of 'cultural' (patriarchal) beliefs about women. She explained that her parents prevented her from engaging with the world beyond her community and culture, restricting her to particular assumptions about marriage and a woman's role; she told us that this negatively impacted her life, such as her ability to leave her abusive husband. Roja's husband also controlled her and isolated her from the rest of the world. In the quote below she described how he did not want people to phone her or for her to help people; Roja explained in the interview that she likes helping people and people often approached her for support, but her husband would get angry at her for engaging with people other than him.

> *"I'm really angry with [my] dad because he's leave [he kept] us [Roja and her sister] in the one round [motioning keeping her in an enclosed space]*

he don't know allowed to our the world know [he didn't allow us to know the world], you know, [he is] very strict, we don't know anything. That is [how] the [my] parents make [made] [a] big mistake. They thinking [think], culture, culture, culture, they put [made] our life very bad really." -Roja

"he don't like somebody call me [he doesn't like if someone calls me], he don't like I'm helping somebody [he doesn't like if I help someone], he wants in the round now [he wants to keep me in] [motioning keeping her in an enclosed space]" -Roja

The control of women may have made the participants dependent on external support to leave the relationship, elongating their entrapment in abusive relationships. Sarmini was reliant on children's services to escape; she was not able to escape herself and so had to wait and hope that services came to her door.

"So the next day so children [children's] services came to their house to speak to [child's name] and [child's name] told them [children's services] […] all about their fights and father hitting mother and everything, […] so she [Sarmini] was waiting for that moment" -Sarmini

Several women did not know support services existed and felt alone in attempts to leave. Being unaware of where to turn for help might have been an outcome of their restricted access to the world. It may also reflect the inaccessibility of services.

"most of the women doesn't [don't] know these [this] kind of help exists. That's the problem" -Vathani

"So she thinks that there are more women who doesn't [don't] know how to come out of this domestic violence, so it would be useful for them to have that kind of help available" -Sarmini

Statutory services, including the police, GPs, mental health services, schools, and councils, were portrayed as not adequately understanding or helping

participants. Participants felt abandoned by services in attempts to leave abusive relationships and in setting-up a new life. This was extremely detrimental to the women who had little or no access to independent resources as a result of being controlled.

> *“So after that I called the doctor and I say this this happening [explained what happened]. So one day somebody calling me and talking [called me and we talked], after that nobody calling me [but after that they didn’t call again]- and I need really help [I really need help], but I try […] my best [to get help], nobody find [gave] it.” -Roja*

Roja explained that after attempting to take her own life she called her doctor to tell them what happened. After an initial conversation with a service no one called her back or offered her support. Roja felt she had really tried to get help but services neglected her.

Nisha explained that when she reported her husband to the police they took her to the hospital, because she had taken an over-dose of medication. After the medical professionals ensured that Nisha was healthy and her life was not at risk from the over-dose, they attempted to send her home. Nisha said she refused because of the danger of returning home to her husband after reporting him. The medical professionals nor the police offered Nisha an alternative safe place to stay or signposted her to a refuge.

> *“after they [the police] took her to the hospital, they [the medical practitioners] did all the checks and everything […] and after all the experiments [tests] […] they [the medical practitioners] asked her to go home, and then she said, ‘I'm not going home, I don't want to go home’, but they [the medical practitioners] said […] they have no [hospital] beds available, but she said she refused to go home, ‘I can't go home after I reporting [reported] him to the police.’ [she said]” -Nisha*

Nisha was put in an extremely dangerous position by the police and hospital who tried to send her home to the perpetrator. Similarly, Rame was put in a dangerous position by services who failed to identify the domestic abuse (they

identified the husband's problem-drinking), or understand the complexity of leaving an abusive relationship. By suggesting that they would not support her if she took her husband back, Rame found it difficult to leave when the abuse started again.

> *"they [the council] advised Rame, […] 'you can take him back in if you see any improvement, or if he's given [he gives] up on drinking, but you cannot come back to us if there's any more issues.'" -Rame*

A few participants named being blamed and shamed by services. In Abi's case, she did not want an abortion but was forced to by her husband, and then shamed by the GP, instead of supported. When Abi's husband forced her to go to the GP to seek an abortion, the GP said Abi should have 'been cautious', insinuating that it was Abi's fault that she became pregnant and that having an abortion was morally wrong.

> *"You should have been careful in the first place before […] you [had sex], you should have been cautious if you didn't want a child. Now the child is here" -Abi*

Being blamed by services reflects a broader problem of institutional patriarchy, that re-victimises, and sometimes criminalises, women victim-survivors. This is reflected in Rame's comment regarding the experience of some victim-survivors who have their children removed by social services. In failing to see the women as victims of abuse, services problematise women's ability to mother, and sometimes provide the perpetrator sole custody. Fear of their children being taken away prevents some women engaging with services. Fortunately, in Rame's case, TCC advocated for her and she was able to keep her children.

> *"So she's saying her kids are with her because of the Tamil Community Centre, otherwise the kids would have been taken out [away] from her, so she would be living alone." -Rame*

3.3. Consequences of *Being* Shamed

Being blamed and shamed by one's husband, community, and services, through victim-blaming and control, had emotional consequences for participants, including the pain of destructed identities and fear and distress of being judged or not believed. The consequences of being blamed and shamed were likely associated with external shame, which is the shame of being judged by others (Gilbert, 1998). However, the internalisation of cultural values may have made being shamed for 'violating' cultural expectations internally shameful as well; internal shame is the shame of negative self-judgement (Gilbert, 1998).

3.3.1. Destructed Identities

Participants' husbands and husbands' families insulted and blamed the women's core identities, positioning the women as intellectually and socially inferior to their husbands. Participants described the consequence of this public mockery, jeering and shaming as extremely painful.

> *"they [Roja's husband's family] make fun of her languages [how she speaks], sarcasm, in a sarcastic way […]. Fun is different, fun is different [joking or making fun of someone is different]. They are hurting, their fun is hurting [their comments were hurting]" -Roja*

Roja's husband's family made sarcastic comments about how she speaks Tamil. For Roja, it may have been hurtful to have her Tamil insulted because of the importance of her Tamil identity and culture; response-based therapy postulates that an attack to one's values is painful, and thus resisted against by victim-survivors (Flaskas et al., 2007; Renoux & Wade, 2008). Roja was also verbally shamed by her husband for being dark-skinned; in front of Roja her husband told others that the only reason he married her was for a visa, and because of that it didn't matter that she was dark-skinned, indicating that he wouldn't have married such a dark-skinned woman otherwise. According to Rothbart (2018), humiliation is a strategy deployed against oppressed groups as a form of control and legitimisation of inequality. Roja was hurt by the comment, but also upset that her 'blackness' 'affected' her husband, indicating that she may have partly blamed herself and her skin colour for the abuse

arising. Roja may have felt ashamed, because experiencing racism can be felt as shame (Webster, 2021).

> *“these people coming visit to [came to visit] my house [and] he [Roja’s husband] said to them [in] front of me, I'm [I] married her because I don't care about black [that she is dark-skinned], [because] I'm [I] married [her] for the visa. I was very upset that time.” -Roja*

> *“I don’t [didn’t] know [that] he’s [he was] affected that [by] I am black [me being black] affect him, I don't know that” -Roja*

Blaming the women for promiscuity, infidelity and separation was used to shame the participants and justify abuse. These comments may have been especially painful for participants because they referred to important cultural and personal beliefs about monogamy, and a woman’s role in maintaining a marriage. Being ‘told off’ for violating cultural norms may have also shaped participants’ shame-experiences.

> *“he will […] create [a] story […] [such as] ‘you don't like me, that's why you're not sleeping with me, […] you looks [look] like you like someone else’, so he will twist the story […]. So he will use really abusive words when he's telling her off, she said […] it’s unbearable to hear what […] comes out of his mouth. […] So he will say, ‘oh, you were thinking about somebody else, you are thinking about another man’. And so like it’s unbearable to hear, she says.” -Nisha*

When Nisha would not have sex with her husband he would accuse her of being uninterested in him because she was interested in another man, thus making himself the victim. For Nisha, her husband’s suggestion that she may be unfaithful to the marriage was a very painful insult to her identity.

> *“He talks bad about the sister [Rame’s sister] as well, so that's the main thing that […] effects [Rame] […]. So her sister is divorced from [her] husband so […] he [Rame’s husband] always make [makes] fun of Rame like, ‘oh, you're going to be like her too’, […] ‘there must be something*

wrong with your sister, that's why the husband left,' he talks like that, you know, 'she must have done something that's why the husband left'."
-Rame

In terms of verbal abuse, Rame was most hurt by her husband's intentionally shaming comments about her sister being divorced, and the blame he placed on her sister for the divorce. She was also hurt by his taunt that she could become a divorced woman.

3.3.2. Fear of Judgement

Participants were hurt and afraid of being judged by their family and community for leaving the perpetrator. Community shaming resulted in participants' fear and low mood, which ultimately caused them to become more isolated. In this way, community and familial shaming was used as a powerful tool to control women.

"when she was in the marriage, that was one of the reasons that she was afraid to come out, what would other people think and everything" -Nisha

Nisha was afraid of escaping the abusive relationship because of what the community would say about her for leaving.

"still they [the community] [are] talking about me and then they say to me, 'Roja, you know your daughter, when you get married [try to get your daughter married] you could the struggling [struggle], the people [community] thinking [think] this is a bad family. They [families] don't [won't] give the man [their sons] for your daughter [to marry].' Now sometime [sometimes] I am make my strong [I feel strong], I think, [I] don't care, […] my children could study, they coming everything good [everything will be good for them]. But sometimes the people [community judgement] make [makes] me down." -Roja

Community judgement about Roja's separation from the perpetrator, and the potential impact this could have on her children affected Roja's mood. The community suggested that Roja's daughter would not be desirable to families

hoping to set up arranged marriages for their sons because Roja had brought shame on herself and her children; thus, ostracising Roja and her children from the community.

Participants similarly appeared to fear being judged, misunderstood, or unsupported by services.

> *“My children need […] counselling, but I'm scared for [of] the counselling for [in] the [their] school. I don't want it. I want Tamil people [to support my children], they [who] know Tamil culture and everything.” -Roja*

> *“So when she went to the police station, she was holding onto the cover of the tablets […], so [because] she just wanted to tell them that she took [had taken] these tablets” -Nisha*

Nisha explained how she took an overdose before reporting her husband to the police, and then took the packaging of the tablets with her to show the police. Nisha may have done this out of fear of not being believed or being judged by the police. The overdose may have been used as proof of the extent of her struggles or to make sure the police helped her, even if they did not understand or trust her statement.

Self-harm, suicidal thoughts and suicide attempts were discussed by all participants. For many women suicide was seen as the only way out of the relationship or to escape being shamed.

> *“at one point she thought, what is the point of living, because she knows that [her] parents are not going to come for [to] the [her] rescue, [her] husband is not going to come for [to] the [her] rescue, and no one is going to save me [her], [so] what's the point in living?” -Abi*

> *“Some people talking about me bad [talk badly about me], [and so] I think, can I kill my [myself] and my children altogether?” -Roja*

The internalisation of cultural expectations around marriage may have made public judgement for separating both internally and externally shameful. Vathani explained how she internalised the Tamil word ‘vaala vetti’, a shaming word for a single or separated woman, insinuating a waste of life. While Vathani believed that a separated woman was a waste of life, or shameful, it made it difficult for her to leave.

> *“in Sri Lankan culture we use a word called ‘vaala vetti’ which is meaning [means] […] a woman who doesn't live with the [her] husband, […] so at first she thought like that” -Vathani*

3.4. Personal Shame

Women felt personally ashamed by the violations to their bodily integrity and autonomy, including violations to the control of their privacy. These violations may have been felt as shame for the ‘spoiled identity’, in that participants perceived aspects of themselves to be defiling (Goffman, 1990).

3.4.1. Degradation

Experiences of sexual abuse were particularly difficult and emotive for participants to speak about. For those that were sexually abused, it was the most shameful type of abuse. Participants discussed feeling degraded, disrespected and reduced to a body. For some, traumatic memories remained vivid.

> *“So mainly the sexual abuse. She thinks that, […] he didn't treat her like a woman, he always thinks [thought] that whatever he wants to do, he gets it [can have it] from her” -Sarmini*

> *“She was saying mostly the sexual abuse. So he used to come and put his penis in her mouth and then put it all the way towards her throat and his semen comes out and he put [puts] [it] on the [her] face and that thing [memory], even to nowadays [now], she said it's just- she just still remembers that. And that's so hard for her to speak about” -Abi*

> *“And sexual abuse sides [side], she has some medical issues and also the three children were caesarean, […] [so] her body was really weak, but that time [those times] he wanted to have sex, so that […] was really painful. She will [would] cry on that [those] days.” -Nisha*

Nisha explained that after having a caesarean her husband forced her to have sex.

Participants described feeling degraded by being treated as less than human, being watched, controlled and tortured. A painful experience for two participants was a lack of dignity in using the toilet. Dignity can be conceptualised as the opposite of shame, and therefore events that degrade dignity can be shaming (Salter & Hall, 2020).

> *“there was [were] times, she said, that he locks [locked] her in a room for a week, so she says, sometimes you [she had to] go to the loo, [and do] everything in the room, there’s no choice” -Abi*

> *“if he's going to the toilet he will leave the door open so that he can see what she's up to. At the same time, if she goes to the toilet, then […] he will follow her [into the toilet] as well. She's saying this [was] unbearable, the pain that she went through is unbearable.” -Nisha*

Roja spoke about ‘agreeing’ to sexual acts after their legal marriage, but before the cultural marriage, to please her husband. She explained that her husband asked to see her body after their wedding registration and so she showed it to him. After this he started verbally abusing her, potentially ‘slut-shaming’ her. She had not told anyone about the event before and cried when telling me, indicating it was a shameful memory.

> *“So my husband after [the] register [wedding registration], I think [thought], ok he asked me ‘I want [to] see your body’, [so] I'll show you him [so I will show him]. So, only this you know, nobody [else] know [knows], I tell you, no [not] my parents, nobody know [knows] that […].*

After that he start [started] fighting with me, so [saying] bad words [to me].” -Roja

Roja may have felt ashamed about ‘agreeing’ because she had not realised it broke cultural norms around a woman’s ‘purity’ before marriage (Couture-Carron, 2020). Additionally, Roja was used by her husband and then verbally abused by him for agreeing to his demands, which may have felt shameful.

3.4.2. Vulnerability

‘Vulnerability’ speaks to participants’ disappointment or shame in themselves for being ‘weak’ or a ‘fool’. Participants’ self-perception and shame of vulnerability might have been shaped by victim-blaming and the control of women, insofar as people can become powerless and helpless as a result of being controlled.

Feelings of helplessness and powerlessness stood out in participants’ accounts of not knowing how to leave the relationship or how to manage on their own. According to Herman (2011), words such as ‘helpless’, ‘weak’, and ‘dependent’ are part of the ‘vocabulary of shame’.

“it was only like [a] few days [after] she came to this country [that the abuse started] so […] she doesn't [didn’t] know how to speak the language, she doesn't [didn’t] know what to do if she get out of [left] the house, she doesn't [didn’t] know how to get back to the house, so she was calm [stayed quiet] for a while, and [because] […] she was helpless, […] she was quiet for a while, for a few months […], and the household has only [had only] one phones [phone], so even if she has [had] to speak to someone, she has [had] to call on his phone.” -Vathani

Vathani described how she felt helpless when the abuse started a few days after her arrival in the UK. Vathani could not speak English and did not have access to a phone, or know where to go to seek help. As a result, she felt her only option was to take the abuse, stay with the abuser, and not seek help.

A couple of participants also spoke to feeling like a ‘fool’ for believing their husband loved them or that he would change.

> *“she really believed that he will [would] [change], because that's what he promised her, saying he will not drink, he will be good with the kids and everything. So when after she took him in and then he went back to the [his] normal self, she said it effected [her] a lot, because she really believed him that she could be happy, [that] we [they] could bring up the kids better [together], but he didn't keep his word, so that affected her very badly [a lot]” -Rame*

> *“So he love or not love [me], that time I don’t [didn’t] know. And he don’t [didn’t] have also [a] visa. So I don’t [didn’t] know that problem, that Sri Lankan people [get] married for the visa, really I don't [didn’t] know that, really I don't [didn’t] know that. I think [thought] my husband love to [loved] me” -Roja*

For Roja, it was heart breaking to find out that her husband had married her for a visa, because she had hoped that he loved her. Roja emphasised that she “didn’t know” that people got married for a visa, which could indicate a feeling of vulnerability, and being taken advantage of. Linking back to the sub-theme ‘control of women’, Roja felt that the primary cause of her problems was having a restricted knowledge of the world beyond ‘the culture’.

One participant explained that the ‘vulnerability’ of Tamil women was shameful. Living in a refuge, Nisha found that shame was cross-cultural, but she thought that the difference in shame-experiences between cultures was that Tamil women were less self-sufficient, more dependent on men, and less able to resist abuse. According to the shame literature, shame may be expressed through the discussion of inferiority (Herman, 2011) or self-blame and inadequacy (Thaggard & Montayre, 2019).

> *“She feels normally Tamil women are more vulnerable [than other women], they're not strong enough to stand up to men, but other cultures women [women from other cultures] are stronger, she feels. So they [other women] can stand up to man [men] and then they can handle things better. She thought when she was in [experiencing] abuse only*

our culture feel shame about it [abuse], but when she was living in the temporary accommodation, she realises [realised] not only our culture, there's a lot of cultures feel the shame." -Nisha

Another participant spoke about over-coming shame through the development of strength. This may suggest that feeling weak is part of shame. Sarmini spoke about how she became stronger through experiencing repeated abuse, and that this strength reduced her feeling of shame.

"the amount of abuse she had [experienced] is […] [what] made her stronger not to feel shame about it [the abuse], […] she […] felt really stronger" -Sarmini

3.4.3. Shame of Others Knowing

Being ashamed of others knowing about abuse is common across cultures. It relates to the shame of the self-perceived 'flawed self' being exposed (Hazard, 1969; H. Lewis, 1971; M. Lewis, 1992; Tomkins, 1963).

Participants felt embarrassed and ashamed by others hearing or witnessing verbal abuse.

"the neighbours can hear […] so […] when she goes out […] it's embarrassing for her because there's always screaming and shouting of his swearing [coming from] inside the [their] house, so she feel [felt] embarrassed to walk out [the house]" -Sarmini

Sarmini described how she felt embarrassed by the neighbours being able to hear her husband's screaming and swearing. The embarrassment isolated Sarmini to her house in order to avoid the neighbours.

"[in] front of [my] mother-in-law and [his] mum he's very bad behaviour to me [he behaves badly towards me], shouting […] [about] my character and […] shouting and do this [shouting orders]. I [felt] shame [ashamed] by that […]. I don't shout [in] front of the people because I feel shame, I don't want [to] fight [in] front of the people." -Roja

Roja described feeling ashamed by her mother-in-law witnessing her husband talking down to her; she potentially also felt ashamed about her character being attacked by her husband. Though Roja, like many of the participants, regularly stood-up to her husband, and generally felt pride in her resistance, she suggested that fighting back in public was shameful.

The community knowing about a husband's affair was also shameful. This was especially so for the women who loved their husbands. According to Wurmser (1981), shame arises from the want to be loved, which is rejected.

> *"So while she was in the abusive marriage, […] she was ashamed to talk about her husband having an affair with another woman, that was shameful for her then, but not anymore, she doesn't feel that anymore"* *-Vathani*

Vathani's husband publicly paraded his affair for the community to see. Vathani said she felt ashamed about others knowing about the affair while she was in the relationship. Since leaving, she no longer feels this shame. Vathani felt that his affair was particularly painful because it was a love marriage. It may have felt shameful if she blamed herself for not having an arranged marriage and instead loving and marrying an abusive man. This thus links back to the shame of being a 'fool'.

3.4.4. Mothering Guilt

Though participants blamed their abusive husbands for the impact on their children, they also blamed themselves. Abi blamed both her husband and herself for their child's trauma and consequential foster placement. Abi felt that ultimately her child was traumatised by witnessing their father's sexually abusive behaviour. However, she also blamed herself for not giving her child as much time and love as she felt she should have, or as much as she was able to give her first-born.

> *"her [child] was taken into foster care because […] they were exposed to their father's sexual things [abuse]." -Abi*

> *“she didn't spend that much time with the second one [child], so [they] didn't get that love, […] that's probably one of the reason [they’re] affected.” -Abi*

There was particular guilt around miscarriages and abortions. Some participants blamed themselves for miscarrying as a result of being mentally and physically weak from the abuse. Others blamed themselves for aborting their child to prevent bringing a child into an abusive home. In the excerpt below the translator initially used the word ‘abortion’ and then later clarified that Sarmini had meant miscarriage.

> *“So she was saying she was mentally really [weak]- there [she] was [in] a state that she couldn't cope with anymore, […] she's think [she thinks] that's one of the reason that […] she had an abortion [a miscarriage] because […] her body was weak, she was mentally weak, she was in a state really, she was really in a bad state.” -Sarmini*

Guilt and self-blame could relate to the importance of the mother role for participants, in line with internalised, culturally validated, standards of being a “good mother”. Most participants spoke about their focus in and after leaving the relationship being to provide their children with a better future. It is possible that the women felt guilty about what their children had been exposed to and about the shame they brought on their children by separating.

> *“So because she was a single parent, […] her brothers were very supportive […]. They were very supportive and there [they] was [were] advising her that [because] she's a single parent, […] she needs to look after the kids properly […] most of the times [time] Sri Lankan family [families] they [are] very much focused on the kids’ education and all that, so [her brother’s advised her], ‘you have to do well to look after your kids’” -Rame*

Rame explained that her brothers advised her of the additional importance of bringing her children up well given that she is a single-parent. Bringing children up well particularly related to educating them well. It is possible that leaving for

‘the children’s sake’ or successfully bringing one’s children up well could reduce the shame on the family caused by the separation.

3.5. Protection Through Denial

It was important to the participants to speak out about domestic abuse, to reduce the shame around it, and support other women. Yet, as discussed in the following sections, participants also continued to deny the abuse and separation from their family and community, and denied the perpetrators’ guilt during the interviews.

> *“So she believes [that there are] still a lot of Tamil women […] [who] hide domestic violence within their household [households], so Rame [would] prefer those women to come out and speak openly about it [the abuse] to the people [community], and then come out of these domestic abuse [relationships]. They [Tamil women] still protect their husbands and they […] hide the things [abuse] from the society, they don't want other people to know about what's happening inside the house. So she wants people to come out and be like her.” -Rame*

Vathani said that the problem is that abuse is hidden within the community. By hiding abuse, the community leave women to believe that they are the only one’s experiencing violence, and hence are in some way to blame, fostering a sense of shame.

> *“these things happen in our culture […], in [including] back home in Sri Lanka, but we don't come to know about it, that's the problem.” -Vathani*

Many participants described their distress as pressure in their bodies, which was exacerbated by denial and silencing, and relieved through speaking openly. Participants’ accounts of bodily pressure sounded like the embodiment of oppression and shame.

> *“because of the shame […] she feels the shortness of breath […] she feels like she can’t breathe- because she thinks too much and that […]*

makes her [experience] a shortness of breath […]. She's suffocating like not being able to breathe freely." -Vathani

"So it's like she wants to scream out like really loud because [but] she is controlling [herself] because she's doing an interview, but her […] chest is like it's almost like about to burst and her head is about to explode like full of sadness and anger […] inside there." -Abi

"more painful for [in] my head and I do very stressful [I am very stressed] and so [I experience] too much struggling" -Roja

"She said that she felt the pressure [in her head] when she didn't tell anyone, after she talked about it she felt relieved, you know at last she had […] told someone about it." -Nisha

Based on this, participants felt that useful mental health services should encourage women to leave abusive relationships and speak openly about their experiences.

"encourage the women to come out, […] rather than hiding everything, encourage the women to come out of these kind [kinds] of marriages" -Rame

Rame's advice to mental health practitioners was to help women escape abusive relationships and no longer feel the need to hide it.

"not only [speaking] about the domestic violence, anything about the feeling [feelings], or [and] about the domestic violence, or [and] about the shame, anything. Or everything basically." -Sarmini

Sarmini's advice to mental health services was for practitioners to encourage women to speak about everything, not just about their experiences of domestic abuse, but also about how it made them feel, including speaking about shame.

3.5.1. Protecting Family

Women spoke about hiding the abuse and separation from family for several reasons, including ‘not to worry them’ and to uphold their honour. For many participants it was most important to hide the abuse and separation from their parents. This relates to reflected shame.

> *“it's mainly the culture […] because that [is] the way that we were brought up, you know, [if] you're getting [you get] married in [to] a family it's a shame [brings shame] to come out of a [the] marriage […] she didn't want that shame to [on] the [her] family” -Vathani*

> *“she thinks it's a [the] culture and [that means] she doesn't want to worry her parents and the family about [by] telling [them] about it [the abuse] too soon because […] it was a difficult thing to marry her, like marrying a woman [organising an arranged marriage for a woman] is not easy in Sri Lanka.” -Nisha*

> *“parents of women, they mainly fear how if […] they [women] […] just come out of the marriage, how they're going to manage on their own without the support of a male character in the household” -Sarmini*

Ahmed (1999) suggests that the act of hiding information from one’s parents in order to maintain their honour can be a guilty or shameful experience in itself. In contrast, sharing the abuse and separation with their family benefited women’s well-being. Being encouraged by family and community to forget about others’ judgement may have reduced shame.

> *“But it's lucky my family is very support [supportive] for [of] me, my sister and my parents, everybody, [are] good supporting [supports]. They say, ‘don't think about people, we […] support […] you.’” -Roja*

3.5.2. He Isn’t to Blame

Participants avoided blaming their husbands as the perpetrators of abuse. Instead, financial problems, alcohol, mental health difficulties, his family, friends, and other women were offered as factors to blame.

> *“So she believes that [it] is the alcohol [that] is the one making him […] speak like that. So she didn't think he's deliberately [abusive]- […] the alcohol is making him do that. So [she] just put [puts] the blame on the alcohol and then she walks away from there.” -Rame*

Rame believed that the alcohol was to blame for her husband’s abusive behaviour. This enabled Rame to externalise the problem from her husband and just walk away from him when he was drinking and abusive, without becoming upset by his words.

It seemed easier to blame other women (included the perpetrator’s mother, sisters, and girlfriends) than to blame the male perpetrator. This may relate to the power that men hold which makes it difficult to confront them; blaming the man may also result in negative ramifications for the victim-survivor, that a blamed woman does not have the power to enact.

> *“I know he's very depression [depressed], but [and] he don't [doesn’t] manage [it] […] he had depression, too much depression from [caused by] [his] parents, the [his] mum is very torture [tortured/torturing] woman.” -Roja*

Roja felt sorry for her husband, understanding him to be injured by his mother, and as a result, not to blame for his abusive behaviour. Roja blamed her husband’s mother for his depression and subsequent abusive behaviour, and the depression itself, but not her husband.

> *“so she thinks that […] [the] abuse reason [reason for abuse], another reason, could be the [his] responsibility towards […] back home in Sri Lanka, the [his] […] sisters, sending money [to them] and all that and also, [to] the [his] girlfriend” -Abi*

Abi blamed her husband’s responsibility to financially support his sisters and girlfriend in Sri Lanka for the abuse. She felt that if he didn’t have to take care of

these other women, then he wouldn't have physically abused her for refusing to abort their child; the child being an additional expense and responsibility.

Several participants sought external support to 'scare' their husbands into improving, with no intention of separating. Sarmini called the police on her husband multiple times with no intention of pressing charges against him, because ultimately, she saw him as 'good', and the alcohol as to blame. In addition, seeing him co-operating with the police made her feel guilty for calling them.

> *"she called the police twice on him […] but she thought it was just to threaten him so that he wouldn't do that again" -Sarmini*

> *"Even after she called the police, […] [she felt] it was horrible [that she] had to call the police on him. Even after she called the police when the police was [were] asking questions to him [him questions], he was sitting in a really, you know, in a nice manner- it was difficult for her to see him in that position. That's why she decided not to press charges against him, you know, he was like a good boy and answering all the questions to police [the polices' questions] and all that." -Sarmini*

A love or care for the perpetrator and hoping he would change was discussed by several participants and could explain the denial of guilt. Alternatively, women may not have blamed their husbands because of the (cultural/patriarchal) belief that women must look after their husbands. A benefit of not blaming the perpetrator, but external factors that might more easily change, may be protection against one's shame of staying with an abusive partner or being a victim.

> *"So every time […] she doesn't agree to come for sex […] he will [would] just drag her out of the house and then he would just lock her out and then him and the […] kids […] will [would] be inside the house, and she doesn't want to go out and tell the neighbours because […] she's [she] still has that [mentality like] 'it's my husband'"-Abi*

4.0. DISCUSSION

4.1. Overview

This chapter explores how each sub-theme may answer the research questions, with reference to shame theory and domestic abuse studies. I then consider the implications of the findings, followed by my critical appraisal and reflections.

4.2. Discussion of Findings

4.2.1. What Shapes the Experience of Shame for First-Generation Tamil Women Victim-Survivors of Domestic Abuse?

I suggest that participants' experiences of shame are shaped by: the role of criticism in addition to violence, particularly where this is reinforced by community expectations; the reduction in agency that comes with control by both perpetrators and their families; and the failure of services to take the needs of victim-survivors seriously. Thus, this study identified personal (individual criticism), cultural (community expectations), and structural (control of women) factors that may influence shame. This is different from the literature summarised and critiqued in the scoping reviews, which largely focussed on how culture shapes shame (see section 1.10.1.5. for the relevant critical evaluation in the introduction).

4.2.1.1. Criticism as a form of abuse: this study found that perpetrators used criticism as a form of abuse to shame and blame the participants, which I suggest shaped participants' shame-experiences.

Victim-blaming and 'punishment' for a woman's 'failings' are common tactics used by men who abuse (Pence & Paymar, 1993). Many studies support the commonality of this type of abuse, which can include name-calling, humiliation, and rejection (Gill, 2004; Hyman & Mason, 2006; R. Mason et al., 2008). As well as shaming by their husbands, participants spoke of being criticised by their parent-in-laws, which was also reported in Hyman et al.'s (2011) study.

I suggest that through the internalisation of psychological abuse, criticism may have shaped participants' shame-experiences. This interpretation is supported by Gill's (2004) finding that victim-survivors internalise perpetrators' victim-blaming, humiliation, and rejection as self-blame. Perpetrators blame women for their 'bad' habits, 'failures' in domestic tasks, and 'inadequacies' in meeting their husbands' needs to deflect responsibility for violence (Cavanagh, 2003). Women may then feel that their 'failings' as wives mean that they are in some way to blame for the abuse (Cavanagh, 2003). Cognitive-attributional theories suggest that shame arises from the cognitive perception of a global problem with the self, caused by a failure to uphold one's own beliefs or that of a group (M. Lewis, 1992). Thus, by 'failing' to be a 'good wife', women may feel ashamed about violating internalised patriarchal beliefs about women.

4.2.1.2. Community and familial expectations: participants experienced pressure from their community and family to get and remain married, despite abuse, which I understand to have shaped shame.

Most studies exploring the experiences of Tamil and South-Asian victim-survivors speak to the marital and gender-role pressures on women, and the consequential community shaming for 'failing' to uphold these expectations (e.g. Aujla, 2013; Gilbert et al., 2004; Sabri et al., 2018; Sooch et al., 2006; Tonsing, 2014; Tonsing & Barn, 2017).

Cheers et al. (2006) suggests that being shamed by family and community shapes women's feelings of shame by suggesting the victim-survivor has 'failed' to endorse the standards and norms of others. Shame is thus a tool used by cultures to uphold social control (Kaufman, 1985) and the consequential individual sense of shame is tethered to a fear of being ostracised (Tonsing & Barn, 2017). Experiencing shame from being shamed by others fits with an evolutionary perspective that shame arises in response to a social threat, allowing defensive action to conceal and prevent exposure to danger (Elison, 2005; Gilbert, 1989; Gilbert & McGuire, 1998; Sznycer et al., 2016). It could also be explained by Dillon's (1997) theory that within contexts of inequality and discrimination (e.g. gender inequality) particular groups are often targets of

social patterns of shame and devaluation, which can be felt as shame, or an injury to the self-concept.

4.2.1.3. Control of women: a finding of the study was that participants were controlled by the perpetrator, their families and communities, and let down by services, which I interpret to have shaped their feelings of shame.

The control of women sits with a feminist understanding of domestic abuse (Solomon, 1992; Straka & Montminy, 2006); by upholding patriarchal ideologies about the roles and value of women, the participants' husbands, families, communities, and services, enabled abuse. Similarly to the findings of this study, Hyman et al. (2011) found that Tamil victim-survivors identified gender inequality and male domination as contributing to abuse. The commonality of financial abuse is also reported in the literature (e.g. Hyman & Mason, 2006; Mason et al., 2008). Holding feminist assumptions about domestic abuse may have influenced my development of the findings to explore structural factors shaping shame and domestic abuse; this differs from some of the scoping review studies summarised and critiqued in the introduction (see section 1.10.1.5.), which did not adopt a theoretical stance to their research, and risked solely blaming South Asian cultures for the development of shame (e.g. Couture-Carron, 2020; EACH, 2012).

Due to being controlled, participants were dependent on services. Services therefore had the power to help participants or re-victimise them. Aujla's (2013) grounded theory, based on interviews with Indian and Pakistani participants, postulates how victim-survivors continue to feel powerless, shamed and marginalised following abuse, including through interactions with services. This study's findings that SLT victim-survivors experienced insensitive or problematic treatment from services may lend support to Aujla's (2013) theory, developing its transferability to SLT communities, and thus more South Asian communities.

The finding that participants did not know where to turn to for support and felt let down by the support on offer reflects similar studies with South Asian and Tamil victim-survivors (Guruge & Humphreys, 2009; Pandalangat, 2011). Social care and health services have been found to inadequately respond to attempts by

South Asian victim-survivors to access help, leaving the women feeling invalidated, blamed, and alone (Anitha, 2008). It was suggested that some GPs still fail to explore the underlying causes of mental health problems (domestic abuse) and instead treat the symptoms, such as headaches. Similarly, when victim-survivors sought social care support, certain local authorities suggested taking the children away, rather than supporting the mother to leave with the children. This may indicate that institutional discourses about the normality of domestic abuse in some groups still exists and prevents services from intervening and appropriately supporting victim-survivors.

Other studies have identified that Tamil and South Asian victim-survivors may be discriminated against by services (Gilbert et al., 2004; Guruge & Humphreys, 2009). Participants in this study spoke about being let down and blamed by services, and though participants did not label these events as discriminatory, it is possible that they were experienced as such. Participants may have been less forthcoming about racism on behalf of services because of my position as a White health professional.

I suggest that being controlled shaped participants' experiences of shame, especially 'vulnerability' shame. According to philosophers and sociologists, shame may be felt in response to the control and oppression of women as an 'appreciation of inequality' (Bartky, 1990; Enander, 2010; Lehtinen, 1998; Neckel, 1991). Gendered-shame is a woman's understanding of her inferior position in the social hierarchy, shaped by women's powerlessness in society, including lack of socio-economic resources (Bartky, 1990). In South Asian cultures gendered-shame may be influenced by the control of women to uphold familial honour, and prevent reflected shame (Raj & Silverman, 2002).

Gendered-shame makes sense in the context of sexist societies which pervasively undermine girls and women through structures of humiliation (e.g. dominant discourses) (Dillon, 1997), shaping women's perceptions of themselves (Romito & Volpato, 2005). Thus, linking back to the previous sub-theme, I suggest that criticism may also be a tool used by the participants' husbands, families and communities to control them, emphasising their inferior position, and shaping their perceptions of themselves as 'vulnerable'.

Based on Gill's (2004) suggestion, I propose that financial control could have also shaped shame by increasing participants' dependence on the perpetrators, reducing their self-esteem and agency. In addition, inequality and poverty are intrinsically shameful experiences in themselves (Sen, 1983; Walker et al., 2013). Poverty may be particularly shameful because of the lower-status in the social hierarchy forced upon people living in poverty and the victim-blaming rhetoric about people in poverty (McGrath et al., 2016).

In line with Salter & Hall's (2020) paper, I suggest that feeling let down by services may have further shaped participants' shame-experiences; this is consistent with a study with LGBTQ+ victim-survivors, which identified that the shame of abuse was compounded by the shame of negative experiences of seeking support (Thaggard & Montayre, 2019). Being excluded, discriminated against and criticised are shameful experiences, accompanied by powerlessness and a diminished sense of self (Elshout et al., 2017). It has been suggested that inadequate or trivialising institutional responses to violence, especially sexual abuse, is a type of systemic humiliation with unintended shaming consequences for victim-survivors (Birrell et al., 2017; C. P. Smith & Freyd, 2013).

Recent data highlights the failures of the CJS in prosecuting sexual assault and rape cases, captured by increased delays and a marked fall in charges and prosecutions, with 1.3% of the recorded rape offences in 2020-2021 resulting in a charge or summons (Home Affairs Committee, 2022). The Home Affairs Committee's (2022) investigation found that the majority of cases were closed because victim-survivors did not support further action, due to the failures of the CJS, particularly the police. Victim-survivors felt disrespected and ignored by the police, and like they were the focus of scrutiny and investigation, as opposed to the perpetrator. Neglect, disbelief and betrayal are common responses by institutions towards victim-survivors (Freyd & Birrell, 2013), but especially towards women from the global-majority, given that institutional betrayal is shaped by racism and sexism (Gómez, 2019). The Home Affairs Committee's (2022) report found that minoritised women receive inadequate support from police, shaped by unhelpful assumptions about 'culture', and by racism.

4.2.2. How is Shame Experienced and Expressed by First-Generation Tamil Women Victim-Survivors of Domestic Abuse?

4.2.2.1. Destructed identities: this sub-theme, of the theme 'consequences of being shamed', captures participants' pain of being blamed and insulted by their husbands and husbands' families, which I go on to interpret as a shame-experience.

Similarly to these findings, Mason et al. (2008) found that for Tamil victim-survivors, verbal abuse was particularly distressing, especially being called a whore, prostitute, or animal name. It was suggested that derogatory words for animals and women are more powerful, abusive and hurtful in Tamil than English. In addition, Mason et al. (2008) found that participants were hurt by their intelligence and appearance being insulted. In this study and the existing literature, women spoke about the intolerable pain of their husband's suspicion, jealousy and suggestion of their promiscuity (Hyman & Mason, 2006; Mason et al., 2008).

It is likely, in my opinion, that underlying participants' hurt could be humiliation or shame. Humiliation, like shame, is a self-conscious emotion. Humiliation often develops from an intentional action of another to lower one's status, through targeting a particular characteristic that the victim is aware of (Elison & Harter, 2007). But due to the intensity of the pain and the severity of the implications made against participants, I suggest that participants' hurt was shame. My interpretation that underlying hurt is shame is supported by a Sinhalese-based study which identified that women blamed of sexual impropriety felt ashamed (Abeyasekera & Marecek, 2019).

4.2.2.2. Fear of judgement: this sub-theme speaks to participants' fear reaction to being shamed and betrayed, which I suggest was linked with external shame.

I found that participants worried about others' judgement, and it made them feel low or 'depressed', particularly in relation to getting divorced. Previous studies have similarly identified that South Asian and Tamil victim-survivors can fear community judgement (Hyman & Mason, 2006; Kallivayalil, 2007).

I suggest that the expression of fear and low mood here is linked to external shame. Kaufman (1989) argued that shame can bind with different emotions; for example, shame inhibits positive affect, and thus, a low-arousal state may be an indication of a shame state (Barrett, 1995; Broucek, 1982; R. Mills, 2005; Schore, 2019; Tomkins, 1963). Similarly, Gilbert (1993) suggests that anxiety is central to the shame-experience and episodes of shame can be expressed as panic. Thus, fear and low-mood associated with being judged is likely linked to external shame. This would sit with findings that external shame is a large part of the shame-experience in South Asian cultures (Gilbert et al., 2007), such that external shame dominated over internal shame in Gilbert et al.'s (2004) study.

Fear of judgement also had consequences for engagement with services. Participants' shame in and fear of not being understood or believed by services led them to take extreme measures or avoid services. Participants' fears of being judged by services and insufficiently supported could have also come from external shame. Several studies with South Asian victim-survivors similarly identified women's fear of judgement and a lack of confidentiality, as well as shame about involving people from outside the community (Gilbert et al., 2004; Sooch et al., 2006; Tonsing & Barn, 2017). Especially in the case of disclosing sexual abuse, women felt ashamed about disclosure to professionals (Guruge & Humphreys, 2009; Kanagaratnam et al., 2012). A study in Sri Lanka identified that victim-survivors feared disclosing abuse out of the shame of being judged or blamed by the professional (Silva et al., 2022). Not being understood and being misdiagnosed with mental health problems may have serious implications for the mental health of Tamil victim-survivors (Pandalangat, 2011).

In relation to being unsupported and shamed, participants spoke about self-harm and suicidality. This reflects the idea that suicidality can arise from being shamed by society for not meeting (restrictive) expectations on ways of being (Hunter, 2020). Additionally, suicidality may be an expression of shame, given that shame is often implicated in suicide in response to a perceived moral failing (C. Mills, 2018). Suicidality could have also felt shameful because of the shame of suicide (Chandler, 2020; Fullagar, 2003). Literature based in Sri Lankan Sinhalese experiences suggest that suicide is often seen as the only way to escape the shame of gender-based violence; suicide can be a tool for signalling

to others that a transgression took place against the deceased, and transfer the shame from the diseased to the family that survives them (Said, 2014). Alternatively, living with self-harm and suicidality could be interpreted as resistance and a way to take back control in response to being shamed by others (Hunter, 2020; Mahmood, 2019).

4.2.2.3. Degradation: a key finding of the theme 'personal shame' was participants' experiences of feeling degraded and ashamed by being sexually abused and tortured. Different from the previous theme ('consequences of being shamed'), which mainly focussed on external shame, the sub-themes within the theme 'personal shame' speak largely to internal shame-experiences.

The finding that victim-survivors feel shame about sexual abuse is supported and well-documented in the domestic abuse literature (Kelly, 1988). Herman (2005) suggests that the crime of sexual abuse, and domestic abuse more generally, is an act of degradation intended to take away dignity, and shame and dishonour victims to themselves and others. In Anitha et al.'s (2009) study, South Asian victim-survivors expressed 'embarrassment' about the sexual abuse, which made them hide it and prevented disclosure. In other studies with Tamil and South Asian victim-survivors, sexual abuse is named as a type of domestic abuse, but not discussed further (e.g. Guruge et al., 2012; Mason et al., 2008; Tonsing & Barn, 2017). Guruge et al. (2012) suggest that participants' silence about sexual abuse in research may be because of the shame surrounding it. In contrast, participants in this study spoke in-depth about their experiences of sexual abuse. This supports my critical evaluation of the restrictive methodologies used in the scoping review studies, and the need for more person-centred, open-ended, qualitative approaches to explore such sensitive topics.

The shame of degradation may be felt as intensely painful and uncomfortable, characterised by the belief that one is inadequate, flawed, and incompetent (H. Lewis, 1971; M. Lewis, 1992; Nathanson, 1987; Tomkins, 1963). This type of shame may sit with a psychoanalytic theory of shame, given its intrapsychic nature; according to psychoanalytic theory, shame arises from a conflict between the actual self (ego) and the ideal self (ego ideal) (Broucek, 1982; H.

Lewis, 1971). However, internal shame caused by interpersonal violation cannot be separated from its context, and the intersectionality of context; sexual and domestic abuse are tools of social subordination, and the consequential shame is shaped by gender, class, race, ability, and other factors (Herman, 1992). In other words, the self and personal experiences of shame are linked with wider culture and society, although this is not to say that 'culture' is the single organising feature of shame.

Participants expressed unbearable emotional pain from torturous forms of domestic abuse, including being locked in a room without food or water, constant surveillance, and being prevented from sleeping. I suggest that the emotional pain expressed was associated with shame. The literature on torture suggests that one of the purposes of torture is to humiliate and dehumanise victims through fear and suffering (Gorman, 2001); shame is deliberately induced by torturers to erode victims' self-worth, integrity and sense of security (Silove et al., 2002). The trauma literature also suggests that shame and trauma can become inseparably linked following traumatic events (Montgomery, 2004), and that shame can play an important role in shaping trauma (Aakvaag et al., 2016; Lee et al., 2001).

4.2.2.4. Vulnerability: participants expressed self-blame for being taken advantage of, for not resisting more or leaving sooner, and for their restricted ability and knowledge about how to leave or live independently. I interpret these as a shame of 'vulnerability'. The domestic abuse literature more broadly discusses shame of 'vulnerability', but studies with Tamil and South Asian participants have not.

Self-blame, feeling responsible and ashamed for being victimised are frequently reported by victim-survivors of domestic abuse. For example, a study in Norway found participants blamed themselves for 'giving in', and giving the abuser their trust, love, presence, and bodies; this included feeling like a 'fool' for loving the perpetrator and having sex with him (Enander, 2010). Another study with an African American community found that women perceived themselves to be 'stupid' for staying in abusive relationships (K. Morrison et al., 2006). Similarly, a study in Australia identified that women felt ashamed about their powerlessness

and loss of agency, which had a corrosive impact on self-worth and relationships (Thaggard & Montayre, 2019). According to Andrews et al. (2002), victim-survivors not only feel shame about traumatic events, but also about their responses to it, and both can cause trauma symptoms. Response-focussed therapy suggests that the cause of distress for victim-survivors is the side-lining of their resistance and an over-emphasis on what was done to them, assuming 'passivity' in response to abuse (Renoux & Wade, 2008).

Feelings of vulnerability and dependence may have been shaped by being controlled. In Gilbert et al.'s (2004) study with South Asian women, a participant described the patriarchal control of women as feeling like 'a dog on a lead'. Oppression may have degraded participants' confidence in their abilities and agency, forcing them to adopt self-blaming coping mechanisms. This is supported by work which suggests a connection between self-blame (labelling oneself 'stupid'), shame, and women's conceptions of their agency (Hydén, 2005; Kurri & Wahlström, 2001).

4.2.2.5. Shame of others knowing: this sub-theme encapsulates participants' experiences of shame from their marital problems and abuse being exposed to others. It is associated with the painful shame feeling of being exposed and a desire to hide the 'flawed' self (Hazard, 1969; H. Lewis, 1971; M. Lewis, 1992; Tomkins, 1963).

This sub-theme is supported by Gill's (2004) finding that participants found public humiliation extremely shameful. McCleary-Sills et al. (2016) also found that acts which were seen as abusive behind closed doors became unbearable for women if perpetrated in public. A study about the barriers to disclosure in UK health services identified that the shame of what one has been through made the act of telling a healthcare service about the abuse shameful or embarrassing (Heron et al., 2022). McCleary-Sills et al. (2016) found that for South Asian victim-survivors, both the fear of dishonouring one's family and internal shame of exposing oneself made it difficult to disclose abuse. This differs from the fear of disclosure out of external shame of being judged, outlined in section 4.2.2.2.

An idea within this sub-theme was that resisting in public was shameful, which differs from participants' pride of resisting in private. This may be because arguing back could be seen by onlookers as the victim-survivor's 'failure' to engage in 'gender-appropriate' behaviour (Hyman et al., 2011). Cultural expectations on a woman to be quiet and unobtrusive blames women who resist for failing to prevent abuse perpetrated against them (Hyman et al., 2011). Additionally, it may relate to an attempt to protect the family from reflected shame (discussed further in section 4.2.2.7.).

This sub-theme relates to both an internal and external experience of shame, insofar as shame is a social emotion and all types involve self-protection from others (Gruenewald et al., 2004). However, it relates more to participants' attempts to hide personal experiences and internal shame, rather than a fear of being judged or dishonouring one's family. It could be explained by cognitive theories of shame as a self-conscious emotion which threatens the positive self-image (M. Lewis, 1993; Tangney, 1999; Tangney & Fischer, 1995). Under threat of exposure to others, shame elicits fear of negative judgement and engagement with strategies to restore a positive self-image (de Hooge et al., 2010, 2011, 2018). Participants' attempts to hide the abuse could be seen as strategies to restore a positive public self-image.

4.2.2.6. Mothering guilt: in this study participants partly blamed themselves for certain situations inflicted on their children, which I interpret as feelings of guilt.

This finding and my interpretation are reflected in the domestic abuse literature which suggests mothers commonly blame themselves for not protecting their children from abuse, and feel guilty about the consequences (Moulding et al., 2015; Showalter, 1987). Though mothering guilt is an established finding within the wider domestic abuse literature, studies focussed on Tamil and South Asian diasporic victim-survivors have not spoken to the experience.

I suggest that the emotion being conveyed in the interviews was one of guilt, rather than shame, because the participants were not attempting to 'hide' or 'cover up' (shame). Instead, participants spoke about 'repairing' the situation and moving forward differently (guilt). Participants appeared to blame

themselves for specific actions or lack of action (guilt or adaptive self-blame), as opposed to holding negative views about their ability to be a mother or blaming their overall character (shame or maladaptive self-blame) (Janoff-Bulman, 1979; Tangney et al., 1996). It is possible that feeling guilt or adaptive self-blame facilitated the women's taking action and leaving the abusive situations, for the children's sake, instead of becoming immobilised by shame.

Participants may have previously felt shame about their ability to mother while trapped in the abusive relationship. The process of leaving and 'repairing' the situation could have transformed shame to guilt (Karlsson & Sjöberg, 2009). It is theorised that changing shame to guilt can bring reparative feelings (Aakvaag et al., 2016; Tangney, 2015) and improve relationships and self-esteem (R. H. Smith et al., 2002; Tangney, 2015), experiences reported by the participants post-separation.

Though shame and guilt are distinct, they are also interconnected, and some academics argue that they should be treated as similar emotions, because they both perceive the self as the causal agent (Frijda et al., 1989; Roseman, 1984; C. A. Smith & Ellsworth, 1985) and involve negative self-evaluation (Niedenthal et al., 1994). Wong & Tsai (2007) suggest that shame and guilt are less differentiated in collectivist contexts because of the interconnectedness between evaluations of the self and evaluations of the self by others. Though this may be, the findings from this study could suggest that guilt led to tangibly better outcomes than shame may have. Thus, I chose to include the guilt-experience in analysis because of the interconnectedness of the concepts and the potential clinical implications (see section 4.3.2.2.).

4.2.2.7. Protecting family: the theme 'protection through denial' captures the findings that participants hide abuse and divorce from their family and community, and avoid discussing the perpetrator's guilt. Protecting one's family from shame can be understood as reflected shame.

The finding that women hide abuse from their family and others to uphold their family's honour is reported in several studies. The literature suggests that reflected shame silences victim-survivors, acting as a barrier to disclosure (Aujla, 2013; EACH, 2012; Gill, 2004; Tonsing & Barn, 2017). Sabri et al. (2018)

found that domestic abuse is seen as a private family matter in some South Asian communities and that women can be victimised by their families for sharing the information publicly and bringing shame on the family. Pinnewala (2009) suggests that women are socialised to feel shame to prevent them seeking help and dishonouring their family. Thus, familial and community victim-blaming and control may shape experiences of reflected shame.

Another finding of this sub-theme was that women hide their separation from their family and community. Hyman & Mason (2006) similarly found that Tamil victim-survivors felt pressure to avoid bringing shame on their family, which involved avoiding divorce. Tonsing (2014) also found that South Asian women more generally did not want to divorce or separate because of the shame it would bring to their families. This fits with Gilbert et al.'s (2004) explanation that abiding by socio-cultural rules, including remaining married, is central to reflected shame, and a failure to do so brings shame on the family.

The majority of literature exploring shame-experiences of South Asian and Tamil victim-survivors focusses on reflected shame. This could be because in collective cultures, emotions are often associated with the impact on others, whereas emotions in individualistic cultures focus on the self (Mesquita, 2001). Alternatively, a focus on reflected shame may indicate researchers' pre-conceptions and aims, restricting a more holistic exploration of shame.

4.2.2.8. He isn't to blame: a finding of the study was that participants attempted to deny the perpetrator's guilt, which I suggest could be an expression of shame, for multiple reasons.

The finding that participants blamed factors other than their husbands is captured in several other studies with Tamil victim-survivors. In my opinion, it is possible that participants did not blame their husbands because they felt at fault or ashamed for 'failing' to prevent the abuse. In Hyman et al.'s (2011) study participants blamed their husbands for the abuse, as well as mental health problems, infidelity and alcoholism. Women also blamed themselves as holding the responsibility to reduce conflict and prevent provocation (Hyman et al., 2011). Similarly, Guruge et al.'s (2010) study found that Tamil victim-survivors

presented multiple reasons for why their husbands may have abused them, including self-blame for 'provoking' abuse and the condoning of certain events.

Another reason participants may have denied the perpetrators' guilt is because exposing the perpetrator could bring shame upon the self (Anitha et al., 2009), due to the amount of power men yield and the victim-blaming, patriarchal beliefs about the dangers of women's sexuality (A. Wilson, 2006). Alternatively, a study by Gill (2004) suggests that denying the perpetrator's guilt or domestic abuse may be a technique for avoiding the shame of being a victim. Differently again, a love for the perpetrator or internalised beliefs about the carer role of a woman may explain participants' protection of their husbands. Towns & Adams (2000) found that victim-survivors wanted to be able to change and help their 'wounded' husbands through love and care. Similarly in this study, women stayed out of care or love for their husbands. Participants may have therefore denied the perpetrator's guilt out of shame of 'failing' to fulfil a woman's supposed carer role.

4.3. Implications

4.3.1. Implications for Theory

The biopsychosocial framework proposes that shame is universal but that the experience varies according to cultural and historical contexts (Gilbert, 2002b). The model suggests that shame can be conceptualised as external or internal (Gilbert, 2002a), which aligns with the findings from this study, insofar as participants described negative self-evaluation as well as fear of judgement. The framework also speaks to reflected shame, particularly in the context of collective cultures (Gilbert, 2002a; Mesquita, 2001). This is supported by the findings of the current study. Different from the majority of studies with South Asian and Tamil victim-survivors, however, the findings of this study found internal shame to play as significant a role in shame-experiences as external and reflected shame, the more culturally-bound aspects of shame.

The biopsychosocial framework suggests that evolutionarily shame was beneficial to group-cohesion, but in modern societies is primarily maladaptive (Tangney & Salovey, 2010). This contrasts some other Western theorists that view shame as continuing to play an important role in enhancing one's ability to

reconcile with the group and avoiding collective exclusion (Keltner & Buswell, 1996; Keltner & Harker, 1998). Similarly, cross-cultural literature has suggested that shame is positively valued as an appropriate response to failure in non-Western cultures, due to the importance and joy of performing one's duty (Wong & Tsai, 2007); this has specifically been noted in South Asian cultures (Bhawuk, 2017; Lindquist, 2004). It has been suggested that the negative self-evaluation associated with shame is not universally harmful to psychological wellbeing (Menon & Shweder, 1994; Wong & Tsai, 2007), and in some contexts, may lead to constructive behaviours, such as relationship building (Bagozzi et al., 2003; Wong & Tsai, 2007). However, in the current study, shame appeared to be associated with poor mental health, as well as a break-down in supportive relationships, and increased social isolation. Shame may therefore be socially useful at an individual level, but become problematic when experienced in contexts that are not the fault of the ashamed person, and in which the ashamed person has minimal control. Thus, shame in the context of domestic abuse has negative implications for wellbeing, safety and relationships, regardless of a victim-survivor's culture.

The literature on gender-differences in shame is contested, but some suggest that shame is a more feminine experience than masculine (H. Lewis, 1971). The difference (if it exists) has been theorised as a result of gender-roles such that women are socialised to care for others, resulting in self-criticism in order to maintain relationships and appease others (Cradwick, 2020). The findings from this study may suggest that shame is experienced differently across genders because of the normalisation of victim-blaming women in societies organised and structured by men, for the benefit of men; this fits with Dillon's (1997) theory of the shame of inequality and discrimination.

4.3.2. Implications for Clinical Practice

4.3.2.1. Sharing shame and speaking-out: participants discussed the relief of sharing previously hidden experiences. This differs from the findings of Guruge & Humphreys (2009), which suggests that Tamil victim-survivors prefer practical support to talking therapy. I propose that this discrepancy could be explained by the lack of victim-survivor perspectives informing Guruge & Humphreys' (2009) findings, compared to this study. Instead of asking victim-survivors about the

support they require, Guruge & Humphreys (2009) interviewed community leaders.

The existing literature and results from this study suggest that shame-focussed interventions could benefit Tamil victim-survivors (Tonsing & Barn, 2017). Shame is a body-based emotion (Karlsson & Sjöberg, 2009) and therefore more appropriate for a holistic understanding of distress than a cartesian dualism, diagnostic approach. Shame also aligns with the Tamil community's social determinants understanding of health, as it is caused by poverty, inequality and relationships (Pandalangat, 2011; Pandalangat & Kanagaratnam, 2021). Shame-based interventions may be preferable to diagnostic-based interventions such that the broader literature and participants in this study appeared to reject Western medical models of distress and therapeutic support (Bahu, 2019; Kanagaratnam et al., 2012; Reavey et al., 2006).

Gilbert (1998) suggests that awareness of shame and finding ways to alleviate hiding is important to clinical practice. Yet shame is often avoided by clinicians and service users in the therapeutic process because of the hidden, sensitive and shameful nature of it (Dearing & Tangney, 2011a; Gilbert, 2011; Teyber et al., 2011); the shameful nature of shame means that discussing it can invoke shame, and hence it is complicated to attend to in therapy (Munt, 2000). One way to encourage a discussion of shame may be through less direct and confronting methods than face-to-face talking therapy, such as writing (Pachankis & Goldfried, 2010). In line with this, group therapy may facilitate sharing of shame in the presence of others with similar worries and experiences (Bieling et al., 2006). However, the offer of group therapy and the facilitation of sessions would need to be carefully managed to prevent any indication of victim-blaming, re-victimisation and traumatisation. Victim-survivors can feel frustrated by having to go to therapy to do the work to improve their situation, when it is the perpetrator who caused the problems. Singh & Hays (2008) found that South Asian victim-survivors benefited from Feminist Group Counselling, facilitated by South Asian women, with an emphasis on culture and intersectional feminism. The group enabled women to share and externalise their feelings of shame and guilt by placing responsibility and blame on systemic factors.

Participants spoke with pride about speaking-out on abuse and separation, to reduce the community's shame and stigma, and support other women to leave abusive situations. Tamil victim-survivors may therefore benefit from becoming involved in activism. This could involve groups of Tamil victim-survivors joining together to advocate for social change, such as in Sue Holland's White City Project (Holland, 1992). Participants spoke about being disconnected from their family and community due to geographical distance or being ostracised. Those participants supported by their families or who felt accepted by groups within the Tamil community experienced considerable mental health benefits, including reduced shame. Supporting Tamil victim-survivors to come together therefore offers the additional benefit of growing victim-survivors' support networks. Groups for Tamil victim-survivors could hence be beneficial in that they increase community connections, offer peer-support, and enable opportunities for advocacy and social change.

4.3.2.2. Focus on the mother role: given the importance to the participants of being a mother, focussing on the needs of their children may offer an avenue to engage Tamil victim-survivors. It could support the development of a trusting therapeutic relationship by indicating an understanding of the victim-survivor's context. Discussing reasons to leave abusive relationships that focus on children may also be less shaming and met with more openness. However, such discussions need to be handled with care and consideration to avoid any suggestion that woman are culpable for harm caused to the children by the domestic abuse (Douglas & Walsh, 2010; Humphreys, 2010). Buchanan & Moulding (2021) suggest that professionals may benefit from training in how to talk with victim-survivors in ways that do not blame or shame mothers. They also suggest support should explore women's experiences of mothering in domestic abuse to heal shame and self-blame. Professionals could do this by exploring ways in which mothers exercise their agency to protect their children from abuse. This may alleviate shame for victim-survivors who blame themselves for the impact of abuse on their children. Alternatively, for women like the participants in this study who felt guilty but not ashamed in relation to motherhood, it could prevent a regression to shame caused by shaming interactions with services.

Due to the different implications of guilt and shame for victim-survivors, it may be important to differentiate between the experiences in the clinical setting, and focus on shame (Karlsson & Sjöberg, 2009). Given the hidden and painful reality of shame, starting with conversations about guilt may provide opportunities to progress into discussions about shame, in a staged and containing manner. Discussing ways to reduce or avoid guilt may also be helpful.

4.3.2.3. Culturally-relevant approaches: the participants preferred therapeutic support from Tamil practitioners, which may suggest that working with Tamil victim-survivors through a cultural lens is a favourable approach (Affleck et al., 2018; Kanagaratnam et al., 2020). If Tamil victim-survivors are open to support from non-Tamil practitioners, it may require learning and development on behalf of the practitioner, including reflecting on one's biases and assumptions (J. Campbell & Campbell, 1996) and self-education about cultural norms, values and practices (Asnaani & Hofmann, 2012). Having knowledge of a client's cultural and familial values and their expectations concerning support is pivotal in providing effective care (Ashbourne & Baobaid, 2019; Migrant & Refugee Women's Health Partnership, 2019). Therefore, we (non-Tamil practitioners) should remain connected to research and literature about Tamil victim-survivors' experiences of abuse and support (Asnaani & Hofmann, 2012), especially research about what experiences Tamil women find shaming and fear in interactions with professionals (J. Campbell & Campbell, 1996).

It is important to understand the value of a victim-survivor's culture, and also not to condone violence against women because it is upheld by patriarchal structures within a culture. Meetoo & Mirza (2010) suggest that acceptance of violence against women in an attempt to be respectful of one's culture is a misguided form of cultural relativism. As practitioners we must be respectful while challenging unjust practices (James, 2010). Within cultures and communities there is often strong resistance to unjust treatment and the justification of oppression based on tradition (James, 2010), which professionals could join alongside. This is supported by the United Nations, which emphasises that practices which involve violence against women cannot be justified or overlooked on the grounds of culture (Coomaraswamy, 1996).

4.3.2.4. Beyond culture to the personal: this study illuminated Tamil victim-survivors' experiences of internal shame. An implication from the study may therefore be that shame-focussed interventions should not reduce an individual to their culture but understand cultural groups as heterogeneous populations for whom certain themes may be more or less present (Asnaani & Hofmann, 2012). Before jumping to adjust interventions for Tamil victim-survivors, a comprehensive culturally-informed, person-specific assessment of the client's difficulties should be considered (Sue et al., 2009). The findings from this study and existing literature with Tamil victim-survivors suggests that shame of sexual abuse is extremely painful, and may therefore benefit from therapeutic support. Multiple interventions have been developed to target personal experiences of shame, including developing self-compassion (Germer & Neff, 2015), Compassion Focussed Therapy (CFT) (Gilbert, 2011), and strengths-based empowerment projects (Lloyd et al., 2017).

Promoting dignity can ameliorate the shame caused by abuse and trauma (Chefetz, 2017). Herman (2005) found that victim-survivors of sexual abuse desired the recognition and restoration of their dignity, but that too often interactions with services compounded the shame of the original abuse. Tamil victim-survivors of domestic abuse may therefore benefit from the promotion of their dignity through engagement with services. Dignity could be promoted in therapy by acknowledging and addressing victim-survivors' vulnerability to shame and harm, as well as focussing on their value (Hicks, 2011).

4.3.3. Implications for Policy

4.3.3.1. Service-level policy: service-level policies to reduce victim-survivors' shame-experiences involve reducing institutional betrayal and increasing dignity (Salter & Hall, 2020). Services could establish more dignified environments by developing safe, fair and accountable processes, through which victim-survivors feel recognised and understood (Hicks, 2011). This could involve policies on services' efficient access to interpreters, recruitment of staff that represent the local population, and staff development (Centre for Culture Ethnicity and Health, 2012). Services could also promote dignity through personalised, Trauma Informed Care (TIC) (Salter & Hall, 2020). TIC is a framework of professional practice and service response that acknowledges staff and clients' trauma (C. Wilson et al., 2013) to promote health and wellbeing (Salter & Hall, 2020).

Without TIC, traumatised clients may experience services as humiliating and retraumatising, upheld through routine misdiagnosis.

4.3.3.2. National-level policy: policy can be used as a government tool to humiliate and shame certain populations, in order to legitimise their oppression and entrench inequality (Klein, 1991; Rothbart, 2018). Social and economic inequality, upheld by policy, can be shaming in itself (Sen, 1983; Walker et al., 2013), as well as create the conditions conductive to other shaming practices; inequality can create the conditions for abuse, discrimination, and social subordination (Marmot, 2015), which may inevitably result in victim-survivors' shame (Salter & Hall, 2020). Therefore, primary prevention against victim-survivors' shame-experiences requires macro-level change.

Policy that bolsters financial security could prevent family stress and the abusive responses of some men (Jeremiah et al., 2013), as well as poverty-induced shame (Walker et al., 2013). It could also prevent the entrapment of women in abusive relationships, enabling them more autonomy (Tolman & Rosen, 2001), and reducing the shame of dependence. Similarly, the development of dignified migration policies and state responses to people who move to the UK could reduce the control of women and subsequent shame (Salter & Hall, 2020). The control of women could also be challenged by policies that promote gender equality and women's empowerment and employment (Madhivanan & Dongre, 2021).

A community mobilisation and development program could support and resource the Tamil community to address the collective problems of domestic abuse, victim-blaming and shaming. Community mobilisation and development programs resource and support a community's capacity, with an aim to strengthen social bonds, expand community networks, develop a community-based action plan, deliver community activities, and invest in skilled workers and services (Mehta & Gopalakrishnan, 2007; Michau, 2007). This could include social marketing and community campaigns to change social norms and attitudes around victim-blaming and promote victim-supportive attitudes (Clayton et al., 2018; Salter & Hall, 2020).

4.3.4. Implications for Future Research

The participants in this study were separated from the perpetrators and had received support from the TCC, thus their levels and experiences of shame may differ from other Tamil victim-survivors, particularly those still in abusive relationships. Developing on the findings in this study, research should explore the heterogeneity of Tamil victim-survivors' experiences, including those of women in and out of abusive relationships, as well as exploring intersectional identities. Interviewing participants living with their abusive partners would have to be carefully considered and managed, to ensure participants' safety.

I adopted a non-leading approach to the interviews, where I invited participants to share what they deemed important. By using a more structured and directive approach, future research could explore specific aspects of Tamil victim-survivors' shame-experiences in more detail. For example, based on the assumption that seeking professional support and engaging in therapy can be a shame-inducing process (Greenberg & Iwakabe, 2011), future research could examine how involvement with psychological services shapes shame, including how shame is experienced in the therapy room. A member of the Tamil community and non-clinician may be the most appropriate researcher to support participants' openness. Such research could have important implications for how mental health professionals manage shame in the therapeutic process with Tamil victim-survivors.

In light of the research questions, this study focussed on Tamil victim-survivors' experiences of shame. However, resistance and resilience are natural responses to trauma and should be considered in tandem with suffering (Bonanno, 2004; Renoux & Wade, 2008). An exploration of how Tamil victim-survivors resist shame could help develop a culturally-relevant strength-based approach to therapy (Singh, 2009). In line with this, future research should examine Tamil victim-survivors' views on healing shame, to develop targeted interventions that meet their needs. It could be useful to clinical practice to explore this from both the perspective of Tamil victim-survivors and Tamil service-providers. Tamil service-providers' knowledge of the community and experience offering support may be helpful to inform clinical approaches (Pandalangat, 2011).

4.4. Critical Analysis

4.4.1. Strengths

The relative rarity of psychological research with victim-survivors of domestic abuse and with marginalised groups in the UK may indicate that these groups can be challenging to recruit to research, as it requires additional consideration and sensitivity on behalf of the researcher. Therefore, engaging six Tamil victim-survivors may be considered a strength of the research and was made possible through relationship building with gatekeeper organisations.

Conducting the interviews with a translator and member of the Tamil community enabled me access to a population that I would not have had access to otherwise. Conducting interviews with a member of the participants' community can foster trust and engagement (Caretta, 2015; Edwards, 2013). It was helpful to have the same interpreter across the interviews because we were able to develop a good working relationship and continually reflect and improve the process. The interpreter held power as a gate-keeper and I became reliant on them to access participants, and organise and conduct interviews (Edwards, 2013; Harris et al., 2013). Yet I was also aware of my own power in the relationship and attempted to ensure that power was shared as much as possible in other aspects of the process.

Conducting translation during the interviews may have also benefited the research such that early-stage translation is recommended over late-stage translation (Santos et al., 2015). Early-stage translation enables an interactive process between researcher and translator, which reduces the limitations of the researcher not having direct access to participants' responses.

Some participants spoke about the interviews as a therapeutic intervention which had felt relieving and benefited their wellbeing. It is possible that having an open, empathetic, and supportive space to be witnesses benefited the participants. In fact, the literature indicates that qualitative research can benefit participants (Bergen, 1993) such that it creates an opportunity for participants to share their victimisation with an interested and validating listener (Becker-Blease & Freyd, 2006). Using a feminist interviewing process might have

fostered the benefits of being involved in the research by emphasising power-sharing and participants' agency. I did this by asking open-ended questions and prioritising the containment of participants' emotions (Jaggar, 1989; Oakley, 1981).

4.4.2. Limitations and Potential Methodological Alternatives

4.4.2.1. Translation: a limitation of translation was that analysis was based on the translator's summary of what was said, rather than a verbatim translation. As shame is a complex concept, dependent on subtle differences in language (e.g. shame vs. guilt), it is possible that shame experiences were missed or misinterpreted in the process. It is also possible that some speech may not have been translated, and by missing some of the contextual information in participants' responses, the meaning of pivotal quotes were misinterpreted. Given the complexities of analysing translated data, the results should be held lightly, as a suggested interpretation. To minimise the limitations of not speaking Tamil, I tried to stay close to the data and continually questioned my interpretations. Verbatim translation may have reduced the impacts of translation on the research, but could have halted participants' ability to freely share their stories, and may have therefore been less therapeutic for the participants.

The 'participant information sheet' was translated by a Tamil organisation but was found to not meet TCC's standards. The reason for using another service for translation was due to the university research budget available. TCC therefore offered additional support to ensure participants' informed consent.

Despite the limitations of interpretation, I chose to engage in the research because it is unfortunately rare that a researcher is fluent in the language of communities she is working with (Temple & Young, 2004). As well, Twine (2000) suggests that conducting research from the position of an 'insider' can also be complicated, and that difference may be a stimulator to communication, as well as a block. An alternative approach could have been to support the translator to conduct the research themselves (Edwards, 2013). Translation into English in the transcription process would have enabled the translator more time to consider the translation. However, supporting a member of the Tamil

community to conduct the interviews, and translate in the transcription process, would have been an expensive and time-consuming process.

4.4.2.2. Credibility of qualitative research: the qualitative nature of the research could be criticised for not meeting the 'trustworthiness' of quantitative research. However, objectivity, reliability, validity and generalisability are not as meaningful to qualitative research (Willig, 2013). Therefore, I adopted alternative quality-management strategies, including reflexivity, documentation, and transferability (Henwood & Pidgeon, 1992).

Instead of triangulation, I attempted to clearly describe the methods and analysis process and be open in my reflections, to show how the findings developed (Varpio et al., 2017). In regards to saturation, it cannot be conclusively achieved (Dey, 1999) and is not applicable to reflexive TA (Braun & Clarke, 2019). The data collected from six participants was therefore deemed rich and complex enough to appropriately answered the research questions (Braun & Clarke, 2019; Malterud et al., 2016). This was because of the specificity of the research questions and sample, and the amount and depth of data collected from each participant (Braun & Clarke, 2019; Malterud et al., 2016).

Pragmatic constraints influenced sample size, including the limited availability of participants for such research (Braun & Clarke, 2019). In addition, most of the participants lived in or around London, and therefore may not represent a UK-wide experience. In addition, the participants volunteered to speak about abuse and shame, which may indicate they have overcome shame to some extent, and differ from many victim-survivors.

Participants correcting analysis for interpretation errors (member-checking) was deemed incongruent with the research's interpretative, qualitative approach. According to Varpio et al. (2017) and Morse et al. (2002), thematic analysis should be based on a researcher's theoretical knowledge to combine data across interviews, thus may not reflect individual participants' experiences. In contrast, co-produced research demands the privileging of the community's views. Therefore, I did not seek confirmation from participants, but I shared the

research with members of the community and Tamil professionals to ensure that the findings fit with their experience of supporting Tamil victim-survivors more generally and would be useful for the community. Ideally, I would have preferred increased levels of community involvement in analysis in line with co-produced research. This was unfortunately not possible given the lack of resources available to pay community members for their time working on the project beyond interpretation services.

The results were based on first-generation SLT women victim-survivors of domestic abuse living in the UK, who have left the abusive relationship, and may be applicable or transferable to this group, given the specificity of the sample (Henwood & Pidgeon, 1992). Results applicable to the population of interest are important for professionals to understand in order to improve targeted support for this group. Results focussed on this population also address the neglect of the SLT population in UK-based health research (Aspinall, 2019).

4.4.2.3. Community involvement: a higher-level of co-production could have developed more beneficial research for the SLT community. Adopting a rights-based approach to co-production which redistributed power would have enabled the community to shape the research and conduct it as they decided (Arnstein, 1969). As power was not equal between myself, TCC, and participants, it was not a true partnership in line with Arnstein's ladder of participation. For example, given that I held the power and was unable to consult many Tamil victim-survivors in the development of the research questions, their input was minimal. I was unable to consult many victim-survivors as a consequence of time constraints and a need to maximise the pool of potential participants. It is possible that the limited power held by TCC and participants in the research may have had further implications that I am unaware of, such as feeling frustrated or powerless. Given the slower pace of co-production, equal power-sharing could have been facilitated with a longer time frame and a larger research budget.

4.4.2.4. Time: given the hidden nature of shame, the research and participants may have benefited from an extended engagement period, as well as multiple

interviews. An extended engagement period of months could have helped build participants' trust and openness to share their emotions. Despite interviews running over the allocated time, there was much left unexamined; it was difficult to both witness the participants' narratives and explore their emotional experiences in one interview. Multiple interviews may have enabled a deeper analysis. A methodological approach focussed more on personal meaning-making, and less on understanding shame more broadly, could have been used to manage the difficulties with time-constraints; for example, a narrative approach or Interpretative Phenomenological Analysis (IPA).

4.4.2.5. Interview schedule: the interview questions were developed to open-up discussions about topics within which shame may be evident. Instead of asking directly about shame, shame was often explored through follow-up questions, where relevant to the participants' narrative. On the one hand, asking directly about shame, using the word 'shame', or a single translation of the word, could have constrained the participants to a specific linguistic understanding, limiting them from speaking to the different and multiple experiences that can be interpreted as shame. On the other hand, the approach used required more interpretation to identify shame than directly asking about shame would have.

Given that shame can be shame-inducing to discuss (Biddle, 1997), it was thought that asking directly about shame may have closed-down the discussion. In addition, emotions and lived experiences, particularly shame, can be difficult to describe and explain. Therefore it was thought that asking directly about shame would have been unproductive. However, not having questions in the interview schedule asking about shame could have also restricted its exploration. A question about the lived or felt experience of shame could have furthered the limited findings about the embodiment of shame for SLT victim-survivors. More directive questions about shame could have also helped to focus the participants on their emotions, instead of their narratives of abuse.

4.5. Reflections

The research process had a weighty impact on me, something I should have predicted, but hadn't. Witnessing the women's stories was extremely

distressing, and adopting the ‘researcher’ position made me feel helpless. A further discussion about the emotional impact on myself and participants, and negotiating the ethics of research in the context of heightened-distress can be found in Appendix N.

I felt anxious about being an outsider and how this would impact the way in which I represented the victim-survivors in the research. Given that speaking for others is political (Alcoff, 1991), and that I am not Tamil and do not speak Tamil, I worried about not doing the participants and the community justice, and unintentionally offending or harming. For example, it was difficult to navigate how to present participants’ negative views of Tamil culture while ensuring that as an outsider, I did not reproduce stereotyping research. I therefore developed relationships with members of TCC and encouraged their input and feedback. In order to conduct ethical research that benefited the participants, I worked to sustain the longevity of these relationships, so that I was not being extractive but offering myself as a resource to the Tamil community (Hugman, 2005; Pittaway et al., 2010). TCC and I are now working together to plan the next steps, including writing a summary paper to circulate with the UK-based Tamil community, and sharing learning to support Tamil victim-survivors.

I feared leading the interviews and doing analysis of the data because I worried that it would amplify my voice, and undermine the voices of SLT victim-survivors. However, Braun & Clarke (2021) suggest that reflexive TA researchers should offer their interpretations, analysing beyond the content of participants’ words, similar to a psycho-dynamic therapeutic approach. This was unsettling for me as it contrasts with my personal values and approach to clinical work, in which I attempt to create space to witness clients’ narratives and share power. My fear of analysis and interpretation in research and clinical work is that it may further disenfranchise oppressed clients/participants. In the interviews I therefore found it difficult to navigate the balance between asking questions that would help answer the research questions, and giving space to participants to express what they would find beneficial. Similarly, in analysis I tried to balance being interpretive with staying close to the participants’ words. Yet, in line with ‘mindful ethics’, I often chose to weight participant-centred practices more highly than researcher incentives (González-López, 2011).

4.6. Conclusion

This study examined shame with first-generation SLT victim-survivors of domestic abuse living in the UK, as well as the factors that may shape shame. Results indicate that victim-blaming, betrayal, and control of women may shape shame. Shame-experiences included destructed identities, fear and low mood associated with being judged, feeling degraded, vulnerable, guilty and exposed. Shame was also expressed in terms of denial. The results may be applicable to SLT women victim-survivors of domestic abuse living in the UK due to the specificity of the sample (Henwood & Pidgeon, 1992).

Implications for theory support the biopsychosocial framework of shame (Gilbert, 2002a, 2002b; Tangney & Salovey, 2010). Implications for practice include support for shame-focussed therapeutic interventions. Policy implications involve services adopting dignified environments to reduce institutional betrayal (Salter & Hall, 2020). At a national level, policies could support the agency of victim-survivors and reduce victim-blaming. Future research may further explore Tamil victim-survivors' shame-experiences when engaging with therapeutic services, and the antithesis to shame.

REFERENCES

Aakvaag, H. F., Thoresen, S., Wentzel-Larsen, T., Dyb, G., Røysamb, E., & Olff, M. (2016). Broken and Guilty Since it Happened: A Population Study of Trauma-Related Shame and Guilt after Violence and Sexual Abuse. *Journal of Affective Disorders*, *204*, 16–23. https://doi.org/10.1016/j.jad.2016.06.004

Abeyasekera, A. L., & Marecek, J. (2019). Embodied shame and gendered demeanours in young women in Sri Lanka. *Feminism & Psychology*, *29*(2), 157–176. https://doi.org/10.1177/0959353518803976

ABNU. (2017). *ANBU UK Tamil Society Event- Interactive Questions and Answers*. ABNU. https://2c652841-a5ca-4959-afff-47dcbd0f8c9f.filesusr.com/ugd/b124e7_a71819ef0211439e8b684c828fbe6d7d.pdf

Abraham, M. (2000). *Speaking the Unspeakable: Marital Violence Among South Asian Immigrants in the United States*. Rutgers University Press.

Affleck, W., Thamotharampillai, U., Jeyakumar, J., & Whitley, R. (2018). "If One Does Not Fulfil His Duties, He Must Not Be a Man": Masculinity, Mental Health and Resilience Amongst Sri Lankan Tamil Refugee Men in Canada. *Culture, Medicine, and Psychiatry*, *42*(4), 840–861. https://doi.org/10.1007/s11013-018-9592-9

Ahmad, F., Riaz, S., Barata, P., & Stewart, D. E. (2004). Patriarchal beliefs and perceptions of abuse among South Asian immigrant women. *Violence Against Women*, *10*(3), 262–282. https://doi.org/10.1177/1077801203256000

Ahmad, F., Shik, A., Vanza, R., Cheung, A., George, U., & Stewart, D. E. (2004). Voices of South Asian Women: Immigration and Mental Health. *Women & Health*, *40*(4), 113–130. https://doi.org/10.1300/J013v40n04_07

Ahmed, K. (1999). Adolescent Development for South Asian American girls. In *Emerging Voices: South Asian American Women Redefine Self, Family and Community* (pp. 48–57). Altamira.

Akpinar, A. (1988). *Challenged Family and Kinship Ideals: Family Crises and Social Networks Among Turkish Immigrants*. University of Stockholm.

Akpinar, A. (2003). The Honour/Shame Complex Revisited: Violence Against Women in the Migration Context. *Women's Studies International Forum*, *26*(5), 425–442. https://doi.org/10.1016/j.wsif.2003.08.001

Alcoff, L. (1991). The Problem of Speaking for Others. *Cultural Critique*, *20*, 5–32. https://doi.org/10.2307/1354221

Alexander, H., Macdonald, E., & Patons, S. (2005). Raising the issue of domestic abuse in schools. *Children & Society*, *19*, 187–19. https://doi.org/10.1002/chi.837

Alvesson, M., & Skoldberg, K. (2009). *Reflexive Methodology: New Vistas for Qualitative Research*. Sage Publishing.

Amnesty International. (2004). *Reservations to the Convention on the Elimination of All Forms of Discrimination against Women—Weakening the protection of women from violence in the Middle East and North Africa region*. https://www.amnesty.org/en/documents/IOR51/009/2004/en/

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD Symptoms in Victims of Violent Crime: The Role of Shame, Anger, and Childhood Abuse. *Journal of Abnormal Psychology*, *109*(1), 69–73. https://doi.org/10.1037//0021-843x.109.1.69

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting Depressive Symptoms with a New Measure of Shame: The Experience of Shame Scale. *British Journal of Clinical Psychology*, *41*(1), 29–42. Scopus. https://doi.org/10.1348/014466502163778

Anitha, S. (2008). Neither Safety Nor Justice: The UK Government Response to Domestic Violence Against Immigrant Women. *Journal of Social Welfare and Family Law*, *30*(3), 189–202. https://doi.org/10.1080/09649060802550592

Anitha, S., Chopra, P., Farouk, W., Haq, Q. J., Khan, S., & Mansoor, A. (2009). *Domestic Violence and Mental Health: Experiences of South Asian Women in Manchester* [Project Report]. Saheli Asian Women's Project. http://saheli.org.uk/sites/default/files/Full%20Report.pdf

Antony, R. (2012). *British-born Tamils: A study of Young Tamil Londoners* [Doctor of Philosophy, University of Surrey]. https://openresearch.surrey.ac.uk/esploro/outputs/doctoral/British-Born-Tamils-A-Study-of-Young/99516985602346

Appiah, K. A. (2011). *The Honor Code*. W.W. Norton & Co.

Arksey, H., & O'Malley, L. (2005). Scoping Studies: Towards a Methodological Framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Arnstein, S. R. (1969). A Ladder of Citizen Participation. *Journal of the American Institute of Planners*, *35*(4), 216–224. https://doi.org/10.1080/01944366908977225

Ashbourne, L. M., & Baobaid, M. (2019). A Collectivist Perspective for Addressing Family Violence in Minority Newcomer Communities in North America: Culturally Integrative Family Safety Responses. *Journal of Family Theory & Review*, *11*(2), 315–329. https://doi.org/10.1111/jftr.12332

Asnaani, A., & Hofmann, S. G. (2012). Collaboration in Multicultural Therapy: Establishing a Strong Therapeutic Alliance Across Cultural Lines: Collaboration in Culturally Responsive Therapy. *Journal of Clinical Psychology*, *68*(2), 187–197. https://doi.org/10.1002/jclp.21829

Aspinall, P. J. (2019). The Sri Lankan Community of Descent in the UK: A Neglected Population in Demographic and Health Research. *South Asian Diaspora*, *11*(1), 51–65. https://doi.org/10.1080/19438192.2018.1505065

Aujla, W. (2013). *Voicing Challenges: South Asian Immigrant Women Speak Out about their Experiences of Domestic Violence and Access to Services* [Master of Arts, University of Alberta]. https://era.library.ualberta.ca/items/927dc9f1-2177-4460-815a-0386020ca556

Bagozzi, R. P., Verbeke, W., & Gavino, J. C. (2003). Culture Moderates the Self-Regulation of Shame and its Effects on Performance: The Case of Salespersons in The Netherlands and the Philippines. *The Journal of Applied Psychology*, *88*(2), 219–233. https://doi.org/10.1037/0021-9010.88.2.219

Bahu, M. (2019). War, Trauma and Culture: Working with Tamil refugees and Asylum Seekers Using Culturally Adapted CBT. *The Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X1900031X

Baker, N. V., Gregware, P. R., & Cassidy, M. A. (1999). Family Killing Fields: Honor Rationales in the Murder of Women. *Violence Against Women*, *5*(2), 164–184. https://doi.org/10.1177/107780129952005

Barrett, K. C. (1995). A functionalist approach to shame and guilt. In *Self-Conscious Emotions: The Psychology of Shame, Guilt, Embarrassment, and Pride* (pp. 25–63). Guilford Press.

Bartky, S. L. (1990). *Femininity and Domination: Studies in the Phenomenology of Oppression*. Routledge.

Beck, J. G., McNiff, J., Clapp, J. D., Olsen, S. A., Avery, M. L., & Hagewood, J. H. (2011). Exploring Negative Emotion in Women Experiencing Intimate Partner Violence: Shame, Guilt, and PTSD. *Behavior Therapy*, *42*(4), 740–750. https://doi.org/10.1016/j.beth.2011.04.001

Becker-Blease, K. A., & Freyd, J. J. (2006). Research Participants Telling the Truth about Their Lives: The Ethics of Asking and Not Asking About Abuse. *The American Psychologist*, *61*(3), 218–226. https://doi.org/10.1037/0003-066X.61.3.218

Beiser, M., Simich, L., Pandalangat, N., Nowakowski, M., & Tian, F. (2011). Stresses of Passage, Balms of Resettlement, and Posttraumatic Stress Disorder among Sri Lankan Tamils in Canada. *The Canadian Journal of Psychiatry*, *56*(6), 333–340. https://doi.org/10.1177/070674371105600604

Bergen, R. K. (1993). Interviewing Survivors of Marital Rape: Doing Feminist Research on Sensitive Topics. In *Researching Sensitive Topics* (pp. 197–211). Sage.

Bhaskar, R. (1998). Philosophy and scientific realism. In *Critical Realism Essential Readings*. Routledge.

Bhawuk, D. P. S. (2017). Individualism and Collectivism. In *The International Encyclopedia of Intercultural Communication* (pp. 1–9). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781118783665.ieicc0107

Biddle, J. (1997). Shame. *Australian Feminist Studies*, *12*(26), 227–239. https://doi.org/10.1080/08164649.1997.9994862

Bieling, P. J., McCabe, R. E., & Antony, M. M. (2006). *Cognitive Behavioural Therapy in Groups*. The Guilford Press.

Birrell, P. J., Bernstein, R. E., & Freyd, J. J. (2017). With the Fierce and Loving Embrace of Another Soul: Finding Connection and Meaning After the Profound Disconnection of Betrayal Trauma. In E. M. Altmaier (Ed.), *Reconstructing Meaning After Trauma* (pp. 29–43). Academic Press. https://doi.org/10.1016/B978-0-12-803015-8.00003-6

Bograd, M. (1999). Strengthening Domestic Violence Theories: Intersections of Race, Class, Sexual Orientation, and Gender. *Journal of Marital and Family Therapy*, *25*(3), 275–289. https://doi.org/10.1111/j.1752-0606.1999.tb00248.x

Bonanno, G. A. (2004). Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events? *The American Psychologist*, *59*(1), 20–28. https://doi.org/10.1037/0003-066X.59.1.20

Booth, A., Sutton, A., & Papaioannou, D. (2012). *Systematic Approaches to a Successful Literature Review*. Sage Publishing.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, *13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., & Clarke, V. (2021a). *Thematic Analysis: A Practical Guide*. SAGE Publications Ltd.

Braun, V., & Clarke, V. (2021b). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughes, J., Tysall, C., & Suleman, R. (2014). Mapping the Impact of Patient and Public Involvement on Health and Social Care Research: A Systematic Review. *Health Expectations*, *17*(5). https://doi.org/10.1111/j.1369-7625.2012.00795.x

British Psychological Society. (2021a). *Ethics Guidelines for Internet-Mediated Research*. British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Ethics%20Guidelines%20for%20Internet-mediated%20Research.pdf

British Psychological Society. (2021b). *Code of Ethics and Conduct*. British Psychological Society.

https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct.pdf

British Psychological Society. (2021c). Code of Human Research Ethics. *British Psychological Society*. https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Broucek, F. J. (1982). Shame and its relationship to early narcissistic developments. *The International Journal of Psycho-Analysis*, *63*(3), 369–378.

Brubaker, R. (2006). *Ethnicity Without Groups*. Harvard University Press.

Buchanan, F., & Moulding, N. T. (2021). Mothering During Domestic Abuse: Protective Agency as a Force for Change. *Qualitative Social Work*, *20*(3), 665–680. https://doi.org/10.1177/1473325020917743

Buchbinder, E., & Eisikovits, Z. (2003). Battered Women's Entrapment in Shame: A Phenomenological Study. *American Journal of Orthopsychiatry*, *73*(4), 355–366. https://doi.org/10.1037/0002-9432.73.4.355

Bui, H. N., & Morash, M. (1999). Domestic Violence in the Vietnamese Immigrant Community: An Exploratory Study. *Violence Against Women*, *5*(7), 769–795. https://doi.org/10.1177/10778019922181473

Burman, E., Smailes, S. L., & Chantler, K. (2004). 'Culture' as a Barrier to Service Provision and Delivery: Domestic Violence Services for Minoritized Women. *Critical Social Policy*, *24*(3), 332–357. https://doi.org/10.1177/0261018304044363

Campbell, J., & Campbell, D. (1996). Cultural competence in the care of abused women. *Journal of Nurse Midwifery*, *41*(6), 457–462. https://doi.org/10.1016/s0091-2182(96)00094-8

Campbell, R., Adams, A. E., Wasco, S. M., Ahrens, C. E., & Sefl, T. (2010). 'What has it been like for you to talk with me today?': The Impact of Participating in Interview Research on Rape Survivors. *Violence Against Women*, *16*(1), 60–83. https://doi.org/10.1177/1077801209353576

Caretta, M. A. (2015). Situated Knowledge in Cross-Cultural, Cross-Language Research: A Collaborative Reflexive Analysis of Researcher, Assistant and Participant Subjectivities. *Qualitative Research*, *15*(4), 489–505. https://doi.org/10.1177/1468794114543404

Cavanagh, K. (2003). Understanding women's responses to domestic violence. *Qualitative Social Work*, *2*(3), 229–249. https://doi.org/10.1177/14733250030023002

Centre for Culture Ethnicity and Health. (2012). *Cultural Competence in Governance*. Centre for Culture Ethnicity and Health. https://www.ceh.org.au/resource-hub/cultural-competence-in-governance/

Chakraborty, K. (2010). The sexual lives of Muslim girls in the bustees of Kolkata, India. *Sex Education*, *10*(1), 1–21. https://doi.org/10.1080/14681810903491339

Chandler, A. (2020). Shame as Affective Injustice: Qualitative, Sociological Explorations of Self-Harm, Suicide and Socioeconomic Inequalities. In *Suicide and Social Justice: New Perspectives on the Politics of Suicide and Suicide Prevention* (pp. 32–49). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9780429460494-3

Chase, E., & Walker, R. (2013). The Co-construction of Shame in the Context of Poverty: Beyond a Threat to the Social Bond. *Sociology*, *47*(4), 739–754. https://doi.org/10.1177/0038038512453796

Cheers, B., Binell, M., Coleman, H., Gentle, I., Miller, G., Taylor, J., & Weetra, C. (2006). Family Violence: An Australian Indigenous Community Tells Its Story. *International Social Work*, *49*(1), 51–63. https://doi.org/10.1177/0020872806059401

Chefetz, R. A. (2017). Dignity is the opposite of shame, and pride is the opposite of guilt. *Attachment: New Directions in Relational Psychoanalysis and Psychotherapy*, *11*(2), 119–133.

Clarke, V., & Braun, V. (2014). Thematic Analysis. In *Encyclopaedia of Critical Psychology* (pp. 1947–1952). Springer.

Clarke, V., & Braun, V. (2020). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*. https://doi.org/10.1002/capr.12360

Clayton, E., Jones, C., Brown, J., & Taylor, J. (2018). The Aetiology of Child Sexual Abuse: A Critical Review of the Empirical Evidence. *Child Abuse Review*, *27*(3), 181–197. https://doi.org/10.1002/car.2517

Cook, D. R. (1996). Empirical Studies of Shame and Guilt: The Internalized Shame Scale. In *Knowing Feeling: Affect, Script, and Psychotherapy* (pp. 132–165). W. W. Norton & Company.

Coomaraswamy, R. (1996). *Report of the Special Rapporteur on Violence Against Women, Its Causes and Consequences*. United Nations Commission on Human Rights. https://digitallibrary.un.org/record/228137?ln=en

Council of Europe. (1952). *The European Convention on Human Rights*. https://www.echr.coe.int/documents/convention_eng.pdf

Couture-Carron, A. (2020). Shame, Family Honor, and Dating Abuse: Lessons From an Exploratory Study of South Asian Muslims. *Violence Against Women*, *26*(15–16), 2004–2023. https://doi.org/10.1177/1077801219895115

Cowburn, M., Gill, A., & Harrison, K. (2015). Speaking about Sexual Abuse in British South Asian Communities: Offenders, Victims and the Challenges of Shame and Reintegration. *Journal of Sexual Aggression*, *21*(1), 4–15. https://doi.org/10.1080/13552600.2014.929188

Cradwick, E. (2020). *Shame Regulation Strategies used by Children and Adolescents: A Systematic Scoping and Narrative Review* [Master of Science in Psychology, University of Canterbury]. https://ir.canterbury.ac.nz/handle/10092/100885

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, *1989*(1), 31. https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf

Crozier, W. R. (1990). *Shyness and Embarrassment: Perspectives from Social Psychology*. Cambridge University Press.

Daniel, V., & Thangaraj, Y. (1995). Forms, Formations and Transformations of the Tamil Refugee. In *Mistrusting Refugees* (pp. 225–256). University of California Press.

Das, G. (2008). *Our cultures, Our Rights: Reconciling Human Rights and Cultural Practice*. Indo-Canadian Women's Association.

Dasgupta, A. (2003). Repatriation of Sri Lankan Refugees: Unfinished Tasks. *Economic and Political Weekly*, *38*(24), 2365–2367. https://www.jstor.org/stable/4413676

de Groot, M., Schaafsma, J., Castelain, T., Malinowska, K., Mann, L., Ohtsubo, Y., Wulandari, M. T. A., Bataineh, R. F., Fry, D. P., Goudbeek, M., & Suryani, A. (2021). Group-based shame, guilt, and regret across cultures. *European Journal of Social Psychology*, *51*(7), 1198–1212. https://doi.org/10.1002/ejsp.2808

de Hooge, I. E., Breugelmans, S. M., Wagemans, F. M. A., & Zeelenberg, M. (2018). The Social Side of Shame: Approach Versus Withdrawal. *Cognition and Emotion*, *32*(8), 1671–1677. https://doi.org/10.1080/02699931.2017.1422696

de Hooge, I. E., Zeelenberg, M., & Breugelmans, S. M. (2010). Restore and protect motivations following shame. *Cognition and Emotion*, *24*(1), 111–127. https://doi.org/10.1080/02699930802584466

de Hooge, I. E., Zeelenberg, M., & Breugelmans, S. M. (2011). A functionalist account of shame-induced behaviour. *Cognition and Emotion*, *25*(5), 939–946. https://doi.org/10.1080/02699931.2010.516909

Dearing, R. L., & Tangney, J. P. (2011a). *Shame in the Therapy Hour*. American Psychological Association.

Dearing, R. L., & Tangney, J. P. (Eds.). (2011b). Working with Shame in the Therapy Hour: Summary and Integration. In *Shame in the Therapy Hour* (pp. 375–404). American Psychological Association. https://doi.org/10.1037/12326-016

Department of Health. (2005). *Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services and the Government's Response to the Independent Inquiry into the Death of David Bennett*. Department of Health. https://documents.manchester.ac.uk/display.aspx?DocID=54691

Department of Health and Social Care. (2012). *Greater voice for patients – The Health and Social Care Act 2012*. Department of Health and Social Care. https://webarchive.nationalarchives.gov.uk/ukgwa/20121002234529/http://healthandcare.dh.gov.uk/factsheets/

Dey, I. (1999). *Grounding Grounded Theory*. Academic Press.

Dillon, R. S. (1997). Self-Respect: Moral, Emotional, Political. *Ethics*, *107*(2), 226–249. https://doi.org/10.1086/233719

Dion, K., & Dion, K. (2002). Gender and Cultural Adaptation in Immigrant Families. *Journal of Social Issues*, *57*, 511–521. https://doi.org/10.1111/0022-4537.00226

Dobash, R. E., & Dobash, R. (1979). *Violence Against Wives: A Case Against the Patriarchy*. Free Press.

Douglas, H., & Walsh, T. (2010). Mothers, Domestic Violence, and Child Protection. *Violence Against Women*, *16*(5), 489–508. https://doi.org/10.1177/1077801210365887

Dutton, D. G., van Ginkel, C., & Starzomski, A. (1995). The role of shame and guilt in the intergenerational transmission of abusiveness. *Violence and Victims*, *10*(2), 121–131.

EACH. (2012). *Asian Women, Domestic Violence and Mental Health- A Toolkit for Health Professionals*. Government Office for London. https://equation.org.uk/wp-content/uploads/2012/12/Asian-women-Domestic-Violence-and-Mental-Health.pdf

Edge, D., & Lemetyinen, H. (2019). Psychology Across Cultures: Challenges and Opportunities. *Psychology and Psychotherapy*, *92*(2), 261–276. https://doi.org/10.1111/papt.12229

Edwards, R. (2013). Power and Trust: An Academic Researcher's Perspective on Working with Interpreters as Gatekeepers. *International Journal of Social Research Methodology*, *16*(6), 503–514. https://doi.org/10.1080/13645579.2013.823276

Elison, J. (2005). Shame and Guilt: A Hundred Years of Apples and Oranges. *New Ideas in Psychology*, *23*(1), 5–32. https://doi.org/10.1016/j.newideapsych.2005.07.001

Elison, J., & Harter, S. (2007). Humiliation: Causes, Correlates, and Consequences. In *The Self-Conscious Emotions: Theory and Research* (pp. 310–329). Guilford Press.

Eller, J. D. (1999). *From Culture to Ethnicity to Conflict* (Third edition). University of Michigan Press.

Elshout, M., Nelissen, R. M. A., & van Beest, I. (2017). Conceptualising Humiliation. *Cognition and Emotion*, *31*(8), 1581–1594. https://doi.org/10.1080/02699931.2016.1249462

Elster, J. (1999). *Strong Feelings: Emotion, Addiction, and Human Behavior* (pp. xii, 252). The MIT Press.

Enander, V. (2010). “A Fool to Keep Staying”: Battered Women Labeling Themselves Stupid as an Expression of Gendered Shame. *Violence Against Women*, *16*(1), 5–31. https://doi.org/10.1177/1077801209353577

Fessler, D. (1999). Toward an understanding of the universality of second order emotions. In *Biocultural Approaches to the Emotions* (pp. 75–116). Cambridge University Press.

Flaskas, C., McCarthy, I., & Sheehan, J. (2007). *Hope and Despair in Narrative and Family Therapy.* Routledge.

Fontaine, J. R. J., Poortinga, Y. H., Setiadi, B., & Markam, S. S. (2002). Cognitive structure of emotion terms in Indonesia and The Netherlands. *Cognition & Emotion*, *16*(1), 61–86. https://doi.org/10.1080/02699933014000130

Foreign, Commonwealth & Development Office. (2021). *Human Rights and Democracy: 2020 Foreign, Commonwealth & Development Office report*. GOV.UK. https://www.gov.uk/government/publications/human-rights-and-democracy-report-2020/human-rights-and-democracy-2020-foreign-commonwealth-development-office-report

Freyd, J., & Birrell, P. (2013). *Blind to Betrayal: Why We Fool Ourselves We Aren’t Being Fooled*. Turner Publishing Company.

Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198237907.001.0001

Frijda, N. H., Kuipers, P., & ter Schure, E. (1989). Relations among emotion, appraisal, and emotional action readiness. *Journal of Personality and Social Psychology*, *57*(2), 212–228. https://doi.org/10.1037/0022-3514.57.2.212

Fujii, L. A. (2012). Research Ethics 101: Dilemmas and Responsibilities. *PS: Political Science & Politics*, *45*(4), 717–723. https://doi.org/10.1017/S1049096512000819

Fullagar, S. (2003). Wasted lives: The social dynamics of shame and youth suicide. *Journal of Sociology*, *39*(3), 291–307. https://doi.org/10.1177/0004869003035076

García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., Montoya, O., Bhate-Deosthali, P., Kilonzo, N., & Watts, C. (2014). Addressing Violence Against Women: A Call to Action. *The Lancet*, *385*(9978), 1685–1695. https://doi.org/10.1016/ S0140-6736(14)61830-4

Gardner, Z. (2021). *Evidence to the Human Rights Committee on the Nationality and Borders Bill*. Joint Council for the Welfare of Immigrants.

George, M. (2013). Sri Lankan Tamil refugee experiences: A qualitative analysis. *International Journal of Culture and Mental Health*, *6*(3), 170–182. https://doi.org/10.1080/17542863.2012.681669

George, M. S., & Rahangdale, L. (1999). Domestic violence and South Asian women. *North Carolina Medical Journal*, *60*(3), 157–159.

Germer, C. K., & Neff, K. D. (2015). Cultivating self-compassion in trauma survivors. In *Mindfulness-Oriented Interventions for Trauma: Integrating Contemplative Practices* (pp. 43–58). The Guilford Press.

Giddens, A. (1991). *Modernity and self-identity*. Polity Press.

Gilbert, P. (1989). *Human nature and suffering*. L. Erlbaum Associates.

Gilbert, P. (1993). Defence and safety: Their function in social behaviour and psychopathology. *British Journal of Clinical Psychology*, *32*(2), 131–153. https://doi.org/10.1111/j.2044-8260.1993.tb01039.x

Gilbert, P. (1998). What is shame? Some core issues and controversies. In *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 3–38). Oxford University Press.

Gilbert, P. (2002a). Body shame: A biopsychosocial conceptualisation and overview with treatment implications. In *Body Shame*. Routledge.

Gilbert, P. (2002b). Understanding the biopsychosocial approach II: Individual and social interventions. *Clinical Psychology*, *15*, 28–32.

Gilbert, P. (2011). Shame in psychotherapy and the role of compassion focused therapy. In *Shame in the Therapy Hour* (pp. 325–354). American Psychological Association. https://doi.org/10.1037/12326-014

Gilbert, P. (2019). Psychotherapy for the 21st century: An integrative, evolutionary, contextual, biopsychosocial approach. *Psychology and Psychotherapy: Theory, Research and Practice*, *92*(2), 164–189. https://doi.org/10.1111/papt.12226

Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C., & Sanghera, J. (2007). Cultural differences in shame-focused attitudes towards mental health problems in Asian and Non-Asian student women. *Mental Health, Religion & Culture*, *10*(2), 127–141. https://doi.org/10.1080/13694670500415124

Gilbert, P., Gilbert, J., & Sanghera, J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion & Culture*, *7*(2), 109–130. https://doi.org/10.1080/13674670310001602418

Gilbert, P., & McGuire, M. T. (1998). Shame, Status, and Social roles: Psychobiology and Evolution. In *Shame: Interpersonal Behavior, Psychopathology, and Culture* (pp. 99–125). Oxford University Press.

Gill, A. (2004). Voicing the Silent Fear: South Asian Women's Experiences of Domestic Violence. *The Howard Journal of Criminal Justice*, *43*(5), 465–483. https://doi.org/10.1111/j.1468-2311.2004.00343.x

Gill, A., & Brah, A. (2014). Interrogating cultural narratives about 'honour'-based violence. *European Journal of Women's Studies*, *21*(1), 72–86. https://doi.org/10.1177/1350506813510424

Goddard, V. A. (1987). Honour and Shame: The Control of Women's Sexuality and Group Identity in Naples. In *The Cultural Construction of Sexuality*. Tavistock Publications.

Goffman, E. (1990). *Stigma: Notes on the Management of Spoiled Identity*. Penguin.

Gómez, J. M. (2019). What's the harm? Internalized prejudice and cultural betrayal trauma in ethnic minorities. *American Journal of Orthopsychiatry*, *89*(2), 237–247. https://doi.org/10.1037/ort0000367

González-López, G. (2011). Mindful Ethics: Comments on Informant-Centered Practices in Sociological Research. *Qualitative Sociology*, *34*(3), 447. https://doi.org/10.1007/s11133-011-9199-8

Goode, W. J. (1971). Force and violence in the family. *Journal of Marriage and Family*, *33*, 624–636. https://www.jstor.org/stable/349435?seq=1

Goodhand, J. (2000). Research in Conflict Zones: Ethics and Accountability. *Forced Migration Review*.

https://www.academia.edu/53636021/Research_in_conflict_zones_ethics_and_accountability

Gorman, W. (2001). Refugee Survivors of Torture: Trauma and Treatment. *Professional Psychology: Research and Practice, 32*(5), 443–451. https://doi.org/10.1037/0735-7028.32.5.443

Greenberg, L. S., & Iwakabe, S. (2011). Emotion-focused therapy and shame. In *Shame in the Therapy Hour* (pp. 69–90). American Psychological Association. https://doi.org/10.1037/12326-003

Greenwald, D. F., & Harder, D. W. (1998). Domains of shame: Evolutionary, cultural, and psychotherapeutic aspects. In *Shame: Interpersonal Behavior, Psychopathology, and Culture* (pp. 225–245). Oxford University Press.

Griffin, M. G., Resick, P. A., Waldrop, A. E., & Mechanic, M. B. (2003). Participation in trauma research: Is there evidence of harm? *Journal of Traumatic Stress*, *16*(3), 221–227. https://doi.org/10.1023/A:1023735821900

Grønseth, A. S. (2007). Tamils' Quest for Well-Being: Moving as a Success or Failure? *Anthropology in Action*, *14*(1 & 2), 28–40. https://doi.org/doi:10.3167/aia.2007.14010204

Gruenewald, T. L., Kemeny, M. E., Aziz, N., & Fahey, J. L. (2004). Acute Threat to the Social Self: Shame, Social Self-Esteem, and Cortisol Activity. *Psychosomatic Medicine*, *66*(6), 915–924. https://doi.org/10.1097/01.psy.0000143639.61693.ef

Gupta, J., Acevedo-Garcia, D., Hemenway, D., Decker, M. R., Raj, A., & Silverman, J. G. (2009). Premigration exposure to political violence and perpetration of intimate partner violence among immigrant men in Boston. *American Journal of Public Health*, *99*(3). https://doi.org/10.2105/AJPH.2007.120634

Gupte, M. (2013). The Concept of Honour: Caste Ideology and Patriarchy in Rural Maharashtra. *Economic and Political Weekly*, *48*(18), 72–81. https://www.jstor.org/stable/23527311

Guruge, S. (2010). Perceptions of intimate male partner violence and determinants of women's response to it: Findings from a study in the Sri Lankan Tamil community in Toronto. In *Out of the Shadows: Women*

Abuse in Ethnic, Immigrant, and Aboriginal Communities (pp. 264–283). Women's Press.

Guruge, S., Ford-Gilboe, M., Varcoe, C., Jayasuriya-Illesinghe, V., Ganesan, M., Sivayogan, S., Kanthasamy, P., Shanmugalingam, P., & Vithanarachchi, H. (2017). Intimate Partner Violence in the Post-War Context: Women's Experiences and Community Leaders' Perceptions in the Eastern Province of Sri Lanka. *PLOS ONE*, *12*(3), e0174801. https://doi.org/10.1371/journal.pone.0174801

Guruge, S., & Humphreys, J. (2009). Barriers Affecting Access to and Use of Formal Social Supports Among Abused Immigrant Women. *The Canadian Journal of Nursing Research*, *41*(3), 64–84.

Guruge, S., Khanlou, N., & Gastaldo, D. (2010). Intimate Male Partner Violence in the Migration Process: Intersections of Gender, Race and Class. *Journal of Advanced Nursing*, *66*(1), 103–113. https://doi.org/10.1111/j.1365-2648.2009.05184.x

Guruge, S., Roche, B., & Catallo, C. (2012). Violence against Women: An Exploration of the Physical and Mental Health Trends among Immigrant and Refugee Women in Canada. *Nursing Research and Practice*, *2012*, 1–15. https://doi.org/10.1155/2012/434592

Haddad, Y. Y., Smith, J. I., & Moore, K. M. (2006). *Muslim women in America*. University Press.

Hammersley, M. (1997). Qualitative Data Archiving: Some Reflections on its Prospects and Problems. *Sociology*, *31*(1), 131–142. https://doi.org/10.1177/0038038597031001010

Harris, L. M., Boggiano, V., Nguyen, D. T., & Pham, L. H. L. (2013). Working in Partnership With Interpreters: Studies on Individuals Affected by HIV/AIDS in Vietnam. *Qualitative Health Research*, *23*(10), 1408–1418. https://doi.org/10.1177/1049732313506964

Hastings, M. E., Northman, L. M., & Tangney, J. P. (2002). Shame, guilt, and suicide. In *Suicide science: Expanding the boundaries*. Springer.

Hazard, P. (1969). Freud's Teaching on Shame. *Laval Théologique et Philosophique*, *25*(2), 234–267. https://doi.org/10.7202/1020145ar

Hendin, H. (1991). Psychodynamics of suicide, with particular reference to the young. *The American Journal of Psychiatry*, *148*(9), 1150–1158. https://doi.org/10.1176/ajp.148.9.1150

Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, *83*(1), 97–111. https://doi.org/10.1111/j.2044-8295.1992.tb02426.x

Herman, J. L. (1992). *Trauma and Recovery*. Basic Books.

Herman, J. L. (2005). Justice from the victim's perspective. *Violence Against Women*, *11*(5), 571–602. https://doi.org/10.1177/1077801205274450

Herman, J. L. (2011). Posttraumatic stress disorder as a shame disorder. In *Shame in the Therapy Hour* (pp. 261–275). American Psychological Association. https://doi.org/10.1037/12326-011

Heron, R. L., Eisma, M. C., & Browne, K. (2022). Barriers and Facilitators of Disclosing Domestic Violence to the UK Health Service. *Journal of Family Violence*, *37*(3), 533–543. https://doi.org/10.1007/s10896-020-00236-3

Hicks, D. (2011). *Dignity: The Essential Role It Plays in Resolving Conflict*. Yale University Press.

Hirsch, S. (2019). Racism, 'second generation' refugees and the asylum system. *Identities*, *26*(1), 88–106. https://doi.org/10.1080/1070289X.2017.1361263

Holland, S. (1992). From social abuse to social action: A neighborhood psychotherapy and social action project for women. In *Gender Issues in Clinical Psychology*. Routledge.

Home Affairs Committee. (2022). *Investigation and prosecution of rape* (Eighth Report of Session 2021–22). House of Commons Committee. https://publications.parliament.uk/pa/cm5802/cmselect/cmhaff/193/report.html#heading-3

Home Office. (2014, May 22). *Immigration statistics, January to March 2014* [National Statistics]. GOV.UK. https://www.gov.uk/government/statistics/immigration-statistics-january-to-march-2014/immigration-statistics-january-to-march-2014

Home Office. (2020). *Migrant Victims of Domestic Abuse Review Findings*. HMSO. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/897472/Migrant_Victims_of_Domestic_Abuse_-_Review_Findings_v.3._FINAL.pdf

Hondagneu-Sotelo, P. (1992). Overcoming Patriarchal Constraints: The Reconstruction of Gender Relations Among Mexican Immigrant Women and Men. *Gender & Society*, *6*(3), 393–415. https://doi.org/10.1177/089124392006003004

Domestic Abuse Act 2021, UK Parliament (2021) (testimony of House of Commons). https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

Hugman, R. (2005). *New Approaches in Ethics for the Caring Professions*. Palgrave Macmillan.

Huisman, K. (1996). Wife Battering in Asian American Communities: Identifying the Service Needs of an Overlooked Segment of the U.S. Population. *Violence Against Women*, *2*(3), 260–283. https://doi.org/10.1177/1077801296002003003

Humphreys, C. (2010). Crossing the Great Divide: Response to Douglas and Walsh. *Violence Against Women*, *16*(5), 509–515. https://doi.org/10.1177/1077801210366288

Hunter, C. (2020). *Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality* [Professional Doctorate in Clinical Psychology, University of East London]. https://doi.org/10.15123/uel.88830

Hydén, M. (2005). *'I Must Have Been an Idiot to Let it Go On': Agency and Positioning in Battered Women's Narratives of Leaving*. https://doi.org/10.1177/0959353505051725

Hyman, I., & Mason, R. (2006). Perceptions of and Response to Woman Abuse Among Tamil Women in Toronto. *Canadian Woman Studies*, *25*(1). https://cws.journals.yorku.ca/index.php/cws/article/view/5972

Hyman, I., Mason, R., Guruge, S., Berman, H., Kanagaratnam, P., & Manuel, L. (2011). Perceptions of Factors Contributing to Intimate Partner Violence Among Sri Lankan Tamil Immigrant Women in Canada. *Health Care for Women International*, *32*(9), 779–794. https://doi.org/10.1080/07399332.2011.569220

Ilkkaracan, P. (2002). Women, Sexuality, and Social Change in the Middle East and the Maghreb. *Social Research*, *69*(3), 753–779. https://doi.org/10.32380/alrj.v0i0.456

Inman, A. G., Ladany, N., Constantine, M. G., & Morano, C. K. (2001). Development and Preliminary Validation of the Cultural Values Conflict Scale for South Asian women. *Journal of Counseling Psychology*, *48*(1), 17–27. https://doi.org/10.1037/0022-0167.48.1.17

International Crisis Group. (2010). *War Crimes in Sri Lanka* (Asia Report No. 191). International Crisis Group. https://www.crisisgroup.org/asia/south-asia/sri-lanka/war-crimes-sri-lanka

International Crisis Group. (2011). *Sri Lanka: Women's Insecurity in the North and East* (Asia Report No. 217). International Crisis Group. https://www.crisisgroup.org/asia/south-asia/sri-lanka/sri-lanka-women-s-insecurity-north-and-east

International Crisis Group. (2012). *Sri Lanka's North I: The Denial of Minority Rights* (Asia Report No. 219). International Crisis Group. https://www.crisisgroup.org/asia/south-asia/sri-lanka/sri-lanka-s-north-i-denial-minority-rights

IOM. (2019). *World Migration Report 2020*. International Organization for Migration.

Jaggar, A. M. (1989). Love and Knowledge: Emotion in Feminist Epistemology. *Inquiry*, *32*(2), 151–176. https://doi.org/10.1080/00201748908602185

James, K. (2010). Domestic Violence Within Refugee Families: Intersecting Patriarchal Culture and the Refugee Experience. *Australian and New Zealand Journal of Family Therapy*, *31*(3), 275–284. https://doi.org/10.1375/anft.31.3.275

Janoff-Bulman, R. (1979). Characterological Versus Behavioral Self-Blame: Inquiries into Depression and Rape. *Journal of Personality and Social Psychology*, *37*(10), 1798–1809. https://doi.org/10.1037//0022-3514.37.10.1798

Jeremiah, R. D., Gamache, P. E., & Hegamin-Younger, C. (2013). Beyond Behavioral Adjustments: How Determinants of Contemporary Caribbean Masculinities Thwart Efforts to Eliminate Domestic Violence. *International Journal of Men's Health*, *12*(3), 228–244. https://doi.org/10.3149/JMH.1203.228

John, N., Casey, S. E., Carino, G., & McGovern, T. (2020). Lessons Never Learned: Crisis and gender-Based Violence. *Developing World Bioethics*, *20*(2), 65–68. https://doi.org/10.1111/dewb.12261

Jones, D. (2016). Being Tamil, being Hindu: Tamil migrants' negotiations of the absence of Tamil Hindu spaces in the West Midlands and South West of England. *Religion*, *46*(1), 53–74. https://doi.org/10.1080/0048721X.2015.1027968

Jones, L., Hughes, M., & Unterstaller, U. (2001). Post-Traumatic Stress Disorder (PTSD) in Victims of Domestic Violence: A Review of the Research. *Trauma, Violence, & Abuse*, *2*(2), 99–119. https://doi.org/10.1177/1524838001002002001

Kallivayalil, D. (2007). Feminist Therapy: Its Use and Implications for South Asian Immigrant Survivors of Domestic Violence. *Women & Therapy*, *30*(3–4), 109–127. https://doi.org/10.1300/J015v30n03_09

Kanagaratnam, P., Mason, R., Hyman, I., Manuel, L., Berman, H., & Toner, B. (2012). Burden of Womanhood: Tamil Women's Perceptions of Coping with Intimate Partner Violence. *Journal of Family Violence*, *27*(7), 647–658. https://doi.org/10.1007/s10896-012-9461-1

Kanagaratnam, P., Rummens, J. A., & Toner, B. (2020). "We Are All Alive . . . But Dead": Cultural Meanings of War Trauma in the Tamil Diaspora and Implications for Service Delivery. *SAGE Open*, *10*(4). https://doi.org/10.1177/2158244020963563

Kandiyoti, D. (1988). Bargaining with Patriarchy. *Gender and Society*, *2*(3), 274–290. https://doi.org/10.1177/089124388002003004

Kanigel, R. (2019). Diversity Style Guide. Wiley-Blackwel.

Kapadia, D., Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarroel-Williams, N., Bécares, L., & Esmail, A. (2022). *Ethnic Inequalities in Healthcare: A Rapid Evidence Review*. NHS Race & Health Observatory. https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_Summary_v.4.pdf

Karlsson, G., & Sjöberg, L. G. (2009). The Experiences of Guilt and Shame: A Phenomenological–Psychological Study. *Human Studies*, *32*(335). https://doi.org/10.1007/s10746-009-9123-3

Kaufman, G. (1985). *Shame: The Power of Caring*. Schenkman Books.

Kaufman, G. (1989). *The Psychology of Shame: Theory and Treatment of Shame-Based Syndromes*. Springer.

Kelly, L. (1988). *Surviving Sexual Violence*. Polity Press.

Keltner, D., & Buswell, B. N. (1996). Evidence for the Distinctness of Embarrassment, Shame, and Guilt: A Study of Recalled Antecedents and Facial Expressions of Emotion. *Cognition & Emotion*, *10*(2), 155–171. https://doi.org/10.1080/026999396380312

Keltner, D., & Harker, L. (1998). The forms and functions of the nonverbal signal of shame. In *Shame: Interpersonal Behavior, Psychopathology, and Culture* (pp. 78–98). Oxford University Press.

Klein, D. C. (1991). The Humiliation Dynamic: An Overview. *The Journal of Primary Prevention*, *12*(2), 93–121. https://doi.org/10.1007/BF02015214

Kurri, K., & Wahlström, J. (2001). Dialogical management of morality in domestic violence counselling. *Feminism & Psychology*, *11*(2), 187–208. https://doi.org/10.1177/0959353501011002009

Larkin, P. J., Dierckx de Casterlé, B., & Schotsmans, P. (2007). Multilingual Translation Issues in Qualitative Research: Reflections on a Metaphorical Process. *Qualitative Health Research*, *17*(4), 468–476. https://doi.org/10.1177/1049732307299258

Lasch, C. (1991). *The Culture of Narcissism*. W. W. Norton.

Lee, D. A., Scragg, P., & Turner, S. (2001). The Role of Shame and Guilt in Traumatic Events: A Clinical Model of Shame-Based and Guilt-Based PTSD. *British Journal of Medical Psychology*, *74*(4), 451. https://doi.org/10.1348/000711201161109

Lehtinen, U. (1998). *Underdog Shame: Philosophical Essays on Women's Internalization of Inferiority.* Göteborg University.

Lester, D. (1997). The role of shame in suicide. *Suicide & Life-Threatening Behavior*, *27*(4), 352–361. https://doi.org/10.1111/j.1943-278X.1997.tb00514.x

Lewis, H. (1971). Shame and guilt in neurosis. *Psychoanalytic Review*, *58*(3), 419–438.

Lewis, M. (1992). *Shame: The Exposed Self*. Free Press.

Lewis, M. (1993). Self-Conscious Emotions: Embarrassment, Pride, Shame, and Guilt. In *Handbook of Emotions* (pp. 742–756). The Guilford Press.

Lim, I.-S. (1997). Korean Immigrant Women's Challenge to Gender Inequality at Home: The Interplay of Economic Resources, Gender and Family. *Gender & Society*, *11*, 31–51.

Lindquist, J. (2004). Veils and Ecstasy: Negotiating Shame in the Indonesian Borderlands. *Ethnos*, *69*(4), 487–508. https://doi.org/10.1080/0014184042000302317

Lloyd, M., Ramon, S., Vakalopoulou, A., Videmšek, P., Meffan, C., Roszczynska-Michta, J., & Rollè, L. (2017). Women's Experiences of Domestic Violence and Mental Health: Findings from a European Empowerment Project. *Psychology of Violence*, *7*(3), 478–487. https://doi.org/10.1037/vio0000111

Loewenthal, D., Mohamed, A., Mukhopadhyay, S., Ganesh, K., & Thomas, R. (2012). Reducing the Barriers to Accessing Psychological Therapies for Bengali, Urdu, Tamil and Somali communities in the UK: Some Implications for Training, Policy and Practice. *British Journal of Guidance & Counselling*, *40*(1), 43–66. https://doi.org/10.1080/03069885.2011.621519

MacKinnon, C. A. (1983). Feminism, Marxism, Method, and the State: Toward Feminist Jurisprudence. *Signs: Journal of Women in Culture and Society*, *8*(4), 635–658. https://doi.org/0097-9740/83/0804-0003$01.00

MacLeod, L., & Shin, M. Y. (1990). *Isolated, Alone, Forgotten: The Service Delivery Needs and Realities of Immigrant and Refugee Women who are Battered*. National Clearinghouse on Family Violence, Health and Welfare Canada.

Madhivanan, A., & Dongre, A. R. (2021). How to reduce Domestic Violence against married women? A mixed methods study from rural Tamil Nadu. *Journal of Injury & Violence Research*, *14*(1). https://doi.org/10.5249/jivr.v14i1.1602

Mahan, R. (2013). *PLACING THE PAST IN THE PRESENT TAMIL ORAL HISTORY IN LONDON*. Race on the Agenda (ROTA). https://www.rota.org.uk/content/rota-january-2013-placing-past-present-tamil-oral-history-london

Mahmood, A. (2019). *Surviving Thoughts of Suicide: Experiences of Having Suicidal Ideation and Not Acting Upon Them* [University of East London]. https://repository.uel.ac.uk/download/5c3c0be8512bd7fd27cacfe8423a5da9c7d7f420c5f8a3b0fcd039f9e4ee69bd/1580590/2019_DCP_Mahmood.pdf

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mangar, R. (2011). *Samvedna Shakti: An Empowerment Program for South Asian Immigrant Women Survivors of Domestic Violence*. Chicago School of Professional Psychology.

Mannell, J., Grewal, G., Ahmad, L., & Ahmad, A. (2021). A Qualitative Study of Women's Lived Experiences of Conflict and Domestic Violence in Afghanistan. *Violence Against Women*, *27*(11), 1862–1878. https://doi.org/10.1177/1077801220935191

Marmot, M. (2015). The Health Gap: The Challenge of An Unequal World. *The Lancet*, *386*(10011), 2442–2444. https://doi.org/10.1016/S0140-6736(15)00150-6

Mason, G., & Pulvirenti, M. (2013). Former Refugees and Community Resilience: 'Papering Over' Domestic Violence. *The British Journal of Criminology*, *53*(3), 401–418. https://doi.org/10.1093/bjc/azs077

Mason, R., Hyman, I., Berman, H., Guruge, S., Kanagaratnam, P., & Manuel, L. (2008). "Violence Is an International Language": Tamil Women's Perceptions of Intimate Partner Violence. *Violence Against Women*, *14*(12), 1397–1412. https://doi.org/10.1177/1077801208325096

Mays, N., & Pope, C. (2000). Assessing Quality in Qualitative Research. *BMJ*, *320*(7226), 50–52. https://doi.org/10.1136/bmj.320.7226.50

McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Salvatory, A., & Steven, E. (2016). Stigma, shame and women's limited agency in help-seeking for intimate partner violence. *Global Public Health*, *11*(1–2), 224–235. https://doi.org/10.1080/17441692.2015.1047391

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: Young LGBT people, homophobia and self-destructive behaviours. *Culture, Health & Sexuality*, *10*(8), 815–829. https://doi.org/10.1080/13691050802380974

McGrath, L., Griffin, V., & Mundy, E. (2016). The Psychological Impact of Austerity: A Briefing Paper. *EDUCATIONAL PSYCHOLOGY RESEARCH AND PRACTICE*, *2*(2), 46–57. https://doi.org/10.15123/uel.885xw

Meetoo, V., & Mirza, H. S. (2010). “There is nothing ‘honourable’ about honour killings”: Gender, Violence and the Limits of Multiculturalism. In *Honour, Violence, Women and Islam*. Routledge-Cavendish.

Mehta, M., & Gopalakrishnan, C. (2007). ‘We Can’: Transforming power in relationships in South Asia. *Gender & Development*, *15*(1), 41–49. https://doi.org/10.1080/13552070601178906

Menon, U., & Shweder, R. A. (1994). Kali’s Tongue: Cultural Psychology and the Power of Shame in Orissa, India. In *Emotion and culture: Empirical studies of mutual influence* (pp. 241–282). American Psychological Association. https://doi.org/10.1037/10152-007

Mesquita, B. (2001). Emotions in collectivist and individualist contexts. *Journal of Personality and Social Psychology*, *80*(1), 68–74. https://doi.org/10.1037/0022-3514.80.1.68

Michael, V. M. (2021). Caught In-Between: Diversifying Tamil Women’s Voices From the Sri Lankan Civil War. *Cultural Studies ↔ Critical Methodologies*, 1–9. https://doi.org/10.1177/15327086211050334

Michau, L. (2007). Approaching Old Problems in New Ways: Community Mobilisation as a Primary Prevention Strategy to Combat Violence Against Women. *Gender & Development*, *15*(1). https://doi.org/10.1080/13552070601179144

Migrant & Refugee Women’s Health Partnership. (2019). *Culturally Responsive Clinical Practice: Working with People from Migrant and Refugee Backgrounds*. Migrant & Refugee Women’s Health Partnership. https://culturaldiversityhealth.org.au/wp-content/uploads/2019/02/Culturally-responsive-clinical-practice-Working-with-people-from-migrant-and-refugee-backgrounds-Jan2019.pdf

Mills, C. (2018). ‘Dead people don’t claim’: A Psychopolitical Autopsy of UK Austerity Suicides. *Critical Social Policy*, *38*(2). https://doi.org/10.1177/0261018317726263

Mills, R. (2005). Taking stock of the developmental literature on shame. *Developmental Review*, *25*(1). https://doi.org/10.1016/j.dr.2004.08.001

Ministry of Justice. (2021). *Code of Practice for Victims of Crime in England and Wales*. HMSO. https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime/code-of-practice-for-victims-of-crime-in-england-and-wales-victims-code

Minority Rights Group International. (2013). *Living with insecurity: Marginalization and sexual violence against women in north and east Sri Lanka*. Minority Rights Group International.

Montgomery, E. (2004). Tortured Families: A Coordinated Management of Meaning Analysis. *Family Process*, *43*(3), 349–371. https://doi.org/10.1111/j.1545-5300.2004.00027.x

Morash, M., Bui, H. N., & Santiago, A. M. (2000). Cultural-Specific Gender Ideology and Wife Abuse in Mexican-Descent Families. *International Review of Victimology*, *7*(1–3), 67–91. https://doi.org/10.1177/026975800000700305

Morrison, A. (2011). The psychodynamics of shame. In *Shame in the Therapy Hour* (pp. 23–43). American Psychological Association. https://doi.org/10.1037/12326-001

Morrison, K., Luchok, K. J., Richter, D. L., & Parra-Medina, D. (2006). Factors Influencing Help-Seeking From Informal Networks Among African American Victims of Intimate Partner Violence. *Journal of Interpersonal Violence*, *21*(11), 1493–1511. https://doi.org/10.1177/0886260506293484

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods*, *1*(2), 13–22. https://doi.org/10.1177/160940690200100202

Moulding, N. T., Buchanan, F., & Wendt, S. (2015). Untangling Self-Blame and Mother-Blame in Women's and Children's Perspectives on Maternal Protectiveness in Domestic Violence: Implications for Practice. *Child Abuse Review*, *24*(4), 249–260. https://doi.org/10.1002/car.2389

Munt, S. R. (2000). Shame/pride dichotomies in Queer As Folk. *Textual Practice*, *14*(3), 531–546. https://doi.org/10.1080/095023600750040694

Narayan, U. (1995). 'Male-Order' Brides: Immigrant Women, Domestic Violence and Immigration Law. *Hypatia*, *10*(1), 104–119. https://www.jstor.org/stable/3810460

Nathanson, D. L. (1987). *The Many Faces of Shame*. Guilford Press.

National Institute for Health Research. (2015). *Patient and Public Involvement in Health and Social Care Research: A Handbook for Researchers*.

National Institute for Health Research. https://www.rds-yh.nihr.ac.uk/wp-content/uploads/2015/01/RDS_PPI-Handbook_2014-v8-FINAL-11.pdf

National Institute of Health and Care Excellence. (2016). *Domestic violence and abuse: How health services, social care and the organisations they work with can respond effectively*. National Institute of Health and Care Excellence. https://www.nice.org.uk/guidance/ph50

Neckel, S. (1991). *Status und Scham. Zur symbolischen Reproduktion sozialer Ungleichheit [Status and shame. On symbolic reproduction of social inequality]*. Campus.

NHS. (2020). *Advancing mental health equalities strategy*. NHS. https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

NICE. (2014). *Domestic violence and abuse: Multi-agency working*. NICE guideline. https://www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-pdf-1996411687621

NICE. (2016). *Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities*. NICE guideline. https://www.nice.org.uk/guidance/ng44

Niedenthal, P. M., Tangney, J. P., & Gavanski, I. (1994). 'If only I weren't' versus 'If only I hadn't': Distinguishing Shame and Guilt in Conterfactual Thinking. *Journal of Personality and Social Psychology*, *67*(4), 585–595. https://doi.org/10.1037/0022-3514.67.4.585

Oakley, A. (1981). Interviewing women: A contradiction in terms. In *Doing Feminist Research* (pp. 30–61). Routledge and Kegan Paul.

Office for National Statistics. (2020a). *Domestic abuse prevalence and trends, England and Wales: Year ending March 2020*. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2020

Office for National Statistics. (2020b). *Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales: November 2020*. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/

articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020

Office for National Statistics. (2020c). *Domestic abuse in England and Wales overview: November 2020*. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020

Pachankis, J. E., & Goldfried, M. R. (2010). Expressive writing for gay-related stress: Psychosocial benefits and mechanisms underlying improvement. *Journal of Consulting and Clinical Psychology*, *78*(1), 98–110. https://doi.org/10.1037/a0017580

Pandalangat, N. (2011). *Cultural Influences on Help-Seeking, Treatment and Support for Mental Health Problems A Comparative Study using a Gender Perspective* [Doctor of Philosophy, University of Toronto]. https://tspace.library.utoronto.ca/bitstream/1807/31890/3/Pandalangat_Nalini_201111_PhD_thesis.pdf

Pandalangat, N., & Kanagaratnam, P. (2021). Refugee Mental Health Framework: A Systematic Tool and Approach That Optimizes Outcomes. *Asian American Journal of Psychology*, *12*(3), 241–249. https://doi.org/10.1037/aap0000194

Patel, N. (2011). The psychologisation of torture. In *De-Medicalising Misery: Psychiatry, Psychology and the Human Condition*. Palgrave Macmillan.

Pease, B., & Rees, S. (2008). Theorising Men's Violence Against Women in Refugee Families: Towards an Intersectional Feminist Framework. *Insight (Melbourne)*, *47*, 39–45. http://ecite.utas.edu.au/103878

Peebles, P. (1990). Colonization and Ethnic Conflict in the Dry Zone of Sri Lanka. *The Journal of Asian Studies*, *49*(1), 30–55. https://doi.org/10.2307/2058432

Pence, E., & Paymar, M. (1993). *Education Groups for Men Who Batter: The Duluth Model*. Springer Publishing Company.

Petrie, C., UN Internal Review Panel on United Nations Action in Sri Lanka, & UN Secretary-General. (2012). *Report of the Secretary-General's Internal Review Panel on United Nations Action in Sri Lanka*. United Nations. https://digitallibrary.un.org/record/737299

Pilgrim, D., & Bentall, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*, *8*(3), 261–274. https://doi.org/10.1080/09638239917427

Pinnewala, P. (2009). Good Women, Martyrs, and Survivors: A Theoretical Framework for South Asian Women's Responses to Partner Violence. *Violence Against Women*, *15*(1), 81–105. https://doi.org/10.1177/1077801208328005

Pittaway, E., Bartolomei, L., & Hugman, R. (2010). 'Stop Stealing Our Stories': The Ethics of Research with Vulnerable Groups. *Journal of Human Rights Practice*, *2*(2), 229–251. https://doi.org/10.1093/jhuman/huq004

Rai, A., & Choi, Y. J. (2018). Socio-cultural risk factors impacting domestic violence among South Asian immigrant women: A scoping review. *Aggression and Violent Behavior*, *38*, 76–85. https://doi.org/10.1016/j.avb.2017.12.001

Raj, A., & Silverman, J. (2002). Violence against immigrant women: The roles of culture, context, and legal immigrant status on intimate partner violence. *Violence Against Women*, *8*(3), 367–398. https://doi.org/10.1177/10778010222183107

Raphael, D. (2009). *Social determinants of health: Canadian perspectives*. Canadian Scholar's Press.

Reavey, P., Ahmed, B., & Majumdar, A. (2006). 'How can we help when she won't tell us what's wrong?' Professionals working with South Asian women who have experienced sexual abuse. *Journal of Community & Applied Social Psychology*, *16*(3), 171–188. https://doi.org/10.1002/casp.856

Renoux, M., & Wade, A. (2008). Resistance to Violence: A Key Symptom of Chronic Mental Wellness. *Context*, *98*, 2–4.

Retzinger, S. (1998). Shame in the therapeutic relationship. In *Body Shame: Conceptualisation, Research and Treatment* (pp. 206–222). Oxford University Press.

Rodríguez, M., Valentine, J. M., Son, J. B., & Muhammad, M. (2009). Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. *Trauma, Violence & Abuse*, *10*(4), 358–374. https://doi.org/10.1177/1524838009339756

Romito, P., & Volpato, C. (2005). Women Inside and Outside Academia: A Struggle to Access Knowledge, Legitimacy and Influence. *Social Science Information*, *44*, 41–63.

Roseman, I. J. (1984). Cognitive Determinants of Emotion: A Structural Theory. *Review of Personality & Social Psychology*, *5*, 11–36.

ROTA. (2014). *Mapping the Mental Health Support Needs of Tamil People in West London*. ROTA. https://www.rota.org.uk/content/mapping-exercise

Rotberg, R. I. (1999). *Creating Peace in Sri Lanka: Civil War and Reconciliation*. World Peace Foundation and Belfer Center for Science and International Affairs.

Rothbart, D. (2018). *Systemic Humiliation in America: Finding Dignity within Systems of Degradation*. Palgrave Macmillan.

Rubin, H. J., & Rubin, I. S. (2005). *Qualitative Interviewing: The Art of Hearing Data* (2nd ed.). Sage.

Sabri, B., Hartley, M., Saha, J., Murray, S., Glass, N., & Campbell, J. (2020). Effect of COVID-19 Pandemic on Women's Health and Safety: A Study of Immigrant Survivors of Intimate Partner Violence. *Health Care for Women International*, *41*(11–12), 1294–1312. https://doi.org/10.1080/07399332.2020.1833012

Sabri, B., Simonet, M., & Campbell, J. (2018). Risk and Protective Factors of Intimate Partner Violence Among South Asian Immigrant Women and Perceived Need for Services. *Cultural Diversity and Ethnic Minority Psychology*, *24*. https://doi.org/10.1037/cdp0000189

Said, M. (2014). Suicide and Shame in Southern Sri Lanka: Networks of Dependency. *South Asia Research*, *34*(1), 19–30. https://doi.org/10.1177/0262728013517027

Salter, M., & Hall, H. (2020). Reducing Shame, Promoting Dignity: A Model for the Primary Prevention of Complex Post-Traumatic Stress Disorder. *Trauma, Violence, & Abuse*. https://doi.org/10.1177/1524838020979667

Sandelowski, M., & Leeman, J. (2012). Writing Usable Qualitative Health Research Findings. *Qualitative Health Research*, *22*(10), 1404–1413. https://doi.org/10.1177/1049732312450368

Santos, H. P. O., Black, A. M., & Sandelowski, M. (2015). Timing of translation in cross-language qualitative research. *Qualitative Health Research*, *25*(1), 134–144. https://doi.org/10.1177/1049732314549603

Scherer, K. R. (1997). The role of culture in emotion-antecedent appraisal. *Journal of Personality and Social Psychology*, *73*(5), 902–922. https://doi.org/10.1037/0022-3514.73.5.902

Scherer, K. R., & Wallbott, H. G. (1994). Evidence for universality and cultural variation of differential emotion response patterning. *Journal of Personality and Social Psychology*, *66*(2), 310–328. https://doi.org/10.1037/0022-3514.66.2.310

Schore, A. N. (2019). *Right Brain Psychotherapy*. W. W. Norton & Company.

Schulz, P. (2021). Recognizing research participants' fluid positionalities in (post-)conflict zones. *Qualitative Research*, *21*(4), 550–567. https://doi.org/10.1177/1468794120904882

Sen, A. (1983). Poor, Relatively Speaking. *Oxford Economic Papers, 35*(2), 153–169. https://are.berkeley.edu/courses/ARE251/fall2008/Papers/sen83.pdf

Shankar, J., Das, G., & Atwal, S. (2013). Challenging Cultural Discourses and Beliefs that Perpetuate Domestic Violence in South Asian Communities: A Discourse Analysis. *Journal of International Women's Studies*, *14*(1), 248–262. https://vc.bridgew.edu/jiws/vol14/iss1/15

Sheldon, K., & Harding, E. (2010). *Good Practice Guidelines to Support the Involvement of Service Users and Carers in Clinical Psychology Services*. British Psychological Society. https://consaludmental.org/publicaciones/Goodpracticeinvolvementserviceuserscarersclinicalpsychologyservices.pdf

Shirwadkar, S. (2004). *Canadian Domestic Violence Policy and Indian Immigrant Women*. *10*(8), 860–879. https://doi.org/10.1177/1077801204266310

Showalter, E. (1987). *The Female Malady: Women, Madness and English Culture 1830-1980*. Virago Press.

Shweder, R. A. (2003). Toward a Deep Cultural Psychology of Shame. *Social Research*, *70*(4), 1109–1130. https://doi.org/10.1353/sor.2003.0035

Silove, D., Steel, Z., McGorry, P., Miles, V., & Drobny, J. (2002). The impact of torture on post-traumatic stress symptoms in war-affected Tamil refugees and immigrants. *Comprehensive Psychiatry*, *43*(1), 49–55. https://doi.org/10.1053/comp.2002.29843

Silva, T., Agampodi, T., Evans, M., Knipe, D., Rathnayake, A., & Rajapakse, T. (2022). Barriers to help-seeking from healthcare professionals amongst women who experience domestic violence—A qualitative study in Sri Lanka. *BMC Public Health*, *22*(1), 721. https://doi.org/10.1186/s12889-022-13116-w

Singh, A. A. (2009). Helping South Asian Immigrant Women use Resilience Strategies in Healing From Sexual Abuse: A call for a Culturally Relevant Model. *Women & Therapy*, *32*(4), 361–376. https://doi.org/10.1080/02703140903153229

Singh, A. A., & Hays, D. G. (2008). Feminist group counseling with South Asian women who have survived intimate partner violence. *Journal for Specialists in Group Work*, *33*(1), 84–102. https://doi.org/10.1080/01933920701798588

Smith, C. A., & Ellsworth, P. C. (1985). Patterns of cognitive appraisal in emotion. *Journal of Personality and Social Psychology*, *48*(4), 813–838. https://doi.org/10.1037/0022-3514.48.4.813

Smith, C. P., & Freyd, J. J. (2013). Dangerous Safe Havens: Institutional Betrayal Exacerbates Sexual Trauma. *Journal of Traumatic Stress*, *26*(1), 119–124. https://doi.org/10.1002/jts.21778

Smith, R. H., Webster, J. M., Parrott, W. G., & Eyre, H. L. (2002). The role of public exposure in moral and nonmoral shame and guilt. *Journal of Personality and Social Psychology*, *83*(1), 138–159. https://doi.org/10.1037/0022-3514.83.1.138

Solomon, J. C. (1992). Child Sexual Abuse by Family Members: A Radical Feminist Perspective. *Sex Roles: A Journal of Research*, *27*(9–10), 473–485. https://doi.org/10.1007/BF00290004

Somasundaram, D. (2007). Collective Trauma in Northern Sri Lanka: A Qualitative Psychosocial-Ecological Study. *International Journal of Mental Health Systems*, *1*(1), 5. https://doi.org/10.1186/1752-4458-1-5

Sooch, R., Kalyan, G., & Rai, J. (2006). *Oppressed Voices Understanding the Effects of Domestic Violence for South Asian Women* [Project Report]. Rethink Sahayak.

Staley, K. (2009). *Exploring Impact: Public Involvement in NHS, Public Health and Social Care Research*. INVOLVE. https://www.invo.org.uk/wp-content/uploads/2011/11/Involve_Exploring_Impactfinal28.10.09.pdf

Straka, S. M., & Montminy, L. (2006). Responding to the Needs of Older Women Experiencing Domestic Violence. *Violence Against Women*, *12*(3), 251–267. https://doi.org/10.1177/1077801206286221

Street, A. E., & Arias, I. (2001). Psychological Abuse and Posttraumatic Stress Disorder in Battered Women: Examining the Roles of Shame and Guilt. *Violence and Victims*, *16*(1), 65–78. https://doi.org/10.1891/0886-6708.16.1.65

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The Case for Cultural Competency in Psychotherapeutic Interventions. *Annual Review of Psychology*, *60*(1), 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Sznycer, D., Tooby, J., Cosmides, L., Porat, R., Shalvi, S., & Halperin, E. (2016). Shame closely tracks the threat of devaluation by others, even across cultures. *Proceedings of the National Academy of Sciences*, *113*(10), 2625–2630. https://doi.org/10.1073/pnas.1514699113

Tambiah, S. (1986). *Sri Lanka: Ethnic Fratricide and the Dismantling of Democracy*. University of Chicago Press.

Tangney, J. P. (1999). The Self-Conscious Emotions: Shame, Guilt, Embarrassment and Pride. In *Handbook of Cognition and Emotion* (pp. 541–568). John Wiley & Sons Ltd. https://doi.org/10.1002/0470013494.ch26

Tangney, J. P. (2015). Psychology of self-conscious emotions. In *International Encyclopedia of the Social & Behavioral Sciences* (2nd edition, Vol. 21, pp. 475–480). Elsevier.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and Guilt*. Guilford Press.

Tangney, J. P., & Fischer, K. W. (1995). *Self-Conscious Emotions: The psychology of Shame, Guilt, Embarrassment, and Pride*. Guilford Press.

Tangney, J. P., & Salovey, P. (2010). Emotions of the Imperiled Ego: Shame, Guilt, Jealousy, and Envy. In *Social Psychological Foundations of Clinical Psychology* (pp. 245–271). Guilford Press.

Tangney, J. P., Wagner, P. E., Hill-Barlow, D., Marschall, D. E., & Gramzow, R. (1996). Relation of shame and guilt to constructive versus destructive responses to anger across the lifespan. *Journal of Personality and Social Psychology*, *70*(4), 797–809. https://doi.org/10.1037/0022-3514.70.4.797

Temple, B., & Edwards, R. (2002). Interpreters/Translators and Cross-Language Research: Reflexivity and Border Crossings. *International Journal of Qualitative Methods*, *1*(2), 1–12. https://doi.org/10.1177/160940690200100201

Temple, B., & Young, A. (2004). Qualitative Research and Translation Dilemmas. *Qualitative Research*, *4*(2), 161–178. https://doi.org/10.1177/1468794104044430

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In *The Sage Handbook of Qualitative Research in Psychology* (2nd edition, pp. 17–37). SAGE.

Teyber, E., McClure, F. H., & Weathers, R. (2011). Shame in Families: Transmission Across Generations. In *Shame in the Therapy Hour* (pp. 137–166). American Psychological Association. https://doi.org/10.1037/12326-006

Thaggard, S., & Montayre, J. (2019). “There was no-one I could turn to because I was ashamed”: Shame in the Narratives of Women Affected by IPV. *Women’s Studies International Forum*, *74*, 218–223. https://doi.org/10.1016/j.wsif.2019.05.005

Thiara, R. K., & Sumanta, R. (2022). ‘The disparity is evident’: COVID-19, Violence Against Women and Support for Black and Minoritised Survivors. *Journal of Gender-Based Violence*, 1–16. https://doi.org/10.1332/239868021X16425822144020

Thurairajah, K. (2017). The Case of the Sri Lankan Tamil Diaspora and Homeland: A Shared Ethnic Identity? *Studies in Ethnicity and Nationalism*, *17*(1). https://doi.org/10.1111/sena.12222

Tolich, M., & Fitzgerald, M. H. (2006). If Ethics Committees were Designed for Ethnography. *Journal of Empirical Research on Human Research Ethics*, *1*(2), 71–78. https://doi.org/10.1525/jer.2006.1.2.71

Tolman, R. M., & Rosen, D. (2001). Domestic violence in the lives of women receiving welfare. *Violence Against Women*, *7*(2), 141–158. https://doi.org/10.1177/10778010122182361

Tomkins, S. S. (1963). *Affect Imagery Consciousness, Volume II: The Negative Effects*. Springer.

Tonsing, J. (2014). Conceptualizing Partner Abuse Among South Asian Women in Hong Kong. *Journal of Transcultural Nursing*, *25*(3), 281–289. https://doi.org/10.1177/1043659614522650 tcn.sagepub.com

Tonsing, J., & Barn, R. (2017). Intimate Partner Violence in South Asian Communities: Exploring the Notion of 'Shame' to Promote Understandings of Migrant Women's Experiences. *International Social Work*, *60*(3), 628–639. https://doi.org/10.1177/0020872816655868

Towns, A., & Adams, P. (2000). "If I Really Loved Him Enough, He Would Be Okay": Women's Accounts of Male Partner Violence. *Violence Against Women*, *6*(6), 558–585. https://doi.org/10.1177/10778010022182038

Tribe, R. (2007). Health Pluralism—A more appropriate alternative to western models of therapy in the context of the conflict and natural disaster in Sri Lanka? *Journal of Refugee Studies*, *20.1*, 21–36. https://doi.org/10.1093/jrs/fel031

Twine, F. (2000). Racial Ideologies and Racial Methodologies. In *Racing Research Researching Race: Methodological Dilemmas In Critical Race Studies*. New York University Press.

UN Committee on the Elimination of Discrimination against Women. (1994). *CEDAW General recommendation No. 21: Equality in Marriage and Family Relations*. https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/A_49_38(SUPP)_4733_E.pdf

UN General Assembly. (1966). *International Covenant on Economic, Social and Cultural Rights* (Treaty Series No. 993). United Nations. https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

UN Secretary-General. (2011). *Report of the Secretary General's Panel of Experts on Accountability in Sri Lanka*. https://www.refworld.org/docid/4db7b23e2.html

United Nations General Assembly. (1993). *Declaration on the Elimination of Violence against Women*. https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.21_declaration%20elimination%20vaw.pdf

Usoof-Thowfeek, R. (2018). *Psychosocial Assessment of the War Affected Northern and Eastern Provinces of Sri Lanka: Distress and Growth Post-*

War. International Centre for Ethnic Studies and World Bank. http://ices.lk/wp-content/uploads/2018/11/psychosocial-assessment.pdf

van Gelder, N., Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., & Oertelt-Prigione, S. (2020). COVID-19: Reducing the Risk of Infection Might Increase the Risk of Intimate Partner Violence. *EClinicalMedicine*, *21*. https://doi.org/10.1016/j.eclinm.2020.100348

Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C., & Rees, C. E. (2017). Shedding the Cobra Effect: Problematising Thematic Emergence, Triangulation, Saturation and Member Checking. *Medical Education*, *51*(1), 40–50. https://doi.org/10.1111/medu.13124

Wagers, S., & Radatz, D. L. (2020). Emerging Treatment Models and Programs in Intimate Partner Violence Treatment: An Introduction. *Partner Abuse*, *11*(3). http://dx.doi.org/10.1891/PA-2020-0015

Walby, S., & Allen, J. (2004). *Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey* (No. 276). Home Office.

Walker, R., Kyomuhendo, G. B., Chase, E., Choudhry, S., Gubrium, E. K., Nicola, J. Y., Lødemel, I., Mathew, L., Mwiine, A., Pellissery, S., & Ming, Y. (2013). Poverty in Global Perspective: Is Shame a Common Denominator? *Journal of Social Policy*, *42*(2), 215–233. https://doi.org/10.1017/S0047279412000979

Warren, J. (2021). *The Experience of Sri Lankan Tamil Refugees in the UK: Migration and Identity* [Degree of Doctor of Philosophy, Canterbury Christ Church University]. https://repository.canterbury.ac.uk/download/8b054de66cb8ea2466ecc03ee3d01466b80f4fcd7d3ab82f04a5e2c9d28395e3/3581716/PhD_thesis_Warren_final.pdf

Weaver, H. N. (2005). Reexamining What We Think We Know: A Lesson Learned From Tamil Refugees. *Affilia*, *20*(2), 238–245. https://doi.org/10.1177/0886109905274546

Webster, A. K. (2021). Making Sense of Shame in Response to Racism. *Canadian Journal of Philosophy*, *51*(7), 535–550. https://doi.org/10.1017/can.2021.41

Werbner, P. (2002). *Imagined Diasporas among Manchester Muslims*. James Curry.

Wessells, M., & Kostelny, K. (2021). Do No Harm Issues in Psychosocial Support: Post-Tsunami Practitioner Learning in Sri Lanka. *Asian American Journal of Psychology*, *12*(3), 225–233. https://doi.org/10.1037/aap0000191

Wilkinson, S., Joffe, H., & Yardley, L. (2004). Qualitative Data Collection: Interviews and Focus Groups. In *Research Methods for Clinical and Health Psychology* (pp. 39–55). SAGE Publications Ltd.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (3rd edition). Open University Press.

Wilson, A. (2006). *Dreams, Questions, Struggles: South Asian Women in Britain*. Pluto Press.

Wilson, C., Pence, D., & Conradi, L. (2013). Trauma-Informed Care. In *Encyclopedia of Social Work* (pp. 1–22). Oxford University Press.

Winslow, D., & Woost, M. D. (2004). *Economy, Culture, and Civil War in Sri Lanka*. Indiana University Press. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=242726

Wong, Y., & Tsai, J. (2007). Cultural Models of Shame and Guilt. In *The Self-Conscious Emotions: Theory and Research* (pp. 209–223). Guilford Press.

World Health Organization. (2005). *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Summary Report- Initial Results on Prevalence, Health outcomes and Women's Responses*. World Health Organization. https://apps.who.int/iris/handle/10665/43309

World Health Organization. (2010). *A Conceptual Framework for Action on the Social Determinants of Health*. World Health Organization. https://www.who.int/publications/i/item/9789241500852

World Health Organization. (2013). *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*. World Health Organization. https://www.who.int/publications/i/item/9789241564625

Wurmser, L. (1981). *The Mask of Shame*. Johns Hopkins University Press.

Yllö, K. (1988). Political and Methodological Debates in Wife Abuse Research. In *Feminist Perspectives on Wife Abuse* (pp. 28–50). Sage Publications, Inc.

Yuval-Davis, N. (2006). Intersectionality and Feminist Politics. *European Journal of Women's Studies*, *13*(3), 193–209. https://doi.org/10.1177/1350506806065752

APPENDICES

Appendix A: Discrimination Against Sri Lankan Tamils in Sri Lanka

Following independence from Britain in 1948, Sri Lankan Tamils have been discriminated against in Sri Lanka's official rhetoric and government policies (Winslow & Woost, 2004). The first major abuse and anti-Tamil rhetoric is attributed to the 1956 elections in which S.W.R.D. Bandaranaike ran on a pro-Buddhism and Sinhalese-language campaign, and then, upon election, adopted Sinhala as the official language of Sri Lanka (Winslow & Woost, 2004). The Sinhala Only Act discriminated against and isolated Tamils from all areas of life, including government, court, employment and education (Mahan, 2013). The government economic development schemes of the time also discriminated against Tamils in that they involved the resettling of Sinhalese farmers in traditionally Tamil areas (Peebles, 1990).

In the 1960s, the main Tamil political party, the Tamil Federal Party, sought equal status for Tamils, citizenship on the basis of residence (many 'Indian' Tamils were not granted citizenship following independence), and the creation of a Tami-speaking state(s) in Sri Lanka. However, discrimination against Tamils worsened across the 1960s and 1970s, under prime minister Sirimavo Bandaranaike (wife of S.W.R.D. Bandaranaike), who extended the resettlement scheme, and the primacy of Buddhism and Sinhala in the constitution and government policies (Winslow & Woost, 2004). In response, in 1976, the idea of a Tamil state grew legs, with the establishment of the Tamil United Liberation Front (TULF), a Tamil political party pledging a separate state, and the development of Tamil resistance groups, including the Tamil New Tigers (Winslow & Woost, 2004).

Abuse against Tamils broke out across the country shortly after the 1977 election, which saw J.R. Jayawardene and the United national Party (UNP) come to power. By 1978, a group of youths broke from the TULF and established the Liberation Tigers of Tamil Eelam (LTTE), whose aim was to create a Tamil state by force (Rotberg, 1999). In 1979, Jayawardene called a state of emergency and sent the Sri Lankan army to Jaffna, with broad powers

to arrest and hold suspected LTTE members (Winslow & Woost, 2004). Anti-Tamil riots increased significantly in July and August 1983, with varying estimates of 350-4000 people killed over a few week period (Winslow & Woost, 2004), and 100,000 Colombo-based Tamils, and 175,000 Tamils elsewhere in the country made homeless (Rotberg, 1999).

Fighting between the LTTE and Sri Lankan army officially started the civil war in 1983, with fighting mainly taking place in the North and East of the country, disproportionately impacting the Tamil population. The war ended in 2009, when government forces declared victory over the LTTE (Petrie et al., 2012). Tens of thousands of people were killed in the political abuse and conflict across the 1970s and 1980s (Petrie et al., 2012). Though official figures of total fatalities and injuries across the entirety of the civil war are unavailable, the International Crisis Group (2010) report estimated tens of thousands of Tamil civilians were killed in the final months alone (January to May 2009), and hundreds of thousands more deprived of food and medical care, leading to further deaths.

The United Nations (UN) 'Report of the Secretary-General's Panel of Experts on Accountability in Sri Lanka' found credible allegations against the government forces and the LTTE in their failure to uphold international humanitarian and human rights law during the war (UN Secretary-General, 2011). Allegations against the Sri Lankan army include the heavy shelling of 'No Fire Zones' (where the government had encouraged civilians to flee to), causing large numbers of civilian deaths. The army is also alleged to have bombed hospitals, the UN hub, and near the International Committee of the Red Cross (ICRC) ships, which were picking up wounded civilians and their relatives from the beaches (UN Secretary-General, 2011). In addition, the Panel found credible allegations of the rape of women and torture of men suspected of being LTTE fighters, at the hands of the government, violating human rights law (UN Secretary-General, 2011). On the other side, the Panel found credible allegations against the LTTE, including using civilians as human barriers and killing civilians attempting to flee LTTE controlled-areas, forced recruitment of children, and killing civilians using suicide attacks (UN Secretary-General, 2011). At the UN Human Rights Council (HRC) in 2020, the Sri Lankan

government withdrew its support for the HRC's 'Post-Conflict Resolutions for Justice, Accountability and Reconciliation in Sri Lanka' (Foreign, Commonwealth & Development Office, 2021). The Sri Lankan government stated a commitment to domestic methods of reconciliation and accountability, but no progress has been made (Foreign, Commonwealth & Development Office, 2021).

Following the end of the war, many areas in the North and East remain heavily militarised. The domination of reconstruction of the area by the military and the 'Sinhalisation' of the area continues to marginalise Tamils (International Crisis Group, 2012). Tamil women in particular face a lack of economic security and physical mobility, as well as an ongoing fear of abuse from various sources, including gender-based abuse and domestic abuse (International Crisis Group, 2011). A 2020 report by the UK government identified ongoing deterioration of human rights in Sri Lanka, including increased surveillance and intimidation of civilians, and appointment of controversial military figures accused of war crimes into government roles (Petrie et al., 2012).

Appendix B: Scoping Reviews Search Strategy

Search Terms

Each combination of the following terms were searched across the databases:

- ‘shame’, ‘guilt’, or ‘self-blame’
- AND ‘domestic abuse’, ‘domestic violence’, ‘intimate partner violence’, ‘battered women’, or ‘violence against women’
- AND ‘mental health services/interventions/care’, ‘psychological services/interventions/care’, ‘therapeutic services/interventions/care’, or ‘therapy’
- AND ‘South Asian’ or ‘Tamil’

Inclusion Criteria:

Publications were included regardless of date of publication, methodology, and whether the study set out to study the key concepts or whether they developed throughout the findings.

Exclusion Criteria:

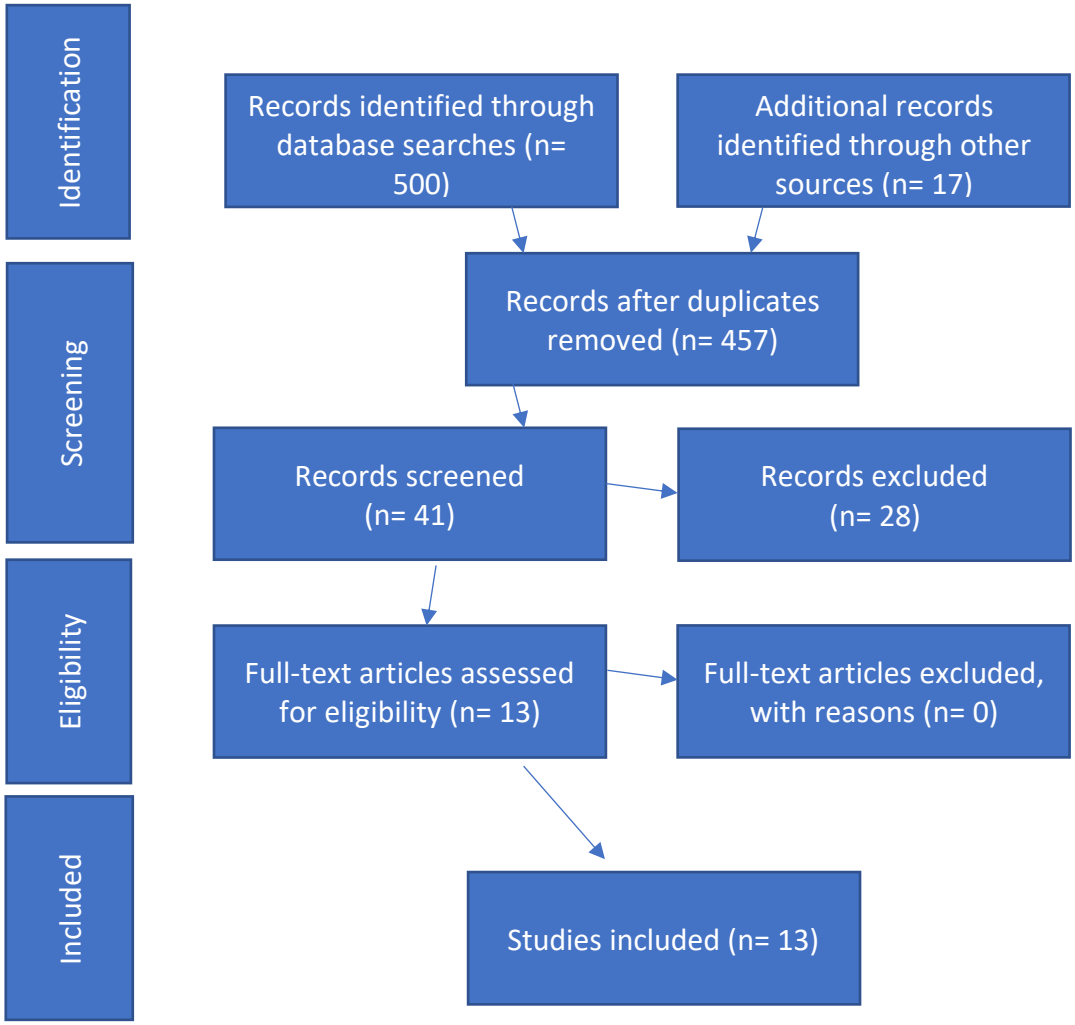
Publications were excluded if they were not conducted in a Western context because of the difference between being South Asian or Tamil in South Asia, and being identified as a minority ‘migrant’ group.

Additional exclusion criteria:

- Poetry, fiction and other artistic literature
- Non-English language
- Non-human
- Non-woman
- Other forms of abuse, including abuse against men or childhood abuse.

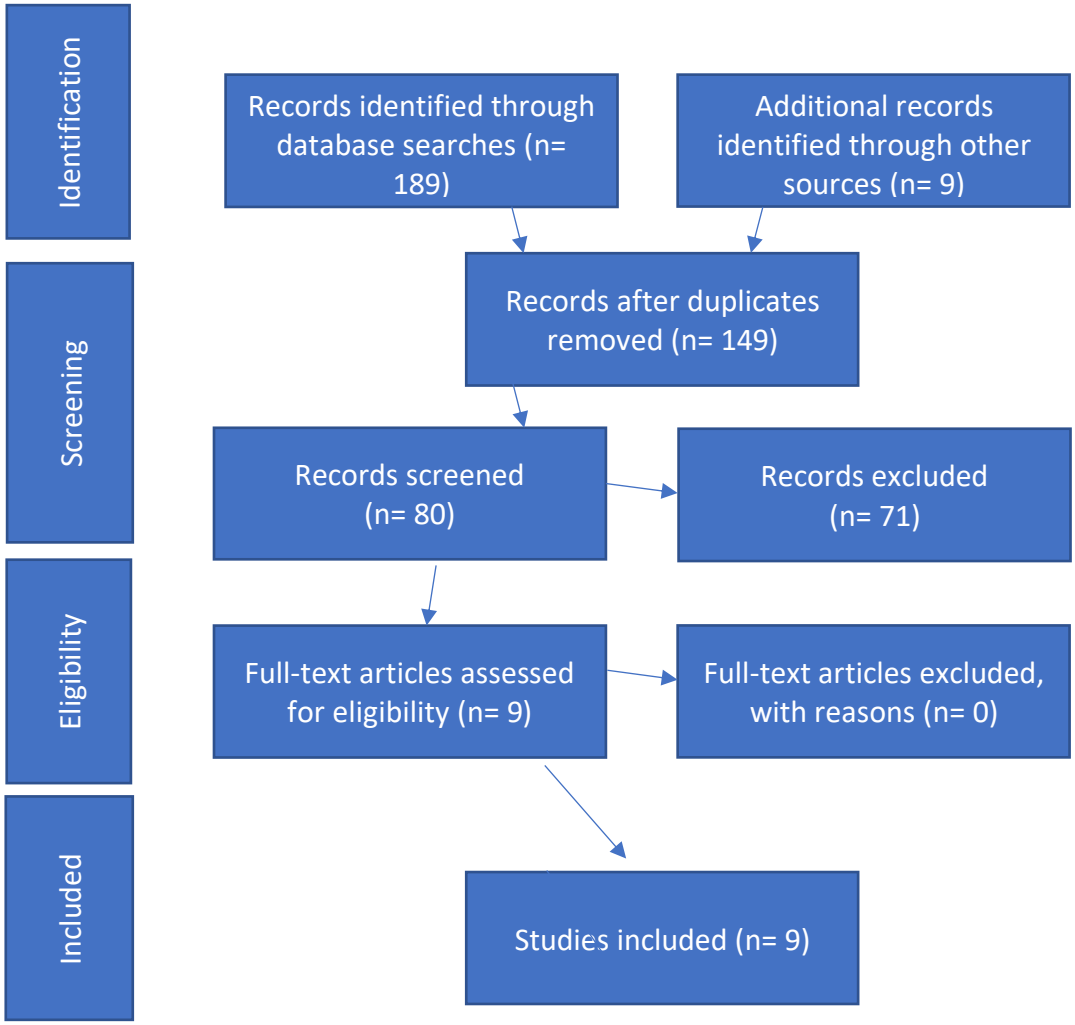
Appendix C: Charting Scoping Review One

517 records were identified when searching the term ‘South Asian’ with a combination of terms for ‘domestic abuse’, ‘shame’ and ‘mental health’. Of these 517 records, 13 were relevant for the scoping review such that they discussed domestic abuse and shame, in the context of psychological research.



Appendix D: Charting Scoping Review Two

198 records were identified when searching the term ‘Tamil’ with a combination of terms for ‘domestic abuse’, ‘shame’ and ‘mental health’. Of these 198 records, 9 were relevant for the scoping review such that they discussed domestic abuse in the context of psychological research.



Appendix E: Memorandum of Understanding

Memorandum of Understanding
Phoebe Neville, Trainee Clinical Psychologist, University of East London
Tamil Community Centre

Phoebe Neville and the Tamil Community Centre (TCC) have agreed to enter into a collaborative research project together. The research study on "DOMESTIC VIOLENCE WITHIN THE SRI LANKAN TAMIL COMMUNITY IN THE UK: UNDERSTANDING SHAME AND EXPEREINCES OF MENTAL HEALTH SERVICES" will be conducted using individual semi-structured interviews lasting about 1 hour, and a focus group, lasting about 1.5 hours. The data will be analysed using Thematic Analysis.

Roles and Responsibilities

- Phoebe Neville will register the research and apply for ethical approval through the University of East London.
- Phoebe Neville and the TCC will jointly develop the interview and focus group schedules.
- TCC will identify potential participants for the research:
    - Interviews will be conducted with service users who have been victims of domestic violence
    - A focus group will be conducted with staff and volunteers interested in providing their perspective on Tamil women's experiences of shame and mental health services, in the context of domestic violence
    - Inclusion criteria for service users:
        - Adults (18 years plus)
        - Women who are first generation Tamil, who moved from Sri Lanka to the UK, and have experienced domestic violence **OR** staff and volunteers supporting first generation Tamil victims of domestic violence
        - Speak English and/or Tamil

        - No longer in an abusive relationship and living in a safe environment
        - A period of time has passed since the abuse and the participant feels comfortable to reflect with distance on the abusive relationship. A minimum of 12 months should have passed since the abuse.
        - Experience of mental health services, including experience of the NHS mental health services
    - Exclusion criteria for service users:
        - Women who experience domestic violence within same-sex relationships is beyond the scope of this research
        - Currently in an abusive relationship
        - Those for whom speaking about the abuse would be highly distressing
        - 8-12 service users/ Tamil women who have experienced domestic violence are required for participation in individual interviews
    - Inclusion criteria for staff/volunteers:
        - Adults (18 years plus)
        - Have experience supporting first-generation Tamil women who have experienced domestic violence, within a Tamil community organisation
        - Speak English or Tamil
    - Exclusion criteria for staff/volunteers:
        - Those for whom speaking on the topic of domestic abuse and shame within a group context would be highly distressing
        - 6-8 staff/volunteers are required for participation in the focus group
- TCC will provide an interpreter/advocate for interviews with Tamil speaking participants.
- Phoebe Neville will collect and securely store participants' names, contact information and address, as well as signed consent forms, prior to the interviews. This personal data will be stored on the researcher's personal storage space on the UEL OneDrive in a password protected

folder, separate from the research data. Only Phoebe Neville will have access to this information. The participants' personal data will be deleted as soon as they have completed the interview process and been paid for their time.

- Paper consent forms will be scanned in PDF format, saved on the UEL H: Drive, and the originals shredded and deleted from the email inbox. Paper versions will then be destroyed. Scanned/electronic consent forms will be saved in a separate H: Drive folder to other research data and will be encrypted. Electronic copies of consent forms will be kept until papers based on the research have been accepted for publication. Following the completion of the researcher's studies at UEL, the consent forms will be transferred from the H Drive to their supervisor's UEL OneDrive. They will then be deleted from the supervisor's UEL OneDrive following the acceptance of the research for publication.
- Phoebe Neville will conduct the interviews and facilitate the focus group, with an interpreter/advocate where required. The interviews and focus group will be audio-recorded for transcription. No personal identifiable data will be asked for during the interviews or focus group. Any personal information that is disclosed during the interviews or focus group will be anonymised during the transcription process.
- Dependent on Covid-19 restrictions and participants' preferences, the interviews and focus group will be conducted online using Microsoft Teams or Zoom, or in person, at the TCC, for the comfort and convenience of the participants and interpreter/advocate.
- If the interviews and focus group are conducted online, they will be conducted using Microsoft Teams/Zoom and recorded using Teams/Zoom and a Dictaphone, as a back-up recording. If conducted in person, the interviews and focus group will be held in a suitable room at the Tamil Community Centre, taking into consideration privacy and safety during the interviews, and recorded using a Dictaphone.
- If the interviews and focus group take place online, the Microsoft Team/Zoom recording will be saved on Phoebe Neville's UEL OneDrive cloud service. Whether conducted online or in person, audio recordings on Phoebe Neville's Dictaphone will be uploaded and stored in a password protected folder on the researcher's UEL OneDrive. Each

audio file will be named with the participants' pseudonym. Audio files will be uploaded to Phoebe Neville's UEL OneDrive and deleted from the Dictaphone immediately after each interview. Only Phoebe Neville will have access to audio recordings.

- Audio files and transcripts will be stored separately. Once the audio files have been transcribed, transcripts will be saved on the OneDrive and audio files will be stored on the H Drive in a separate and encrypted folder from the consent forms. Audio recordings will be deleted after the thesis has been examined and passed.
- TCC to offer follow-up support for participants/service users who are distressed from engagement in the interviews. Phoebe Neville to discuss distressed participants with the TCC, with the participant's consent, for follow-up support. Phoebe Neville will also signpost participants to their G.P. and any mental health services they are currently engaged in. Phoebe Neville will also signpost participants to other free or low-cost domestic violence and therapeutic organisations for support following the interview.
- Phoebe Neville will transcribe the audio recorded interviews and focus group and start data analysis using Thematic Analysis. Phoebe Neville will anonymise the interviews and focus group during the transcription process.
- The anonymised interview transcripts will be stored on Phoebe Neville's UEL OneDrive in a password protected folder only accessible to Phoebe Neville. They will be securely backed up on the H Drive, separate from the consent forms and audio recordings. Once Phoebe Neville has left UEL the transcripts will be stored on her supervisor's UEL OneDrive until the publication of studies based on the research.
- Phoebe Neville will share the anonymised transcripts with TCC and her research supervisors via the UEL File Sharing facility. Transcripts may also be accessed by the UEL thesis examiners. Fully anonymised extracts from the transcripts will be included in the final research thesis and any subsequent publications. Anonymised transcripts will not be deposited via the UEL repository.
- All data will be stored on the UEL OneDrive or H Drive in encrypted folders. Only Phoebe Neville will have access to her computer through

which she will access the drives. The laptop is a personal laptop with a password only known to Phoebe Neville.

- Phoebe Neville will consult with TCC regarding the preliminary themes from the interviews and focus group and further develop the themes/data analysis together.
- Phoebe Neville will write the research up as a doctoral thesis as well as write a shorter summary of the research for dissemination within the Tamil community. The thesis will be publicly available in the University of East London's institutional repository (ROAR). Phoebe Neville will also attempt to have the research published in academic journals for wider dissemination. Dissemination will may also include conference presentations.
- Supervision of the research will be provided by Dr. Kenneth Gannon and Dr. Trishna Patel [named removed for confidentiality]
- The University of East London will be indemnifying and sponsoring the research.

Timeline

- Interviews will be conducted between July 2021- April 2022.
- Data analysis and write-up will start in July 2021 and be completed for submission for the doctoral thesis deadline in May 2022.

Appendix F: Semi-structured Interview Schedule

- Could you tell me a bit about your experience of domestic abuse?
- How do people in the Tamil community feel when they hear about domestic abuse happening?
- Did you try to get some help or support when you were abused?
- Did you get any help from psychological services?
- Is there anything you think would be important or relevant to talk about that I did not ask about?

Appendix G: Ethics Application, Request for Amendment, Request for Change of Title, and Approval Letters

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes: [x]

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics

application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter [x]
- The participant consent form [x]
- The participant debrief letter [x]

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.

Included [ ] or

Not required (because no participation adverts will be used) [x]

- A general risk assessment form for research conducted off campus (see section 6).

Included [x] or

Not required (because the research takes place solely on campus or online) [ ]

- A country-specific risk assessment form for research conducted abroad (see section 6).

Included [ ] or

Not required (because the researcher will be based solely in the UK) [x]

- A Disclosure and Barring Service (DBS) certificate (see section 7).

Included [ ] or

Not required (because the research does not involve children aged 16 or under or vulnerable adults) [x]

- Ethical clearance or permission from an external organisation (see section 8).

Included [x] or

Not required (because no external organisations are involved in the research) [ ]

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.

Included [ ] or

Not required (because you are not using pre-existing questionnaires or tests) [x]

- Interview questions for qualitative studies.

Included [x] or

Not required (because you are not conducting qualitative interviews) [ ]

- Visual material(s) you intend showing participants.

Included [ ] or

Not required (because you are not using any visual materials) [x]

2. Your details

2.1 Your name: Phoebe Neville

2.2 Your supervisor's name: Dr. Kenneth Gannon & Dr. Trishna Patel

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date): May 2022

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study: DOMESTIC VIOLENCE WITHIN THE SRI LANKAN TAMIL COMMUNITY IN THE UK: UNDERSTANDING SHAME AND EXPEREINCES OF MENTAL HEALTH SERVICES

3.2 Your research question:

- For first generation Tamil women living in the UK, how is shame experienced and understood within the context of domestic violence?
- How does shame in the context of domestic violence act as a barrier to accessing mental health services?
- How does shame in the context of domestic violence interact with engagement in mental health services?

3.3 Design of the research: A qualitative approach to data collection and analysis will support an exploration of how victims understand shame and experience metal health services. A focus group will also be conducted with staff and volunteers at Tamil community organisations that support the victims/service users. Thematic analysis will be used to analyse the data.

Semi-structured interviews and the focus group will be conducted online or face-to-face, depending on Covid-19 restriction laws and participants' needs.

3.4 Participants:

First generation Tamil women living in the UK who have experienced domestic violence will be invited to engage in individual semi-structured interviews. In addition, a focus group will be conducted with staff and volunteers who support these women through Tamil community organisations.

Inclusion criteria for Tamil women participating in individual interviews:

- Adults (18 years plus)
- Women who are first generation Tamil, who moved from Sri Lanka to the UK
- Speak English and/or Tamil
- No longer in an abusive relationship and living in a safe environment

- A period of at least 12 months has passed since the abuse and the participant feels comfortable to reflect with distance on the abusive relationship

Exclusion criteria for individual interviews:

- Women who experience domestic violence within homosexual relationships is beyond the scope of this research
- Currently in an abusive relationship
- Someone for whom speaking about the abuse would be highly distressing

Inclusion criteria for staff/volunteers in focus group:

- Adults (18 years plus)
- Staff and volunteers supporting first-generation Tamil victims of domestic violence, within a community organisation

Exclusion criteria for staff/volunteers in focus group:

- Someone for whom speaking about the abuse would be highly distressing

Recruitment: Recruitment of victims of domestic violence for participation will be supported by the research collaborator organisations, [organisation name removed for confidentiality] and Tamil Community Centre (TCC). Potential participants will be identified and approached by the heads of the organisations who work with and support Tamil victims of domestic violence. Participants will be carefully considered based on staff's knowledge of their service users' current physical environment and emotional stability. Only women deemed physically and psychologically 'safe' and comfortable to engage in the sensitive interview topic will be approached.

Staff and volunteers supporting victims of domestic violence within the [organisation name removed for confidentiality] and TCC will be informed about the research in team meetings. Staff and volunteers will then be encouraged to participate in the focus group.

Participants will be informed about what participation will involve and about the aims of the research; it will be explained that the research will help to inform mental health services and aims to benefit the UK-based Tamil community. Participants will be fully informed about the topics and questions involved in the interview/focus group and prepared that engaging in the interviews/focus group may trigger memories and difficult emotions. Participants will also be informed about how the research will be used and disseminated. In addition, participants will be informed about the option of receiving a voucher for their valuable time.

Participants who would like to engage in the research will be provided with an information sheet, in Tamil or English, as appropriate, and asked to sign a consent form and return it to the researcher. A time and date for the interview will be co-ordinated between the organisation, acting as a translator, the participant, and the researcher. A time/date for the focus group will be organised between the researcher and the TCC and [organisation name removed for confidentiality]

3.5 Measures, materials or equipment: If the interviews/focus group take place online, the researcher and research participants will need access to a computer and internet for conducting the interviews/focus group online. They will also require Microsoft Teams and Zoom. In addition, the researcher will need to purchase a sim card to contact participants on a phone number used specifically for the research project. Though interviews/focus group can be recorded on Microsoft Teams and Zoom, the researcher will require a Dictaphone as a secondary method of recording as back-up. The researcher will need to download NVivo, a qualitative data analysis programme, for data analysis.

If the interviews/focus group take place face-to-face, a room for conducting interviews/focus group will be required. The interviews/focus group can take place at the TCC, a space where the victims of domestic violence and staff are comfortable. In addition, the researcher will need to purchase a sim card to contact participants on a phone number used specifically for the research project. A Dictaphone will also be required for recording. The researcher will

need to download NVivo, a qualitative data analysis programme, for data analysis.

3.6 Data collection: Potential participants will be sent an information sheet and consent form. Having read and understood the information sheet, participants interested in engaging in an interview/focus group will be asked to sign the consent form and return it via email or in person to the researcher.

Interviews/focus group will be conducted using video conference calls on Microsoft Teams or Zoom and will be securely recorded through Microsoft Teams or Zoom. The interviews/focus group will also be recorded on a Dictaphone as a back-up for any potential technology problems. If it is possible and safe to conduct interviews and the focus group in person, dependent on Covid-19 restrictions, interviews and the focus group may be conducted in person. However, if the participant prefers to conduct the interview online that can be accommodated. Interviews and the focus group will be conducted in a quiet room at the TCC and recorded using a Dictaphone.

The interviews will last about 1 hour each. A minimum of 8 participants and a maximum of 12 will be recruited for interview. The focus group will last about 1.5 hours. 6-8 participants will be invited to engage in the focus group. After the interview and focus group participants will be provided with a debrief sheet signposting to relevant services.

Data analysis: The recorded interviews and focus group will be transcribed by listening to the recordings.

The data will be analysed using a qualitative approach. The interviews with victims of abuse will be analysed using thematic analysis and then the focus group will be analysed separately also using thematic analysis. The approach to analysis is congruent with the critical realist epistemology of the study. Thematic analysis will allow for the development of themes that investigate what and how shame is understood and experiences of mental health services. The use of thematic analysis will draw on guidance from (Braun & Clarke, 2006). NVivo, a qualitative data analysis programme, will be used for data analysis.

Thematic analysis relies on the interpretation of interviews and the focus group and the development of themes by the researcher (Chamberlain, 2000); the data is therefore understood through the researcher's experiences, assumptions and biases. In order to improve quality of interpretation the researcher will engage in reflexivity throughout the analysis process and be clear in the write up on the analysis where the researcher stands of issues and how their values and presumptions may have impacted interpretation. As the researcher is not from the Tamil community there is potential for fallibility in interpretation of the interviews and focus group discussion. Thus, after the initial development of themes, the researcher will consult with the research collaborators to further develop the themes collaboratively with members of the Tamil community.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously? No, the researcher will know the participants name and contact information and will meet the participant face-to-face or over video conferencing.

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

Personal identifiable information will not be collected, stored or analysed for the purpose of the research.

The participant's name, contact information, and address, for the purpose of contact between researcher and participant, will be stored in a password protected document, in a password protected folder, separate from the research data. Only the researcher will have access to this information, and it will be

deleted after the participant has been interviewed/engaged in the focus group and received their voucher for their time. The collection of this information will be with participants' consent and in their interest, in order that they can be sent a voucher for their time.

Interview and focus group participants will be asked to choose a pseudonym to be used for the purpose of the interview/focus group and will not provide their real name or any other personal data during the interview/focus group.

Potentially identifiable information in interviews/focus group will be fully anonymised during the transcription process. The anonymised transcripts will only be accessed by the researcher, partner research organisations, the researcher's supervisor, and the thesis examiners.

Paper consent forms will be scanned in PDF format and saved on the H: Drive, and the originals shredded and deleted from the email inbox. Paper versions should then be destroyed. Scanned/electronic consent forms will be saved in a separate H: Drive folder to other research data and will be encrypted. Following the completion of the researcher's studies at UEL, the consent forms will be transferred from the H Drive to their supervisor's UEL OneDrive. They will then be deleted from the supervisor's UEL OneDrive following the acceptance of the research for publication.

The participants will be anonymous in the thesis and any future publication of the project. Only anonymised extracts of interviews will be used in the thesis.

4.3 How will you ensure participants details will be kept confidential?

Personal identifiable information will not be collected, stored or analysed for the purpose of the research.
The participant's name, contact information, and address, for the purpose of contact between researcher and participant, will be stored in a password protected document, in a password protected folder, separate from the research data, on the researcher's UEL OneDrive. Only the researcher will have access to this information, and it will be deleted after the participant has been

interviewed/engaged in the focus group and received a voucher for their time. The collection of this information will be with participants' consent and in their interest, in order that they receive a voucher for their time.

Paper consent forms will be scanned in PDF format and saved on the H: Drive, and the originals shredded and deleted from the email inbox. Paper versions should then be destroyed. Scanned/electronic consent forms will be saved in a separate H: Drive folder to other research data and will be encrypted. Following the completion of the researcher's studies at UEL, the consent forms will be transferred from the H Drive to their supervisor's UEL OneDrive. They will then be deleted from the supervisor's UEL OneDrive following the acceptance of the research for publication.

Interview and focus group participants will be asked to choose a pseudonym to be used for the purpose of the interview/focus group and will not provide their real name or any other personal data during the interview/focus group. If the interviews/focus group are conducted online, the interviews/focus group will be recorded using Microsoft Teams or Zoom and a Dictaphone. If conducted in person, a Dictaphone will be used for recording. Audio files from the Dictaphone will be uploaded onto the researcher's UEL OneDrive immediately after the interview/focus group and subsequently deleted from the Dictaphone. All audio recordings from Microsoft Teams/Zoom and the Dictaphone will be saved on the researcher's password protected laptop within their UEL OneDrive cloud service. All audio files will be moved from the UEL OneDrive to the UEL H Drive following transcription, so as to store the audio files and transcriptions separately. Audio recordings will be deleted following passing the thesis.

Potentially identifiable information in interviews/focus group will be fully anonymised during the transcription process. The transcripts will be saved on the researcher's UEL OneDrive cloud service, as .docx files which will be encrypted. The transcripts will be backed up on the H: Drive in a separate folder from the consent forms and audio recordings. Once the researcher leaves UEL, the transcripts will be stored electronically on the supervisor's UEL OneDrive, until publication of papers based on the research. The anonymised transcripts

will only be accessed by the researcher, the research partner organisation, the researcher's supervisor, and the thesis examiners.

The participants will be anonymous in the thesis and any future publication of the project. Only anonymised extracts of interviews will be used in the thesis.

4.4 How will the data be securely stored?

Participants' names, contact information, and addresses, for the purpose of contact between researcher and participants, will be stored in a password protected document, in a password protected folder, separate from the research data, on the researcher's personal storage space on the UEL OneDrive. Only the researcher will have access to this information, and it will be deleted after the participant has been interviewed/engaged in the focus group and paid for their time.

Paper consent forms will be scanned in PDF format and saved on the H: Drive, and the originals shredded and deleted from the email inbox. Paper versions will then be destroyed. Scanned/electronic consent forms will be saved in a separate H: Drive folder to other research data and will be encrypted.

If the interviews/focus group take place online, an audio recording of the interviews and focus group will be recorded within Microsoft Teams/Zoom. Teams recordings are stored by default on the Microsoft Stream Library. For Teams recordings, I will download a copy for upload to OneDrive for Business and ensure that any local copies created are deleted from my laptop and that I don't have synchronisation to my personal Cloud storage such as iCloud enabled on my machine. Microsoft Teams recordings will be accessed via the researcher's password protected laptop within their UEL OneDrive cloud service. Any recordings on Zoom will be uploaded from Zoom on the researcher's laptop onto the UEL OneDrive cloud service and subsequently deleted from Zoom; any local copies created in the process will be deleted from my laptop.

Whether conducted online or in person, audio recordings from the Dictaphone will be saved on the researcher's UEL OneDrive account. Each audio file will be named with the participants' pseudonym. The focus group audio file will be named 'focus group'.

Audio files and transcripts will be stored separately. After transcription, audio files will be saved in the H Drive in a separate and encrypted folder from the consent forms.

The transcripts will be saved on the researcher's UEL OneDrive account.

Transcripts will be backed up on the H Drive in a sperate folder from the consent forms and audio recordings.

Transcription files will be named by the participant's pseudonym; the focus group transcription file will be named 'focus group'.

The researcher will share the anonymised transcripts with the research partner organisation, the researcher's supervisors, and examiners via UEL email.

4.5 Who will have access to the data?

All data will be obtained and stored by the researcher.

All data will be stored on the UEL OneDrive or H Drive. The OneDrive and H Drive will be accessed through the researcher's personal password protected laptop, with a password only known to the researcher.

The OneDrive will be accessed using a two-factor authentication using passwords only known to the researcher. Files on OneDrive for Business are encrypted. The researcher will encrypt the files saved on the H Drive. All identifiable data will be password protected.

Only the researcher will have access to the participants' personal information, collected for the purposes of contacting and paying them.

All audio recordings will be moved to the UEL H Drive following transcription, to be saved separately. Only the researcher will have access to the audio files.

The researcher will transcribe all interviews and focus group, anonymising any participant personal or identifying data in the process. The researcher will be mitigating the risk by storing transcripts in anonymised format.

Transcriptions will be within the researcher's UEL OneDrive cloud service, as .docx files which will be encrypted.

Only the researcher, research partner organisation, researcher's supervisors and examiners will have access to the anonymised transcripts.

Anonymised transcripts will be shared with the research supervisor and partner organisation via UEL's File Sharing facility. Files will be named using the participant's pseudonym.

Access to consent forms will be granted only if necessary and with participant consent.

All data will be obtained and stored by the researcher.

All data will be stored on the UEL OneDrive or H Drive. The OneDrive and H Drive will be accessed through the researcher's personal password protected laptop, with a password only known to the researcher.

The OneDrive will be accessed using a two-factor authentication using passwords only known to the researcher. Files on OneDrive for Business are encrypted. The researcher will encrypt the files saved on the H Drive. All identifiable data will be password protected.

Only the researcher will have access to the participants' personal information, collected for the purposes of contacting and paying them.

All audio recordings will be moved to the UEL H Drive following transcription, to be saved separately. Only the researcher will have access to the audio files.

The researcher will transcribe all interviews and focus group, anonymising any participant personal or identifying data in the process. The researcher will be mitigating the risk by storing transcripts in anonymised format.

Transcriptions will be within the researcher's UEL OneDrive cloud service, as .docx files which will be encrypted.

Only the researcher, research partner organisation, researcher's supervisors and examiners will have access to the transcripts.

Anonymised transcripts will be shared with the research supervisor and partner organisation via UEL's File Sharing facility. Files will be named using the participant's pseudonym.

Access to consent forms will be granted only if necessary and with participant consent.

In order to ensure data is safe using Zoom, a Data Protection Addendum has been completed. Additionally, privacy settings will be set within Zoom to limit access to the data and ensure the data is secured. Personal data is processed by Zoom under the following GDPR lawful basis for processing personal data: contract, legitimate interests, protect vital interest, legal compliance, legal obligation. Zoom only shares personal data with companies, organisations or individuals outside of Zoom when one of the following circumstances applies: Zoom share personal data with companies, organizations, individuals outside of Zoom and others when they have consent from an individual (as applicable); if Zoom received personal data from a third-party partner and the person becomes a Customer, Zoom may disclose select personal data to that partner or their designee for the purpose of the partnership agreement. Zoom's partners have contractually agreed to comply with appropriate privacy and security obligation; Zoom may share personal data with actual or prospective acquirers, their representatives and other relevant participants in, or during negotiations of,

any sale, merger, acquisition, restructuring, or change in control involving all or a portion of Zoom's business or assets, including in connection with bankruptcy or similar proceedings; Zoom may provide data to vendors and services providers to help provide the Services and for Zoom's business purposes; Zoom share personal data if they believe that access, use, preservation or disclosure of the information is reasonable necessary to meet any applicable law or respond to valid legal processes, enforce applicable Terms of Service, detect, prevent or otherwise address fraud, security or technical issues, and to protect against harm to the rights, property or safety of Zoom, users or the public as required or permitted by law.

4.6 How long will data be retained for?

The participants' personal data, stored on the researcher's personal storage space on the UEL OneDrive, will be deleted as soon as they have completed the interview/focus group process and been paid for their time.

Electronic copies of consent forms will be kept until papers based on the research have been accepted for publication. Following the completion of the researcher's studies at UEL, the consent forms will be transferred from the H Drive to their supervisor's UEL OneDrive. They will then be deleted from the supervisor's UEL OneDrive following the acceptance of the research for publication. Participants will be informed that the consent forms will be stored until the research is accepted for publication on the information sheet prior to interview and will be asked to provide consent for this.

All audio recordings will be deleted once the thesis has been examined and passed.

The anonymised data from interviews and focus group will be deleted from the researcher's UEL OneDrive once the thesis has been examined and passed. The transcripts will be stored securely until publication of any papers based on the research, on the supervisor's UEL OneDrive, and then deleted by the researcher.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: [x]

5.2 Your research question: [x]

5.3 The purpose of the research: [x]

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: [x]

5.5 That participation is strictly voluntary: [x]

5.6 What are the potential risks to taking part: [x]

5.7 What are the potential advantages to taking part: [x]

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): [x]

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation): [x]

5.10 How long their data will be retained for: [x]

5.11 How their information will be kept confidential: [x]

5.12 How their data will be securely stored: [x]

5.13 What will happen to the results/analysis: [x]

5.14 Your UEL contact details: [x]

5.15 The UEL contact details of your supervisor: x

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.

No.

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

Personal identifiable information will not be collected, stored or analysed for the purpose of the research.

The participant's name, contact information, and address, for the purpose of contact between researcher and participant, will be stored in a password protected document, in a password protected folder, separate from the research data, on the researcher's UEL OneDrive. Only the researcher will have access to this information, and it will be deleted after the participant has been interviewed/engaged in the focus group and received a voucher for their time. The collection of this information will be with participants' consent and in their interest, in order that they receive a voucher for their time.

Paper consent forms will be scanned in PDF format and saved on the H: Drive, and the originals shredded and deleted from the email inbox. Paper versions should then be destroyed. Scanned/electronic consent forms will be saved in a separate H: Drive folder to other research data and will be encrypted. Following the completion of the researcher's studies at UEL, the consent forms will be transferred from the H Drive to their supervisor's UEL OneDrive. They will then be deleted from the supervisor's UEL OneDrive following the acceptance of the research for publication.

Interview and focus group participants will be asked to choose a pseudonym to be used for the purpose of the interview/focus group and will not provide their

real name or any other personal data during the interview/focus group. If the interviews/focus group are conducted online, the interviews/focus group will be recorded using Microsoft Teams or Zoom and a Dictaphone. If conducted in person, a Dictaphone will be used for recording. Audio files from the Dictaphone will be uploaded onto the researcher's UEL OneDrive immediately after the interview/focus group and subsequently deleted from the Dictaphone. All audio recordings from Microsoft Teams/Zoom and the Dictaphone will be saved on the researcher's password protected laptop within their UEL OneDrive cloud service. All audio files will be moved from the UEL OneDrive to the UEL H Drive following transcription, so as to store the audio files and transcriptions separately. Audio recordings will be deleted following passing the thesis.

Potentially identifiable information in interviews/focus group will be fully anonymised during the transcription process. The transcripts will be saved on the researcher's UEL OneDrive cloud service, as .docx files which will be encrypted. The transcripts will be backed up on the H: Drive in a separate folder from the consent forms and audio recordings. Once the researcher leaves UEL, the transcripts will be stored electronically on the supervisor's UEL OneDrive, until the publication of papers based on the research. The anonymised transcripts will only be accessed by the researcher, the research partner organisation, the researcher's supervisor, and the thesis examiners.

The participants will be anonymous in the thesis and any future publication of the project. Only anonymised extracts of interviews will be used in the thesis.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

Participants will receive vouchers for their involvement in the research. Participation in the research takes time and may be emotionally-taxing for participants, and thus participants will be given a voucher as a taken of gratitude. Participants will receive a 15-pound voucher for their involvement in the research.

Reimbursement, such as travel costs, won't be necessary if interviews/the focus group are conducted online. If interviews/the focus group are conducted in person, participants will be reimbursed for their travel costs.

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

There are no physical risks to participation in the research.

Participants may experience psychological distress from discussing shame and domestic violence. Participants will be provided with detailed information about the research prior to engaging in an interview/focus group. This allows them the opportunity to consider the impact that the interview/focus group may have on them and end their involvement in the research. All participants will be asked to voluntarily consent to involvement in the research prior to any participation.

For some participants it may be the first time they have discussed feelings of shame or domestic violence, which could bring up distressing emotions and memories. Following the interview/focus group, all participants will be given a debrief letter with information about support services through which they can seek psychological support around shame and/or processing the domestic violence. They will also be signposted to access support from their G.P. or mental health services they are currently engaged with. The researcher's contact details will also be provided if participants would like to contact the research to discuss options for support.

If a participant who has experienced domestic violence (a service user of TCC or [organisation name removed for confidentiality]) becomes very distressed during the interview then, with their consent, the researcher will discuss follow-up support through the TCC. The researcher will discuss the participant's needs with a staff member at TCC and then a staff member or volunteer from the organisation will offer follow-up support to the participant/service user.

Participants will be provided with the option to withdraw from the research at any time, without needing to give a reason. If participants choose to withdraw during an interview, then their data can also be withdrawn. Interview data will not be able to be withdrawn once it has been fully anonymised and the analysis process has begun, as it will not be possible to identify the participant's data from other data. If participants choose to withdraw during the focus group it will not be possible to withdraw their data, as it will be difficult to decipher their contributions from other group members' contributions on the audio recording.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

The experiences of shame and domestic violence voiced by participants could be emotionally distressing for the researcher. The researcher will seek supervision from their research supervisors to discuss the impact of the research on them.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

Appropriate mental health and domestic violence services have been identified in the debrief letter. The services chosen are accessible financially as they are either free or low- cost. Both mental health and domestic violence services were identified as potentially useful for participants due to the focus on experiences of domestic violence as well as shame and mental health.

The participants will also be signposted to support through TCC and to contact their GP or other mental health services they are engaged with if they

experience distress from the interview. If any participants are experiencing suicidal thoughts they will be signposted to tell their GP and any mental health service they are currently engaged in; this information will be on the debrief sheet and reiterated by the researcher at the end of the interview.

6.4 Does the research take place outside the UEL campus? If so, where?

All research will likely be conducted online through Microsoft Teams or Zoom. However, if it is possible and safe to do so, dependent on the Covid-19 pandemic, interviews and the focus group may be conducted in person. Interviews and the focus group will take place at the TCC, a location that is accessible and comfortable for the research participant.

If so, a 'general risk assessment form' must be completed. This is included below as appendix G. Note: if the research is on campus, or is online only (e.g., a Qualtrix survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed: [x]

6.5 Does the research take place outside the UK? If so, where?

No.

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researcher or the participants.] If a 'country-specific risk assessment form' *is* needed, please tick to confirm that this has been included: [ ]

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then

'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.

- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

NO

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have ☐

included this instead:

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

NO If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

NO

9.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

NO

9.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

The research involves collaboration with non-governmental organisations working within the Tamil community. The main research partners are the [organisation name removed for confidentiality], set up by [name removed for confidentiality], and the Tamil Community Centre, [name removed for confidentiality].

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix: [x]

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation,’ or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Phoebe Neville

Student's number: [removed for confidentiality]
Date: 22/01/2021

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee.

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: [name removed for confidentiality]

SUPERVISOR: Kenneth Gannon

STUDENT: Phoebe Neville

Course: Prof Doc in Clinical Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the

same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

3.3 please add that the qualitative approach will be a thematic analysis on two groups – first victims and second support services. In this first section it is not directly clear how it will be done. 3.4 – how many women will be recruited? How many are you aiming for it the focus group? 4.5 – why will the Tamil community centre and [organisation name removed for confidentiality] staff have access to the anonymised data? Only the researcher and supervisor? Participant letter – The example interview questions are useful, and it would be good for them to see the main questions to feel safe exploring them in discussion. Consent form needs a signature section.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature):* Phoebe Neville Student number: [removed for confidentiality] Date: 13/07/2021

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?
YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

HIGH ☐

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

MEDIUM (Please approve but with appropriate recommendations) ☐

LOW ☒

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: [name removed for confidentiality]

Date: 7th July 2021

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

University of East London

UNIVERSITY OF EAST LONDON

School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact [name removed for confidentiality].

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: [name removed for confidentiality]
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: Phoebe Neville Programme of study: Professional Doctorate in Clinical Psychology Title of research: DOMESTIC VIOLENCE WITHIN THE SRI LANKAN TAMIL COMMUNITY IN THE UK: UNDERSTANDING SHAME AND EXPEREINCES OF MENTAL HEALTH SERVICES Name of supervisor: Dr. Kenneth Gannon and Dr. Trishna Patel

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
I propose to collect the following demographic information: - Self-identified ethnicity - Age - Relationship status (in a relationship with the abusive partner or separated) - Number of years living in the UK	This information needs to be collected to ensure that the participants meet the inclusion criteria for the research. It may also be useful to consider if there is a large variety in their perspectives. Existing research has identified differences in views on domestic abuse for Tamil women of different ages.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): Phoebe Neville

Date: 18/11/2021

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: [name removed for confidentiality]

Date: 18/11/2021

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to [name removed for confidentiality]
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents	
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Phoebe Neville**
Programme of study:	**Professional Doctorate in Clinical Psychology**
Title of research:	DOMESTIC VIOLENCE WITHIN THE SRI LANKAN TAMIL COMMUNITY IN THE UK: UNDERSTANDING SHAME AND EXPEREINCES OF MENTAL HEALTH SERVICES
Name of supervisor:	**Dr. Kenneth Gannon and Dr. Trishna Patel**

Proposed title change	
Briefly outline the nature of your proposed title change in the boxes below	
Old title:	DOMESTIC VIOLENCE WITHIN THE SRI LANKAN TAMIL COMMUNITY IN THE UK: UNDERSTANDING SHAME AND EXPEREINCES OF MENTAL HEALTH SERVICES
New title:	Domestic Abuse in the UK Sri Lankan Tamil Community: Understanding Shame
Rationale:	The research title needs to change to reflect the tighter focus of the research that developed out of the interviews

Confirmation		
Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature	
Student: (Typed name to act as signature)	**Phoebe Neville**
Date:	**29/03/2022**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the research study and will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	[name removed for confidentiality]	
Date:	**30/03/2022**	

Appendix H: Example Transcription

Translator
So to relax her mind she's learning English. She's keeping herself busy basically. She does participate in the exercise classes and then she's going to English classes and then she also take the kids out to London, not she hasn't been abroad, but she's, you know, go around taking the kids outside, so that the kids doesn't think about the father, so she's keeping them busy as well.

Researcher
Great.

Translator
Ok, so obviously her [sibling] came as well after the lockdown has been removed. The [sibling] with the kids came to visit her.

Researcher
Oh, that's nice. And I want some of your advice for me, what would be helpful for doctors and psychologists to do to help Tamil women who have been abused?

Translator
Is it more like a reach out to kind of help? How can they help? Or-?

Researcher
Yeah, anything how can what- what could they do, or what should they say?

Translator
She feels that professionals should help the kids to come out of these kind of domestic violence abuse household. And also encourage the women to come out, or rather than hiding everything, encourage the women to come out of these kind of marriages, will help them to have a freedom.

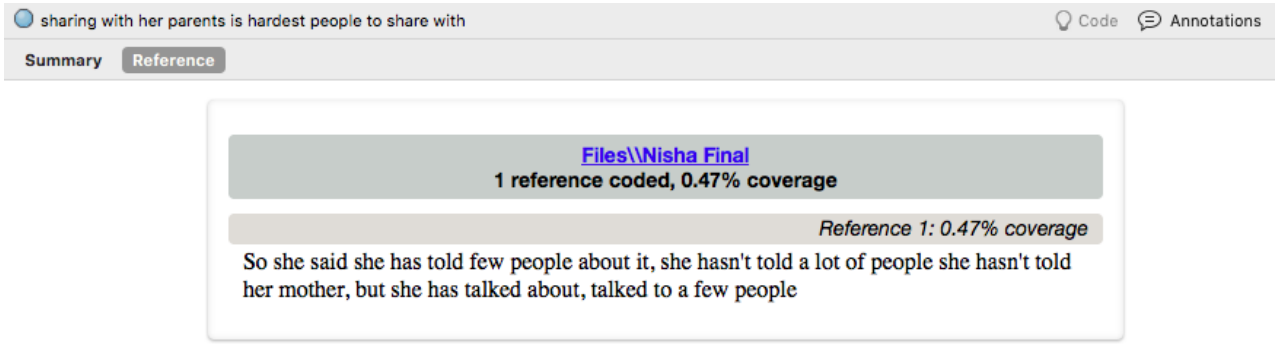
Researcher
Yeah. How would a health professional know when someone is being abused, so you know to help them?

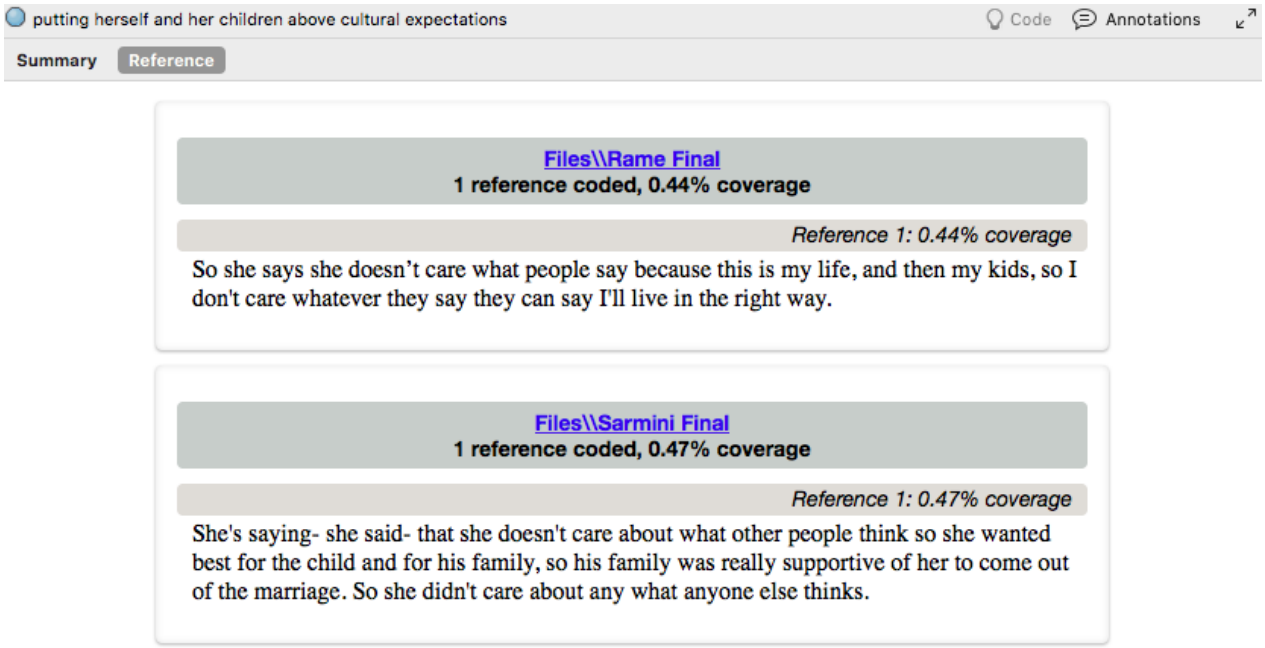
Translator
So she's saying once the women get effected they should be depressed, so obviously she will go to the doctors for help. Then once they reach out for the doctors, then doctors will give the right advice to for them to reach out to right organisations to get the help they needed.

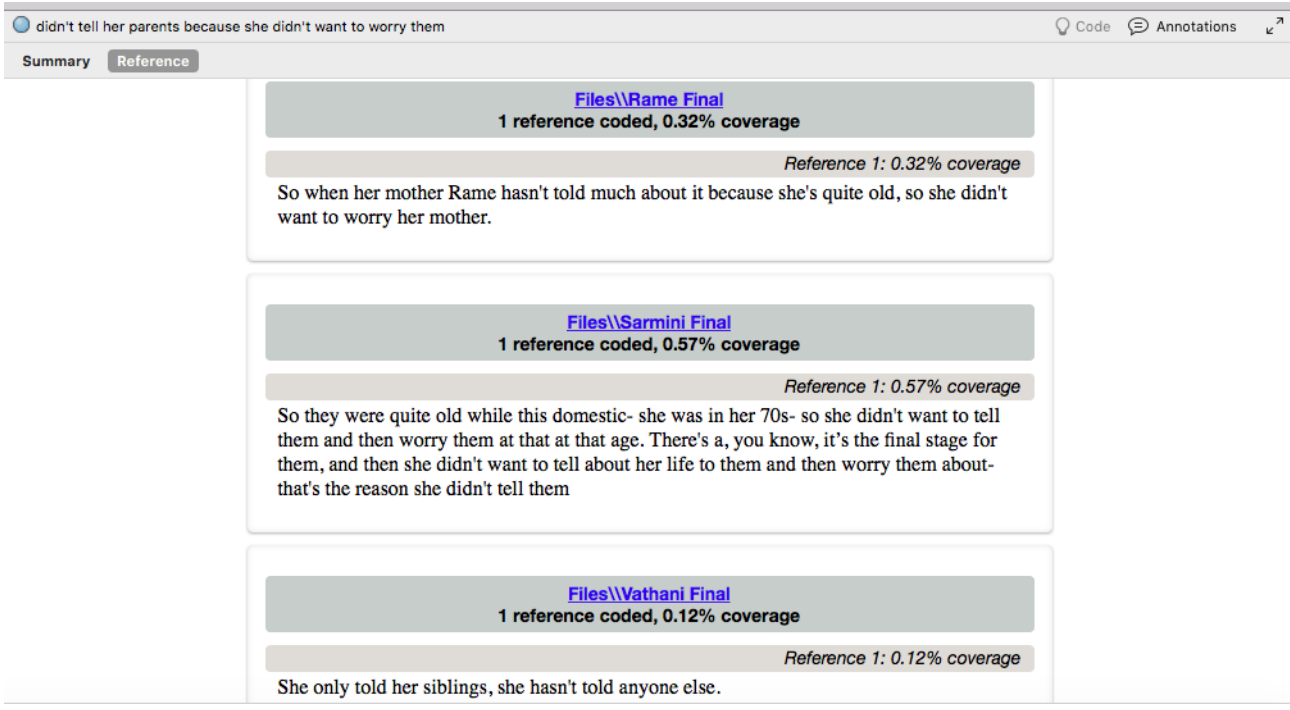
Researcher
Ok, so if it Tamil woman comes to the doctor and is depressed then the doctors might think that that's domestic abuse?

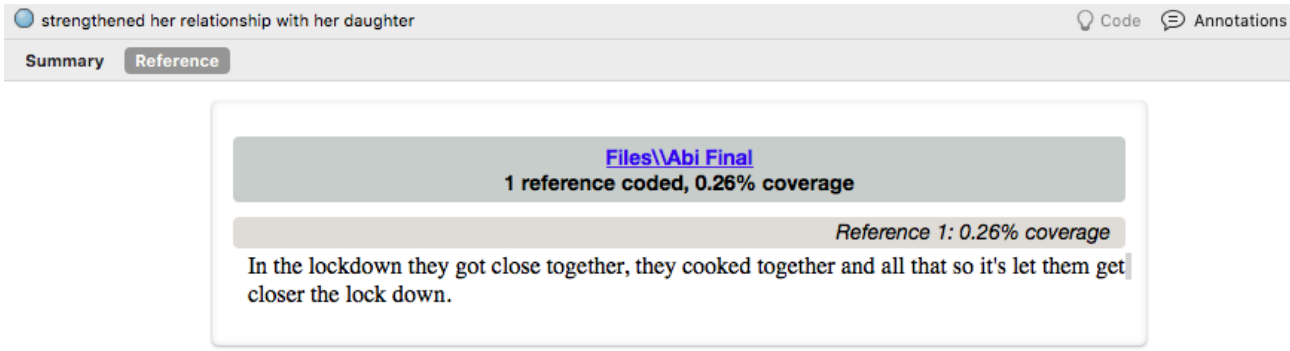
Translator
So she's saying the doctors are quite clever at finding that's why, but she's also saying that women have to open up because doctor is not a magician to find out what's in her mind. So when the doctor asked ‘what is bothering you?’, they had to open up and speak about what’s happening in the household, and then only the doctors can help, obviously, but be more open and tell your problems to the doctors.

Appendix I: Example Thematic Analysis Codes in NVivo

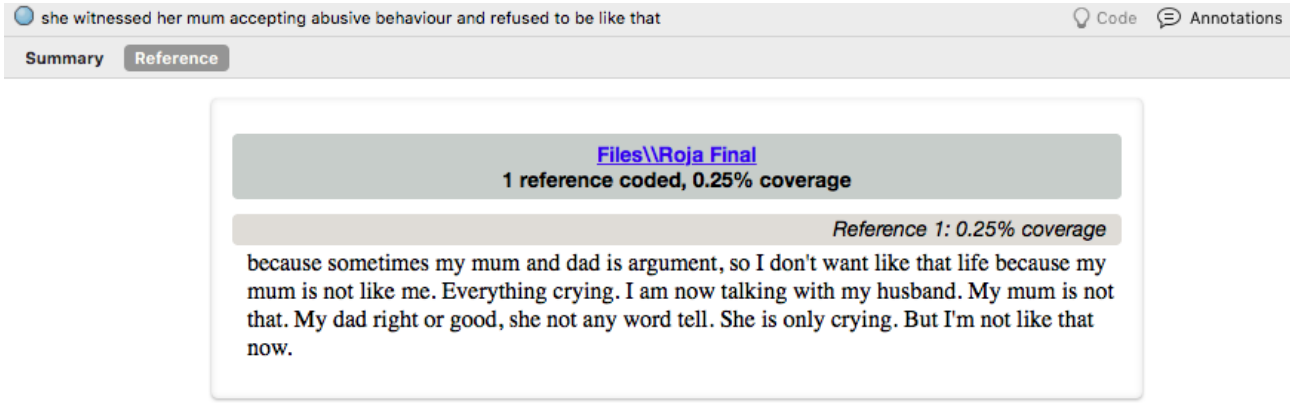




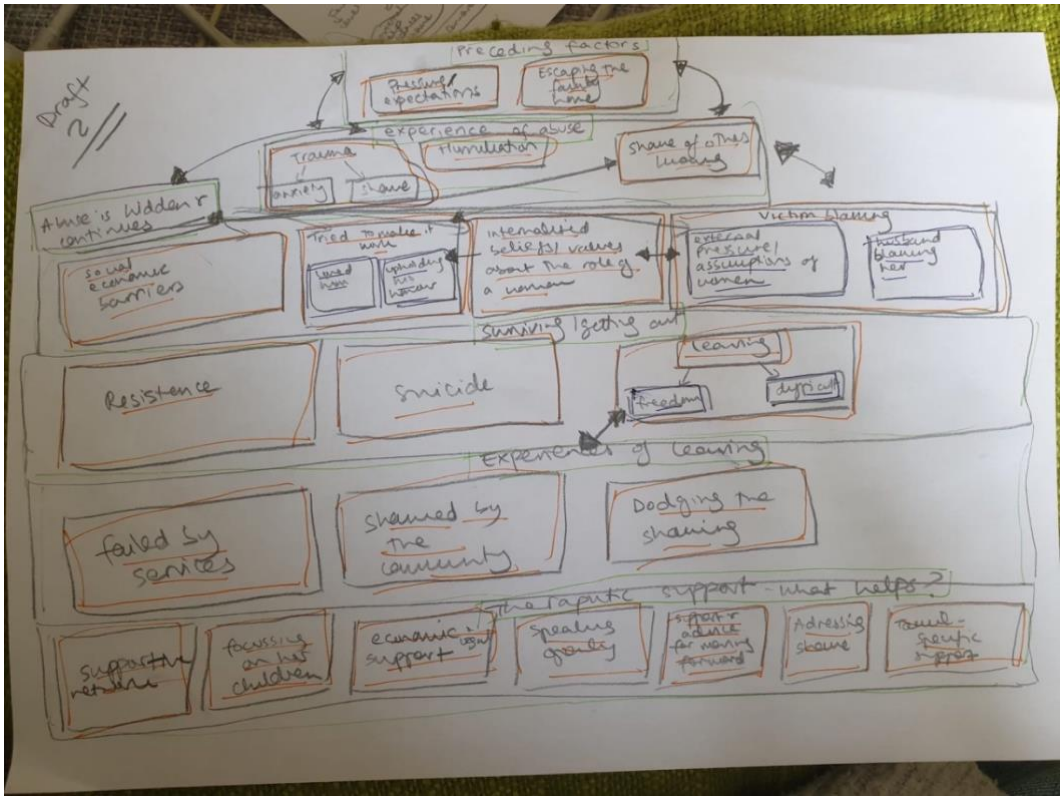


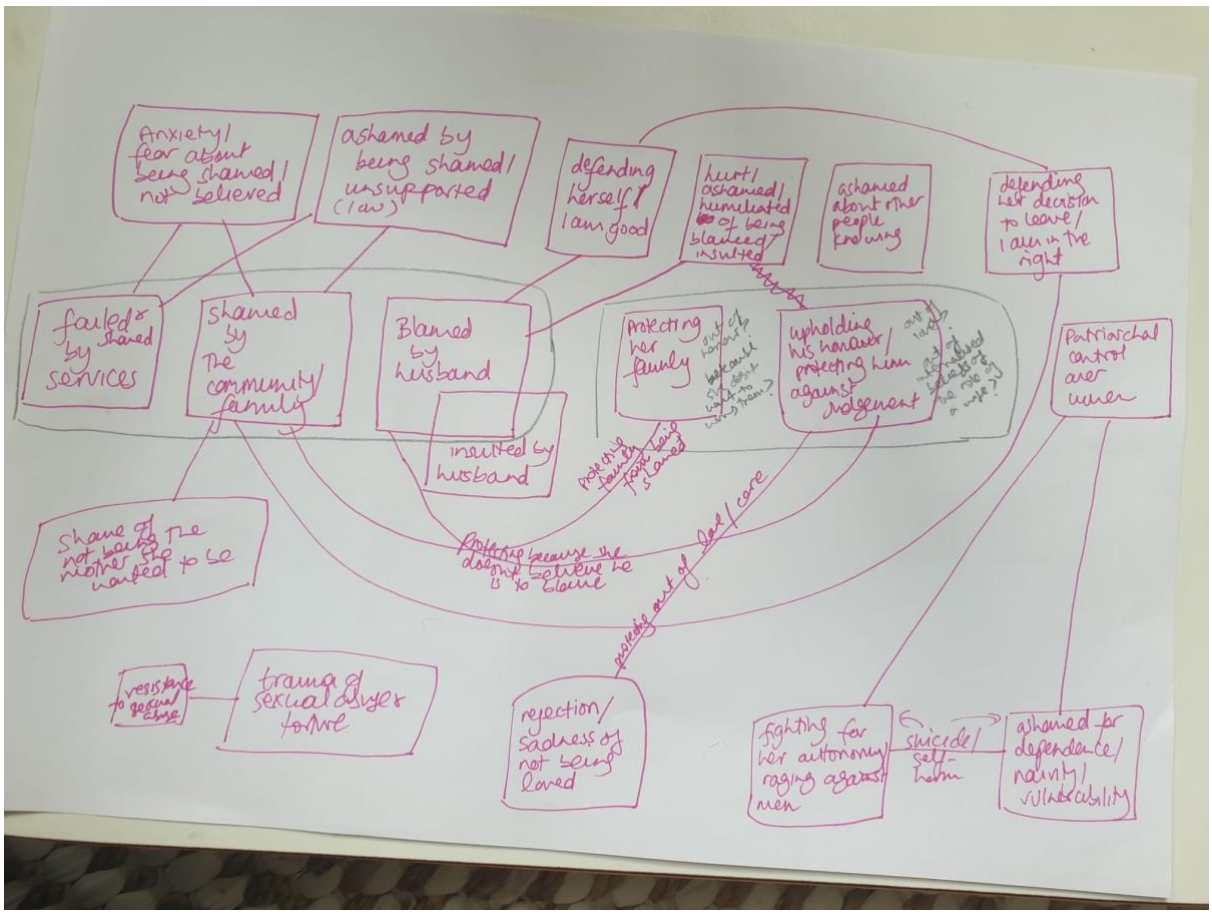

strengthened her relationship with her daughter
Code
Annotations
Summary
Reference
Files\\Abi Final
1 reference coded, 0.26% coverage
Reference 1: 0.26% coverage
In the lockdown they got close together, they cooked together and all that so it's let them get closer the lock down.

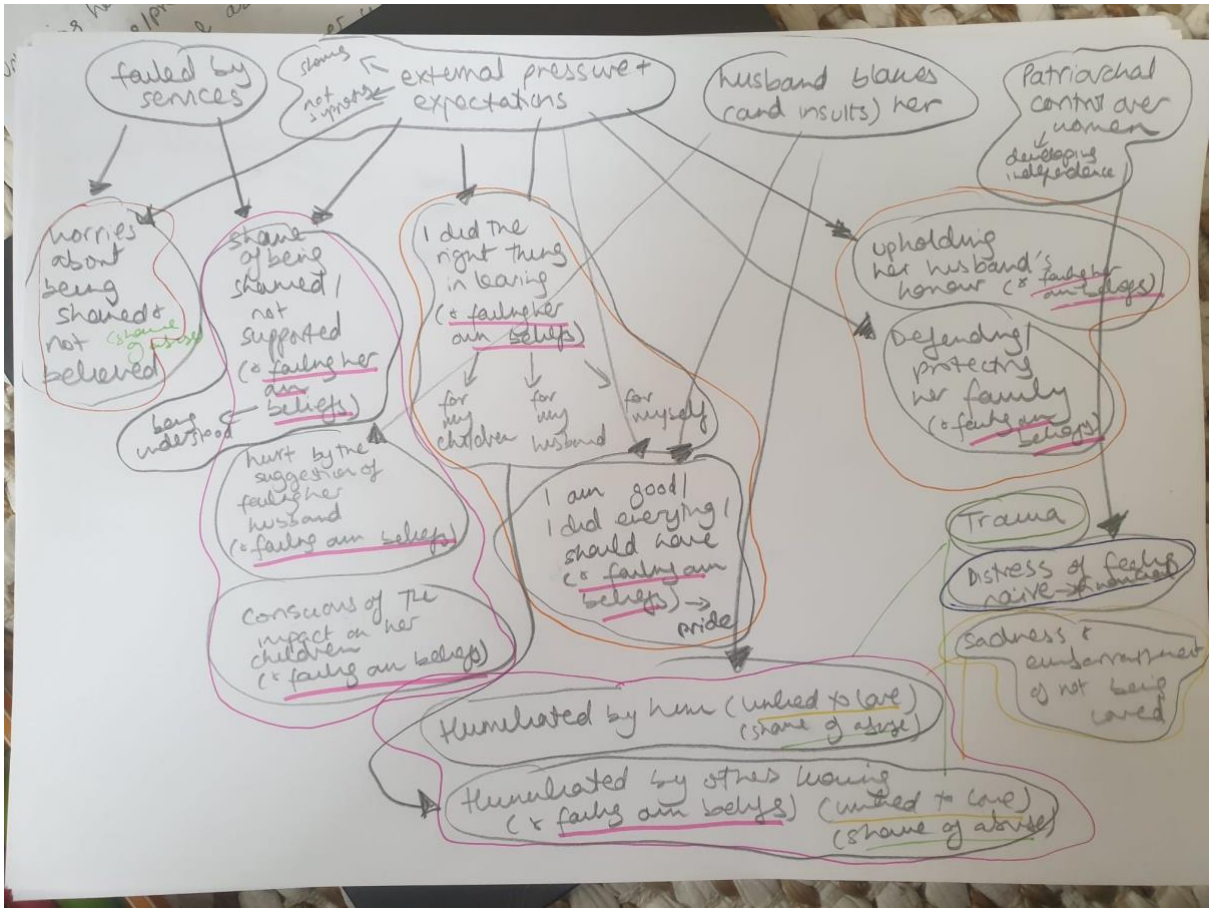

alcohol increased the abuse
Code
Annotations
Summary
Reference
Files\\Sarmini Final
1 reference coded, 0.20% coverage
Reference 1: 0.20% coverage
he just very violent when he drinks- so he started drinking again, then being violent towards her again.
Files\\Vathani Final
1 reference coded, 0.24% coverage
Reference 1: 0.24% coverage
So, always, always arguments if he drinks in the morning in the night, whenever he's drinking is always argument.

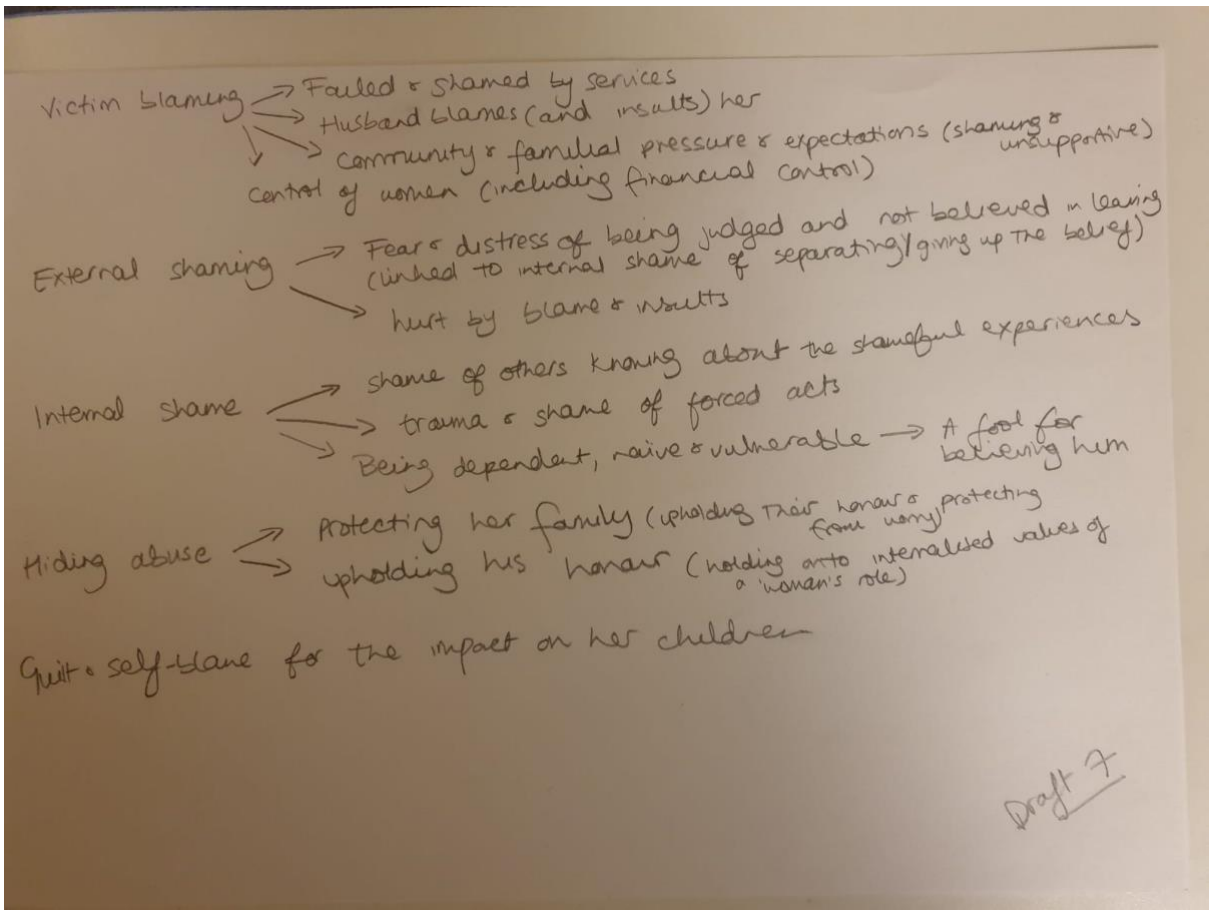

she witnessed her mum accepting abusive behaviour and refused to be like that
Code
Annotations
Summary
Reference
Files\\Roja Final
1 reference coded, 0.25% coverage
Reference 1: 0.25% coverage
because sometimes my mum and dad is argument, so I don't want like that life because my mum is not like me. Everything crying. I am now talking with my husband. My mum is not that. My dad right or good, she not any word tell. She is only crying. But I'm not like that now.

Appendix J: Thematic Mapping Process




Anxiety/ fear about being shamed/ not believed
ashamed by being shamed/ unsupported (law)
defending herself/ I am good
hurt/ ashamed/ humiliated of being blamed/ insulted
ashamed about other people knowing
defending her decision to leave/ I am in the right
failed by services
shamed by the community/ family
Blamed by husband
insulted by husband
protecting her family
upholding his honour/ protecting him against judgement
Patriarchal control over women
shame of the not being the mother she wanted to be
trauma of sexual abuse torture
rejection/ sadness of not being loved
fighting for her autonomy raging against men
suicide/ self-harm
ashamed for dependance/ naivety/ vulnerability


failed by services
external pressure + expectations
husband blames (and insults) her
Patriarchal control over women
worries about being shamed & not believed
shame of being shamed/ not supported (& failing her own beliefs)
I did the right thing in leaving (& failing her own beliefs)
upholding her husband's honour (& failing her own beliefs)
Defending/ protecting her family (& failing own beliefs)
for my children
for my husband
for myself
hurt by the suggestion of failing her husband (& failing own beliefs)
I am good/ I did everything I should have (& failing own beliefs) → pride
Trauma
Distress of feeling naive → humiliated
conscious of the impact on her children (& failing own beliefs)
Sadness & embarrassment of not being loved
Humiliated by him (linked to love) (shame of abuse)
Humiliated by others knowing (& failing own beliefs) (linked to love) (shame of abuse)


Victim blaming → Failed & shamed by services
→ Husband blames (and insults) her
→ community & familial pressure & expectations (shaming & unsupportive)
control of women (including financial control)
External shaming → Fear & distress of being judged and not believed in leaving (linked to internal shame of separating/giving up the belief)
→ hurt by blame & insults
Internal shame → shame of others knowing about the shameful experiences
→ trauma & shame of forced acts
→ Being dependent, naive & vulnerable → A tool for believing him
Hiding abuse → protecting her family (upholding their honour & protecting from worry)
→ upholding his honour (holding onto internalised values of a woman's role)
Guilt & self-blame for the impact on her children
Draft 7

Appendix K: Information Sheet

DOMESTIC VIOLENCE WITHIN THE SRI LANKAN TAMIL COMMUNITY IN THE UK: UNDERSTANDING SHAME AND EXPEREINCES OF MENTAL HEALTH SERVICES

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a Clinical Psychology Doctorate. As part of my studies, I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research to better understand how shame is experienced by Tamil women who have been victims of domestic violence, and the impact on accessing and engaging with mental health services. The research aims to understand how Tamil women describe their experiences of shame, what impact this has on their behaviour, including accessing mental health services, and how shame is experienced in mental health services and therapy.

The purpose of the research is to improve health professionals' understanding, so that they can provide mental health services that meet the needs of the Tamil community. The research will add to the information available to services and psychologists to use in adapting and changing services to benefit the Tamil community.

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone with experience and knowledge of the research topic. I am looking to interview first generation Tamil women who have been a victim/survivor of domestic violence.

I am inviting women who experienced violence while in a relationship with a man, though the perpetrator does not have to have been this man, but could also be a family member in the man's family. Due to the differences in understanding same-sex relationships, the study will not be exploring violence within same-sex relationships.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect. The research wants to better understand your experience, as a Tamil woman who has experienced domestic violence.

The decision to participate in the research is your own, and you should not feel coerced into participating.

What will your participation involve?

If you agree to participate in the research, you will be contacted to set up a time and date for an interview. Depending on Covid-19 restrictions and your

preference, the interview will be done over Microsoft Teams/Zoom or face-to-face at the Tamil Community Centre.

The interview will be an informal chat between yourself and myself, the researcher, and should last about an hour. If you would benefit from a translator, they will also join the interview. The conversation will be audio recorded.

The questions I ask you will be broad, focussing on your experiences and understanding of domestic violence, shame, and mental health services. You can tell me as much or as little as you feel comfortable with. As the topic is sensitive and can be difficult to talk about, we will go at your pace and can take breaks or end the interview whenever you need. Also, if there is a question you feel uncomfortable answering, please let me know and we can move on. Discussing domestic violence and shame may bring up painful memories and emotions, so please only participate in the research if you feel safe and comfortable to talk about these topics.

The main interview questions are:

- Why do you think domestic violence is not spoken about, or is denied, within the Tamil community?
- Would it be ok to tell me a bit about your experience of domestic violence?
- Many people who are victims of domestic violence feel ashamed or shameful. Is this something you experienced?
- What makes mental health services or talking therapy difficult to access for Tamil women who have been abused?
- Are there any examples of your experience of therapy that you would feel comfortable talking about?
- How do you think mental health services and mental health professionals could best support Tamil women who have experienced domestic violence?
- Is there anything you think would be important or relevant to talk about that I did not ask about?

Once the interview is complete you will receive a voucher for your time and commitment to the research. I will send you a £15 voucher for your participation, either over email or to your address.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

- The personal information that you provide so that I can contact you and pay you for your participation, such as your name and contact information, will not be used in the research. This information will be stored separately from the research data.
- The signed consent form will be securely stored, separate from the research data, until the research has been accepted for publication and then it will be deleted.
- You will be asked to choose a pseudonym, a fake name, for the purpose of the interview. I will not ask you for any information that may identify you during the interview.
- The audio recording of the interview will be deleted once the project has been examined and passed. The audio recording will be transcribed (written up) without any information that may identify you as the interviewee. The transcription will be saved securely until publication of any papers based on the research, before being deleted.
- Any potentially identifiable information that you tell me in the interview will be anonymised. Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research.
- You do not have to answer all questions asked of you and can stop at any time.
- If you feel unsafe at any point during our conversation, then we can end it immediately. You will also be provided with my contact information and information about services that can support you if you feel affected by the topics we discuss.

What will happen to the information that you provide?

What I will do with the material you provide will involve:

- Your name and contact information will not be included in the research. This information will be stored separately from the research data in a secure file on the researcher's UEL OneDrive. This information will only be accessible by the researcher and will be deleted as soon as your involvement in the research is finished.
- Your signed consent form will be securely saved on the UEL H: Drive, separate from the research data during the research process. Following completion of the research, it will then be saved on the research supervisor's UEL OneDrive until the research has been accepted for publication. The signed consent form will then be deleted.
- Your name and identifiable information will not be asked for in the interview. Any potentially identifying information will be anonymised in the transcription of the audio recording.
- The interview will be recorded in Microsoft Teams/Zoom and/or using a Dictaphone. Audio files will be uploaded onto the researcher's university secure drive immediately after the interview and subsequently deleted from Teams/Zoom and/or the Dictaphone. Only I, the researcher, will have access to the audio recordings. The audio recording will be stored separately from the transcription of the interview and will be deleted once the project has been examined and passed.
- The anonymised interview transcript will be stored on the researcher's OneDrive cloud service. Once the researcher has left UEL, the anonymised interview transcript will be securely stored on the researcher's supervisor's OneDrive until publication of any papers based on the research, and then deleted.
- The anonymised interview transcripts may be read by the researcher's partner organisations (Tamil Community Centre and [organisation name removed for confidentiality]), supervisor and examiners, and may be included in the write-up of the research, including in published academic journals. Anonymised extracts of the interviews may also be included in presentations, reports and other publications.

- Some broad demographic information may appear in the thesis and following publications, but this information will not identify you as an individual participant.
- The thesis will be publicly accessible on UEL's institutional repository.
- You are free to end the interview whenever you want. You will also be able to withdraw your data from the study within three weeks of conducting the interview. However, once the data analysis stage begins and the anonymised transcripts are combined with other participants' data, it will not be possible to withdraw your data.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Engaging or not in the research will not impact the support you receive from [organisation name removed for confidentiality] or the Tamil Community Centre. You will also be able to withdraw your data within three weeks of participating in the interview. However, once the data analysis stage begins and the anonymised transcripts are combined with other participants' data, it will not be possible to withdraw your data.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Phoebe Neville

[contact information removed for confidentiality]

If you have any questions or concerns about how the research has been conducted please contact the research supervisors, Dr. Kenneth Gannon and Dr. Trishna Patel [contact information removed for confidentiality]

Appendix L: Consent Form

DOMESTIC VIOLENCE WITHIN THE SRI LANKAN TAMIL COMMUNITY IN THE UK: UNDERSTANDING SHAME AND EXPEREINCES OF MENTAL HEALTH SERVICES

UNIVERSITY OF EAST LONDON

I confirm that I have read the information sheet dated XX/XX/XXXX (version X) for the above study and that I have been given a copy to keep. ☐

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation in the study is voluntary and that I may withdraw at any time, without providing a reason for doing so. ☐

I understand that if I withdraw from the study, my data will not be used. ☐

I understand that if I participated in an individual interview I have 3 weeks from the date of the interview to withdraw my data from the study. I understand that if I engaged in the focus group I am unable to withdraw my data from the study. ☐

I understand that the interview will be recorded using Microsoft Teams/Zoom and/or a Dictaphone. ☐

I understand that my interview data will be transcribed from the recording and anonymised to protect my identity. ☐

I understand that my personal information and data, including audio recordings from the research will be securely stored and remain strictly confidential. Only the research team will have access to this information, to which I give my permission. ☐

It has been explained to me what will happen to the data once the research has been completed. ☐

I understand that short, anonymised quotes from my interview may be used in the thesis and that these will not personally identify me. ☐

I understand that the thesis will be publicly accessible in the University of East London's Institutional Repository (ROAR). ☐

I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in professional and academic journals resulting from the study and that these will not personally identify me. ☐

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to. ☐

I will offer you an Amazon/Love2Shop voucher as a token of appreciation for your participation. However, HMRC regulations require that recipients must

☐

provide details of their name, address and National Insurance Number. If you wish to receive a voucher you should tick to indicate that you have been informed of this requirement.

I agree to take part in the above study. ☐

Participant's first name:……

Participants' last name:……

Participant's signature:……

Date signed:……

Appendix M: Debrief Sheet

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on "DOMESTIC VIOLENCE WITHIN THE SRI LANKAN TAMIL COMMUNITY IN THE UK: UNDERSTANDING SHAME AND EXPEREINCES OF MENTAL HEALTH SERVICES". This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

- Your name and contact information will not be included in the research. This information will be stored separately from the research data in a secure file on the researcher's UEL OneDrive. This information will only be accessible by the researcher and will be deleted as soon as your involvement in the research is finished.
- Your signed consent form will be securely saved on the UEL H: Drive, separate from the research data during the research process. Following completion of the research, it will then be saved on the research supervisor's UEL OneDrive until the research has been accepted for publication. The signed consent form will then be deleted.
- Your name and identifiable information will not be asked for in the interview/focus group. Any potentially identifying information will be anonymised in the transcription of the audio recording.

- The interview/focus group will be recorded in Microsoft Teams/Zoom and/or using a Dictaphone. Audio files will be uploaded onto the researcher's university secure drive immediately after the interview and subsequently deleted from Teams/Zoom and/or the Dictaphone. Only I, the researcher, will have access to the audio recordings. The audio recording will be stored separately from the transcription of the interview/focus group and will be deleted once the project has been examined and passed.
- The anonymised transcript will be stored on the researcher's OneDrive cloud service. Once the researcher has left UEL, the anonymised transcript will be securely stored on the researcher's supervisor's OneDrive until publication of any papers based on the research, and then deleted.
- The anonymised transcripts may be read by the researcher's partner organisations (Tamil Community Centre and [organisation removed for confidentiality]), supervisor and examiners, and may be included in the write-up of the research, including in published academic journals. Anonymised extracts of the interview/focus group may also be included in presentations, reports and other publications.
- Some broad demographic information may appear in the thesis and following publications, but this information will not identify you as an individual participant.
- The thesis will be publicly accessible on UEL's institutional repository.
- If you engaged in an individual interview you will also be able to withdraw your data from the study within three weeks of conducting the interview. However, once the data analysis stage begins and the anonymised transcripts are combined with other participants' data, it will not be possible to withdraw your data.
- If you engaged in a focus group you will not be able to withdraw your data from the study, as it will not be possible to decipher your contributions from other group members' contributions on the audio recording.

What if you have been adversely affected by taking part?

The topic of the interview/focus group was sensitive, and you may feel distressed, upset or uncomfortable. Discussing shame, domestic violence and mental health services may have triggered difficult memories and emotions for you.

If you are feeling distressed following the interview/focus group, please let me know and with your permission, I can discuss follow-up support for you through the Tamil Community Centre. Alternatively, you can seek support yourself from the Tamil Community Centre who have agreed to offer follow-up support for research participants.

You can also seek support from your G.P. or any mental health services that are you currently engaged with. If you are worried for your safety or anyone else's, including having thoughts about self-harm or suicide, it is very important that you speak to your G.P. or mental health professional about this.

You may also find the following resources/services helpful in relation to obtaining information and support:

[information removed for confidentiality]

You are also very welcome to contact me or my supervisor if you have any specific questions or concerns or would like further information about the research.

Phoebe Neville
Email: [removed for confidentiality]

If you have any questions or concerns about how the research has been conducted please contact the research supervisors, **Dr. Kenneth Gannon** and **Dr. Trishna Patel** [address removed for confidentiality]
Email: [removed for confidentiality]
Email: [removed for confidentiality]

Appendix N: Reflections on Distress and Ethics in Research

Hearing participants' trauma and connecting with their shame was distressing and overwhelming. It was made more difficult by the inescapability of violence against women in society, so that gender-based violence became all encompassing; I was witnessing the impact of abuse on women in the research, at work, in personal relationships, and in the media. In my reflective journal I have described feeling sad, scared, shameful and helpless following interviews; these feelings were shaped by my position as a White researcher and clinician, including feeling ashamed about the negative experiences participants had in services, and powerless in my ability to help. I wonder whether these were also feelings felt by the participants.

The impact on me was to become burn-out. In one interview recording I watched back I noticed how disconnected I was from the participant, and felt guilty about how she may have experienced the interview. In my reflective journal entry from that interview I noted that the participant seemed unemotional and did not want to speak about negative experiences with me. On reflection I wonder whether my inability to emotionally engage prevented the participant from being able to share her feelings and instead act in defence of herself and her community. After seeing myself in the recording I tried to look warm and encouraging in the following interviews.

Negotiating safeguarding concerns within a research role was anxiety-provoking because I did not have the same control and structures in place as in clinical work. Yet, I wanted to ensure the women were safe and their distress soothed. I therefore worked with TCC to ensure the women were supported, without over-stepping the boundaries of research. For the women who disclosed large amounts of distress in the interviews, they seemed to have benefited from additional support from TCC post-interview.

At the start of the research I viewed ethics as completion of the institutions' ethics application and protection against risk. However, through the process I realised that academic institutions' research ethics processes emphasise risk management strategies primarily aimed at protecting institution, not necessarily

participants (Tolich & Fitzgerald, 2006), and can limit meaningful and ongoing engagement with participant-centred ethical considerations (Schulz, 2021). Due to the complexity of the research I became more actively engaged in considering the ethics of research and found the idea of participants' agency particularly useful (Fujii, 2012).

Considering participants' agency was particularly helpful when I worried about the distress participants expressed in the interviews and whether the interview process had exacerbated participants' distress. By reflecting on agency I realised that I had positioned myself as solely responsible for the participants and the research, thus adopting a neo-colonial approach to research that infantilised the participants as passive subjects (Schulz, 2021). I therefore re-framed my understanding to see the participants as active contributors to the research who volunteered to be interviewed for their own reasons and had control over what to disclose. Acknowledging the agency of participants did not mean I no longer considered the power-imbalance between myself and participants, or didn't attempt to protect against risk and harm (Schulz, 2021).

Through the process, I learnt a lot about my assumptions. The lack of clear boundaries around shame and domestic abuse came up repeatedly and formed a more complicated context than I had anticipated. For example, an informal conversation with someone involved with TCC revealed the complexities of 'leaving' an abusive relationship such that a women may both be separated from the perpetrator and live in the same house. This made me re-consider whether my inclusion and exclusion criteria were overprotective; the criteria may have undermined victim-survivors' ability to safely decide for themselves whether they would benefit or be harmed by participating in the research, regardless of being in an abusive relationship or separated. Given that this research was an examined piece of work, my supervisor and I aired on the side of caution.

Shame was also less boundaried, and more complicated to examine than I had expected. I realised that shame does not exist on its own, but overlaps with other emotional experiences, and may also be avoided in discussion. With practice, I became more comfortable with identifying shame as a latent

experience. Focussing on how participants' emotional expressions changed across topics and noticing what they avoided discussing helped illuminate shame. On several occasions I noticed that participants may have been attempting to deny shame, out of shame.