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Narrative storytelling as mental health support for women experiencing gender-based violence in Afghanistan

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Abstract:

Rationale. Experiencing gender-based violence (GBV) can have serious consequences for women's mental health. However, little is known about how to address the health consequences of GBV against women in high-prevalence settings societies where GBV is widely accepted as normal.

Objective. This study examines the potential for narrative storytelling to support women's mental health and alleviate the suffering caused by GBV in high-prevalence settings. It adopts a symbolic interactionist perspective to explore the perceptions and lived experiences of women living in safe houses for GBV in Afghanistan expressed through storytelling.

Method. In-depth semi-structured interviews were carried out with women (*n*=20) in two Afghanistan safe houses between March and May 2017. The data were analysed both inductively and deductively using thematic network analysis.

Results. The findings reveal the stigmatising and traumatic experiences many women have had when telling their stories of GBV in this context. In contrast, storytelling under supportive conditions was perceived to be a highly valuable experience that could help formulate positive social identities and challenge broader social structures. The supportive conditions that contributed to a positive storytelling experience included the presence of a sympathetic non-judgemental listener and a supportive social environment.

Conclusions. These findings offer an alternative to biomedical models of mental health support for women experiencing GBV in high-prevalence settings. They raise the importance of tackling broader social changes that challenge patriarchal social structures, and highlight the potential role that narrative storytelling approaches can play in high-prevalence settings like Afghanistan.

Key words: storytelling, gender-based violence, mental health, Afghanistan

Introduction

Women who experience gender-based violence (GBV) are more likely to experience depression and anxiety (Estefan et al., 2016; Kennedy et al., 2009; Kothari et al., 2016), suicidal ideation (Canetto, 2015; Devries et al., 2013), and to have symptoms of post-traumatic stress disorder (PTSD) (Benitez et al., 2009; Rahill et al., 2015). In high-prevalence settings, where over 50% of women experience GBV, interventions to address these mental health consequences are few and far between (Ellsberg et al., 2015). GBV comes in many forms in high-prevalence settings, including domestic violence, psychological abuse, sexual assault, honour killings, torture, and acid attacks. While seemingly different, these violent acts all share the common purpose of enforcing gendered ideals of masculinity or femininity, resulting in significant consequences for the mental health of the survivor (Mannell and Hawkes, 2017).

In recent years, storytelling forums have emerged in many high-prevalence settings as a means of addressing GBV by encouraging personal expression and empowering women. For instance, *Ana El-Hekaya* ('I am the story') is an Egyptian storytelling project that aims to provide gender education and advocacy through having women write fictional stories from real life interviews (Ali, 2014). Literary societies such as the Mirman Baheer Literary Society and the Kapisa Writers and Poets Society in Kabul provide spaces for women writers to develop their art and self-expression (Fernandes, 2017). Storytelling has also been used as a research method with Iraqi women as both a post-colonial critique, and as a means of dismantling researcher and participant power hierarchies (Bryant, 2016). These initiatives reflect a broader 'narrative turn' in the social and political sciences, and in interest around the role of storytelling in meaning construction and human agency (Davis, 2012). However, despite this shift there has been little research on the role of storytelling in the lives of women experiencing GBV, its potential for

building agency or empowerment, or the risks and benefits that stories have for women in high-prevalence settings.

In order to contribute a deeper understanding of the potential effects of storytelling in relation to GBV, we take a symbolic interactionist perspective (Mead, 2015) to explore self-perceptions and lived experiences of storytelling with women living in two Afghanistan GBV safe houses. Afghanistan shares similar characteristics with other high-prevalence settings. The prevalence of ever-married women who have experienced violence is 53% with 46% having experienced violence in the past year (Central Statistics Organization/Afghanistan, 2017). These high rates of violence arise from the patriarchal characteristics of Afghan society with religious and tribal norms that severely restrict women's lives to the domestic sphere (Ahmad and Avoine, 2016). A woman's 'virtuous' behaviour is deeply connected to a family's honour in ways that grant permission for violence to be used against women by both the family and the state (Moghadam, 1999). The widespread acceptance of GBV makes the reporting of violence to family, neighbours, or the police extremely dangerous for women (Baldry et al., 2013). Equally, it reduces the provision of services for survivors of GBV and creates a stigmatised environment for safe houses, which are seen as protecting 'perverse' women who have broken important moral codes (Rasa, 2017). Culturally-relevant, tailored interventions which support women in challenging the patriarchal structures that perpetuate GBV in high-prevalence settings are urgently needed in order to respond to women's mental health needs and prevent further harm.

Limitations of biomedical models for high-prevalence settings

Telling one's story is the foundation of well-evidenced biomedical psychotherapies for trauma, including cognitive behavioural therapies and exposure therapies, which employ specific methods for formulating stories and measuring the reconstruction of a story. These therapies take

a biomedical approach by focusing on how emotional memories elicit particular biological responses in the brain. For instance, cognitive behavioural approaches emphasise the role of 'maladaptive cognitions' in producing symptoms of trauma, and seek to address these through testing and challenging unhelpful thought-patterns and behaviours through collaborative problem-solving with a trained therapist (Hofmann et al., 2012). Other approaches focus on the process of repeating the painful memory as a means of reducing symptoms of trauma. Techniques such as Prolonged Exposure (PE) (Foa et al., 1991) and Narrative Exposure Therapy (NET) (Robjant and Fazel, 2010) aim to address trauma through the telling and retelling of one's story. With these exposure approaches, particularly traumatic events are understood to be left unprocessed by the brain and stored together with emotions and physical sensations that are then re-experienced long after the trauma has ended (Welling, 2012). In response, therapy is understood to play a role in re-enacting the traumatic memories as a means of reconsolidating new and more positive emotional experiences (Lane et al., 2015). From this biomedical perspective, the aim of therapy therefore becomes one of identifying an event in the person's life as the source of the trauma and repeatedly describing the event in order to reconstruct a new more positive cognition.

A biomedical approach to trauma is limited, however, in addressing the mental health of women experiencing GBV in high-prevalence low-income settings such as Afghanistan. Psychoanalytic therapies require highly specialised professionals, who are largely unavailable in most low-income settings (Bruckner et al., 2011). In settings where over 50% of women have experienced violence, the widespread acceptance of violence as normal behaviour can further magnify patriarchal responses by healthcare providers to women (Stark et al., 1979), and perpetuate women's reluctance to approach healthcare providers for GBV-related trauma in the

first place (Stokes et al., 2016). Insisting that individuals who have experienced trauma repeatedly tell their stories may also be unethical in contexts where exposure to gender-based violence is ongoing and chronic, and where disclosure can carry the significant risk of further violence.

The potential for the process of telling stories to improve mental health is unlikely to be recognised when a narrow focus is placed on the alleviation of a particular set of symptoms. The focus of biomedicine on mental illness obscures the potential for storytelling to have wider implications for the mental wellbeing of women experiencing GBV, such as by creating opportunities for women's agency or spaces for advocacy (Campbell and Mannell, 2016). Equally, the focus of the biomedical approach on trauma as a pathology of the individual does not acknowledge the patriarchal structures and gender inequities that perpetuate both GBV and women's suffering in Afghanistan and elsewhere. Socially transformative trauma interventions that not only shift the focus of pathology away from the individual, but also that challenge the neutral positionality of the clinic bracketed from society are needed (Foucault, 2012).

Moreover, the dominance of a biomedical approach that focuses on re-enacting traumatic memories through speech has minimised any consideration of the potential therapeutic value of telling fictional stories or folklore. Yet, the function of storytelling is similar as a means by which information is collected and disseminated within communities (Strauss, 1997). A small collection of studies, which our study contributes to, have examined storytelling in the form of urban myths for the role it plays in disseminating information about health risks and justifying certain health-related behaviours (Roche et al., 2005; Whatley and Henken, 2000). Others have explored the ability of storytelling to help frame experiences in positive ways. For example, in a study of storytelling by immigrant Iranian women, Dossa (2004) discusses the health benefits of

stories in helping women shape positive narratives of mental health and mediate the negative framings of depression and anxiety arising from their host country. A recent ethnographic collection explores the role of writing poetry in breaking boundaries of marginalisation for Afghan immigrants, and the ways that traditional forms of Persian poetry are evolving to challenge gender norms (Olszewska, 2015). Stories might also mediate the effects of stigma and discrimination related to GBV in high prevalence settings. For instance, in Gergen and Gergen's (2011) study examining storytelling as part of transitional justice for Acholi women in Uganda who had experienced GBV during conflict, stories were used to counteract discrimination from neighbours and family. It was also used to reinterpret the past in ways that defended the moral character of the woman in order to defend her place in Acholi society.

We aim to contribute to this literature on storytelling and to current gaps in the response to GBV in high-prevalence settings by asking the following research question: *what is the potential for storytelling to support women's mental health through challenging societal narratives of gender and violence?* In answering this question, we take a symbolic interactionist perspective that recognises the structures that perpetuate GBV and that limit options for women, while also acknowledging the role that individuals can play in challenging these patriarchal social structures (Campbell and Mannell, 2016). Within this perspective, the potential of narrative storytelling as a response to the mental health needs of women experiencing GBV arises from the role of storytelling as a social and political practice which 'defines the way certain things are represented, thought about, practiced and studied' (Hall, 1997, p. 6). In this way, storytelling opens up new possibilities for transforming both the self and society through reconfiguring an individual's relationship with societal narratives of gender and violence. Stories can provide a space not only for reinforcing representations of GBV, but also for challenging

them through changing the stories we tell or telling them in different ways. As such, storytelling offers a powerful tool for reinterpreting identities, shifting claims of difference and challenging commonly shared values (Howarth, 2011). Following the emphasis of symbolic interactionism on how symbolic meaning arises from the interaction between individuals (Mead, 2015), in this study we draw on women's own perceptions and lived experiences of telling stories about GBV in Afghanistan in order to embed our understanding of storytelling within the relationships, interactions, and experiences of this context.

Method

To understand women's perceptions and lived experiences of storytelling in relation to GBV, we partnered with a local non-governmental organisation (NGO) that operates 'safe houses,' which provide temporary shelter for women who have experienced violence. In Afghanistan, NGOs operate all safe houses and there is no government provision for women who have been abused. Women are referred to these safe houses by the police, government agencies, or other NGOs, and while self-referral is possible, it is rare due to significant cultural and societal barriers. During data collection from March to May 2017, the safe houses were experiencing considerable political pressure and were at risk of being formally closed by the government.

Participant recruitment

A purposeful sample of 20 women who had experienced violence from their husbands or other male authority figures was recruited from the two safe houses run by our partner organisation. This environment provided an ideal sample for a study of storytelling, as women living in the safe houses have had multiple experiences of telling their story of GBV in order to

obtain access to the safe house's services. The women participants came from all over Afghanistan and spoke four different languages as their mother tongue including Pashto, Dari, Nooristani, and Uzbeki. The majority had been referred to the safe house by the Ministry and Women Affairs, and had been living at the safe house for durations ranging between 1 month and 4 years. Several of the women lived in the safe house with their children, while others had children who remained with their husband's family. The lives of women and children in the safe houses are highly restricted, and they rarely leave due to concerns for their safety.

Having previously conducted research in the safe houses, LA was known to the staff and some of the women, which helped to build rapport. A detailed conversation took place between all staff and safe house residents about the research prior to recruiting participants. Any concerns about the research were discussed openly and women were then invited to participate in individual semi-structured interviews. Safe house staff members were also invited to participate in semi-structured interviews and 8 staff members participated in the study. This provided a means of triangulating the data (Flick, 1992) in order to provide a richer understanding of women's lived experiences and the potential role of storytelling in addressing GBV-related trauma.

Data collection

LA conducted semi-structured interviews in Dari and Pashto, asking the women questions about their experiences of storytelling in general and in relation to GBV, and about the benefits and challenges of telling stories about GBV-related experiences. The interviews were audio recorded, and LA transcribed and translated them into English verbatim for analysis. The original study design also included a group storytelling activity that used fictional and non-fictional stories of GBV (including a recent news story, a folk tale, an excerpt from a well-known

novel, and a poem) to facilitate a group discussion about the role of society in perpetrating GBV against women. The purpose of the group activity was to investigate the practical dynamics of a storytelling intervention such as this in a safe house environment. However, we were unable to complete the group activities as originally planned because of the political pressures mentioned previously, and persistent government surveillance within the safe houses at the time of data collection. Since we would have been unable to obtain data saturation from a single group activity, these data were removed prior to the analysis.

Data analysis

The interview data were analysed both deductively and inductively in two stages (Fereday and Muir-Cochrane, 2006). In the first deductive stage, AA read through all of the transcripts and met LA in person in Afghanistan to discuss LA's direct experience of conducting the interviews and any contextual material she felt was relevant to the data. There was significant discussion on the purpose or meaning of stories in the Afghan current socio-cultural context and the rich historical traditions of storytelling as well as the symbolism of giving a story to a listener. Specific stories were also shared. AA and LA then discussed broad overarching analytical themes that could be applied to the data. These analytical observations were recorded as field notes to inform the analysis.

As an independent deductive stage, JM independently coded the data for themes about what the women themselves said about storytelling, and then organised the themes into overarching categories (organising themes). This independent coding helped to establish inter-rater reliability through a process of comparing and contrasting the two sets of codes to come up with an agreed coding framework. JM and AA then met to collaboratively establish global themes and complete a thematic network from the interviews with the women who had

experienced violence. This last step was done through an iterative process of reviewing the organising themes and abstracting shared themes into global themes (i.e. overarching analytical ideas which summarise the meanings embedded within the entire dataset) (Attride-Stirling, 2001).

As an additional step in the analysis, the eight semi-structured interviews with safe house staff were used to triangulate the thematic network arising from the interviews with women who had experienced violence and were living in the safe houses. The safe house staff interviews helped to confirm women's perceptions of the negative implications of telling their stories of violence to others.

Ethics

Ethical approval for the project was granted by the partner NGO in Afghanistan and by University College London's (UCL) research ethics committee (REC). We followed the World Health Organisation's guidelines for conducting research on violence against women (2001), including safeguarding the research team to avoid secondary trauma, ensuring participants had access to counselling services through the safe houses, and ensuring policy impact of the research through dissemination of research findings. All researchers were appropriately trained in sensitive interviewing techniques and had worked previously with GBV survivors. We also considered the recommendations of Mannell and Guta (2017) for a critically-informed approach to ensuring ethical procedures for GBV research are context-relevant. This involved additional considerations such as ensuring that only LA, as the local researcher, visited the safe houses in order to maintain the security of the women, and that the name of the partner organisation remained confidential in any dissemination. Because most participants were illiterate, verbal

consent was audio recorded. Participant numbers have been used in this article to protect the confidentiality of the participants.

Results

The women living in the safe houses discussed many different types of stories that had meaning in their lives, including their own life story as well as stories of family members, moral tales, myths, and songs. Despite the differences in these types of stories, they were all discussed as having similar effects on their sense of wellbeing in terms of bringing happiness and sadness, and/or relieving suffering. The overarching themes arising from our findings were that storytelling offers a means of *shaping identity and societal norms*, thus revealing the transformative power of stories. However, women's lived experiences of storytelling in relation to violence were often tainted by *GBV stigma*. Factors protecting against these negative storytelling experiences included *acceptance and support from the listener* and a *supportive social environment*.

Shaping identity and societal norms

Stories had great importance for the participants and played a significant role in their own process of learning about the world as children and the social expectations of Afghan society. Stories from their childhood were discussed as providing them with an identity, for instance, as a daughter:

> I: Can you tell me a story (poem, song) from your childhood?
>
> P17: My mother told me the story of my father. From the time I can remember, my father had been sick. He couldn't walk or move his hands. I was 12 years old when he died. The story of my father is that I was very young - 9 months old - when he went to do his

> military duty for two years. During those two years, he got rheumatism. He was sick but we couldn't treat him properly, because we were poor and live in a remote village in north of Afghanistan.
>
> I: Why is this story important to you?
>
> P17: This story is important for me because it is my father's story and it is my family story.
>
> [P17: age 41, 1.5 years in the safe house]

This story of a father who died before she can remember is important because it provides her with a positive sense of identity as a daughter in a family. In a society where women often leave their family when they marry, and where the husband's family may be abusive, stories of a birth family can hold enormous importance.

The stories women identified with were not always stories of relatives, but almost always provided women with a positive sense of identity:

> I like a song that is in Nuristani. It is about an orphan girl, first she lost her father, then her mother, then her land and sheep. At the end of the song the orphan girl goes with her lamb to a new place and starts a new life…It is important for me because it is exactly my life story. I lost my father and two brothers, they were killed in a family conflict. In Nuristan, people have many family conflicts that come from the past. They fight and kill each other because of land and because of women…I love this song and when I lost my father, I would always sing this song on my own because it touched my heart.
>
> [P10: age 21, 4 months in the safe house]

This fictional story told through song is important because it helped reaffirm this woman's identity as an orphan who lost her family and then 'started a new life'. She can see herself in the story, a story that she tells as ending with hope and opportunity.

When asked about the role of storytelling in Afghan society, women talked about how stories had taught them about life and suffering:

> We Afghans tell stories to each other. We tell stories to our children, and by telling stories we socialize them and teach them what is bad and what is good.
> [P8: age 20, 3 months in the safe house]

This quotation sheds light on the role of storytelling in setting societal norms and expectations, and in defining good versus bad behaviour. In this way, stories may sometimes act as a means of normalising violence and women's trauma. For example, storytelling was discussed as teaching children about suffering and appropriate responses to adversity:

> My father told me the stories of our Bibis, how life was difficult for them, the suffering they faced and how they struggled. These stories are important because I have learned from them, the way they dealt with suffering and the difficulty of their lives.
> [P1: age 27, 4 years in the safe house]

In this way, sharing stories of suffering provide women with an understanding of the social expectations about their behaviour and the consequences when social rules are broken. However, determining whether stories are able to help women to understand their experiences in a way that effectively minimises GBV-related trauma requires a deeper understanding of women's lived experiences of storytelling.

Experiences of storytelling and GBV stigma

The stigmatisation of GBV within the broader social environment and by the women themselves played a significant role in women's lived experiences of storytelling. For some of the participants, stories were psychologically upsetting. Women did not always feel that telling their story made them feel better, and at times, it made them feel worse:

> I: When do you think of this story?
>
> P17: I love my parents, but they are not alive. After my father's death, my life and those of my five sisters were ruined. I think about my father's story when I am in pain. I think: why we are so unlucky as a family.
>
> I: Does it help to think of this story?
>
> P17: It is sad story, it makes me sadder and disappointed.
>
> [P17: age 41, 1.6 years in the safe house]

This interview points to the complexity of telling stories as a therapeutic approach in this context. Stories of GBV are heavily stigmatised in Afghanistan, and several women described the shame they felt from telling their stories:

> I am ashamed of my story. I always try to hide my story from other people. My husband beat me even when we were engaged. I didn't tell anyone, not even my father. I think that if people know my story they will think that I am not a good wife. [P13: age 19, 7 months in the safe house]

The stigma surrounding GBV also plays a significant role in women's fear and experiences of being blamed for their stories:

> For me and for other women it is difficult to tell our story. First it is difficult to find the right person to tell. Some people don't keep secrets. Some people blame you for all bad things that happen in your life.
>
> [P1: age 27, 4 years in the safe house]

This concern that they will be blamed for their story is compounded by a fear that even if they tell their story, as women they will not be heard:

> In Afghanistan, everything makes it difficult for women to even tell stories, especially when it is their own story. We never think about ourselves. I think we are not considered to be human, and when you are not really a human, who is going to hear your story?
>
> [P5: age 19, 1.2 years in the safe house]

This fear is well founded in Afghanistan. All of the NGO staff members interviewed discussed the stigma of GBV and the challenges this raised for women who live in the safe houses. The safe houses themselves are stigmatised, as they house women who have left their husbands, and this stigma created problems for NGO staff in getting women help from health professionals for example. As the psychologist for one of the safe houses explained:

> These women are not criminals, but the safe house is like a jail. Security is a big issue for these women, so they have to stay here. They can never go out. If they go to the doctor or visit their family they have to go with a car and bodyguards because they are constantly under threat.
>
> [Safe house psychologist]

As this quotation highlights, women living in the safe houses experience ongoing risks to their personal safety and security because of their experiences. Telling stories about these experiences can therefore be extremely dangerous. In some cases, stories can lead to imprisonment or even death:

> Yes, it is difficult for Afghan women to tell their story. I never tell my real story to anyone. There is a man I love, and he loves me. But I never talk about it to anyone. I know if someone knew about this, they would tell my family and my brother would kill me.
>
> [P2: age 19, 2 months in the safe house]

Several of the women told of how their stories had been used as a means of manipulation, sometimes leading to domestic slavery and sexual abuse. Almost all women told stories of how they had confiding in someone who had eventually taken advantage of them by using the fact that they had tried to leave the violence of their husband or family, which is socially and morally unacceptable in Afghanistan.

Acceptance and support from the listener

All participants described how they felt after telling their story to others in a similar way: they often used the word *subic*, which is used to refer to relief from suffering and is best translated as 'being empty after having been full.' The release achieved through telling one's story was described as an embodied, cathartic experience:

> Today I told you my whole story. I cry and it helps me. Now I am a bit relaxed. [P16: age 20, 1 year in the safe house]

The positive benefits of storytelling were not from the telling alone, but as a result of being heard by another individual. The women described how the listener plays a supportive role in the storytelling by showing interest in their story:

> Today when I talk with you, it helps me. It makes me think that in this world at least there are some people who want to know about me and my life story.
> [P1: age 27, 4 years in the safe house]

It is through the interest of the listener in the story being told that women feel they can have hope:

> [Sometimes] I lose my hope to live, but people like you, when you hear my story it gives me power and I find new hope.
> [P7: age 18, 10 months in the safe house]

In this way, the therapeutic value of storytelling is about the physical release obtained through the process of telling and crying, but also the validation of knowing that the story has been heard and accepted without judgment or blame by another individual. The women explain the value of being heard as about having someone else that both understands them and values who they are:

> I am going to a psychologist. She talks with me. I tell her my story. It helps me a lot. It reduces my suffering and pain. I feel relaxed. It helps me because I share my pain and suffering with someone, and it gives me an idea that there is still someone who wants to hear me in this world.
> [P5: age 19, 1.2 years in the safe house]

For these women, being heard by another individual provides a means of reducing the suffering and pain they have experienced.

A supportive social context

In a context where women are often blamed for the violence they have experienced, acceptance of their story without judgment from those in their surrounding environment plays an important role in their recovery from trauma:

> It is good to tell your story when you think it is a secure place and supportive. When I feel that the people who hear my story will understand me and not blame me.
> [P2: age 19, 2 months in the safe house]

Women described how the safe house environment provides this type of supportive social environment through the shared experience of women who have all experienced violence:

> People tell their story to reduce their pain. I am here in the safe house, and here I have met many women and girls who have suffered. Sometimes we tell our story to each other and cry together. Then we feel as if something is coming out of our bodies. We talk about our pain just to share it with each other and it helps us. So, I think people tell stories to share their sadness and happiness.
> [P5: age 19, 1.2 years in the safe house]

Yet, the world outside of the safe houses remains dangerous for these women. Many of the women living in the safe houses have no choice but to return to their husbands once their physical wounds have healed. Others will remain in the safe house indefinitely because of the

ongoing threat to their lives, which points to the need for broader social changes to occur in order to support women's recovery in its entirety.

Discussion

The aim of this study is to explore the potential for storytelling to challenge socio-cultural narratives of gender and violence in ways that support women's mental health. Our findings show that despite some negative experiences when telling their stories, women experiencing GBV perceive stories and storytelling to be a cathartic experience important for their mental wellbeing. Women who had survived GBV, and currently live in two Afghanistan safe houses, talked specifically about how storytelling offers relief from suffering, helps to reaffirm positive social identities, and fulfils a basic need of being heard and understood. This is consistent with psychological literature on the positive role of narrative construction and biographic storytelling in trauma recovery (Denborough, 2006; Sunderland, 2001).

Our findings point to specific ways in which the act of storytelling offers this positive support for the mental health of women experiencing GBV in a high-prevalence setting such as Afghanistan. The storytelling process helps to reframe stories around a positive narrative of one's life history and social identity (Somers, 1994). One of the ways in which storytelling accomplishes this is through offering a space for the storyteller to imagine a 'hoped for' future and providing a space for healing from trauma through this process of imagining (Toyosaki, 2007). However, imaging a potential future within a therapeutic encounter requires not only a re-construction of the traumatic event itself, but also a process of situating the trauma in a wider life narrative. In our study, the women living in the safe houses expressed a clear desire to contextualise their trauma. While our questions were specifically about storytelling, the majority of women discussed their recent experience of violence as either a function or consequence of

their personal experiences, their role within their husband's family, or the broader experiences of their own family. This result concurs with evidence that the telling of family legacies can help establish one's own identity and create meaning for experiences of violence or traumatic events (Huisman, 2014; Thompson et al., 2009). In contexts of persistent conflict such as Afghanistan, storytelling can also provide a means of 'recrafting' identities that have been fractured through displacement and the death of family members during war (Schwartzman, 2015).

In order for the storytelling process to act as a positive therapeutic encounter, however, our findings point to two enabling factors: a sympathetic listener and a supportive social environment. First, the storytelling process requires a sympathetic listener who acknowledges the difficulty of the experiences storyteller describes. Women in our study specifically highlighted the importance of a sympathetic listener for their own sense of mental safety and wellbeing, or rather, for their story to be received without leading to further harm and violence (including disbelief). Therapy is a relational process, and the possibility for psychological healing exists in the co-construction of a narrative together with another individual (Lieblich et al., 2004). However, this also highlights an important difference between storytelling as part of a therapeutic encounter and an experience of telling one's story for the purpose of reporting the violence to police or authority figure. For the latter, the way the story is told can change the ability of a women to access services, but can also be negative as an experience. In contrast, for storytelling to be therapeutic, the role of the listener and their unconditional acceptance of the version of events is extremely crucial. This is an important distinction for consideration by organisations that offer both safe house facilities and legal support for GBV.

Second, storytelling that successfully supports women's mental health requires support from the social environment in which women live their lives. Much has been written about the

negative consequences of stigma and discrimination for women's mental health, including diminished self-respect and a reluctance to seek help (Clement et al., 2015; Corrigan et al., 2016). The women living in the safe houses provided specific examples of how the stigmatisation of GBV was enacted in Afghanistan: women often feared that their story would not be believed or that they would be judged, and some had been returned to their abuser by people they had trusted with their story. The safe houses did appear to provide this supportive environment through mutual support from women with similar experiences. However, the lack of a supportive environment may not be the case all of the time, or in all safe house environments. Women living in safe houses often have significant mental health needs, which can put enormous stress on other women and on staff (Helfrich et al., 2008). As a result, ensuring that the safe house environment does provide a supportive environment is something that may need to be carefully managed and facilitated. However, the potential for the safe house environment to provide this social support is also limited, which we discuss in more detail below.

In Figure 1, we mapped the relationship between storytelling and the protective factors of a sympathetic listener and a supportive social environment as they arise from our analysis. This conceptual diagram of how women in Afghanistan safe houses describe the therapeutic effects of storytelling largely contradicts biomedical understandings of how individuals recover from trauma through telling personal narratives. Whereas cognitive behavioural therapy (CBT) and exposure therapies (PE and NET) focus on the telling and retelling of a specific traumatic event as a means of alleviating symptoms of trauma (Volpe et al., 2017), our results highlighted the presence of multiple traumatic events and a need for participants to discuss these traumas in the context of narratives that reaffirm positive self-identities in the face of persistent patriarchal and structural gender violence. Doing so presents a major challenge to biomedical approaches to

trauma focused on 'maladaptive' cognitions by highlighting the social, rather than individual, nature of the trauma and its related symptoms. GBV in a high-prevalence setting is rarely a singular event leading to a problem of cognitive adjustment, but rather a persistent experience of inequity and stigmatisation. As a potential alternative to biomedical approaches to trauma, our findings point to the importance of the interpersonal and social process of storytelling, which moves beyond the limited focus on symptoms of mental illness to offer a means for women experiencing GBV to formulate ways of seeing the world that support a positive social identity.

<Insert Figure 1 here

Caption: *Conceptual diagram of a positive storytelling experience for women who suffer gender-based violence.*

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Limitations

This study describes women's experiences of storytelling in relation to GBV in Afghanistan, and highlights its therapeutic potential. However, due to the political situation at the time of the study, we were unable to carry out the planned storytelling activity, which was designed specifically in order to explore the potential for storytelling to help women situate their individual experiences within the broader social context of gender relations and the ongoing conflict that shapes life in Afghanistan today. In addition, there is a need for research on determining which types of stories are most useful in supporting the mental health of women experiencing violence and deeper understandings of the mechanisms through which storytelling might influence broader social norms of violence. These are important areas for future work.

Conclusions

The potential for storytelling to support women's mental health remains limited if it remains within the boundaries and safety of a safe house environment. Our findings point to the potential of the safe house to offer a supportive social environment for women to tell their stories, however, it is clear from our findings that the environment outside the safe house still presents significant dangers for women who have experienced GBV. Living in a safe house is not a long-term solution, and while a supportive safe house environment can provide psychological support for a period of time, women know they will likely eventually leave. Therefore, while safe houses have an important role in fostering opportunities for women to tell their stories, the support they are able to offer may not provide long-term benefits for women's mental health in this context. Storytelling within the safety of safe houses is an important means of challenging the negative aspects of women's perceptions and sense of self, but is limited in challenging GBV outside the safe house environment.

This is not to say that storytelling about GBV is only valuable within the protective and supportive social environments of safe houses. High-prevalence settings may pose many risks for women's stories about GBV and its role in the lives, but equally, storytelling is a powerful socio-cultural, meaning-making process that has the potential to build social movements and bring about significant social change (Davis, 2012; Zingaro, 2009). In Afghanistan, where women are rarely recognised as 'legitimate' storytellers and where the stories they do tell are often not believed, storytelling can play an important role in creating opportunities for women to tell the stories they want to tell about their own lives. It is therefore critical to continue to explore opportunities within mental health interventions for the stories of women to challenge the social

inequities that drive gendered forms of violence and its acceptance within high-prevalence societies such as Afghanistan.

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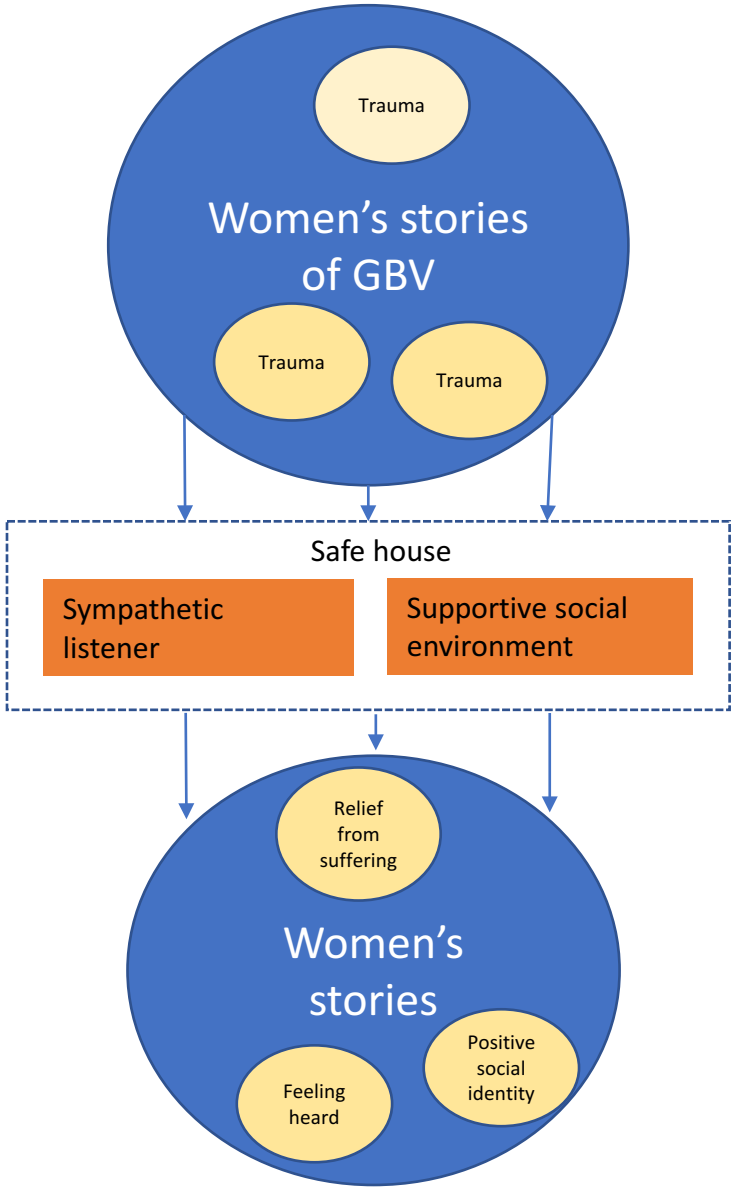
Trauma
Women's stories of GBV
Trauma
Trauma
Safe house
Sympathetic listener
Supportive social environment
Relief from suffering
Women's stories
Positive social identity
Feeling heard

Narrative storytelling as mental health support for women experiencing gender-based violence in Afghanistan

Research Highlights

- Women experience multiple forms of gendered violence in Afghanistan
- Biomedical models of trauma recovery are poorly suited for gendered violence
- Storytelling can create new opportunities for psychological healing from violence
- To be effective, storytelling requires a supportive social environment and listener
- For women to tell stories safely, patriarchal social structures must be addressed