On Becoming Trauma Informed:

Exploring the Narratives of Female Survivors of Intimate Partner Violence

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Research Summary

Aims: The aim of the current research was to explore the narratives of female survivors of Intimate Partner Violence (IPV) to better understand the role of Trauma Informed Care (TIC) for this specific population.

Background: The term Trauma Informed Care has become increasingly popularised over the last decade, but little research exists to examine and understand the role of this approach for particular populations, such as female survivors of IPV. Much of the existing research in this field pertains to developing tools for measuring TIC adherence as opposed to detailed survivor accounts of the IPV journey including finding refuge.

Methodology: A feminist epistemological position was adopted to centralise female survivor voices within the present research. In-depth semi-structured interviews were analysed narratively in order to preserve and share the survivor stories in their entirety, within the scope of this research.

Results: Each interview was analysed individually, which resulted in a minimum of 10 core narratives being identified. These narratives linked to survivor experiences of the abusive relationship, getting out, finding refuge and looking to the future. Two higher-order narrative typologies were derived from the individual accounts shared; these related to the interview process itself, and survivors feeling driven to help one another, particularly within the refuge.

Conclusion: The findings of this narrative study illuminated several implications for clinical practice/services for IPV survivors. The narrative typology regarding the interview process was associated with the principles of TIC in terms of preventing iatrogenic harm. The role of peer support and survivor volunteers within IPV services and refuge was discussed in relation to embracing and harnessing the survivor identity and IPV sisterhood.

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Trauma Informed Care	TIC
Trauma Informed	TI
Intimate Partner Violence	IPV
Gender Based Violence	GBV

CHAPTER ONE: INTRODUCTION

Chapter Overview

This chapter outlines the present study, in terms of highlighting the rationale for the research and addressing gaps in the current literature. The broader context and policies for Intimate Partner Violence (IPV) are presented, alongside a systematic narrative synthesis of the current literature on the topic of Trauma Informed Care (TIC) for female survivors of IPV. The chapter concludes by summarising that further exploration of the role of TIC within services for this population is needed to better understand the significance of TIC and its meaning for IPV survivors.

Intimate Partner Violence

A Definition and Related Terms

IPV has become recognised as the most common form of Gender-Based Violence (GBV) against women (WHO, 2020), whereby GBV refers to violence and abuse perpetrated by known or unknown men against women and girls (Russo & Pirlott, 2006; Heise et al., 2002). Throughout the literature on IPV, there are many different terms used interchangeably to reference such abuse, e.g. partner violence, domestic abuse, domestic violence, spousal abuse, and relationship violence. The National Institute for Health and Care Excellence (NICE) guidelines (2016), which refer to IPV as Domestic Violence and Abuse, describe it as being either a one-off occurrence or a pattern of behaviours that could involve a range of abusive actions, such as control, coercion, threatening or physical violence. They further explicated this description by explaining that such abuse could take the following forms: psychological, physical, sexual, financial and/or emotional and they also included honour-based violence and forced marriage within this terminology. For the abuse to be acknowledged as IPV, the survivor (of any gender) must be aged 16 or over and the abuse must be carried out by a ‘romantic’ partner or spouse, regardless of whether they are dating, cohabitating or married (CPS, 2022; NICE, 2016; Capaldi et al., 2012).

Throughout this thesis, the term ‘survivor’ has been used when referring to those who have experienced IPV or GBV. For some, the term victim is problematic as it implies powerlessness, culpability and weakness (Leisenring, 2006). Victimisation has been described as a form of objectification, i.e. women who have experienced IPV/GBV are understood not as people, but as objects of abuse (Barry, 1979). There exists a victim/survivor dichotomy and some may traverse the space in between these polarities (Kelly et al., 1996). Barry (1979) argued that surviving is the other side of being a victim as it promotes re-establishing agency and autonomy in the face of distressing life events. Language is a route to meaning (Riessman, 2005), which has the power to thicken and/or reauthor narratives (White, 2004). Throughout this thesis, a conscious decision has therefore been made to align with survivorship in recognition of the strength inherent in suffering and to uphold empowering terminology, without in any way undermining the legitimacy of a victim identity.

Prevalence of IPV

The World Health Organization (WHO, 2021) have described IPV as being a violation against all women’s human rights and a significant problem within the domain of public health. WHO (2012) commented that IPV is a burden carried globally by women, as they found that at least one-third of the world’s women have described being subjected to physical and/or sexual abuse perpetrated by their intimate partner. The report from the Office of National Statistics crime survey in 2016 indicated that across England and Wales, women were twice as likely as men to experience IPV, with an estimated 4.3 million female survivors in comparison to 2.2 million males (ONS, 2018).

Women's Aid (Women's Aid, 2020), a feminist charity for female survivors of IPV, have reported statistics from the Office of National Statistics (ONS, 2020a); they stated that from 2017-19, 77% of IPV survivors were female, and 96% of the perpetrators were male. They identified 83 male survivors of IPV and less than half (46%) of these IPV cases were perpetrated by a female. They also highlighted that between 2016-19, 222 women were killed by their partner and 98% of these cases were perpetrated by a male; this statistic equates to three women being murdered by their intimate partner per fortnight (ONS, 2020b).

The prevalence of IPV among male survivors has been explored within research, for example, Lysova & Dim (2022) described that men were more likely to seek informal help than professional support due to toxic masculinity and adherence to conventional social norms. Oram et al. (2022) considered IPV to be mostly committed by men against women, but they also highlighted that there may be an increased IPV risk among transgender people and within same-sex relationships. While many men may not disclose experiences of IPV (Lysova & Dim, 2022), this is also true for women due to a combination of 'microsystem factors' such as self-blame and worries about family/children, and 'macrosystem factors', e.g. a normalisation of violence or societal/religious expectations contributing to the silencing of female IPV survivors (Pokharel et al., 2020). The Office for National Statistics (ONS, 2021a) named IPV as a hidden crime because it often goes unreported to the police, and so statistical reports underrepresent the true IPV prevalence and should therefore be interpreted with caution. However, it could be argued that at the very least, these statistics indicate the direction of prevalence i.e. a greater proportion of women experience IPV than men.

For the purposes of this research, IPV will be discussed in relation to female survivors of IPV by male perpetrators. This decision has been made to reflect the current understanding of the statistics on IPV but also to adopt a feminist stance in thinking about empowering some of the most disempowered women in society.

IPV and the COVID-19 Pandemic. In 2020, little was known about how the COVID-19 pandemic may impact the prevalence of IPV. Emergent data from the pandemic period has since highlighted that there was an exacerbated risk of IPV for women due to increases in stress i.e. linked to job loss/furlough for women and/or their partners, women mostly bearing the brunt of childcare responsibilities and the disruption of social/protective networks (Hisham et al., 2022; WHO, 2020). National closures, scaling back or redeployment also led to decreased access to a range of services, such as hotlines, crisis centres and refuges (WHO, 2020). Havard (2021) reported that between April and June 2020, phone calls to the National Domestic Abuse Helpline increased by 65% in comparison to the start of the year, and between March 2019 to March 2020, police referrals for IPV increased by 7%. However, Williamson et al. (2020) contended that the perceived increase in IPV prevalence due to the pandemic should be contextualised. They argued that spikes in IPV cases were due to pre-COVID patterns of abuse becoming more frequent and readily reported (due to greater media focus and COVID triggers), as opposed to more men becoming violent. They also maintained that holding the pandemic accountable for increases in IPV prevalence excuses perpetrators of abusive behaviour and masks the underlying gendered causes.

Financial Implications of IPV. In 2008, Lancaster University explored the financial costs associated with IPV in the UK, which was an estimated £15.7 billion (Walby, 2009). In their report, they investigated this sum and discovered that £9.9 billion of the total came from 'human and emotional' costs, i.e. policies to reduce/eliminate IPV. Costs for the criminal justice system, other legal services, healthcare, social services, housing, and refuges amounted to greater than £3.8 billion. Finally, they found that IPV cost the economy more than £1.9 billion in terms of survivors taking time off work for injuries; this sum did not include a loss of productivity in relation to stress or mental health difficulties resultant from IPV. The report

(Walby, 2009) stated that these costs could only be calculated based on survivors who utilised support services, such as the criminal justice system; health care; social services; housing and refuges; and civil legal services. For this reason, the true extent of the financial implications of IPV is still largely unknown.

What are the Barriers to Leaving IPV Relationships?

A meta-synthesis conducted by Feder et al. (2006) sought to uncover the complexities of IPV and the implications of these upon survivor help-seeking. Their meta-analysis explored 25 studies looking into how women felt about disclosing IPV to healthcare professionals and how those professionals responded. They found that women's readiness to disclose their abuse often depended upon their perceptions of the relationship held between themselves and the healthcare professional. The review highlighted the importance of service-providers being consistent in their approach to maintain confidentiality, non-judgmental listening and non-blameworthiness across all interactions. It could therefore be inferred that when these fundamental aspects of care are not reliably upheld, IPV survivors may not feel safe to be forthcoming with disclosure, seek help or leave the relationship at all. Oram et al. (2022) noted that some survivors may minimise their abuse as a method of coping or because violence was normalised within their previous family or wider societal context. Other factors impacting upon leaving included the frequency of violence, relationship duration, the survivor's family of origin, support networks and safety perceptions, employment status, maintaining financial security and the impact upon children (Patzel, 2001). There may also be variation in how aspirations for safety are expressed depending upon the meaning made of IPV across different relationship timepoints (Shearson, 2021).

Risk Factors for Intimate Partner Violence. Capaldi et al. (2012) conducted a systematic review to explore the risk factors of IPV for women. Their review highlighted three key characteristics that increased women's risk: contextual characteristics of their partners, e.g. demographic information and locality; developmental and behavioural characteristics of their partners, e.g. family, friends, psychological and cognitive factors; and also relationship influences. A systematic review (Yakubovich et al., 2018) found that being older and/or married were protective factors that reduced the risk of IPV, whereas unplanned pregnancy or having parents who were educated to school-level or less (indicative of lower SES status) greatly increased the risk of IPV. Of clinical significance was the link between a partner's alcohol consumption and increased rates of IPV. Other non-statistically significant risk factors were partners' substance misuse and antisocial behaviour, as well as women's experiences of child abuse, having negative parent-relationships, traditional gender roles and low social support. Minoritised populations, such as Black, Asian, or immigrant women, may be at increased risk of IPV due to the barriers faced when leaving in relation to racism, cultural norms, and issues of lacking representation/diversity among support services and frontline workers (Hulley et al., 2022).

The link between early childhood adversity and the detrimental impact upon development into adulthood has been widely studied, particularly in the longitudinal 'Adverse Childhood Experiences' study (Felitti et al., 1998). They found that greater childhood adversity increased the probability of developing risk factors in adulthood for mental distress and several leading causes of death and more recent research found that children who witness violence in the family of origin are at an increased risk of perpetrating IPV in adulthood (Pournaghash-Tehrani & Feizabadi, 2009). The 'cycle of violence' was explored in Kenya to better understand the links between early childhood adversity and IPV in adulthood; findings indicated that women were at greater risk of experiencing IPV if they had been the victim of either sexual, emotional or physical childhood violence and that the more types of violence experienced in childhood, the greater the associated risk (Chiang et al., 2018). These findings have been supported in another recent study, which described a bi-directional relationship between IPV and psychological distress (Shen & Kusunoki, 2019).

The Physical, Emotional and Psychological Cost of IPV. Research has shown that all types of IPV (e.g. emotional, physical, sexual etc) can have a detrimental impact upon physical health outcomes, particularly linked to chronic pain and illness (Coker et al., 2000). They concluded that to reduce morbidity and mortality rates linked with IPV, earlier identification is needed, which they felt could be achieved through better screening and community-based interventions. Campbell & Lewandowski (1997) also commented on IPV survivors experiencing (often misdiagnosed) neurological injury, as well as the longer-term impacts of IPV associated with stress, for example, immune system suppression or chronic irritable bowel syndrome.

Campbell & Lewandowski (1997) explored the impact of IPV upon mental wellbeing. They found that there is a greater prevalence of depression among female survivors of IPV. The high rates of depression among this population have been corroborated in a systematic review by Devries et al. (2013) who suggested that IPV is linked to increased suicidal behaviour among women. Previous research supported the belief that psychological difficulties may manifest physically, e.g. high levels of internalisation lead to anxiety, social withdrawal, depression, hyperactivity and suicidal ideation (Rakovec-Felser, 2014).

A review conducted by Golding (1999) concluded that the psychological impact of IPV for women frequently culminated in depression, suicidal ideation and substance abuse. Furthermore, they found that a diagnosis of Post-Traumatic Stress Disorder (PTSD) often encapsulated the psychological turmoil experienced and served to de-pathologise the survivors by making explicit links between the traumatic experiences and the physiological and emotional symptoms post-abuse. Golding (1999) recommended that conceptualising the impact of IPV in this way could facilitate understanding and ultimately aid recovery.

Kennedy & Prock (2018) discussed the different levels of stigmatisation that can occur following IPV, such as at an individual level, which often occurs due to wider societal views stemming from ‘victim-blaming’ narratives. They discussed three key terms: ‘self-blame’ linked to feeling responsible for one’s own controllable behaviours; ‘shame’ related to feeling unworthy in comparison to others; and ‘anticipatory stigma’ being the belief that disclosing abuse would render them accountable as blameworthy. Kennedy & Prock (2018) suggested that these three terms work together to create internalised stigma, which they indicated often leads to survivor avoidance, isolation and non-disclosure. The consequence of this, they concluded, is a possible increase in negative psychological and physical health outcomes for survivors of IPV.

However, these studies (Kennedy & Prock, 2018; Rakovec-Felser, 2014; Devries et al., 2013; Coker et al., 2000; Golding, 1999; Campbell & Lewandowski, 1997) reported on heterosexual IPV relationships only, which limited the generalisability of their findings in terms of exploring the impact of IPV within same-sex relationships. Additionally, while there was diversity among the participants in these studies, the impact of intersectionality upon IPV outcomes was not explored. There is also some discrepancy in the literature reporting on the relationship between mental health and IPV, as it is unclear to what extent mental health difficulties pre-dated or developed following IPV exposure (Oram et al., 2022). While the negative consequences of trauma may be widely reported, there also exists an emergent body of literature exploring the phenomenon of post-traumatic growth for IPV survivors. Recent findings in this area have highlighted that IPV survivors may develop new understandings of themselves, of others and relationships, and of their philosophy of life; they may also feel empowered to take care of their own health and wellbeing moving forwards (Bryngeirsdottir & Halldorsdottir, 2022; D’Amore et al., 2021; Ulloa et al., 2015).

Sources of Safety. The UK government website (GOV, 2018) detailed the support currently available to those experiencing IPV, such as using the phrase ‘ANI’ to convey ‘Action Needed Immediately’ in public places, IPV charities and support telephone lines, and details of ‘safe spaces’ to talk within pharmacies. ‘Clare’s Law’ (GOV, 2016) was established in 2014 after petitions from family and friends following the murder of Clare Wood by her ex-partner in 2009. This law affords the opportunity for partners, family and friends to request information from the police if violent behaviour is suspected. The police may then choose to disclose offending histories if they feel there is sufficient risk. Under Clare’s Law, the police also have the right to disclose information to past and current partners if they deem it necessary if offending information comes to light. Clare’s Law has been welcomed to empower partners experiencing IPV to make informed decisions to leave the relationship. However, this law may inadvertently increase risk if based upon information gleaned through Clare’s Law, women leave an IPV relationship without first risk assessing or having a safety plan in place, due to research indicating that women are most at risk of IPV murder one-month post-separation from abusive relationships (FemicideCensus, 2020, 2018).

IPV has been described as a ‘hidden crime’ (ONS, 2018; Fitz-Gibbon & Walklate, 2017) and so if offending behaviour is often not disclosed, or there is not a recorded history of physical violence, it may lead partners into a false sense of security to stay within the relationship (Hadjimatheou & Grace, 2021). In addition to this, it may also undermine and invalidate the experience of psychological and emotional (non-violent) abuse. The safety outcomes of Clare’s Law have also been questioned, e.g. how knowing about perpetrators’ abuse histories will translate into timely protection and security (Fitz-Gibbon & Walklate, 2017). Furthermore, some research has highlighted the fears that as a result of police misogyny and the patriarchy overall, women will be blamed if they do not leave the relationship upon receiving the requested information (Hadjimatheou & Grace, 2021).

Psychological Theories of Intimate Partner Violence

It has been argued that no one psychological theory alone can account for the phenomenon of IPV in terms of its prevalence within society (Ali & Naylor, 2013). However, holding various psychological theories and perspectives in mind can offer valuable insights into the many possible explanations of IPV. To explore this further, four key psychological theories, in addition to feminist theory, are discussed below with reference to feminist critique in line with the epistemological positioning of this research.

Object Relations Theory. Object Relations Theory denotes that from birth, humans have a need for impactful relationships with others and that the earliest relationships may create a template from which other relationships are formed (Fairbairn, 1954). Fairbairn (1954) suggested that from infancy humans begin to develop mental representations of themselves and others, which later inform interpersonal relationships. Hyde-Nolan & Juliao (2012) added that children whose needs may not be adequately nurtured may experience greater difficulty in adulthood, for example with emotion regulation or their self-esteem. For these reasons, it is proposed that individuals may enter abusive relationships in either role in an unconscious attempt to fulfil unmet care needs from childhood (Cogan & Porcerelli, 1996). However, Object Relations Theory has been subjected to feminist critique for the ways in which it outlines infant nurturance as a maternal responsibility, thus failing to account for diversity among family structures and childrearing practices, which could perpetuate gender-based discrimination and oppression (McCluskey, 2010).

Attachment Theory. Attachment Theory is concerned with the reciprocal nature of caregiver-infant relationships, which when adversely affected may lead to longstanding and significant implications (Hyde-Nolan & Juliao; Ainsworth, 1979; Bowlby, 1969, 1951). For example, Ainsworth (1979) and Bowlby (1973, 1969, 1951) outlined that greater caregiving responsivity may lead to increased perceptions of safety and containment in interactions with/without the primary caregiver, leading to the development of a secure attachment. Conversely, they found that attachment can be disrupted by inconsistencies in caregiver availability and nurturance, which can subsequently lead to the development of an insecure attachment i.e. ambivalent, avoidant or disorganised. In terms of IPV, research has shown that threat in the absence of emotional safety can activate a child's insecure attachment and a parent experiencing IPV may have a limited capacity to respond both consistently and appropriately to the child (Noonan & Pilkington, 2020). Further to this, research has found that younger children are more at risk of developing insecure attachments when exposed to IPV, due to the IPV co-occurring during the critical period for development (Noonan & Pilkington, 2020). This may also predict later exposure and/or perpetration of IPV but will likely be dependent upon on the child's perceived level of threat posed by the IPV, length of IPV exposure, the child's relationship with other caregivers and the role of the parent as an IPV 'victim' or perpetrator (Noonan & Pilkington, 2020).

Attachment theory has however come under feminist scrutiny, as it has been argued that it neglects the societal factors and wider systems that may impact upon women and children, and therefore problems become solely situated within the individual (typically the mother) or the parent-infant relationship (Buchanan & Wendt, 2018). For this reason, viewing IPV through such a narrow lens may discount or minimise the responsibilisation from the wider systems involved in the oppression of women (Buchanan & Wendt, 2018).

Social Learning Theory. The key principle of social learning theory is that humans learn mostly by observing and imitating the behaviour of others (Bandura & Walters, 1977). Research has indicated that children who observe abuse from their father towards their mother have an increased risk of entering an abusive relationship themselves, in either 'victim' and/or perpetrator role (Whitfield et al., 2003). Roberts et al. (2010) found a strong association between male perpetration of IPV in adulthood and their own witnessing of IPV in childhood. Based on their results, they concluded that men were between 56%-63% times more likely to perpetrate IPV in adulthood if they witnessed IPV in childhood, yet as 71% of the perpetrators in their research had not observed childhood IPV, they felt that other contributory factors should be explored. Ha et al. (2021) collected data from observations and self-report measures and concluded that there was an association between boys engaging in 'coercive' relationship discourse with their adolescent peers and in violent behaviour as young adults; they felt this highlighted a progression from discourse to perpetration over time. Social learning theory has also been used to show that in addition to abusive behaviour, children living in IPV households may adopt a detrimental attitude towards conflict resolution and interpersonal communication (Rakovec-Felser, 2014). However, not all men who witness IPV in childhood perpetrate in adulthood, and not all IPV perpetrators witness abuse in childhood (Ali & Naylor, 2013). For these reasons, feminist researchers have sought to identify the role of gendered oppression within social learning theory. They suggested that when social learning occurs within families that maintain hierarchical structures, e.g. by age or gender, this could endorse power processes that lead to a normalisation of subordination or oppression (Yount &

Krause, 2017). Furthermore, social learning theory does not speak to biologically inherent vulnerability acquired through the intergenerational transmission of stress/trauma; children born to trauma or severely stress-exposed parents are at increased risk of adverse outcomes due to parental biological (hormonal or epigenetic) changes (Bowers & Yehuda, 2016).

Family Life Cycles Theory. It has been proposed that the family life cycle can be divided into several different stages, each of which involve different family members entering and exiting the various life stages (McGoldrick & Carter, 1982). Of particular interest within this theory is how different family members transition between the stages. This theory proposed that transitional phases could become problematic when there is an expectation that one family member's transition may impact upon another, especially in terms of whether the family system is able to make room for growth and development, and what this subsequently means for everyone within the system (McGoldrick & Carter, 1982). Research has shown that family violence occurs across the lifespan and can be intergenerational (Forsdike et al., 2014) and Oram et al. (2022) explained that for this reason, it is impactful at any age, yet there could be key transitional stages where the prevalence may be increased. Feminist researchers have explored the metaphor of the family life cycle and offered critique based on the universal assumptions they felt the theory has made (Candib, 1989). For example, they felt that it offers only a gendered view of human nature and idealises the nuclear family, therefore not maintaining space for intersectionality and cultural diversity within the model. In terms of the impact of this upon women, feminist researchers have argued that the inference of gender roles may create a distortion of the female identity and therefore perpetuate gendered injustice (Candib, 1989).

Feminist Theory. Feminism has been described as a ‘family of positions’ of great sociopolitical diversity, yet all concerned with ending sexual and gender inequality (Longino, 2017). Many feminists are deeply committed to understanding and improving women’s lives by addressing gender-based injustices, whereby arguably, equality fails to acknowledge gender-based differences (Dicker & Piepmeier, 2016). The feminist perspective of IPV has been responsible not only for illuminating the issue of domestic abuse but for establishing women’s refuges, interventions and changes to the legal system to criminalise acts of IPV (Ali & Naylor, 2013). Feminists (Ali & Naylor, 2013) have contended that IPV is not a family problem but a social issue, whereby patriarchal oppression must be addressed at a systemic level to challenge the narrative of women as subservient, submissive or less than their counterparts. Furthermore, research has suggested that social norms that are gender-stereotyped and violence-supportive have become globally interwoven into language, culture and communication and therefore have a direct link to the prevalence of IPV in terms of such norms becoming psychosocially accepted and embedded (Oram et al., 2022).

Several feminist theories of IPV exist but they have been criticised for contradicting one another (Ali & Naylor, 2013). For example, victim-blaming theories such as learned helplessness, i.e. women becoming demotivated and passive in the face of enduring abuse, contrast other feminist theories around power, control and the patriarchy, whereby the responsibilisation for ending abuse lies with the abuser, and ending men’s systemic dominance over women (Ali & Naylor, 2013).

Damant et al. (2008) discussed three key feminist perspectives of IPV: radical feminism, postmodern feminism and intersectional feminism. Radical feminists largely attributed IPV to the patriarchy and considered that when women perpetrate IPV, they do so in self-defence as a response to the violence encountered from men. Radical feminists raised IPV as a wider societal issue and they campaigned for more resources for women, such as shelters and refuges. Damant et al. (2008) explained that postmodern feminists took umbrage at the inference by radical feminists that women were always being ‘done to’ and therefore this conceptualisation created the perception of women as powerless and passive victims. Postmodern feminists therefore argued the complexities of power, in that power and privilege can shift within different contexts. Lastly, Damant et al. (2008) discussed the introduction of intersectional feminists who brought awareness to the interconnectedness between aspects of social and personal identity (e.g. race, religion, social class) to better understand the diversity among IPV survivors. Intersectional feminism has suggested that the way in which privilege and oppression intersect may impact the experience of gender-based inequality (Smith, 2016).

Feminist perspectives on IPV typically hold men accountable in relation to the patriarchal structures within society, as well as gendered issues around asserting masculinity, power and control (Oram et al., 2022; Ali & Naylor, 2013; McPhail et al., 2007). This contrasts social theories, whereby IPV is believed to derive from the family of origin or difficulties within the intimate relationship itself (Ali & Naylor, 2013). Multiple psychological theories should be held in mind to better understand the phenomenon of IPV (Ali & Naylor, 2013).

In terms of my own feminist position as the researcher, I feel that I identify largely with the principles of intersectional feminism in terms of womanhood being a subjective experience and this therefore presenting a need to both understand and respect the differences between women. I feel that feminism should embody choice, so that women may feel empowered to make decisions about their lives and live in line with their values and beliefs. Where this opportunity does not exist, for example within IPV, I view women not as passive, powerless victims but as survivors in the face of great adversity and oppression.

National Guidelines for Intimate Partner Violence

The NICE guidelines (NICE, 2016) outlined several quality standards in the care and provisions for survivors of IPV. They proposed that training is essential to enable multidisciplinary health professionals to identify IPV and therefore be aware of the appropriate and most effective response following such disclosure. They elaborated on this by adding that every healthcare professional should be familiar with how IPV could contribute to a survivor's presentation or current difficulties, and therefore provide support that is both effective and ensures the survivor's continued safety.

It has been acknowledged that IPV survivors may experience PTSD from their experiences of abuse (Babcock et al., 2008; Golding, 1999). The NICE guidelines for PTSD (NICE, 2018) appealed for further research on the clinical and cost-effectiveness of TIC given the lack of high-quality research in this area, particularly within the UK. They suggested that implementing TIC could lead to significant organisational changes that may also be cost-effective, i.e. reducing hospital stays and number of outpatient visits. This would be in line with the national priority to improve the clinical and cost-effectiveness of mental health services.

Trauma Informed Care

What is Trauma?

There is some variation in the literature regarding how trauma is defined. Some sources share the view that 'trauma' pertains to experiences that can be described as 'unbearable and intolerable', which frequently continue to intrude upon trauma survivors despite their best efforts to suppress trauma memories (Van der Kolk, 2014). Others describe trauma as a subjective phenomenon that should therefore only be defined by one’s own individual perceptions of a distressing event or series of experiences (Weinberg & Gil, 2016).

Toon & Ainscough (2018) argued that the symptoms of trauma can occur by being overwhelmed by an experience, which is then not processed and stored in a coherent way in the brain; this can lead to information getting ‘stuck’. They also described how traumatic memories that have become lodged in the brain can ‘leak out’ over time in the form of intrusions, such as flashbacks or nightmares; these are not accessible on demand but are instead triggered by certain situations. Symptoms of trauma may be linked to an oscillation between high arousal (e.g. hypervigilance and an increased startle response) and low arousal (e.g. low mood, numbness or even depersonalisation or dissociation from reality) when not stabilised within ‘The Window of Tolerance’ (Ogden, 2009). The Window of Tolerance has however been criticised for not accounting for the systemic oppression that could cause someone to be out of their optimal zone, and it may also pathologise heterogeneity among emotional and psychological expressions by promoting an ideal of ‘normal’ functioning, which may not account for individual or cultural differences (Gengler, 2020).

As trauma is diverse, categorisation has been discussed according to the context, intensity and frequency (NICE, 2018). The NICE guidelines (2018) have explored the definitions for different types of trauma such as acute (a one-off high-stress incident e.g. a road traffic collision), chronic (ongoing or prolonged exposure to trauma, e.g. IPV or bullying), complex (several traumatic events usually relating to childhood e.g. sexual abuse in childhood combined with re-victimisation in adulthood from abusive relationships) and vicarious (experiencing symptoms of Post-Traumatic Stress Disorder) through another person e.g. while supporting someone with lived traumatic experiences). Trauma has also been conceptualised as ‘Big-T trauma’ (e.g. a distressing event/s usually accompanied by a fear of death) and ‘Little-t trauma’ (e.g. non-life threatening events that produce overwhelming negative affect; McCullough, 2002). Both may increase vulnerability and sometimes Little-t trauma can be more detrimental than Big-T, e.g. for some the psychological abuse (Little-t) within IPV may be more distressing than physical violence (Big-T; James & MacKinnon, 2012). There is still much debate around the classification of PTSD as a diagnosis, due to an increased understanding of trauma as a precursor for the majority of mental health disorders listed in both the DSM-V and the ICD-11 (Guina et al., 2017). Guinea et al. (2017) argued that the clusters currently required for a diagnosis of PTSD should be removed as they complicate the experience of trauma and drive exclusion.

In the UK, 4 in 100 people are diagnosed with PTSD each week (Mind, 2020) and 1 in 3 people who experience severe trauma will receive a (complex) C-PTSD diagnosis (NHS, 2018). However, the prevalence of undiagnosed trauma is thought to be much greater, particularly in relation to sexual violence trauma (Kessler et al., 2017; Benjet et al., 2016). C-PTSD has been correlated with difficulty disclosing traumatic events, especially childhood and/or sexual trauma (Bedard-Gilligan et al., 2012). Not being believed upon disclosure of trauma can cause significant distress (NSPCC, 2013) and services may drive iatrogenic psychological harm through practices that imply disbelief and blame, hold an uncritical reliance on guidelines/protocol, or use diagnostic labels that position problems within the individual rather than the abusive relationship or oppressive systems (Rees, 2012). Interactions between traumatised service-users; overworked, exhausted/stressed staff; pressured organisations and economic environments that can be described as ‘hostile to recovery’, mirror ‘parallel processes’ linked to retraumatisation (Bloom, 2006). Services operating in this way have the potential to not only retraumatise an individual but make them lose trust in health services altogether and stop them from seeking or engaging with any further support (NAPAC, 2016).

What is Trauma Informed Care?

A distinction has been made between trauma-specific services (of greater intensity) and the trauma informed (TI) approach that can be adopted by all healthcare settings for services to become more inclusive (Butler et al., 2011). Wilson et al. (2013) suggested that the fundamental basis of TIC pertains to service-providers adapting the care they offer by holding in mind the role of trauma in perpetuating difficulty. They questioned how services might be mindful of inadvertently furthering a person's traumatic stress and suggested considering the potential for retraumatisation across entire systems to help inform both policy and practice.

It has been questioned how TIC differs from 'good practice'. Wilson et al. (2013) described that prior to TIC becoming a notable term, many professionals and volunteers were already working within the scope of TIC, simply by being caring and committed. They noted that the feminist movement was influential in driving the voices of survivors to be heard, which ultimately led to the discovery of TIC. For example, Burgess & Holmstrom (1974) explained the 'silent rape reaction', whereby from their research they concluded that clinicians should be alert to possible indications of such abuse, even if it has not been disclosed.

Rees (2012) highlighted that for care to be 'psychologically sensitive', service-users should be placed at the core of practice so that services focus on the individual rather than diagnoses. Perry et al. (2021) explained that services may move from a pathologising position by asking 'what has happened to you?' rather than 'what is wrong with you?'. Working in this way can strengthen the therapeutic rapport by encouraging and developing trust (Raja et al., 2015). Subsequently, adopting TIC has the potential to improve health and wellbeing outcomes for both service-users and service-providers (Schulman & Menschner, 2018), and transfer the responsibility of reducing retraumatisation from individuals to systems (Treisman, 2021). A shift in mental healthcare to this effect would enable services to provide better support in line with the TI values and greater service-user involvement in TI research to continue to shape services would also drive this forward (Sweeney & Taggart, 2018).

Criticisms of Trauma Informed Care

Birnbaum (2019) explored several criticisms of TIC and of note, they found that there was a lack of empirical evidence and conceptual clarity and an overarching concern that TIC may trivialise the more severe and enduring mental health difficulties experienced by some, due to how trauma may be defined under this one approach. The objectivity versus the subjectivity of trauma has also been contested (Weinberg & Gil, 2016), which posits the question of whether TIC is always appropriate based on the meaning attributed to the 'traumatic' experience by an individual.

Sweeney & Taggart (2018) explored several common misconceptions of TIC, such as TIC only being for those who have experienced trauma. They challenged this idea by explaining that TIC is an inclusive, 'whole-systems' approach, that strives to improve accessibility and signposting to specialist trauma services where needed, as opposed to necessarily providing interventions directly. They contended that this organisational shift could enable individuals who have experienced trauma to more effectively have their needs met while bearing no detrimental impact upon those who do not have trauma care needs. They also explored the notion that TIC is simply 'good practice' repackaged. While they explained that often healthcare workers and professionals may practice in line with TIC principles, it could be maintained that some operate in ways that may lead to retraumatisation, e.g. service-users not being involved in decisions about their care. They went on to conclude that there is a need for further survivor-led approaches to explore and break down what TIC means for different populations of service-users and whether it is the most valuable approach in different contexts. In terms of IPV, research has conceptualised the benefits of TIC for this population, such as promoting emotional safety, fostering choice and control and being responsive to identity and context (Wilson et al., 2015), and the emerging empirical evidence base pertaining to TIC for IPV is explored in the present systematic narrative synthesis.

Systematic Narrative Synthesis

Overview

In this section, a systematic narrative synthesis of the extant literature on TIC for IPV survivors is presented. The aim of reviewing the literature within this field was to better understand how well TIC is currently understood and implemented specifically for this population and what the current recommendations for practice are in line with TIC principles. This review aimed to identify gaps within the current research on TIC for IPV survivors, with a view to this being addressed within the current study, as well as offering recommendations for further research in the future.

Rationale and Objective

The principles of TIC have been explored for several decades, however recently, the term has become increasingly popularised (Wilson et al., 2013). Previous reviews on TIC, including interventions, have shown that further research is needed to better understand the implementation of TIC across a broader range of populations (Han et al., 2021; Reeves, 2015). The current review aimed to bridge this gap in the research by addressing the following questions:

1. How is the impact of TIC for IPV survivors currently understood?
2. Which components of TIC have been implemented with IPV survivors?

The questions contained the constructs of understanding, implementation and impact, which linked to three different types of studies outlined by Hong et al. (2020): views studies, process studies and outcome evaluation studies, respectively. The current review was therefore designed to synthesise qualitative, quantitative and mixed-methods literature to address these questions.

In conducting a systematic narrative synthesis of extant TIC literature, the aim was for more information to be gleaned as to how this approach may (or may not) be beneficial to IPV survivors across a range of intersecting health and social contexts. This review assisted the development of a rationale for undertaking further research on TIC for IPV survivors.

Methods

Design. While meta-analysis of statistical data and meta-ethnography for qualitative studies have been considered the gold standard of systematic review, it has been argued that narrative synthesis is best placed to move beyond description and therefore enable similarities, differences, strengths, limitations and relationships/patterns in the literature to be explored (Lisy & Porritt, 2016; Popay et al., 2006). Popay et al. (2006) considered that storytelling is inherent to society and so storytelling in the form of narrative synthesis can be used to bridge the gap between research, policy and practice, particularly with mixed-methods data. For these reasons and to adequately address the research questions, this mixed-methods review synthesised the included qualitative, quantitative and mixed-methods studies narratively.

The PRISMA checklist was utilised to maintain adherence to quality standards and methodological rigour throughout this review (Page et al., 2021).

Search Strategy and Data Sources. A general search on the International Prospective Register of Systematic Reviews (PROSPERO) was conducted to check for existing reviews within this field. No reviews synthesising mixed-methods literature on TIC for IPV survivors were identified.

Between October 2022 and February 2023, six databases were searched to identify peer-reviewed journal articles published up to the current date. EBSCO Host was used to search five relevant databases (APA PsycInfo, APA PsycArticles, MEDLINE, CINAHL, and E-Journals) and the database 'SCOPUS' was also searched.

Search terms were discovered by conducting a general search of the literature while paying particular attention to keywords/phrases utilised in extant research. Phrase searching and truncation were used, as well as the Boolean operators 'Search with AND' and 'Search with OR' to combine terms, as depicted below:

> *"Trauma informed care"* or *"trauma-informed care"* or *"trauma informed practice"* or *"trauma informed approach"* or *"trauma informed"* or *"trauma-informed"* or *"trauma sensi*"* or *"trauma responsi*"*
>
> AND
>
> *"Domestic violence"* or *"domestic abuse"* or *"intimate partner violence"* or *"partner abuse" or "refuge"* or *"domestic violence shelter"* or *"women's shelter"*
>
> AND
>
> *Evaluation* or *Assessment* or *Measurement* or *Analysis* or *Process* or *Explor**

Search terms were evaluated within the research department and were revised following receipt of departmental feedback and guidance.

A manual search was also conducted by scanning reference lists and citations as well as existing TIC literature reviews. Google Scholar and the following journals were hand-searched: ‘Violence against Women’, and ‘Women and Therapy’. Research mapping technology i.e. ‘LitMaps’ (Litmaps, 2023) and ‘Connected Papers’ (ConnectedPapers, 2023) were also used to search for additional related papers and cross-reference included studies. A PRISMA flowchart detailing the search strategy process can be found in Figure 1.

Eligibility Criteria. Inclusion and exclusion criteria were identified using a PICO framework (Schardt et al., 2007). Studies were included if: a) TIC was the primary focus of the research in relation to IPV; b) the study was published in a peer-reviewed journal; c) the study population or participants were female; d) the study was written in the English language. Studies were excluded if: a) IPV was discussed without reference to TIC; b) the study population or participants were male or LGBTQIA+ (VeryWellMind, 2023); c) the study was unpublished, a review, book chapter, dissertation, or protocol; or d) the study was not written in the English language. See Table 1 below for an overview of the inclusion and exclusion criteria.

Table 1

Inclusion and Exclusive Criteria for Narrative Review

Inclusion Criteria	Exclusion Criteria
• The study focused on Trauma Informed Care specifically in relation to Intimate Partner Violence • Peer-reviewed journal • Female population/participants • Written in the English language	• Intimate Partner Violence without reference to Trauma Informed Care • Male or LGBTQIA+ population/participants • Unpublished study, a review, book chapter, dissertation, or protocol • Not written in English language

Data Selection and Extraction. Studies were initially screened using inclusion and exclusion criteria, by scanning titles and abstracts. After the initial screening, full texts were acquired and explored to assess their eligibility within the narrative synthesis. Key data and study characteristics were then extracted from all papers meeting the inclusion/exclusion criteria, e.g. first author, date of publication, country, methods, model of TIC used or discussed, key findings and implications/limitations.

Quality Assessment. When there is vast heterogeneity in research methods within a literature review, it can be difficult to gain an in-depth understanding of the research approaches and quality of all included studies, but critical appraisal tools can be used to facilitate this process (Hong et al., 2020; Aveyard, 2014). That said, Barbour & Barbour (2003) cautioned against utilising critical appraisal tools over-prescriptively as they argued that creative engagement with studies could yield more nuanced and valuable findings.

In this review, the quality of the included studies was assessed using the Mixed-Methods Appraisal Tool (MMAT; see Appendix I; Hong et al., 2018). The reliability and efficiency of the MMAT have been scrutinised; research concluded that the tool was easy to use, and also produced inter-rater reliability scores that ranged from moderately reproducible to perfect agreement (Pace et al., 2012). The MMAT can therefore be utilised within mixed-methods literature reviews to strengthen the methodological rigour (Oliveira et al., 2021).

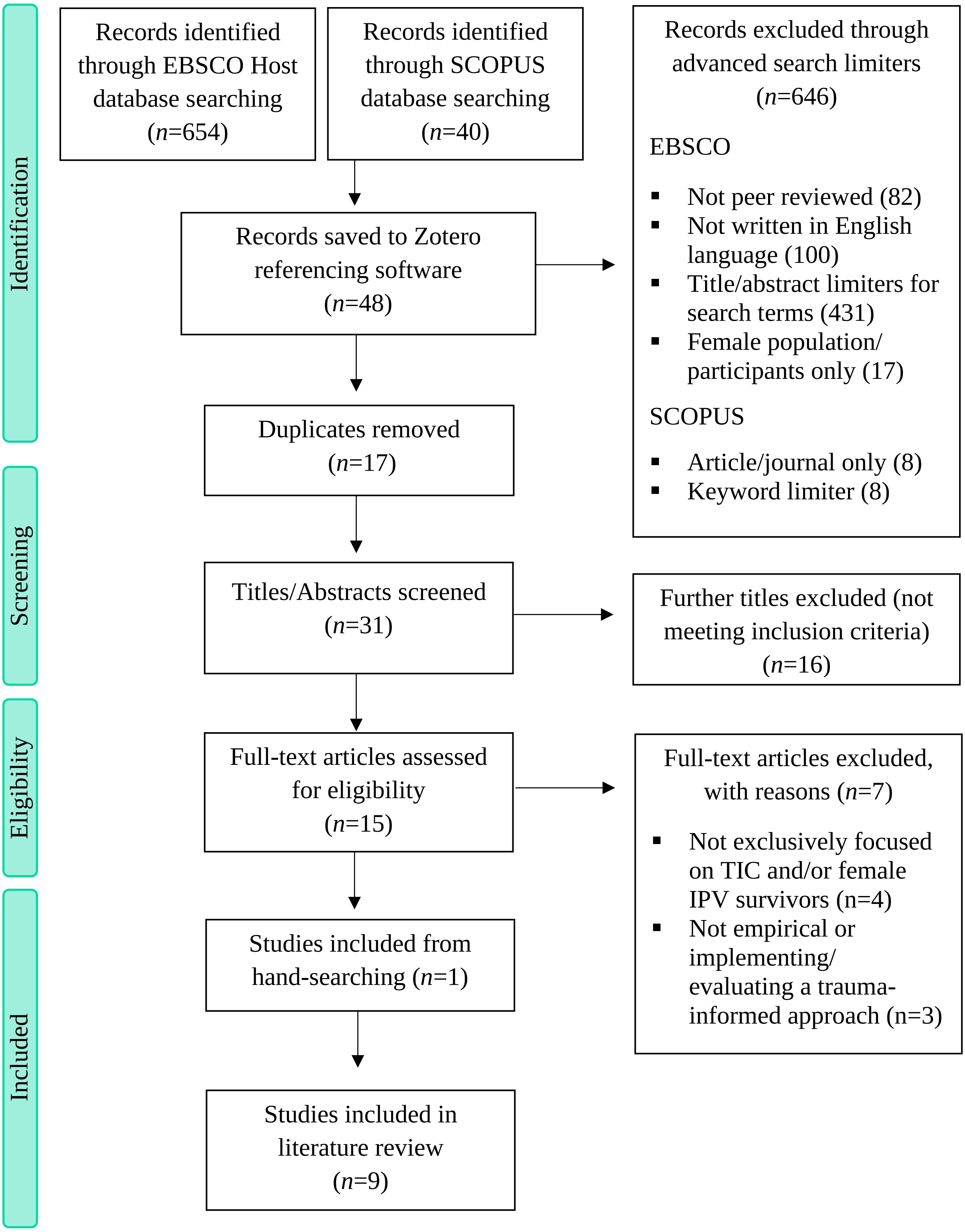
Studies included in this review were therefore assessed initially on study design e.g. qualitative, quantitative (randomised, non-randomised or descriptive), or mixed-methods. The study category explanations provided by Hong et al. (2018), alongside their algorithm for rating in the MMAT, were employed to facilitate this aspect of the process. Questions pertaining to the methodological quality criteria were then answered for each study included in this narrative synthesis. Hong et al. (2018) discouraged calculating overall quality scores based on the individual criteria ratings so that more detailed discussions of the ratings could be provided instead, which they felt better informed the quality of the included studies.

The quality appraisal ratings are presented in Table 3, and the findings of the appraisal are discussed further in the results below.

Narrative Synthesis. The narrative synthesis was conducted by following the three key stages outlined by Popay et al. (2006), which were developing a preliminary synthesis, i.e. describing patterns across the studies, exploring the relationships within/between the studies, and finally establishing the robustness of the studies included in the narrative synthesis through quality appraisal. In line with this approach, the data from all included studies, qualitative and quantitative, were described and analysed narratively to address the research questions. Table 2 provides an overview of each study included in the review with the following data extracted: authors, year, country, methods, TIC reference, key findings and implications and/or limitations.

Figure 1

PRISMA 2009 Flow Diagram



Note: PRISMA Systematic Literature Search Flow Diagram (Moher et al., 2009)

Results

Search Results. This systematic approach generated a total of 654 results from five databases searched on EBSCO Host and a further 40 results from SCOPUS. The following search limiters were then implemented to refine the search results generated: searching terms within the title and abstract only, peer-reviewed journal articles, English language and female population/participants only.

The advanced search yielded a total of 24 results from EBSCO Host and a further 24 from SCOPUS. These 48 search results were downloaded onto Zotero, a reference management service (Zotero, 2023). The studies were inspected for duplicates, of which 17 were identified and removed. The titles and abstracts of the remaining 31 studies were examined against the inclusion/exclusion criteria, after which a further 16 studies were excluded (e.g. they were reviews, did not focus on TIC or the sample population were children, rather than female IPV survivors).

The full texts of the remaining 15 studies, in addition to a further study identified through manual searching, were obtained online and reviewed. The full text of one paper was unavailable online but ordered and accessed through the university library.

After reading each of the papers in full, a further seven studies that did not meet the inclusion criteria were excluded (e.g. the primary focus was not on evaluating or implementing TIC, or female IPV survivors were not an exclusive population within the study). Therefore, nine studies were included in this systematic narrative synthesis.

Characteristics of Included Studies. The was a great deal of heterogeneity among the studies included in the current narrative synthesis. Below is a breakdown of the studies' key characteristics, in terms of methodology, participant demographics and research context.

Study Methodology. The nine papers were empirical based upon data collected quantitatively through surveys (Serrata et al., 2020; Sullivan et al., 2018), qualitatively through interviews (McConnell & Phelan, 2022; Tarshis et al., 2022; Jackson et al., 2020; Mantler & Wolfe, 2018; Williams et al., 2017), or using a combination of the two methods (Decker et al., 2017; Goodman et al., 2016).

In terms of analysis within quantitative studies, including one mixed-methods study, quantitative data were analysed using linear, hierarchical or logistic regression respectively (Serrata et al., 2020; Sullivan et al., 2018; Decker et al., 2017). The remaining mixed-methods study utilised exploratory factor analyses to examine the items included in their proposed Trauma Informed Practice Scale (TIPS; Goodman et al., 2016).

Throughout the qualitative studies, data were analysed first by coding and then by generating and interpreting patterns within the data either in content/thematic analysis (McConnell & Phelan, 2022; Jackson et al., 2020; Mantler & Wolfe, 2018; Decker et al., 2017; Williams et al., 2017) or a grounded theory approach (Tarshis et al., 2022). The analysis of qualitative data within the mixed-methods Goodman et al. (2016) paper was unclear.

Participant Demographics. In total (counting mixed method populations as distinct groups), 885 participants were included in the studies within this review. Of these 885 participants, 818 were classed as service-users or those with lived IPV experience, and 67 were deemed service-providers often in the form of administrators, advocates or practitioners. When calculating participants within qualitative research only, the results were more balanced whereby 84 (56%) participants were service-users and 67 (44%) service-providers. However, only one study (Jackson et al., 2020) exclusively recruited IPV survivors, i.e. not a combination of IPV survivors and service-providers; the three IPV survivor participants that formed their study accounted for only 2% of the total number of participants included in the qualitative research in this review.

In terms of participant age, this information was presented in various forms throughout the different studies, i.e. through age ranges or mean ages of participation. Overall, as reported within the included studies, participants' ages ranged from 18–65 years, however, two studies did not report demographic information pertaining to age and therefore cannot be included in this summary (McConnell & Phelan, 2022; Jackson et al., 2020).

Within the studies included in this review, much ethnical diversity among participants was reported and a range of cultural and racial backgrounds presented e.g. Black or Black/African American, Asian, Hispanic/Latina, White/Caucasian, Canadian, European, Aboriginal, Native American, Alaskan Native, and others who did not fall into these categories and were therefore marked as 'multiracial' or 'other'. Participant ethnicity was reported by all bar one study (McConnell & Phelan, 2022).

Research Context. TIC for a population of IPV survivors was the central focus of this narrative synthesis. However, there were some additional contextual factors that may have been impactful on results in relation to the intersectionality of IPV survivors. The majority of included studies recruited participants from IPV shelters or domestic abuse programs (Serrata et al., 2020; Mantler & Wolfe, 2018; Sullivan et al., 2018; Goodman et al., 2016). A further two studies focused their research on TIC for IPV survivors within either a family planning health centre (Decker et al., 2017) or a hospital setting (Jackson et al., 2020). One study that focused on TIC and the intersectionality of IPV and HIV recruited from a family justice centre and HIV testing sites (Williams et al., 2017). The remaining two studies contextualised

TIC for IPV survivors within employment services (Tarshis et al., 2022) and social services, specifically to support IPV survivors with intellectual disability (McConnell & Phelan, 2022).

Lastly, no UK studies were identified in this review; five studies were conducted in the USA (Serrata et al., 2020; Sullivan et al., 2018; Decker et al., 2017; Williams et al., 2017; Goodman et al., 2016) and four studies in Canada (McConnell & Phelan, 2022; Tarshis et al., 2022; Jackson et al., 2020; Mantler & Wolfe, 2018).

Table 2

Overview of Studies included in the Systematic Review

	Author, Date & Country	Methods	TIC Reference	Key Findings	Implications/Limitations
1	Decker et al., 2017 USA	▪ Mixed-methods ▪ Pre/post-intervention survey (n=132) ▪ Qualitative interviews with providers and patients (n=35)	▪ SAMSHA 6 principles of TIC (2014)	▪ The IPV safety card and/or discussion intervention significantly increased perceptions of providers caring about women's safety (91.9% vs. 73.9%; Risk Ratio (RR) 1.22, 95% Confidence Interval (CI) 1.01–1.47) and feelings that providers know how to help regarding unhealthy relationships (90.7% vs. 67.4%; RR 1.35, 95% CI 1.09–1.66). ▪ Qualitatively, women felt that IPV assessment was a sign of provider concern for their health and safety.	▪ No effect sizes calculated or calculatable as no means/standard deviations provided. ▪ Intervention receipt was self-reported and may be subject to error in recall, particularly in relation to IPV trauma. ▪ Low retention at 3-month follow-up.
2	(Goodman et al., 2016) USA	▪ Mixed-methods ▪ Four components: qualitative analysis of relevant publications; interviews with 15 TIC experts; survivor focus group (n=20); advocate	▪ 6 practices of TIC for IPV survivors outlined by Wilson et al. (2015)	▪ Trauma Informed Practice (TIP) scales were found to be theoretically grounded and ecologically valid tools to assess survivors' experiences of IPV programs in relation to TIC. ▪ TIPS demonstrated excellent construct validity and reliability scores ranged	▪ IPV organisations now have a tool they can use to assess the extent to which they are engaging in TIC and improve practice. ▪ The tool adopted a survivor perspective. ▪ Details of qualitative analysis of relevant publications and interviews with 15 TIC experts not reported.

Author, Date & Country	Methods	TIC Reference	Key Findings	Implications/Limitations
	focus group (n=20); and a survey (n=370)		from .85 to .98, indicating high reliability across subscales.	
3 Jackson et al., 2020 Canada	▪ Qualitative ▪ Case analysis ▪ Semi-structured IPV survivor interviews (n=3)	▪ 4 Trauma (and Violence)-Informed principles by Ponic et al. (2016)	▪ Individual accounts from IPV survivors supported rationale for Trauma (and violence) Informed Cognitive Behavioural Therapy (CBT) to improve IPV-related mood and anxiety disorders.	▪ Study bridged the gap of intersections between motherhood, trauma and mental health. ▪ Retrospective data collection may have increased participant recollection bias.
4 Mantler & Wolfe, 2018 Canada	▪ Qualitative ▪ Multiple case study design ▪ Semi-structured interviews with administrators (n=4), service-providers (n=10) and service-users (n=25)	▪ 5 principles of TIC outlined by Elliott et al. (2005) and Harris & Fallot, (2001)	▪ High acceptability of the TIC in relation to the suitability of integration and comprehensiveness of integrated services. ▪ TIC led to a perception of stronger partnerships with other organisations. ▪ Survivors noticed increased accessibility to healthcare and better outcomes.	▪ Highlighted a lack of TIC outside primary and social care sectors. ▪ Generalisability of findings may be impacted by the homogenous groups identified by using a snowball sampling technique. ▪ Further integration of TIC across all sectors recommended.
5 McConnell & Phelan, 2022 Canada	▪ Qualitative ▪ Semi-structured practitioner interviews (n=5)	▪ Reference to 5 TIC principles by Elliott et al. (2005)	▪ Interviews generated 4 relational principles: reflexivity, recognition, solidarity and safety. ▪ Principles established as a guide to support social workers foster the	▪ Findings and extant literature contributed to the development of a trauma informed framework for social care practitioners.

	Author, Date & Country	Methods	TIC Reference	Key Findings	Implications/Limitations
				autonomy of IPV survivors with intellectual disability.	- Further research needed to guide implementation.
6	Serrata et al., 2020 USA	- Quantitative - Cross-sectional survey (n=175)	- References TIC principles from Harris & Fallot (2001), SAMHSA.gov, (2014) and Wilson et al. (2015)	- Trauma informed Practice (TIP) significantly predicted higher wellbeing (hierarchical regression: R2 =.26, F(1, 171) = 61.43, p < .001). - Practices that were culturally responsive and inclusive significantly predicted higher reported trauma informed outcomes R2 =.24, F(7, 151) = 6.98, p <.001.	- Findings highlighted the need for organisations to understand how cultural variables may influence IPV survivors' outcomes. - Causal inferences could not be made due to temporal limitations in the study and so further longitudinal research would be needed to bridge this gap.
7	Sullivan et al., 2018 USA	- Quantitative - Pre/post surveys (upon shelter arrival and departure, or 30 days into stay).	- Referenced SAMSHA principles of TIC (2014)	- IPV survivors who perceived they had greater TIC also reported improved outcomes related to self-efficacy (F(3, 53) = 24.00, p<.001), safety-related empowerment (F(3, 53) = 14.17, p<.001) and depressive symptoms F(3, 53) = 8.65, p<.001).	- Randomised Controlled Trial (RCT) not ethically viable within the remit of this research and so no randomisation to a baseline/control group was available for comparison. - Future research should move beyond shelter programs to evaluate TIC in a variety of programs serving IPV survivors.

	Author, Date & Country	Methods	TIC Reference	Key Findings	Implications/Limitations
8	Tarshis et al., 2022 Canada	▪ Qualitative ▪ Service-provider interviews (n=10)	▪ Referenced Harris & Fallot (2001)	▪ TIC perceived as a holistic, survivor-centred approach that can be used to facilitate the employment-seeking process for IPV survivors. ▪ TIC could help to address intersecting employment barriers for IPV survivors.	▪ Ethnically diverse sample brought a wealth of social, cultural, and political experience to the research. ▪ Findings advocated for trauma informed approach to employment services, but further research needed for implementation/additional funding.
9	Williams et al., 2017 USA	▪ Qualitative ▪ Semi-structured interviews with IPV survivors (n=10) and IPV service-providers (n=4) and HIV service-providers (n=5)	▪ Referenced SAMHSA.gov (2014)	▪ Facilitators and barriers were identified in relation to HIV testing within an IPV service. ▪ IPV experiences can influence decision-making regarding HIV testing. ▪ TIC may facilitate HIV testing implementation by offering more tailored support.	▪ The research called for partnerships to be established that bring together HIV and IPV services to improve the implementation of HIV testing for IPV survivors who were deemed an at-risk population. ▪ Recruitment included some participants involved in a parent study; sampling bias may have been introduced in terms of participants’ commitment to research.

Quality Assessment. Included studies were quality appraised using the Mixed-Methods Appraisal Tool (MMAT; Hong et al., 2018) designed for use within systematic mixed studies reviews. Of the nine included studies, six met all screening and qualitative methodological quality criteria (Tarshis et al., 2022; Jackson et al., 2020; Serrata et al., 2020; Mantler & Wolfe, 2018; Sullivan et al., 2018; Williams et al., 2017).

Of the three studies that did not meet all criteria, one study (Goodman et al., 2016) did not meet criteria 5.3 pertaining to integrating qualitative and quantitative methods, as parts of their qualitative analysis were unreported, e.g. the qualitative analysis of relevant publications and interviews with 15 TIC experts. It also lacked transparency about the qualitative information collected and how this shaped the development of TIPS; convenience sampling may have introduced sampling bias. Two mixed-method studies did not meet criteria 5.5 for adhering to quality standards for qualitative and/or quantitative data (Decker et al., 2017; Goodman et al., 2016). Of these studies, Decker et al. (2017) was appraised as lower quality due to the ambiguity of the quantitative aspects of the research. For example, no effect sizes were reported and there was the possibility that the self-referring recruitment strategy may have introduced bias into the results.

A qualitative study (McConnell & Phelan, 2022) did not meet criteria 1.4 pertaining to the interpretation of results being sufficiently substantiated by data and criteria 1.5 in terms of there not being coherence between qualitative data sources, collection, analysis and interpretation. The qualitative data in the study by McConnell & Phelan (2022) were not sufficiently substantiated, i.e. there was a distinct lack of anecdotal quotes and cross-referencing the results to the inferences made. For this reason, the study lacked coherence between the different parts, as it was unclear how the interpretation was derived from the data.

Table 3

Mixed-Methods Appraisal Tool Quality Appraisal of Included Studies

Study	Screening Questions		Methodological Quality Criteria															
			Qualitative					Quantitative					Mixed-Methods				
	S1	S2	1.1	1.2	1.3	1.4	1.5	3.1	3.2	3.3	3.4	3.5	5.1	5.2	5.3	5.4	5.5
1. Decker et al., 2017	✓	✓											✓	✓	✓	✓	X
2. Goodman et al., 2016	✓	✓											✓	✓	X	✓	X
3. Jackson et al., 2020	✓	✓	✓	✓	✓	✓	✓										
4. Mantler & Wolfe, 2018	✓	✓	✓	✓	✓	✓	✓										
5. McConnell & Phelan, 2022	✓	✓	✓	✓	✓	X	X										
6. Serrata et al., 2020	✓	✓						✓	✓	✓	✓	✓					
7. Sullivan et al., 2018	✓	✓						✓	✓	✓	✓	✓					
8. Tarshis et al., 2022	✓	✓	✓	✓	✓	✓	✓										
9. Williams et al., 2017	✓	✓	✓	✓	✓	✓	✓										

***Notes**: Mixed-Methods Appraisal Tool (MMAT; Hong et al., 2018; Appendix I). **Responses**: Yes (✓); No (X); Cannot Tell (?)*
***Screening questions**: S1. Are there clear research questions? S2. Do the collected data allow to address the research questions?*
***Qualitative**: 1.1. Is the qualitative approach appropriate to answer the research question? 1.2. Are the qualitative data collection methods adequate to address the research question? 1.3. Are the findings adequately derived from the data? 1.4. Is the interpretation of results sufficiently substantiated by data? 1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?*
Quantitative *(non-randomised): 3.1. Are the participants representative of the target population? 3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)? 3.3. Are there complete outcome data? 3.4. Are the confounders accounted for in the design and analysis? 3.5. During the study period, is the intervention administered (or exposure occurred) as intended?*
***Mixed-Methods**: 5.1. Is there an adequate rationale for using a mixed-methods design to address the research question? 5.2. Are the different components of the study effectively integrated to answer the research question? 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?*

Results from the Narrative Synthesis. The findings of the narrative review are presented below in terms of synthesising results on how the impact of TIC for IPV survivors is currently understood and which components of TIC have been implemented with IPV survivors. Other considerations in relation to intersectionality and context are discussed.

How is the Impact of TIC for IPV Survivors Currently Understood? Within the included studies, several beneficial outcomes of TIC were presented. Some quantitative findings presented measurable outcomes. Statistical data (in the form of regression) pertaining to safety and safety-related empowerment, wellbeing and self-efficacy demonstrated that TIC or perceptions of receiving greater TIC had beneficial outcomes in these areas (Serrata et al., 2020; Sullivan et al., 2018; Decker et al., 2017). These findings suggested that TIC may facilitate greater self-compassion to support wellbeing outcomes, but it also highlighted the relationship between the different TIC principles, for example, safety affording opportunities to develop empowerment. These quantitative findings were supported qualitatively by McConnell & Phelan (2022); they identified that TIC supported practitioners in helping IPV survivors to foster greater autonomy, which led to improved wellbeing outcomes. A second qualitative study also found that the addition of TIC had beneficial clinical outcomes for IPV survivors, e.g. using TI CBT rather than standard CBT (Jackson et al., 2020).

In terms of the impact of TIC for practitioners and services, studies concluded that not only was TIC acceptable, but helped to create strong working alliances and partnerships, which can improve accessibility to IPV support (Mantler & Wolfe, 2018), and also employment opportunities (Tarshis et al., 2022). The TIC adherence tool developed as assessed in one study may be an effective way of exploring how services implement and adhere to the principles of TIC (Goodman et al., 2016), to sustain this unified way of working and achieve shared goals of supporting IPV survivors.

Critiques of TIC or possible shortcomings of TIC principles were not referenced nor discussed within any of the included studies in this review and may therefore create an area to address within future research.

Which Models of TIC have been Implemented with IPV Survivors? Within the included studies in the current review, five different approaches towards TIC were referenced and discussed (Ponic et al., 2016; Wilson et al., 2015; SAMHSA.gov, 2014; Elliott et al., 2005; Harris & Fallot, 2001). The similarities and differences between these approaches are outlined in Table 4 below, in terms of the TIC principles the approaches have unanimously outlined and the principles that are unique to each approach.

Table 4

Similarities and Differences of TIC Approaches within Included Studies

TIC Reference	Cited By	Unanimous TIC Principles	Unique TIC Principles
Ponic et al., 2016	Jackson et al., 2020	▪ Understanding trauma/violence in relation to its impact ▪ Creating emotionally/physically safe environments ▪ Affording opportunities for choice and collaboration	▪ Offering support that is both strengths-based and builds capacity for coping/resilience ▪ Individual strategies, e.g. adopting an affirming and validating stance ▪ Organisational strategies, e.g. training staff on power imbalances and tailoring interventions to meet individual needs
Wilson et al., 2015	Serrata et al., 2020 Goodman et al., 2016	▪ Restoring choice and control ▪ Supporting coping ▪ Responding to identity and context ▪ Building strengths.	▪ Establishing emotional safety ▪ Facilitating connections
SAMHSA.gov, 2014	Serrata et al., 2020 Sullivan et al., 2018 Decker et al., 2017 Williams et al., 2017	▪ Realising the prevalence of trauma and possible paths for recovery ▪ Recognising trauma signs/symptoms ▪ Responding with TI policies/procedures ▪ Practicing in a way that resists retraumatisation. ▪ Safety ▪ Trustworthiness and Transparency ▪ Peer Support ▪ Collaboration and Mutuality ▪ Empowerment, Voice and Choice	▪ Cultural, Historical, and Gender Issues

TIC Reference	Cited By	Unanimous TIC Principles	Unique TIC Principles
Elliott, et al., 2005	Mantler & Wolfe, 2018 McConnell & Phelan, 2022	▪ Recognising the impact of violence ▪ Using an empowerment model to encourage recovery ▪ Facilitating control/choice in a collaborative and respectful strengths-based approach ▪ Minimising the possibility of retraumatisation	▪ Taking on board survivor feedback
Harris & Fallot, 2001	Mantler & Wolfe, 2018 Serrata et al., 2020 Tarshis et al., 2022	▪ Services to understand the meaning-making of trauma ▪ Understand survivors' needs	▪ To recognise impact of trauma on worldview ▪ Treat the person not the problem ▪ Move from cost-conscious symptom management towards fostering autonomy (survivors learn to help themselves and require less input)

It could be questioned whether these approaches to TIC have differing emphases upon their component parts, or they are distinct models altogether. From the synthesis of studies included in this review, the following TIC principles have been identified as key for IPV survivors:

1. Understanding trauma in relation to signs/symptoms, prevalence and impact, as well paths to recovery.
2. Understanding survivor needs based upon the survivor’s identity (i.e. their cultural and historical context).
3. Responding in relation to the survivor identity and context with TI policies and procedures that implement survivor feedback and facilitate their coping/recovery.
4. Facilitating the service relationship by practicing in a respectful and strengths-based way, that seeks to restore choice and promote collaboration so that survivors may be empowered to develop their autonomy.
5. Eliminate risk of retraumatisation by promoting safety, trustworthiness and transparency, and valuing peer support to establish emotional safety and facilitate connections.

The principles reflected what service-providers and IPV survivors considered was valuable based upon the TIC approach adhered to within each of the studies. Qualitatively, studies demonstrated improved wellbeing perceptions and reductions of barriers to services/greater accessibility (McConnell & Phelan, 2022; Tarshis et al., 2022; Jackson et al., 2020; Mantler & Wolfe, 2018; Williams et al., 2017). Quantitatively, TIC predicted greater wellbeing and safety perceptions, which were facilitated by increased cultural and contextual considerations (Serrata et al., 2020; Sullivan et al., 2018; Decker et al., 2017; Goodman et al., 2016). It may be that further research is required to continue such evaluation and refine these principles for this specific population.

Discussion

This narrative synthesis highlighted that although IPV survivors were included in the quantitative and qualitative data, only one study exclusively focused on the survivor voice, but recruited a small sample of three women (Jackson et al., 2020). This may indicate that survivors are underrepresented within the application of TIC to IPV research at present, particularly within the UK, as all included studies were from the USA or Canada.

Furthermore, the review highlighted the heterogeneity in TIC approaches referenced within the extant literature. These were synthesised to gain a better understanding of the current principles, which appeared to offer important benefits for IPV survivors based upon the principles of TIC presented in the literature.

Within the review, the intersectionality of IPV survivors was considered by several studies in relation to health (Williams et al., 2017), intellectual disability (McConnell & Phelan, 2022) and employability (Tarshis et al., 2022). The findings appeared to corroborate the use of TIC within a wider range of practices and services. This may facilitate an improvement in survivor outcomes based on the perceptions of TIC being a more person-centred, tailored form of support (Williams et al., 2017). One study also noted that when practices were culturally responsive and inclusive, they significantly predicted higher reported TI outcomes (Serrata et al., 2020). This indicated that while implementing TIC, services should pay particular attention to the survivor's individual context to fine-tune the support they receive; this finding is reflected in the synthesis of TIC principles.

Strengths and Limitations. A strength of this narrative review has been the synthesis of heterogeneous literature that sought to explore TIC within the constructs of understanding, implementation, and impact for IPV survivors. The narrative approach to this review facilitated a discussion about the extant literature, comparing methodology and findings across a range of contexts to identify gaps within this field of research.

However, this review is not without limitations. To ensure that all included studies specifically addressed TIC within an IPV context, only those who made this explicit (i.e. within the title/abstract or keywords) were included. Despite the addition of manual searching, it is possible that some studies may have been excluded if TIC for IPV survivors was referenced but such terminology not used explicitly. Furthermore, the third search string focused on assessment, measures and exploratory data, but it could have included broader terms to capture more conceptual TIC literature. Also, given the heterogeneous nature of the included studies, it was not possible to gain an in-depth understanding of the research methodology utilised within each study. A secondary quality appraiser was not employed for this review, which may therefore have inadvertently introduced a level of bias into the synthesis of the results. While the results reported positively on the position of TIC for IPV survivors, the findings should be interpreted with caution for this reason.

Rationale for the Current Study

In terms of the studies included in this review, almost half of the qualitative research centred on service-providers perspectives, and only one study exclusively recruited IPV survivors. In addition to this, 43% of the studies included in this review were appraised as not meeting every methodological quality criterion; the quality criteria have been met for the current study. Lastly, none of the included studies were based within the UK, as all were from Canada or the USA. For these reasons, this narrative synthesis has demonstrated the need for further high-quality, qualitative, IPV survivor-focused research to be conducted to fill this gap in the extant literature, particularly within the UK.

Snyder (2016) argued that it is essential to ask women about their experiences of abuse so that they can be actively involved in shaping policies and resources borne out of survivor research. When research is survivor-led, greater opportunities may be afforded to explore survivor perspectives in terms of what helps and what harms (Sweeney & Taggart, 2018). The present research sought to address this apparent gap within the current understanding of TIC for female survivors of IPV, by centralising them within the research.

Social Context

The spotlight has been on Violence Against Women and Girls (VAWG) in light of recent atrocities that women globally have been subjected to. For example, the emergent brutality and misogyny within the UK police force that has caused women to lose trust in the concept of a protective police force and the criminal justice system (Wistrich, 2022), and the USA criminalisation of women's rights to abortion (Gostin & Reingold, 2022) that has created a fear of moving towards to dystopian times (Armstrong, 2018).

In line with the feminist epistemological position adopted in this research (see Methods chapter for further details), the direction of prevalence indicated in the statistics, and UK refuges being gendered to protect and empower survivors (Murray, 2002), this study will explore the experiences of female survivors only.

Researcher's Context

Throughout this research, I have considered my position as a white, female researcher interviewing female survivors of IPV. I have talked more about the emotional impact of interviewing within Appendix F, and of the thesis process overall in Appendix G. I am aware of my educational privilege and research platform, which I have chosen to use with the aim of supporting and empowering others by bearing witness to experiences that can evolve service delivery. With such privilege comes enormous responsibility, particularly in depicting an authentic portrayal of the survivors’ stories. I am aware that my positioning may impact upon my findings in terms of centring the female survivor voice above all others, but ultimately, I hope that in doing so through feminist methodology, my research may advance service delivery and practice, to better support female IPV survivors. My use of critical enquiry throughout and reflexivity (see Appendix F and G) mitigate my self-identified non-neutrality.

Aims and Objectives

Little is known about how TIC translates into clinical practice for IPV survivors and subsequently, how it is received and understood by women currently living in a refuge. The aim of this research was therefore to address the question, what are the experiences of female survivors of IPV, in relation to exploring TIC for this specific population? The research aimed to gain a better understanding of the role of TIC within IPV and refuge contexts. Listening to the women’s stories of the abuse they experienced could offer insights into the significance of TIC and its place within multidisciplinary contexts, in terms of earlier intervention and preventing retraumatisation. The research aimed to explore the ways in which the principles of TIC may be utilised to better support women who have left an abusive relationship and are subsequently living in a refuge, but also the meaning survivors made of their experiences may help to steer service delivery in the future. By centralising the survivors within the research, the hope was for their stories to be kept at the forefront of the research priority, i.e. improving services for these women. As aforementioned, the social context in terms of the prevalence of GBV at the time of writing this thesis was important to understand the decision to explore IPV for women only and adopt a feminist stance to this work.

Chapter Summary

This chapter introduced the key terminology used throughout this research and offered an overview of the existing research and understanding of these key terms, as well as a systematic narrative synthesis to highlight the gaps in the current knowledge. The present study therefore aimed to address such gaps by gaining an insight into the lives and experiences of female survivors of IPV and learning how TIC may be utilised to better support them across all stages of their IPV journey.

CHAPTER TWO: METHODS

Chapter Overview

In this chapter, both the methodology and methods used are discussed. The chapter begins with outlining the feminist epistemological position and ontology to address the narrative focus given to the interview data. The chapter moves on to describe the process of narrative analysis and fundamentally which strands of the approach have been upheld to continue to focus on the survivor voice and minimise the role of the researcher in this process. That said, the context of the researcher is discussed in Appendix F and G so that positionality and subjectivity can be reflected upon at all stages of this research. This chapter closes with ethical considerations for the research as well as the hopes for dissemination.

A Feminist Ontology, Epistemology and Explanation of Methodology

In terms of feminist theories of knowledge, Cain (1993) described ontology as being the theory of how things are, and epistemology as the theory of how things can be known. They argued that discourse may not elicit knowledge about the relationships in which people live; as aspects of female knowledge may be silenced by this, they maintained that female researchers must hold onto unknown or ‘gut’ feelings to begin exploring the unspeakable. In order to do this, epistemology may be guided by feminist standpoint theory (Harding, 2004). Feminist standpoint theorists have contended that knowledge is socially situated; marginalised groups have greater insight into their oppression than the non-marginalised; and research should be conducted with these groups to explore such power imbalances (Bowell, 2022; Harding, 2004). Feminist standpoint epistemology therefore proposed that feminist researchers may see people not only within their societal reality but also within the wider systems in which they exist and that they therefore have an ‘epistemic advantage’ to speak to their experiences of oppression but also of the oppressor/s (Harding, 2004). Feminist standpoint theory has been critiqued on the basis that there is not one unique female perspective to speak from (Bowell, 2022). For this reason, feminist standpoint theorists have acknowledged the diversity among women and the need to explore sexism in relation to other forms of oppression (Collins, 2002; Hekman, 1997). Rather than striving towards unity around the experience of being a woman, it is instead vital to recognise the common goals in facing gender-based oppression (Hekman, 1997).

The feminist ontology of the current research acknowledged the patriarchal underpinnings of IPV and sought to uncover the experiences, feelings and meaning-making of IPV survivors in relation to their individual IPV journeys. These understandings were embodied within the personal reflections shared through the survivor-researcher interactions. The research adopted a feminist standpoint epistemology based upon the research having potential implications for women, and because first-hand insights about IPV were gathered directly from IPV survivors within a refuge setting and context. This feminist stance reflected the ethos of refuge itself i.e. being borne out of the 1970s feminist movement (Bowstead, 2019), and principles of standpoint theory in terms of centralising the survivor voice within the research to challenge gender-based oppression (Harding, 2004).

Study Design

The focus of this research was to offer a space for female survivors of IPV to share stories of their experiences with the purpose of contributing to a wider understanding of IPV in relation to the role of TIC. For this reason, the study used a qualitative design in which data were collected during in-depth semi-structured interviews. The interviews utilised open questions to explore and follow the IPV journey from the beginning of the relationship to seeking refuge. This approach was adopted with the aim of generating more detailed responses, which is imperative to narrative analysis (Riessman, 2008). The design was also informed by feminist epistemology so that the women's survivor stories were at the forefront of the research at all times (Harding, 2004).

Procedure and Recruitment

Study participants were identified through a process of collaboration and networking. The researcher was introduced to the IPV charity through an established working partnership with a locality Trauma Alliance. The Trauma Alliance is a system-facing initiative, which collaborates with partner services and organisations on a journey in strengthening TI practices. While the charity was in contact with the Trauma Alliance, they were not actively working alongside them as a signed-up collaborator, largely due to their operation sitting on the fringe of commissioned geography. However, the charity demonstrated a keen interest in the research, and the focus on showcasing survivor voices particularly seemed to appeal to their charity ethos of empowering IPV survivors. After finalising and approving the research ethics (see more detail in 'Ethical Considerations' below), the Refuge Operations Manager signposted the researcher to the refuge from which recruitment could begin.

The Refuge Operations Manager assisted the process of recruitment by discussing the study with eligible survivors (see more details on the inclusion/exclusion criteria in ‘Participants’ below) and by sharing an email invitation (see Appendix A) to gauge interest. Potential participants who expressed an interest in taking part were then given the participation information sheet (in Appendix B) to provide further details on what participation would entail (i.e. details of the interview format, duration, confidentiality and access to support). The survivors were able to opt-in to the study by signing the consent forms that were kept securely within the central office in the refuge and posted to the researcher upon the completion of the required consent forms (see Appendix C and D). The researcher was then permitted to contact survivors by email/telephone to organise the interviews; see ‘Ethical Considerations’ for how this was managed thoughtfully.

Participants

The study participants were ten women aged between 20 and 51 years old who all identified as having experienced IPV and were living in a female-only IPV refuge at the time of interviewing. In terms of the type of IPV experienced, 9 out of 10 women survived abuse from their former partners/husbands. One survivor discussed her experiences of domestic abuse perpetrated by her stepfather. Among this sample of survivors, all forms of IPV were discussed e.g. physical, sexual, emotional, psychological, financial, stalking and coercive control (De Benedictus & Jaffe, 2004). Most women interviewed were white British (9 out of 10 women) and one woman was from Asia (exact country of origin not to be named to maintain survivor anonymity). A survivor who was white British described her conversion to Islam and subsequent Islamic marriage.

Participants were included in the study if they met the following inclusion criteria: they self-identified as a survivor of IPV (no evidence of this would be required) and were under the care of the recruiting charity i.e. living in the refuge operated by the charity at the time of the interviews. In line with the research ethics, participants were to be excluded from the study if they were subject to conditions under the Mental Health Act or deemed to be at an increased level of risk to themselves or others. Participants were also to be excluded if they were non-English speakers due to the study not having the means to translate interviews. No participants were excluded from the present study as none of the exclusion criteria were met. Further participant demographic information can be found in Table 5.

Interviews

An interview topic guide was developed to decide which questions would be asked within the timeframe of each interview. Had time and funding allowed, the topic guide would have been developed alongside a survivor panel to facilitate this process by tailoring questioning to survivors' needs (Welsh Women's Aid, 2022). However, as this was not possible within the timeframe and costing of the current research, the interview topic guide was instead shared with research supervisors in the field and adapted according to feedback. The aim was to create an interview topic guide that elicited more detailed survivor responses so that these could be analysed narratively (Riessman, 2008). The topic guide therefore included open questions to elicit details about the survivor's journey to refuge and experiences of IPV, but also to explore their understanding of TIC or perceptions of its relevance along their IPV journey (see Appendix E).

Prior to commencing each interview and before starting the recording, consent forms were checked, and participants were reminded of their rights within the research, including transparency about the anonymisation of the data (see ‘Ethical Considerations’ below for further details). There was also an opportunity for the researcher to address any questions the survivors had about the research. All participants were interviewed via video call (in line with the university policy on COVID-19 at the time) on a one-to-one basis; one participant lost internet signal and so the interview was continued via telephone. The researcher ensured that survivors were in a private space where they felt comfortable talking openly at the start of the interview. All survivors interviewed were aware and consented to the interviews being audio-recorded for transcription purposes and this was done using a dictaphone. The audio recordings were then stored on a secure password-protected hard-drive, as outlined in the ethics application. Interviews typically lasted between 45 minutes to 120 minutes, but on average were 90 minutes in duration, not including the initial introduction to the research prior to commencing the recording.

Oakley (2013) maintained that the validation of women’s subjective experiences should be at the heart of feminist research and that this therefore must be demonstrated within the interview process. Lewis et al. (2015) outlined feminist research as involving active listening by the researcher, being respectful and encouraging, and also maintaining honesty and transparency at all stages. The researcher subsequently aimed to uphold TIC and feminist practices throughout the research process, particularly during the interviews and interactions with the survivors. These guiding principles were sustained by the researcher who sought to be attuned to the needs of the survivor, such as pausing to check how they were managing when intense emotional responses were noticed, and also taking time towards the end of the interview to reflect on the process, as well as re-orientating them to their surroundings for closure.

Throughout the interview process, a diary was kept by the researcher to share post-interview researcher reflections at the end of the data collection stage (please see Appendix F for researcher insights into the process of interviewing IPV survivors).

Managing Data

As outlined in the ethics process, interview recordings were held for seven days prior to beginning transcription to allow the survivors time to consider their contribution to the study and decide whether they would like to continue their involvement. This decision was made to ensure that survivors felt they had choice regarding their involvement in the research and that the study had been designed collaboratively, with the survivors in mind at every stage.

The ethics application also described the way in which the data would be stored: interview transcripts and audio recordings that were uploaded to a laptop would be stored on a secure password-protected hard-drive. Transcripts were to be held for five years to allow for write-up in an academic journal or practice guidelines. Interview audio recordings were to be held for two years for examination purposes and then erased after this time. Details of how long these materials were to be held and where/how they would be stored were included in the consent forms (see Appendix C and D) and in the participant information sheet (in Appendix B). Any hard copies of printed interview schedules or notes were kept in a lockable cupboard that only the researcher had access to throughout the data analysis and write-up. After such time, any hard copies were to be cross-shredded/disposed of to ensure the protection and safekeeping of personal data in line with policies on GDPR (ICO, 2023).

Data Analysis

Riessman (2008, 2005) described a story as being a sequence of events connected by the speaker, and that the term ‘story’ is often used interchangeably with ‘narrative’. Narrative analysis is a method of analysis that can be utilised when researchers seek to better understand the meaning people make from their own stories (Stephens & Breheny, 2013). Narrative analysis goes through two key phases; the first is understanding the meaning people make of their own stories, and the second is how the researcher comes to interpret such meaning (Ho & Limpaecher, 2020; Riessman, 2003). In addition to this, it has been acknowledged that stories may take on different meanings depending on the context in which they were told (Wong & Breheny, 2018). Murray (2000) first distinguished four levels of narratives (personal, interpersonal, positional and ideological) to help researchers identify the types of stories being described, although Wong & Breheny (2018) argued that these levels are not distinct as one may impact upon the other. Researchers have since sought to streamline the approach by offering three key levels of narrative known as ‘personal stories’, ‘interpersonal co-creation of accounts’, and ‘social narratives’ (Wong & Breheny, 2018; Stephens & Breheny, 2013). Personal stories are said to be the immediate focus of narrative analysis as they typically order events to time and place, but can also involve a process of informing others how a person would like to be perceived (Wong & Breheny, 2018). Interpersonal stories typically draw an audience in to have an active role in the creation and shaping of the narrative (Wong & Breheny, 2018). Finally, social narratives build upon the personal by offering reflections about the world, which can be used to understand what is happening more broadly within society (Wong & Breheny, 2018).

Hinchman & Hinchman, (1997) described narrative analysis as being split into two distinct approaches, those which follow structuralism and are largely concerned with plot, character and theme, and those who lean towards hermeneutics and therefore adopt a degree of personal reflection when interpreting text. This conversation around form versus meaning in narratives has been further explored by Riessman, (2008), whose work distinguished between different analytic approaches within the field of narrative analysis. She described narrative analysis being conducted in the following ways, thematically, structurally or dialogically. In a thematic narrative analysis, Riessman (2008) described content as being the exclusive focus, i.e. what is said. She explained this differs from the likes of traditional thematic analysis (Braun & Clarke, 2006) or grounded theory (Glaser & Strauss, 1967) by theorising case by case to keep individual narratives intact, as opposed to categorising themes and working across all cases. Riessman (2008) described a shift from the 'told' to the 'telling' in structural analysis, which aims to explore how speech is created by people to construct their stories and subsequently themselves. Lastly, Riessman (2008) suggested that dialogical analysis explores who a narrative may be composed for and to what purpose; she continued that it is much more concerned with the relationship between the speaker and listener, researcher and transcript, and text and reader.

For the purposes of this research, which aimed to emphasise the survivor voice, the narrative analysis focused largely on personal stories, whilst considering interpersonal and societal reflections as they arose (Wong & Breheny, 2018; Stephens & Breheny, 2013). It also adopted a distinct thematical approach to the narrative analysis to better understand the individual IPV journeys of each of the women interviewed, whilst reflecting on some structural components to examine the way in which each story was shared (Riessman, 2005, 2008).

To begin this process, the audio-recorded interview data were transcribed by the researcher and written verbatim to capture all pauses and utterances, such as 'erm', as well as to highlight key emotional states, such as laughter and tearfulness. The interview audios were transcribed in this way so that the researcher could better understand some of the more nuanced structural components of the data and therefore analyse the ways in which some narratives were created and shared, in addition to depicting core narratives (themes) for each case (Riessman, 2008). The process of transcribing facilitated the analysis as it involved reading and re-reading the transcripts, which encouraged familiarity with the data.

The next step was to decipher the stories within each transcript. Wong & Breheny (2018) explained that the beginning of stories are usually depicted by the introduction of days, time, places and characters by the speaker. They added that some stories have a clear beginning, middle and end, while others are more complex and may be interwoven throughout an interview transcript or be briefer in detail but may still have significant contributions based on the experiences shared. A qualitative research listening guide was used to help recognise both the plots and emotional ‘hotspots’ within transcripts (Gilligan & Eddy, 2017) and Riessman's (1993) descriptions of ‘entrance’ and ‘exit’ talk were also held in mind to facilitate this process.

Following the identification of core narratives within each transcript, the structural components of the stories were considered to explore the ‘telling’ of the narratives further. Labov (1997) outlined the functional components that comprise a narrative structure: abstract (a brief summary of the story); orientation (introduces characters and positions the story within time and place), complicating action (climatic events that create tension), evaluation (highlights interesting points), resolution (explanation of events releasing tension), and coda (an indication that the story has finished; Mambu, 2013). However, Wong & Breheny (2018) suggested that some stories adhere to broader concepts of genre and that identifying these (i.e. tragedy, comedy, romance etc) affords the researcher the opportunity to understand why the story was constructed in such a way. Both the functional components of narrative structure and story genre were considered in the current data analysis. The positioning of the narrative was also determined in terms of whether stories reflected a personal, interpersonal or societal account (Wong & Breheny, 2018). Similarly to Riessman (2008), Järvinen & Mik-Meyer (2020) proposed that cases can be analysed individually to identify stories, which may then be compared across cases to develop a narrative typology. In the current research, the core narratives from each interview along with an exploration of story structure and positioning are presented by case in the Results chapter. Narrative typologies (Järvinen & Mik-Meyer, 2020; Frank, 2012), whereby stories shared similar qualities or storytelling strategies, are considered in greater depth within the Discussion chapter.

Methodological integrity was maintained by following the guidelines set out by Levitt et al. (2016), such as being transparent about researcher positioning and perspectives including how these may impact data analysis, as well as considering ‘groundedness’ i.e. whether the findings are evidenced by data that supports them and facilitates understanding. Working in this way ensured that the study maintained fidelity to the research aims.

Ethical Considerations

Conducting research with a population of female IPV survivors required careful ethical consideration to safeguard their wellbeing at every stage of the research process. The survivors worked closely with the Refuge Operations Manager to consider whether the research was the right choice for them and to help facilitate the setup of the interviews. The manager was therefore instrumental in establishing trust within this process. The researcher was acutely aware that the survivors often had multiple complex dynamics to focus on during their time within the refuge, such as pursuing court orders, work and childcare. For these reasons, the researcher was careful not to create a sense of pressure to participate. The survivors who had signed consent forms to participate and have the interviews audio-recorded were then contacted by email and/or telephone by the researcher to set the interview time and date. The researcher kept a password-protected document of survivor contact details for this purpose.

There were some occasions when survivors missed the interview for a number of reasons (as described above) and therefore they were contacted once more to reschedule. For survivors who did not attend a second time, or were non-respondent via email/phone, the researcher checked with the Refuge Operations Manager to ensure that the survivors were well and establish if they had made a decision not to continue. This was the case for two out of twelve women that had signed consent forms to participate but changed their minds based on other commitments. Part of the ethical considerations around this process was recognising how often to contact and pursue this aspect of recruitment, which the Refuge Operations Manager was instrumental in facilitating.

At the beginning of each interview, the survivors were orientated to the purpose of the research, the narrative (storytelling) approach as well as their rights within the study. The researcher emphasised that the women could choose not to answer a certain question, say as much or as little as they preferred, chose to start at a particular part of their story which perhaps felt more manageable, stop the interview at any time and also withdraw from the research up to seven days post-interview. After this time, it was explained that transcribing would commence, and the interviews would be anonymised so identifying individual transcripts to remove them from the study would no longer be possible.

In terms of anonymising the data, the researcher was aware that this would be a crucial ethical consideration given that the safety of the survivors was paramount to the study, particularly as research has highlighted that women may remain at risk of their perpetrator despite living in refuge and relocating across localities (Bowstead, 2015). The interview transcripts were therefore fully anonymised in the following ways: all names of people and places were removed and replaced with pseudonyms for the survivors (see Appendix F for reflections on pseudonym choice) and locations relabelled as ‘city’, ‘county’ or ‘country’. Key dates, for example, when the relationship ended or when the survivor found refuge, were removed and replaced with labels such as ‘month’ or ‘year’. If a specific public holiday was named, this was replaced with such a label as well. Details of children were carefully considered and their names replaced with labels i.e. ‘son’ or ‘daughter’ and their ages made less specific e.g. ‘<10 years old’. No real-life names were shared within the transcripts and so all partners, husbands or others who had committed IPV were referred to consistently as ‘perpetrators’, as this was a term the women had become familiar with in refuge. While the survivors’ stories may have been known to those they had shared them with in refuge, the aim was for complete discretion in the write-up of the data to ensure the survivors’ safety should the research be published in the future. Every care was taken to maintain ethical practice within this research at every stage of the process.

In addition to ensuring the anonymity, safety and wellbeing of the survivors throughout the research process, researcher wellbeing was also considered and outlined in the ethics application. While it was recognised that the researcher and research supervisor may be adept at noticing and managing secondary trauma given their clinical roles and experience, research has highlighted the possibility of vicarious trauma for both clinicians and researchers who are regularly exposed to trauma stories (Branson, 2019; Fenge et al., 2019). Research supervision was therefore utilised to be attuned to detecting secondary trauma and address any arising difficulties. A peer supervision group was also established for those studying within the field, which supported the researcher in recognising the impact of the research upon them, and to think about the effect of this on the research overall, such as acknowledging the need for rest between interviews to help with reflecting on the process and narratives. The University of Essex ethical approval was obtained through the Ethics Review and Management (ERAMS) system (ref ETH2021-0865; see Appendix H).

Dissemination

The research centralised the IPV survivor voice, and therefore to achieve maximum dissemination, the hope would be for the current research to be published within a high-impact factor journal, such as ‘Violence Against Women’, ‘Journal of Interpersonal Violence’ or ‘Journal of Family Violence’. It may also be the case that these findings have ramifications upon clinical practice, which therefore should be disseminated within the NHS and more widely to inform government funding but also commissioners’ decisions about allocating funds. In order to further invest in the dissemination of learning to shape future practices, the researcher aims to develop a poster-style summary of outcomes and recommendations to share with the participants included in this study, as well as local refuges and Women’s Aid projects.

Chapter Summary

This chapter outlined the methods and methodology to which this thesis has been approached. It referenced the researcher’s context in line with epistemological positioning and detailed the aims of upholding feminist epistemology and ontology for the research process and outcomes of this research. It also described the chosen analysis in detail, explaining the reasons for adopting such approach for this particular data set. Lastly, ethical considerations were made explicit, principally with regard to the importance of anonymity and confidentiality for this population of survivors. The plan for dissemination was summarised and the results of the narrative analysis follow in the next chapter.

CHAPTER THREE: RESULTS

Chapter Overview

In this chapter, an overview of the results from the narrative analysis (Riessman, 2008) of ten interviews is provided. Each of the interviews have been analysed in their entirety to identify core narratives, from which two narrative typologies were derived. This decision to analyse the interviews case-by-case was made not only to reflect the methodology of the research but also as an act of respect for each participating survivor. This approach emphasises the researcher's position of responsiveness in upholding and endorsing each survivor's storying of their experience, as to edit would have been akin to discounting, which could have created researcher-led power. The hope was that in keeping their narratives largely intact (within the remit of the thesis) the survivor would be central to the research, and their voice amplified. For an insight into the researcher's positionality and experience of interviewing the survivors, post-interview diary reflections can be found in Appendix F.

Participant Demographic Information

Demographic information was collected from all participants with a view to better understanding the diversity among the women who contributed to this research. This information has been presented in Table 5 below and contains details about age, ethnicity, highest level of education obtained, employment status, marital status and number of dependents. Some of these categories were expanded upon e.g. a survivor identifying as 'single' (separated) while still legally married, or employed but on maternity leave at the time of the interview. These additional details were collected to more accurately represent the demographic information. While the study sample was not ethnically diverse, it was reflective of the region whereby ethnically diverse groups formed approximately 11% of the total population (region not named in adherence to research ethics; ONS.gov.uk, 2021b).

Table 5

Demographic Information from Female IPV Survivors

Demographic Characteristic	Frequency	Percentage (%)
Age in Years		
Mean age (Standard Deviation)	31 (9.75)	-
Age range (Youngest – Oldest)	31 (20 – 51)	-
Ethnicity		
White British	9	90%
Asian British	1	10%
Education Attainment		
School	2	20%
College	7	70%
NVQ	2	20%
Diploma	1	10%
Other	1	10%
Employment Status		
Employed	4	40%
Full-time	0	0%
Part-time	3	30%
Maternity Leave	1	10%
Unemployed	6	60%
Marital Status		
Single	10	100%
Married	1	10%
Divorced	2	20%
Children		
No	3	30%
Yes	7	70%
One	3	30%
Two	2	20%
Three	1	10%
Four	1	10%

Pen Portraits

In order for the reader to feel well-orientated to each of the women's narratives, Table 6 provides the participants' 'pen portraits' (AQR, 2022). These offer a summary of how the women came to be in the refuge and the nature of their relationships with their perpetrators. In the service of safety, efforts to ensure anonymity have been made throughout.

Table 6

Pen Portraits of Female IPV Survivors

Pseudonym	Story
Ivy	Ivy met her perpetrator through online dating. They were together for five years. In that time, Ivy fell pregnant with their daughter, and they moved into their first home together. Ivy noticed 'red flags' at the start of the relationship, which escalated after she became pregnant. Ivy experienced emotional, psychological, financial and physical abuse, which also occurred in front of their young daughter. Ivy managed to leave the relationship and has been in the refuge for a year and a half.
Rose	Rose has two grown-up children from a previous relationship and one child with her perpetrator. Rose talked about knowing her perpetrator since they went to school together and that they met again later on as adults. Rose shared that she felt angry at herself for staying with him for over ten years. However, she described not being able to 'up and leave' so easily due to their son having learning difficulties and therefore needing much more planning around their eventual move to refuge. Rose has been in refuge for six months.

Pseudonym	Story
Daisy	Daisy left her family home as a teenager to embark on a new life with her perpetrator, who then began his coercive control of her and abusing her verbally. Daisy described being with her perpetrator for around four years. She explained that the onset of abuse was gradual and that she was unaware it would be deemed IPV until she found refuge. Daisy shared that the abuse escalated and she suffered brutal physical, sexual and psychological abuse that caused her to feel suicidal and suffer with her trauma long after the relationship ended. Daisy has been in the refuge for a year.
Violet	Violet has been living in refuge for a year and arrived shortly after the birth of her child. Violet shared her concerns about the suitability of refuge for her baby and her struggles in this regard. Violet explained that she had a good relationship with the father of her baby; they parted amicably upon her arrival to the refuge for ease. Violet shared that she suffered domestic abuse at the hands of her stepfather and witnessed her mother living through IPV also. Violet talked about feeling helpless to support her mother, who did not see the abuse taking place. Violet found refuge and awaits housing to begin her new life with her baby, away from her family of origin.
Fleur	Fleur spoke of her relationship with her perpetrator initially feeling like a whirlwind romance but culminated in several violent attacks that almost cost Fleur her life. Fleur found refuge but described battling the system as her short relationship with her perpetrator meant that she did not meet the

Pseudonym	Story
	threshold for certain criteria to obtain safety and protection from the courts (e.g. non-molestation order). Fleur described the impact of this on her and the cost it could have on others. Fleur has been in refuge for around one month.
Olive	Olive had experienced three abusive relationships, the first of which began in adolescence. Olive spoke of her difficult family background; she described her mother as an alcoholic and her father as a heroin addict. She shared that she grew up in a toxic environment, which normalised perpetrator behaviour whereby she was exposed to ‘county lines’ and became involved with drugs and gangs. Olive described an on/off two-year relationship with her third perpetrator. One day, fearing for her life, she fled the relationship and found refuge, where she has been for a year and a quarter. Olive described feeling ‘robbed’ of so much by her perpetrator; this feeling became exacerbated when she came into refuge leaving everything she’d known behind. Olive realised she would never be the same after her traumatic experiences and often found herself wondering whether she would return to her abusive but familiar relationship.
Fern	Fern experienced IPV within two marriages. She met her first perpetrator as a teenager. They married after she became pregnant aged 16 and went on to have two children together. Fern reflected on taking the same path as her mother, who also fell pregnant aged 16 but had an abortion. Following the breakdown of her first marriage, Fern converted her faith to Islam to marry a

Pseudonym	Story
	second time and went on to have two further children. This marriage lasted for over ten years but culminated in Fern finding refuge with their two young children. They have been in refuge now for two and a half years, much to their dismay. Fern talked about the cultural differences between both her marriages, and feeling isolated, hurt and let down by those around her. She also spoke about being ostracised by her adult-children and the impact of this upon her in terms of managing the current IPV.
Willow	Willow is currently married to her perpetrator but tackling divorce proceedings whilst living in refuge with her two children, where they have been for four months. Willow shared that she had been married for over ten years and suffered domestic abuse gradually from the onset of the relationship. She described concealing the abuse over the years from her friends and family and also spoke of sexual abuse that she felt unable to report to the police. Willow talked about suffering with anxiety and her loss of identity during the relationship. Although Willow shared that she felt a weight had been lifted off her shoulders once she left her perpetrator, she also described feeling tired of going around in circles giving statements to the police and just wanting peace.
Holly	Holly shared that she grew up in a challenging domestic environment and felt that abuse was familiar to her based on her difficult relationship with her mother, whom she described as an alcoholic. She also talked about being

Pseudonym	Story
	bereaved of her father from a young age. Holly was with her perpetrator for around six months and became pregnant soon into the relationship. She noticed a change in the perpetrator after this happened, whereby there was physical aggression (e.g. pushing her over while pregnant) and emotional/psychological abuse (e.g. throwing her out of their home, leaving her to sleep in her car while pregnant). Holly explained that they separated during her pregnancy, but she gave him another chance upon the arrival of the baby. Following two weeks of further IPV, in which Holly depicted her perpetrator as frightening both her and the baby, Holly left and found refuge. Holly has been living in refuge with her baby for one month and they await housing to start their lives afresh together.
Lily	Although friends cautioned her not to, Lily married her perpetrator in her home country before embarking on a life in the UK together. Shortly after arriving however, she discovered she was pregnant. Lily recognised that this escalated her experience of IPV. Her perpetrator also battled drug addiction, which Lily felt eventually put her and their two children in grave danger. Lily described feeling positioned to care for her perpetrator throughout his addiction, which prevented her from leaving for some time. When she did leave, she expressed feeling judged and abandoned by her Asian community. After remaining in the marriage for over ten years, Lily eventually found refuge with her two children. After four refuge moves for their safety, Lily has been in the current refuge for around 6 months; her longest stay to date.

Narrative Analysis

The interviews from 10 female IPV survivors were analysed individually using a narrative approach; see Methods chapter for further information.

Ivy's Story

Within Ivy's interview, two core narratives were shared. One pertaining to her maternal guilt from IPV and a second based upon the death of her former self.

"I just want to be a better person, a better parent". A core narrative within Ivy's story was that of her maternal guilt throughout the course of the IPV, which persisted in refuge. Within this core narrative, Ivy shared a story about the onset of IPV during her pregnancy:

> *I got pregnant and we moved into our first property together. And that's when I started to notice…the little red flags but I just thought, it's where I'm pregnant, he's stressed…it will be ok. But then as time moved on, he just got worse…he was like, belittling me, squaring up to me in front of his kids, his friends and his family, it was just disgusting.*

Within this story, Ivy talked about the relationship starting well but deteriorating whereby she used the imagery of a red flag, a term used in IPV/refuge, to convey how it felt her attention was being drawn to the problems within the relationship. Ivy used abrupt language when telling her story, which may have also reflected the sudden onset of the IPV she experienced. Ivy's repetition of 'his' indicated that the people surrounding her in the story were connected to the perpetrator, not her. This further emphasised her sense of isolation within the relationship. Ivy used a metaphor to explain how she was feeling at the time:

> *I never knew what mood he'd be in; I was always walking on eggshells…the cracks started to show.*

This metaphor was presented in two parts in Ivy's story; the ellipses indicated the later continuation of the metaphor within Ivy's transcript. It highlighted that although Ivy had been working hard to maintain the relationship by being cautious of her perpetrator, she identified that this had not been successful. Ivy noticing these cracks demonstrated an awareness that the relationship was in decline.

Within the core narrative of maternal guilt, Ivy shared a story about one experience of abuse, which stood out to her because of the risk to her daughter at the time:

> *I'm cooking on the frying pan and my baby was under my feet. So, I said to him "can you help, I don't want to burn [daughter]". He picked up the frying pan, threw the hot food everywhere and tried to beat me with it.*

Ivy's description of the positioning of her daughter could be both literal and metaphorical. For example, her daughter being under her feet was putting Ivy at risk of IPV due to it disrupting her being able to cook dinner. Ivy then asking for help provoked an unexpected outburst, which her daughter witnessed and could also have been physically harmed by. The way this was presented in Ivy's narrative was sudden and abrupt, which reflected the unforeseen attack Ivy experienced in the story.

Ivy talked explicitly about the disruptions to the attachment between herself and her daughter, due to the psychological space the IPV was taking up within the family:

> *I never really interacted with my baby, I was too busy making sure the place was clean, everything was done for when he gets home so he's happy...I was so stressed, we didn't really bond at all...I know she's only young and she probably won't remember none of this, like she probably might...I think when you're a parent you're*

> *supposed to protect your kids...I can't have her witness any more abuse ever in her life...I need to protect her.*

In the telling of this story, Ivy evoked a genre of reparation as she presented a shift in her positionality from one of defence to one of maternal protection and prioritisation. Ivy discussed her perception of the parental role and how this presented a dichotomy for how she felt she had been positioned within the IPV and her subsequent guilt at not ending the relationship sooner. In order to repair and correct this narrative, Ivy created a sense of urgency in her tone emphasising her protective maternal drive. She furthered this story when talking about her maternal guilt transitioning to shame:

> *I was ashamed to open up about what happened...people look at you like, oh you're a battered wife...You get that stigma around being abused...I thought, I feel so low as it is I can't, I can't dare tell my family...I literally just kept everything to myself and I just was on like a downward spiral really.*

Ivy shared her perception of the prevalence of stigma that could be felt with just a look from another. She also used the word 'dare', which drew a parallel to the common threatening language used within IPV, e.g. a perpetrator daring the victim to leave or tell. This story not only highlighted Ivy's shame at her IPV experiences but also her fear in seeking help from others, particularly when this has been met with sudden violence from her perpetrator in the past.

Ivy ended the core narrative around her maternal guilt with her reflections on her development and growth since leaving the relationship:

> *It does feel good that I'm finally being a good mum...just showing her that I care...interacting with her...That's what I want. I just want to be a better person, a*

> *better parent...[Daughter] is doing really well, she's learning loads. My main concern is her and she's doing well. I don't really care about me.*

Ivy's use of the word 'show' as well as her focus on her daughter's educational outcomes highlighted that she perhaps felt a need to evidence her being a good mum to make it tangible and therefore real, which served to challenge and contrast narratives around not being believed.

"I was very glamorous! … Yeah, he literally killed all of that". A second core narrative within Ivy's interview is that of the psychological death of her former self. Ivy shared several stories that provided insights into how this process occurred. She began with the impact of the IPV on her sense of self:

> *I was very glamorous! I'd have my hair done, make-up done, I'd work all the time, I was very work driven, you know. Very confident and yeah, he literally killed all of that. Yeah. Killed it all.*

This part of the story emphasised two important aspects of Ivy's identity: her prioritising self-care and her motivation within her work. Her use of language in telling this story highlighted that she felt these parts of herself were not only taken, but "killed" within the relationship. It could be acknowledged that Ivy may have been grieving these aspects of her identity that no longer existed. Further to the erosion of self that she incurred through the stripping away of self-care and self-respect within the relationship, Ivy talked about additional losses when finding refuge:

> *You actually do feel ashamed that you've got to come in here...the stigma of women's refuges is degrading...Like, people don't believe you. They automatically just assume that oh you're a battered wife, you're scum,...or you're just playing the system just to*

> *get a property...But with that bad stigma...I do feel like some women may not feel strong enough to do it and they'll just put up with the abuse and their situation...It's a whole new…building, it's not an easy option...with loads of loads of strangers, and I just thought "I've got to hideaway, I don't want no upset, I don't want confrontation"*

In the previous core narrative, Ivy shared that she already felt ashamed of the IPV due to recognising the impact of it upon her daughter. Ivy spoke about refuge stigma eliciting further shame, as she depicted the labels she felt were becoming attached to her in place of her former identity. While stigma is inherently bad, the phrase 'bad stigma' added emphasis within this story, accentuating how loathsome this had been for Ivy. There was mention of strength and that without this, it is not possible to leave abusive relationships. For Ivy, the stigma appeared to reinforce messages from the abuse, such as not being believed or worthy of support, which she felt could diminish strength and therefore prevent leaving.

Within Ivy's narrative around the death of her former self, she appeared to experience a dichotomy within her relationship to help:

> *I expected my caseworker to be with me, to reassure me...smother me and care for me, just to feel cared for. And I didn't get nothing like that...I got so frustrated...and said "you's are all perpetrators!"...They're trying to help but it's just not the help what you wanted.*
>
> *Going through what I've gone through, I just feel very worthless, so why should I disturb their day, what they're doing just to talk to me, to make sure I'm ok...That's how I looked at it, I'm worthless. Why should I interrupt them?*

It appeared Ivy was longing to be cared for, perhaps another aspect that had been killed off within the IPV. The language she used to describe the care she craved could be understood in terms of IPV being a suffocating relationship, and the second part of the quote highlighted the ambivalence often felt within IPV relationships, in terms of the love and hate for the perpetrator, as well as the urges to stay or leave. Ivy did not feel worthy of love/care because she had been made to feel that way by her perpetrator. She appeared to crave the affection she had been denied, which was re-enacted within her relationships in refuge. It could also be the case that Ivy perceiving her caseworkers as perpetrators was based upon her own protective hypervigilant trauma response (Siegel, 1999).

The core narrative concluded with Ivy taking ownership for getting better, or perhaps an attempt to resuscitate the parts of herself that had been killed:

> *I'm doing counselling to try and sort myself out...If I knew more about domestic abuse and all the different kinds of it, then yeah, I probably would have left a long time ago.*

While Ivy had put the onus of recovery upon herself, there was mention of this being a systemic burden as she referenced not feeling IPV-educated to a degree whereby she could have protected herself and her daughter sooner. The indication was that Ivy had suffered unnecessarily for some time, which inferred a level of blame and culpability, but she only named herself as being to blame for this. The moral of Ivy's story was therefore that the burden remains with survivors to resolve and heal from IPV, yet the irony being that it is not possible to resuscitate oneself.

Rose's Story

Rose's story captured two core narratives, one which focused on maternal protection and prioritisation, and the other regarding trauma as a subjective experience.

"I don't know what the future holds for [my son] and when I'm not here, that really worries me". The first of Rose's core narratives was based upon her prioritisation of motherhood, which began with a reflection of her tolerance and perseverance of the relationship:

> *It was just all wrong. I put up with it for ten years...I didn't want [my son] around him. And he was just not a very good role model...He was very immature in the way he spoke, the way he acted.*

This offered an insight into Rose's attitude towards her perpetrator, that she endured him. Rose commented on his inability to demonstrate attributes that she valued in a man. Instead, she described him in an infantile manner, therefore positioning herself within a parental role to both her son and her perpetrator. Rose reflected that her reasons for staying converted into her motivations for leaving:

> *Why did I stay there for as long as I did?...I stayed for [my son], thinking that was the right thing...It was unbearable, when I decided to leave...I just didn't have anywhere to go because for [my son] it had to be proper. I couldn't just sofa surf or go to my sisters...I have to be very prepared...I took a big gamble coming in here, but...he's doing ok and that's the main thing.*

The language Rose used to express her dismay at her inaction conveyed her sense of responsibility for remaining in an abusive relationship. There appeared a paradox between recognising her need to leave and acknowledging the difficulty in doing so, whilst also continuing to blame herself for delaying the process. Rose likened finding refuge to gambling, so it could be presumed that she felt she stood to lose everything or hit the jackpot by finding sanctuary for her son and herself. The fact she considered her son to be thriving since leaving highlighted that she was perhaps now more aligned with the latter, however this may further drive her guilt and sense of culpability for staying in the relationship so long. Rose talked about motherhood being her identity, and therefore prioritising it above all else:

> *I have to be good for him. He's my purpose of getting up every morning and the last thing I think of when I go to sleep. So, he keeps me strong, definitely...[My son] is the one who needs all my energy...I don't know what the future holds for [my son] and when I'm not here, that really worries me.*

The first part of this story reflected the notion of being a good role model as described previously, but it also communicated a fear of having her ability to prioritise/protect her son taken away from her, with reference to her own mortality. Rose used paradoxical language in this story, describing her son as her strength, but also as the greatest demand upon her energy. This echoed her dichotomy regarding how to protect him both within and from the IPV relationship.

"I don't need counselling. I need a spa break". A second core narrative for Rose was that of her drive for psychologically moving on. Rose began this story by talking about her childhood narratives around coping:

> *My mum's greatest one of her sayings is "the side mirrors of a car to look behind are that little for a reason, you just look at the big one where you're going in the front". And it just always made sense.*

The metaphor used contrasted much of the literature on psychological thinking around trauma, in terms of recognising the impact of past experiences upon the present day (Van Der Kolk & Van Der Hart, 1991). It also generated a sense of moving forwards in life while leaving something behind, i.e. driving away from an abusive relationship. It appeared to be important for Rose to share that this metaphor originated from her own mother whom she depicted as wise; it could signify the importance of the maternal relationship and her hope to be remembered in a similar way by her son. To embark upon this process, Rose talked about the value she assigned to being able to leave difficulty in the past:

> *I'm a good mover-oner [laughs]...I don't wallow in self-pity or, what it is it is, it's done, you know I left, that's it, move on...I don't need counselling. I need a spa break.*

Rose spoke about her ability to move on being an achievement whilst inferring that vulnerability and reflection are linked to weakness. However, it could be implied that Rose recognised her need to prioritise self-care and relaxation, but within an acceptable and tolerated framework that would not elicit a sense of helplessness.

In terms of peer support within the refuge, Rose explained her position within the wider group:

> *I think it's cause I am the eldest in here...it could be my age. I can't deal with that no more...I'm not your agony aunt. I'm not being an ice queen, but I've got my own issues...I'm not hard, I'm not heartless, but I don't dwell.*

Although Rose appeared to want to be remembered as being wise like her mother, she described feeling overwhelmed when positioned in this role within refuge, perhaps as a response to being 'parentified' by her perpetrator previously. The language used created imagery of an ice-queen who in fictional stories is often capable of turning things into stone. This emanated a sense of immobility; if Rose engaged with consoling her peers, she may have feared it would prevent her from moving forwards with her life. Instead, Rose urged her peers to join her in focusing on the future:

> *How are you ever gonna get over it if you don't forget...You don't go backwards in life you go forwards...why do you people want to sit in a circle and bring up agony,*

> *misery? I don't understand that part...I don't think it helps you for a start because you just relive it all.*

Rose outlined what could be deemed as a countertherapeutic coping strategy to help her move on, as she described pushing down her IPV experiences that she acknowledged were painful. However, while this may be unhelpful for others, Rose suggested that the alternative could cause her greater distress. For Rose, moving forwards in life appeared to be a literal process of only focusing on the future.

Rose concluded this story by commenting on her relationship to help in terms of trust being a central factor in establishing rapport and how it cannot be assumed:

> *I don't really trust anybody to begin with anyway, you know. I don't trust no one...I've always been that way anyway since I was younger...you have to earn trust don't you.*

This part of the story offered an insight into Rose's starting position, whereby trust must be obtained before a relationship can ensue. This finding was reflected in research on child sexual abuse (CSA) survivors who shared that trust was established through collaborative working and maintaining relational safety (Alyce et al., 2022). The value of not trusting anyone could be protective, perhaps in terms of self-preservation but also as a mother. By not trusting anyone, Rose remained self-sufficient and reinforced her sense of strength to challenge narratives that may be associated with trauma, such as victimisation and vulnerability.

Daisy's Story

Within Daisy's interview, three core narratives were depicted. These pertained to the accumulation of trauma, the gap between intention and action, and survivor identity.

“Sometimes it genuinely feels heavy, like my body can’t take the weight of everything anymore”. In terms of how her trauma amassed, Daisy began by reflecting on her leaving home to live with her perpetrator:

> *I love my family to death...but I can’t live with them...there was a massive family argument...I was always the one in the family who would get like picked on...It was always my fault...I just thought...I’m just gonna leave...[My mother was] like “that’s fine, but you’re not coming back. That’s it, once you’re gone your gone, the grass ain’t greener on the other side”.*

This fable, a story intended to teach a lesson in the face of folly or weakness (Collins, 2023), portrayed Daisy as being ungrateful for seeking what she did not have and Daisy’s mother cautioned her of the fable’s moral, whilst simultaneously withdrawing her support to embed this message. Daisy therefore could be considered to have no secure base from which to explore her world, nor a safe haven to return to (Powell et al., 2009), rendering her position in the world uncertain.

Daisy’s trauma accumulated throughout her life; she named her experiences of adoption, childhood illness, a breakdown in family relationships, miscarriage and IPV as being traumatic. This trauma may have been added to by how she initially experienced refuge:

> *I remember that first day like it was yesterday. I was petrified...I genuinely felt a bit numb...When I first come in here, I would just cry every day...I’ll be upstairs all day. I won’t socialise...And that also means that I won’t cook myself something to eat...Sometimes I wake up and I’m like “where am I?”, thinking that I’m still there.*

The word ‘numb’ conjured an image of being frozen with fear, causing Daisy to withdraw socially from refuge peers, but also from the nurturing parts of herself. Daisy’s mind and body were shutting down into a protective hibernation, but one that caused her to feel confused and displaced once awoken. Daisy added to this by depicting the physical toll of the trauma upon her body:

> *This on top of it has just made it ten times heavier. Like, sometimes it genuinely feels heavy, like my body can't take the weight of everything anymore. I have to go and lay down.*

This imagery conveyed a message not only of the suffocating burden of the trauma but also of her perception of feeling too fragile to carry the load. This may be exacerbated by her apparent isolation after being abandoned by her family and cut off from many of her friends during the IPV. The image of her body giving way beneath her also provided a sense of how oppressed she had felt at different stages of her life. Daisy indicated that the accumulated weight of these experiences was now more than she felt she could carry, which evoked a sense of hopelessness within the narrative.

Highlighting the toll of the trauma she experienced, Daisy developed her narrative by listing accounts of abuse:

> *When I would talk about it with other people, he would get quite jealous...He did seem very jealous of the baby...He started like, kicking me out...I'd walk to the end of the road and just sit there until he called me back...I just think it was generally humiliating sort of being with him...He would sell videos of us being intimate...that was quite disgusting...[He] busted my lip, cause my lip was so fat I couldn't close my mouth. And I had bruises under here...I had blood all down me...It was everywhere.*

Daisy being left outside not only highlighted her isolation but also the manipulation she experienced, which rendered her wholly dependent on her perpetrator for shelter and warmth. This part of the story evoked a sense of a master puppeteer manipulating the puppet, in terms of highlighting the power dynamic between Daisy and her perpetrator. Furthermore, Daisy described sexual abuse but also depicted further violations against her in terms of the selling of intimate videos. This two-pronged attack appeared to leave her feeling used, degraded and ashamed. Daisy also talked about the painful physical abuse she suffered, which covered her in tell-tale injuries. Daisy's wounds may have illustrated a form of branding, whereby the perpetrator left his mark on her to indicate his possession. In Daisy's visceral descriptions of these events, she was perhaps trying to communicate the horrors she experienced to facilitate her own and others' understanding of the IPV.

In her depiction of the multiplicity of abuse that she experienced, Daisy indicated that she felt her death would be the only way out of the relationship:

> *If I'm being honest, I was pretty much waiting for it to end...I knew it was coming but I just didn't know when...In my police notebook, I have...my funeral plans that I wrote down cause I wanted to have these things in place before I died.*

Daisy's anticipation of death seemed both pragmatic and detached. Making such plans perhaps not only served to instil hope that she would eventually find peace and be alleviated from her trauma-burden, but also to re-establish a sense of control, which she had been entirely deprived of throughout the process of the IPV relationship.

"I was like "no I fell and hit my head on the bed" … [the words] literally just fell out my mouth". The second core narrative was the gap between intention and action, which can create victim-blaming narratives. To understand this better, Daisy reflected on her preliminary attitude towards the relationship:

> *I had someone who cared about me and looked after me...I didn't have that before.*

This reflected her sense that despite her mother's caution, the grass seemed very much greener on the other side that she had discovered with her perpetrator. However, there was a gradual process of disempowerment following the onset of abuse. This may have derived from gaslighting, i.e. undermining and invalidating her experience of reality to render her culpable for the IPV (Gass & Nichols, 1988):

> *He would tell me "No one is gonna believe you, tell everyone, they're not gonna believe you, it's fine, nothing's gonna happen to me".*

Daisy was therefore completely silenced by her perpetrator, who implied a favourable outcome for himself, and the opposite for her should she try to leave. The tone of this quote was also threatening as it inferred that her perpetrator believed he would endure no consequences; something he may have understood from other IPV/sexual abuse cases being underreported/unsentenced. This could therefore be interpreted by her perpetrator as a greenlight to up-the-ante of IPV. Daisy reflected upon her powerlessness to escape:

> *I wanted it to change. But I just didn't have the tools or like, the know-how to change it.*

This highlighted a perception of requiring a certain set of skills to leave an abusive relationship, which Daisy did not consider she possessed. It also posed the question of how these tools are disseminated to those who need them. Additionally, it acknowledged the burden being placed on the woman to escape IPV, inferring weakness when this is not achieved.

A key component of this core narrative can be observed in the occasions whereby Daisy was unable to fully communicate her truth:

> *[In hospital] I do wish that I said something at that moment. I wish I went in there and was like "my boyfriend did it, can you help me?". But I didn't…I was like "no I fell*

> *and hit my head on the bed". Why I didn't just say "yeah he did [it]", I don't know. But that just, it literally just fell out my mouth.*

In these stories, Daisy described an automatic urge to conceal the IPV. The wider core narrative afforded the opportunity to explore what may prevent a survivor from sharing their experience with others, such as holding on to ideals of the relationship, being told they would not be believed, mistrust of the other person, and perhaps feeling so oppressed within the IPV that there is simply no fight left to challenge the abuser. The falling of Daisy's words may have reflected her sense of 'rising for a fall', and subsequently evoking an ominous tone to the story, i.e. a sense of foreboding for the events that may follow such a disclosure. Daisy recalled the first time she disclosed her abuse to a healthcare worker:

> *I was like "my boyfriend hits me"...And they were like "oh", I don't think they were expecting me to sort of whip that one out, you know?...I was like… "I'm gonna be fine".*

The word 'whip' emanated violence in telling this story, thus reflecting the theme of IPV. Furthermore, Daisy's account highlighted the healthcare worker's unreadiness for disclosure, which could cause survivors to question other people's tolerance and ability to manage disclosures effectively. Daisy offered reassurance of her safety, which may have been in response to feeling the practitioner's susceptibility to vicarious trauma. This suggested that survivors may be concerned about eliciting secondary trauma and consequently minimise their own distress to protect others. Finally, this story illustrated a failure to recognise the impermanence of Daisy's safety, which posed a question as to how risk is assessed, and meaningful follow-up provided to ensure women's safety following IPV disclosure.

Daisy concluded this core narrative by detailing her experience of disclosing the IPV to the police once her perpetrator was arrested in their home:

> *I called up 101 and I said that I need to report a sexual assault, is there any chance that I can have a couple of members of staff come to my house...And preferably female members, because it would make me more comfortable...They didn't come the day they said they were gonna come. But they came the day after, and it was two men. But I just wanted it to get over and done with...so I just blurted everything out. And I had to do that three times, and the third time was more in-depth than the last and it was quite traumatising.*

Daisy's experience of disclosing her IPV to the police captured feelings of being let down and not taken seriously (i.e. the delay), not being given choice or agency in who the story was told to and how, and exploited in the number of repetitions required to successfully capture the story – and to what end remained to be seen.

"I don't recognise myself anymore … I'm damaged goods now". The third core narrative for Daisy was one of her finding her survivor identity. Daisy reflected on the losses she had incurred along her IPV journey:

> *We may be having a roof over our head, but we are homeless...I don't recognise myself anymore. Now more than ever really, cause, this abuse has sucked up my whole life...I'm broken…[tearful]...I'm damaged goods now.*

The phrase 'damaged goods' depersonalised Daisy and suggested a degree of unlovability and an inference that she felt she would be discarded just like other unwanted items.

In terms of her relationship to help as a survivor, Daisy talked about wanting justice, reparation and equity:

> *I need support but I don't need people to feel sorry for me...I want to be able to have the same opportunities that people have when they haven't been traumatised...I want there to be more for people like me, like everyone else in here who feared for their lives.*

It appeared that this narrative aimed to challenge victimisation whereby Daisy was rejecting of sympathy in place of social and legal justice. In the telling of this story, Daisy brought other survivors with her perhaps in solidarity of the cause and safety in numbers. In terms of her peers in the refuge, Daisy likened these to family:

> *I've got friends in here, like, that will talk to me and support me more than my family will...There's this woman...she talked to me like my mum talks to me...it's easier to talk to her. Cause I can tell her stuff that I'd never even dream of telling my mum.*

Daisy reflected that there was unity in the shared experiences of IPV that brought many of the women of refuge together much like family. It was the very thing that connected them from all walks of life. Having been abandoned by her own family, the relationship established between Daisy and her new mother-figure proved significant for her in terms of replacing the warmth and care she lost when the relationship with her family ended, but also throughout the IPV relationship.

Daisy presented a paradox in terms of the 'unspeakability' of trauma. She appeared to find discussing her IPV experiences valuable in the interview but not within the refuge:

> *I appreciate you letting me talk about it, it is helping...A lot of the girls in here, plus me to be fair, we don't talk about it. It's there but it's not spoken about, you know. Cause it is, it is trauma...We're all in the similar boat ain't we...they get rocked differently.*

The language used highlighted that Daisy felt she had been granted permission to utilise the interview space to talk about her IPV experiences. This indicated that she may have at times felt somewhat silenced in refuge, perhaps for fear of distressing other survivors with her narrative. Her appreciation may be linked to her use of explicit visceral depictions of IPV, whereby she strived to find the meaning of her experiences throughout the interview. Lastly, she emphasised this struggle using a boat metaphor, which offered imagery of Daisy trying to stay afloat despite feeling rocked by her turbulent traumatic experiences.

Violet's Story

Violet's story depicted one core narrative, in which several stories were shared that related to her disentangling from the family narrative and moving towards female empowerment.

"I was pregnant, I was taking her away because I weren't having that around her". To set the scene, Violet portrayed what home life had been like for her given that she had experienced domestic abuse from her stepfather, and witnessed her mother living with IPV:

> *They were all trying to tell me...they think something's wrong with me...There's people in that household when the abuse is happening, it's like why are you not doing anything?...Why are you even just sitting in this household acting normal?...It was honestly a bad environment for me to live in for so long...I didn't ever want to go home...I thought my mum would realise what's going on, but to this day she still doesn't...I wish literally she'd listen to me for once and I could take her away from the situation that she's in...I can't do nothing...they say it's only her that can help herself.*

Violet’s description of the abuse emphasised the isolation she felt by being in a household of family bystanders. She also mentioned ‘acting’, portraying how she felt family members were playing a role within the system, perhaps fearful of the unknown consequences of de-roling, i.e. stepping outside of character. Furthermore, within fictional stories, home is often depicted as a sanctuary, for example, for Dorothy in the Wizard of Oz, *there’s no place like home* (Carpenter, 1985). This was a stark contrast to Violet’s perception of home as somewhere she did not want to be, which created tension and displacement within her story. Adding to this, there appeared an attitude of responsibilisation within the family, as Violet echoed a motto of self-sufficiency to overcome systemic adversity.

Violet’s pregnancy appeared to catalyse a reconsideration of her role within the abusive family system, and also her ‘ghosts in the nursery’, i.e. re-enactments from her own childhood now in parenthood (Fraiberg et al., 2002):

> *I was pregnant, I was taking her away because I weren’t having that around her...As soon as I found out I was pregnant that was it, I said I need to walk away before it gets any worse...Makes me feel disgusted how I stayed there for as long as I did...I should have gone to the police first time it happened, but when you’re experiencing something like that, it’s very difficult to even get on the phone to talk about that situation...I couldn’t push myself to tell them about the abuse that happened...I didn’t know what would come out of it.*

Within this story Violet did not name what she suffered, nor was she able to report it, which may reflect the unspeakable nature of domestic abuse. Furthermore, the revulsion she aimed towards herself may be a process of introjection (Knight, 1940), in terms of Violet unconsciously internalising her experiences of abuse and feeling physically repulsed by them.

Violet recalled her first day in refuge, which initially appeared to perpetuate her sense of isolation that she had experienced within her family:

> *The first day I was in bits. Literally, I didn't want to be here. And obviously I was pregnant...Heavily pregnant...I don't know this area at all...when I come in here, I had no one around. Walking in here on your own it's awful. You don't know where anything is, you don't know how to get to places, it's just not nice...I was sitting there thinking to myself, I was like "what am I gonna do when this baby is here…?"*

In telling this story, Violet stressed her advanced pregnancy, which conflicted with her sense of feeling completely alone. This narrative may be interpreted in relation to a fear of bringing new life into unfamiliar surroundings without familial support and her use of a rhetorical question emphasised her palpable hopelessness.

Violet talked about distance leading to a felt sense of safety, which enabled her to redefine what it meant for her to live her life:

> *I feel like being away from that area, and them not knowing where I am is a big relief...if I didn't...move away, erm, I would never been able to live my life. I would always be terrified...Honestly, I feel so safe, I feel like I haven't got to look over my shoulder every time when I'm out.*

There was an indication that while Violet was living with her family, she was living someone else's life, playing a different role. Prior to leaving, Violet's story adopted a genre of horror/thriller, whereby there was a foreboding sense of angst always cast over her.

Violet utilised the imagery of herself as a book to outline her coping strategy for moving on:

> *Where I'm a closed book...I can just get on with my life not remembering what's gone on...I push everything to one side and I just go for the future.*

It could be proposed that Violet had not only closed this chapter of her life but shelved the book entirely. Violet showed no intention of re-opening the closed book and could be said to have stepped out of her former character and role to start afresh with her daughter. Helping Violet move towards this, she talked about recognising the value of peer support with refuge:

> *They've been through exactly the same sort of situations I've been in...One of my closest friends in here...made me feel comfortable...I'm so welcoming towards new people cause I know what it's like...All the support you get from here...and the way they frame situations and the confidence that I've got back I think is where we do little groups in here as well. Like, self-esteem groups, cooking groups, and that's really brought me out.*

Refuge appeared to afford Violet the opportunity to recognise that she was not alone with her experiences, despite feeling this way for much of her journey. Violet's use of language created imagery depicting a new survivor identity emerging through peer support and refuge interventions. She did however reflect that to facilitate this process, refuge must acknowledge the paradox between women striving for autonomy and seeking support:

> *Some people...could say they're alright but they're actually not. That's why I feel like, you should be more, giving more support than you already are. Because you could just be asking someone, "are you ok?" and they could be like, "yeah", and they're actually really not. They're really depressed or something like that. But you're not asking them fully.*

Violet concluded the narrative by highlighting the difficult process of de-roling, i.e. moving from concealing or minimising abuse and presenting as self-sufficient in the face of responsibilisation, towards letting the guard down to be truly seen, heard and understood. In being asked ‘fully’, Violet may be trying to convey that the responsibility of opening up about trauma does not only lie with the survivor. She may be suggesting that a space which welcomes these conversations must be created first so that women feel safe re-opening and re-exploring the pages of their closed books.

Fleur’s Story

Within Fleur’s interview, one core narrative was identified, based upon the dereliction of duty she experienced within the legal system.

“I just kind of felt a little bit thrown out to the wolves”. Within this narrative, Fleur set the context for the story by outlining the escalation of abuse within a three-month timeframe:

> *He’d never had a girlfriend before, so [it] made me feel I was special...Time went on...it went from...cutting down my contacts and then completely cutting it off...Early hours of the morning...he strangled me three times...The third time I threw up and he tried to strangle me a fourth time...he told me he was going to kill me...I just thought, I can just see exactly how this is gonna go, it’s probably gonna be with me dead.*

The fast-paced escalation of abuse within the relationship was mirrored within Fleur’s telling of the story, whereby she listed the horrors she experienced rapidly. Fleur’s belief that the abuse would culminate in her death served to emphasise the brutality of what she suffered.

Fleur continued her narrative by detailing some of the failings she experienced upon reporting her IPV to the police:

> *I would have preferred to be handled by female officers throughout, and...have no men on the case...they should have said to me...“would you like to wait for a female officer to become available?”, instead they just got the officer and put me in the room with him...I just kind of felt like a number, I didn’t really feel like I was being listened to. I didn’t really feel like there was much empathy either.*

> *Me and my friend were standing outside by the reception area...there was people sitting in the waiting room...and [the police officer] goes, “oh and obviously, with the rape”, and started talking about details of my statement with the doors open.*

Within this story, Fleur conveyed having no agency as a ‘victim’ of IPV crimes. Fear was evoked through her depiction of being done to, rather than being worked with collaboratively. This was corroborated by her use of language, such as ‘handled’, which created a sense of her being controlled or managed, thus exuding tones of IPV. Fleur also described being put in a room with a male officer, as if she were being positioned to fight, e.g. like a bull being put in a ring. Fleur was put into a situation that triggered her threat system and therefore her need to ‘fight’ or ‘flight’ to survive (Frothingham, 2021). This process also appeared to depersonalise Fleur, as she likened the experience to feeling like a number on a ticket, awaiting her turn to be seen. However, she did not feel ‘seen’, due to the police processing her in their way, as opposed to meeting her story with a compassionate ear and pacing the process to meet her needs. Fleur indicated that the police were negligent of her case by openly discussing details outside of the interview room and she suggested that this made her feel as if the police had spotlighted the crime rather than the person:

> *You can’t just look at it as the crime itself, you have to look at the person and how it’s affected their lives...I just kind of felt a little bit thrown out to the wolves when it all happened with the police really...At some points it’s actually felt like they’re on his*

> *side...I don't think they take domestic violence very seriously...If that had been dealt with more discreetly, and I was made to feel less like a criminal...then yeah maybe I would feel different...It still feels like women are being treated as second-class citizens.*

Fleur's description portrayed a sense that at best she was overlooked by the police, but at worst she was made to feel culpable. Fleur's account offered an insight into the demonisation of victims, whereby they are not only disbelieved but held to account for their experiences or even punished, which Fleur depicted by using imagery of being torn apart by the legal process when 'thrown to the wolves'. Fleur outlined a hierarchy whereby she felt pushed down in the order of importance due to her gender identity in the face of the oppression of women.

Fleur talked about there existing a communication barrier between lay-people and the police:

> *I don't always fully understand what the police mean when they talk. They're not always very clear.*

Fleur illustrated a disconnect between herself and the police, which may have reflected her experience of IPV in terms of feeling isolated and unable to access support. The lack of transparency mentioned could also mirror the hidden and unpredictable nature of IPV and consequently perpetuate fear. She also talked about their advice feeling tokenistic at times:

> *I just think in terms of the information they give out there as a victim once they leave, it just kind of feels like going to the dentist and getting a sticker...it's like, "here you go, off you go".*

Fleur implied that the guidance offered by the police felt hollow and misinformed. In likening her experiences to visiting the dentist, who for some may evoke feelings of anxiety and discomfort, it could be inferred that Fleur was communicating her sense of fear of the police who caused her further pain and harm and rewarded her bravery for coming forward with a tokenistic leaflet, which undermined the gravity of her experiences. Fleur recalled further disregard from the police:

> *The police wanted me to come back...where the incident happened...I was 'high-risk' because of the threats to kill me...and because he'd strangled me...I thought, you shouldn't even be putting me in that situation...they just didn't care.*
>
> *I wanted to shower as well because obviously [voice cracking] like that morning I had like sex with him...I felt disgusting...I thought...you're now leaving a rape victim for two days without having a shower, how do you think that makes me feel?*

Within this story, Fleur highlighted the paradoxes, e.g. being high-risk but recalled to her danger zone, and suffering rape but cancelling DNA swab taking thus leaving her without evidence but also unable to attend to her personal hygiene for two days for risk of voiding the DNA. Fleur's anger at this was palpable and emphasised by her language being directed to the police in the telling of this story, but also by the contradictory use of a rhetorical question that commanded an answer.

Fleur talked about her IPV not fitting into the predetermined boxes that she felt the legal system was trying to package it within:

> *They want video evidence or witnesses...It doesn't happen like that...They said to me, "oh well your rape case is difficult because erm there was consensual sex in between". Just because I've consented once doesn't mean that gives him the right to do it whenever he wants to...I might have consented in between because I was in an abusive relationship, where someone manipulated me and brainwashed me on a daily basis.*

> *I have applied for a non-molestation order, and they said, "oh but the relationship would have had to be longer than three months"...This is why a lot of women do end up going back to their perps as well, because they're not given that option to cut that contact between them.*

Fleur evidenced her understanding of the crimes that had taken place, particularly of the sexual abuse within her relationship. This may offer evidence in the way of survivors beginning to feel empowered through knowledge and IPV education. Fleur accessed such learning from refuge, but this could pose the question of how women access such education if they do not seek refuge. Fleur also commented on the unjust policies within the legal system that fail to protect women by implying a minimum threshold of suffering that women must endure in order for their IPV experiences to qualify for legal action.

Fleur discussed her dichotomy of pursuing charges while weighing up the emotional cost to herself against the benefit to other women:

> *It's a bit pointless going through that whole emotional rollercoaster...being told by the defence you're a liar...It's going to be more emotional trauma for me...I want him to have a criminal record because I want there to be something in place to protect other people from him...they'd know about Clare's Law.*

Fleur's choice of language reflected the notion of being in an unescapable situation, i.e. that once she was on the rollercoaster she must see it through. Fleur emphasised that she had already experienced emotional trauma, perhaps in relation to both the IPV and her experiences with the police, and that pursuing justice would add to this. Fleur talked about feeling driven to protect others, perhaps as the only form of justice she could achieve. This therefore created a sense of a sisterhood unanimous with the survivor identity, striving for the same end. Fleur reflected on the value of peer support:

> *Although it's horrible that me and all these women have had to go through very similar experiences, it's also nice to have people around you that understand.*

The support from her peers and refuge appeared to counteract the experience she had in relation to the dereliction of duty from the legal system. The mutual understanding that she described seemed to create a sense of feeling seen, heard and validated.

Fleur concluded this narrative by reflecting upon the impact of the IPV on her, in terms of the grief she had felt following the multiple losses she had incurred:

> *I've had to quit my job [tearful], I have had to leave my home. I'm now staying in a refuge with people I don't know, away from my family and friends...It makes me so angry...[It's] emotionally scarred me forever now, and completely broken my trust in men...It's changed my perception on everything. I don't even know if I want kids now because of this whole experience...I think I want to get to the point in therapy as well, where I'm...not accepting it, but just learning how to move forward with it.*

This narrative established a sense of injustice at Fleur not only experiencing IPV but now also having to grieve for all that she had lost, including material things but also perhaps parts of herself and her hopes for the future. In her telling of this story, Fleur built upon her grievance by naming anger, a stage of grief (Kessler, 2019; Kübler-Ross & Byock, 1969), but also offering the imagery of her emotional scarring. In Fleur's wearing of these scars, she illustrated her sense of vulnerability by indicating that others may see that she has been hurt. Finally, Fleur made an important distinction between acceptance and moving on, whereby she expressed that the two need not co-exist. This may be important for survivors when considering the role of acceptance within attaining closure from IPV relationships.

Olive's Story

One core narrative was elicited from Olive's interview, which was based upon meaning-making in the face of violence.

"You crave it to work so much because what are the bruises for?". Olive explained her family history, which she felt both familiarised and normalised IPV, alcohol abuse and substance misuse. Olive reflected on this in terms of her attitude towards her perpetrators:

> *My second perpetrator, which actually was the best perpetrator of them all cause he wasn't as bad...It's an unhealthy cycle to think they're not as bad, they're just bad.*

Olive utilised the oxymoron "best perpetrator" to imply that less abusive relationships were good relationships. However, by reflecting on this herself, Olive portrayed her inner conflict in striving to challenge and change her thought processes around IPV relationships. She evidenced this battle further by using the word "cycle", which conveyed a sense of entrapment and frustration in breaking out of this pattern.

When trying to leave an abusive relationship in the past, Olive recalled her mother's rejection of her:

> *I ran to a phone box, and I called my mum and I said, "mum I need to come home", she said, "you made your bed, you lie in it".*

This indicated that along with a normalisation of abuse, Olive's family perhaps positioned the responsibility to improve quality of life within the individual. Other services and systems may have perpetuated this message to the family. For example, some drug and alcohol services may only treat addiction rather than intergenerational patterns of misuse and abuse, thus locating the problem within the individual. This ethos of responsibilisation was mirrored in the interactions Olive described with services upon her IPV abuse being identified:

> *I was being strangled...drowned...He'd set alight to my front door...The violence was bad, I had various police calls. He got arrested from my property around three times for threats to kill...I'd called my housing officer and I said to her, "I'm being abused" and she knew, she knew straight away. She's got all the police reports, obviously as a housing officer you know what's going on in your block of flats...People get sick and tired of you. Or they don't want to listen...You got hit the first time so why did you go back to have two teeth taken out the second time?*

The story took on a tone of abhorrence regarding the inaction from others in the face of Olive's ordeal. However, in the telling of her story, Olive used language that may be equated to an exasperated parent being "sick and tired". This spotlighted the toll of the IPV on others, rather than upon Olive. It also served to infantilise Olive, i.e. others perceiving her relationship decisions as being irresponsible and unwise, rather than recognising it as IPV and taking action to protect her.

Olive noted that she was not able to recognise the extent of the violence for some time whilst living it:

> *The violence got bad...I believed we had a passionate relationship. That's what I believed.*

For Olive, intensity within her relationship became paralleled with passion. As a society surrounded by unrealistic presentations of love-stories readily available in the media, intense passion and whirlwind romance may have become normalised and expected. However, Olive grew up within an unstable home environment, which paradoxically may feel familiar and therefore safe in adulthood. This could cause Olive to be somewhat unperturbed by a degree of volatility within her romantic relationships. It may also be that the passionate narrative existed for her to survive the IPV and counteract feelings of helplessness.

Further to understanding her perception of passion within the relationship, Olive reflected upon the meaning made from her experiences of abuse:

> *You want it to work, you crave it to work so much because what are the bruises for? What are the sleepless nights for? These emotions you think must mean something. I can't be crying and feeling this heartache over nothing, it must be special.*

The language used within this passage was evocative of addiction, which elicited a tone of desperation. This was enhanced by the use of rhetorical questioning in which Olive conveyed helplessness in seeking answers to find meaning. The imagery around bruising and Olive's heart aching appeared to mirror IPV, in that her heart had taken a physical hit.

Olive continued her narrative by talking about the losses she had incurred as a result of the IPV:

> *You're already robbed from so much from what that person's taken, you sort of forget your sense of self as well.*

Within this narrative, Olive depicted identity-theft by characterising her perpetrator as a robber. The inference was that Olive no longer felt whole, as key parts of herself had been taken so that she could not reconstruct her sense of self without these. Olive talked about having to start again to re-establish a sense of self outside of the IPV relationship:

> *It's like a Lego building, you crash it back down to get all the pieces and jumble them together, it's not going to look the same. You need to...find out what way you want to build it and what way it was built before and if you want to structure it that way again before you let somebody else have a say on how you're built.*

This highlighted the core narrative of meaning-making after IPV, as Olive used the imagery of Lego blocks to emphasise the need to rebuild in order to understand, i.e. who she wants to be post-IPV. It may be that the language used represented her IPV experiences, for example, ‘crashing down’ could convey the damaging consequences of IPV or her fear of it happening again. The tone also reflected the theme of responsibilisation, as Olive talked about what ‘you’ as the survivor must do to rebuild one’s life. Olive returned her focus back to the survivor at the end of the passage, further emphasising them as the subject of the simile throughout.

For Olive, moving on from refuge was imminent and so she talked about the meaning she had made from her time living there:

> *[The IPV] just follows you...it follows you everywhere you go with everyone...The self-doubt of when you shut that front door, this is gone, refuge is gone and your support network’s gone...It is emotional, cause I’ll be so sad when I leave here...You’re accepted. You don’t feel different. You don’t feel like you have to lie anymore. You don’t feel like you have to hide anything anymore.*

The first part of this story emanated abuse, as Olive used personification to characterise her IPV as a stalker. This may have been reflective of her fears regarding moving on and leaving the safety of refuge behind. Olive also spoke of the value of peer support within the refuge, particularly in belonging to a collective survivor identity. Her fears radiated through this passage as she equated leaving refuge to losing her entire support network. This therefore demonstrated a need for survivors to continue to feel connected to their survivor networks to sustain feelings of belonging and validation. Without this, Olive implied that she could be positioned to conceal her experiences and feelings, which may indicate a vulnerability to further IPV and isolation in the future. Identifying with survivor networks post-refuge could therefore be pivotal to breaking the IPV cycle.

Fern's Story

Fern's core narrative revealed a reliving of IPV in future relationships and experiences.

"In main house…it's like being in with a perpetrator … when people don't get on". Fern had set the scene for her story by reflecting on the secrecy that shrouded her mother's teenage pregnancy and abortion, and how she felt this inhibited her own growth:

> *I didn't have a clue about life to be fair because I'd been tied down since I was 16...I sort of blame my mum...if my mum would have been more open about stuff, maybe I wouldn't have took her footsteps in life...I had the baby and then my mum obviously wasn't very supportive, erm she threw me out.*

Fern used the imagery of physical restraint, which not only emanated abuse but also emphasised her powerlessness within the relationship. There was an inference of inadequate parental oversight, as Fern named being a child herself at the onset of her first IPV relationship. Paradoxically, the unifying experience of the teenage pregnancy ultimately catalysed a breakdown in the maternal relationship, once Fern decided to keep her baby and therefore step outside her mother's path.

Fern had converted to Islam to marry her second perpetrator and so she reflected upon the experience of IPV in the context of her Asian family:

> *I asked his brother, who I was really close with, for help so many times. But being Asian culture, they sweep it all under the carpet, and they don't want to know...Why didn't they help my children?*

Fern's warmth toward her Asian family contrasted her contempt at their purported lack of support. The imagery portrayed of brushing off or cleaning up the IPV could reflect the unspeakability of it but also the disgust, which may have therefore elicited silence among the family. Fern's perplexity at this was highlighted within this contradiction in affection but also in her use of a rhetorical question seeking an explanation.

The experience of being 'thrown out' is one that Fern appeared to relive in adulthood, as both of her IPV relationships resulted in her being made to leave the family home:

> *He asked the police officers for the keys back...The house he bought was in his sole name. Apparently, he had the right to do that, even though you know, they're his children. He literally made us all homeless...stripped us of everything...How can [the police] just take the keys from you knowing that you're gonna be homeless?*

The use of the word "stripped" created imagery around feeling exposed and vulnerable; often this is used to describe a state of undress. This imagery therefore emphasised her degradation and shame. There was also a tone of injustice to this narrative as Fern used a rhetorical question to directly address the police's involvement in her homelessness. Further to these events, Fern reflected upon her experience of seeking housing through her local council:

> *It was nearly home time so she couldn't finish the call, and then she rung me back on the Monday...People should be a bit more passionate. Because if that was me, I would have stayed on that phone...knowing that you're gonna be put somewhere safe.*

A stark reminder of Fern's homelessness was portrayed through the acknowledgement of it being "home time" for the employee, but not for Fern. A degree of objectification could also be inferred, as there was a likeness of treating survivors as important belongings needing to be kept safe. This may have reflected Fern's wish to be prioritised and safeguarded.

Upon arrival at the refuge, the setup of the living arrangements seemed to intensify Fern's sense of homelessness and loss:

> *It is a big shock at first. You know, you've just been thrown out your house...And then you're in this one room, and it is a bit shocking...You've got your life in their hands.*

This passage illustrated Fern's powerlessness, but also her dependency upon refuge as an omnipotent lifeline; this feeling may have mirrored her relationship with her perpetrator. Fern continued to reflect on this resemblance:

> *There's lots of obviously good and bad...lots of conflict...it's like being in with a perpetrator isn't it, when people don't get on...More people should be in self-contained places...it's normal life again isn't it.*

Fern highlighted that relationships in refuge may trigger IPV experiences leading to a reliving of abuse at times. She also referenced normality, which highlighted her desire to experience this following the breakdown of two extensive IPV relationships.

Adding to the sense of refuge emanating perpetrator dynamics, Fern spoke of loss and entrapment:

> *I just didn't know who I was for a moment...it's a lot to lose...If someone said to me at the beginning of the journey, "you're gonna be there for two and a half years"...there would have been some way, some other way we would have got help.*

Fern indicated that she lost herself within the process of IPV and her lengthy stay in refuge. This therefore created a tone of grief in the accumulation of her losses. Fern depicted a feeling of being trapped within refuge, which may have mirrored her IPV relationships, particularly in relation to the legal obstacles that delayed her divorce, but also her children representing an enduring tie to the perpetrator. Fern also reflected on her isolation within refuge, particularly after being moved out of the main refuge house and into a self-contained flat to have greater space and autonomy:

> *Because we was isolated away from people for so long, it's normality for us, like we don't think any different.*

Her experience of this may be parallel to that of IPV, in terms of the gradual normalisation of isolation within the relationship. Fern also demonstrated that there were benefits to the social nature of refuge, whilst also acknowledging the difficulties of the shared living spaces, particularly for women with children. Fern talked about her attitude towards some of her keyworkers within refuge:

> *People I know in refuge as keyworkers who are the best are people who have been through domestic violence themselves, so they know the road to go down...They feel like they're more family...you confide in these people...you know they're doing their very, very best to help you.*

In terms of attachment theory (Ainsworth, 1979; Bowlby, 1951), Fern's difficult bond with her mother may have been re-enacted within her relationships with her keyworkers. This may be due to Fern's internal working model (i.e. relationship template; Bretherton, 1999; Bowlby, 1969), as well as the interpersonal style of her keyworkers. For example, Fern indicated that her mother oscillated between letting her in and then throwing her out emotionally and physically. This dynamic could be replayed in refuge depending on how Fern perceived her connection to her keyworker, i.e. whether they seemed to understand her in the context of her IPV. Fern suggested this process was facilitated by them both having lived experience of IPV. For Fern, this link may have mirrored when she felt closest to her mother i.e. when Fern’s mother was letting her in emotionally by sharing her teenage pregnancy experience. Therefore, when Fern could not identify with a keyworker, she may have felt rejected by them, thus forming a crucial barrier to their working alliance.

Fern ended her story by indicating that her children had moved through and out of trauma:

> *We might be homeless, and we might have gone through all this trauma, but you know what, the kids actually look really well, they are out the other side now.*

This created a sense of hope that Fern may feel this about herself in the future. However, by not naming herself within this story of healing, Fern implied that her trauma was ongoing, which drew parallel to the stories about reliving her experiences through other relationships.

Willow’s Story

Within Willow’s story, one core narrative was identified in relation to the enervation of responsibilisation.

“I feel so drained from it all. I just feel like I need a bit of a break”. In beginning her story, Willow talked about the habituation of IPV, in which she was perhaps desensitised to the nature of abuse throughout the course of the relationship. She also inferred feeling ashamed when pre-empting how she may be received after sharing her story:

> *This is gonna sound really stupid...I noticed...jealousy,...stopping me from doing things I wanted. It started very early on...It just becomes the norm and you just sort of get used to it...I didn’t tell people...No one knew what was going on.*

Willow described almost acclimatising to IPV, which may have eroded her ability to act. She spoke of gaslighting, which may have further driven her disempowerment:

> *He used to make me feel like, what I was feeling was irrelevant and I'm just being silly...I'd start thinking...“am I going mad?”. He used to make me feel like I was going crazy, I was the crazy one.*

Willow's use of a rhetorical question emphasised how her perception of reality had been attacked, in that the IPV caused her to frequently doubt herself. The stigma of being labelled “crazy” is one that has been depicted in many stories. For example, in the Disney film ‘Dumbo’, Dumbo's mother is regarded as mad and is therefore removed from her baby. Similarly, Willow may have feared the consequences of being perceived this way, such as having her children removed, or her being taken away from them. This fear may have entrapped Willow within the IPV relationship.

Willow demonstrated a prioritisation of motherhood by showing that her threshold for the IPV was reached once she felt her children had been brought into the abuse:

> *It was a day he made [sons] cry...That was the turning point for me, my youngest [son], he went...and told his nursery...it just broke me...that was the day that I just thought, no I'm not having this anymore.*

It appeared that Willow only felt able to rebuild herself after breaking altogether. At this point, she seemed to choose to move towards empowerment by making the decision to leave the relationship for the sake of her children. However, Willow highlighted that this was not a straightforward choice through her use of language that illustrated her continued sense of entrapment:

> *When I went to refuge, he tried everything to try and find where I was...It got to a point where...he was harassing me, my mum, my family, my friends, everyone...The*

> *worst thing about it is I feel like I can never escape him, because he's the father to my kids...He will always have this hold on me.*

Through the telling of this story, there was a tone of exhaustion, whereby Willow reflected on feeling hounded by her perpetrator while she sought safety. It appeared that Willow felt incarcerated by the parental connection they shared, but also suffocated by his continued presence in her life, which created a sense of hopelessness at the permanence of the situation.

Willow reflected on the psychological resolve required to sustain her decision to leave:

> *I think it takes a lot of willpower...But I'm not going back...because whenever I think about going back, I think of the kids and I think, no it's not safe.*

It appeared that there was greater energy and resolve required for leaving versus remaining to maintain the family homeostasis. However, Willow indicated that she had decided to leave because of the increased risk the perpetrator presented to the children. It could be inferred that this increased risk now outweighed any risk of her decision backfiring, i.e. being perceived as mad, which she had questioned from gaslighting, and subsequently losing her children. Taking this risk could be seen as the ultimate prioritisation of motherhood.

In telling her story, Willow portrayed how tiresome the journey to safety had been for her:

> *The police were a nightmare...getting him arrested took weeks...I actually had to give the three statements...They were taking so long and I was just getting new stuff coming up constantly. So, they actually had to come to my work three times...It's just a very slow process,...they're not taking it as serious as they should be...They didn't really sound very sympathetic,...they were sort of taking his side a little bit...I feel so drained from it all. I just feel like I need a bit of a break.*

Willow referenced Post Traumatic Stress Disorder (PTSD) symptomology by likening the police to a nightmare, which drew a parallel to her IPV trauma. She then depicted the arduous process of making statements that caused further disruption. On top of the laboriousness and potential for humiliation, Willow felt the police implied responsibilisation on her part for changing the narrative, i.e. leaving sooner. She described this as the police taking sides, and in doing so, implying that either party was right or wrong. Willow's reference to feeling drained emanated a sense that she was no longer in 'fight' or 'flight' but had perhaps arrived at 'flop' (Lodrick, 2007), a self-protective shut-down state in the face of feeling criminalised as a 'victim' of IPV.

Willow shared that being made to feel culpable by the police prevented her from feeling safe to tell them her story in its entirety:

> *I do block a lot of it out...there was rape involved...I don't really talk to anyone about that...the police wanted to arrest him for that, and I just said no, because I just, I don't really want to bring it up.*

Willow offered an insight into the maintenance of her trauma response by pushing down thoughts and feelings linked to her painful IPV memories. Her language emanated sickness as if she feared and felt disgusted by what may 'come up' in retelling her narrative of the sexual abuse. For these reasons, it did not appear possible for Willow to report certain aspects of her IPV to the police. If reporting sexual abuse made her feel ashamed and therefore exposed and vulnerable, these feelings may have mirrored the experience of the IPV itself.

Willow reflected on what served to counteract her draining experiences along her IPV journey. She shared a story about meeting the other women in refuge and described feeling energised by a sense of connectedness:

> *They're gonna be lifelong friends...One girl, she left last week and I'm still seeing her out of the refuge...I think I just feel like a connection with them...cause we've got stuff in common...they don't think I'm such a weirdo [laughs]...I don't have to explain why I'm such an anxious mess all the time...they just get it...They've been through it, they actually understand.*

This passage depicted an 'in-group' and an 'out-group' (Tajfel, 1984), whereby the in-group were those with lived experience of IPV who understood what it meant to survive it, without the need for explicit communication. It appeared that not having to re-explain herself to an out-group invigorated Willow, to the extent that she was then able to establish meaningful connections with her peers. The use of the word "lifelong" reflected the enduring nature of IPV trauma and its impact upon relationships e.g. Willow's pervasive doubt about being perceived as crazy. Willow therefore implied that only those with lived IPV experience can truly know how it feels to survive it. This evoked a sense that in becoming a survivor, a new identity is forged, alongside which comes its own protective grammar and language.

Holly's Story

Holly's core narrative was that of rupture and repair within attachment.

"If my own mum can't love me then I can't expect anyone else to either". Holly set the scene by naming her difficult relationship with her mother and challenging childhood:

> *I just kind of thought that if my own mum can't love me then I can't expect anyone else to either [tearful]...I feel like I've been made to feel like that by my mum like pretty much my whole life...I started to realise like...how much probably damaged I have been, traumatised mentally growing up...through everything that I've been through.*

Holly depicted her mother as being unable to love her; she may therefore have felt that there was something inherently unlovable about her, which initiated the maternal rejection. Holly reflected on the impact of this being lifelong and equating to trauma. It could therefore be proposed that Holly carried this with her into future relationships, particularly as she implied this realisation only occurred sometime afterwards.

Holly talked about meeting her perpetrator, but specifically the attributes that drew her towards him. These may be considered parental qualities that were missing in her childhood, and helped her to therefore repair the ‘unlovable’ script:

> *He was affectionate, and he was caring...And then as soon as I wanted to go spend time with my friends or my family…that’s when it all started to go wrong...I thought...it will get better once the baby arrives...in fact he actually got worse...His temper really flared...He ended up pushing me over while I was pregnant.*

Holly reflected that the warmth she had been drawn to was rescinded and replaced by the onset of IPV. This may have somewhat mirrored her experience with her mother, in terms of her longing for affection, which never emerged. Holly talked about becoming pregnant and hoping that the baby would bring her and her perpetrator closer together, i.e. by healing old wounds through the creation of her own family. For this reason, Holly’s pregnancy felt sacred to her, which then emphasised the sense of outrage elicited by her narrative when she detailed the aggression she was faced with during this time. Holly described an escalation of IPV and how her threshold for this was eventually reached:

> *He actually kicked me out while I was pregnant, and I had to sleep in my car (tearful)...I felt like a bit of like an emotional punchbag...If he wasn’t happy, I was the one that suffered.*

> *He smashed the cup at my feet while I was holding [our baby]...I was like "no, you put the baby in danger"...We actually split up while I was pregnant.*

The language Holly used to tell this story, e.g. "kicked" and "split", was an amalgamation of abuse, demonstrating the space IPV may consume in terms of also taking over language output. Holly created clear imagery of being a punchbag, which not only objectified her but depersonalised her too. This evoked a sense that Holly felt she existed for her perpetrator's use only, as some inanimate object.

Holly shared her sense of a rupture in their relationship as she equated it to pain and perhaps reliving childhood experiences:

> *You're just constantly living in hope and then you get to a point where like you think, when the hell is this going to change?...It's so painful just to keep going round...the same circle.*

Holly depicted there only being one circle of abuse, which reinforced the idea that she felt she was repeating history. She also talked about her hope for change, perhaps recognising the similarities between her relationship with her perpetrator and that to her mother. This emphasised Holly not knowing what to do differently to shift the narrative around being unlovable.

Further evoking her sense of helplessness, Holly talked about responsibilisation in terms of questioning her culpability within the IPV:

> *What have I done? Like have I just pulled the family apart? Like, is it my fault?...It's not how I saw my future being with a baby...I wanted the family life...[crying, sniffs]...I'm now officially like doing it alone...I've taken me and my son away from a danger like to put us first. [Tearful]...I just want to be a bit more proud of that, rather than like ashamed.*

Through her use of repeated rhetorical questions, Holly appeared to be searching for understanding. There was a sense that she desired comfort in this moment to feel validated and contained. Holly referenced seeking ‘family life’, perhaps to repair the ruptures she had experienced. Her isolation was tangible, which then served to contrast her realisation that through her actions, she had prioritised motherhood. There was a sense that she felt empowered by this decision and was almost giving herself permission to recognise this.

Holly reflected on the challenge of self-empowerment when met with indifference, and how this can reinforce a belief of being unlovable:

> *The council just see you as another number, another person moaning about their life...They just think you’re...trying to blag them or like making up a sob story...As if you’re not going through something bad enough as it is, for someone to sit there and...not sympathise, not show any empathy...it is traumatising.*

Within this story, Holly emphasised depersonalisation, highlighting that this interaction felt inhumane to her. The role of dehumanisation within the workforce has been likened to a defence utilised to sustain a sense of duty (Lyth, 1988), however this may mirror IPV experiences. Alongside not being believed, Holly shared that she was made to feel as if she was intentionally acting to deceive others. Implying that she was manipulating the system reflected perpetrator behaviour, which could suggest that Holly was made to feel like an abuser within these exchanges. For Holly, who had experienced childhood and IPV trauma, she described these interactions as “traumatising”, which demonstrated the level of distress caused by this experience and indicated the potential detrimental impact of this upon her wellbeing.

Holly spoke about her relationship to help, which had been ruptured by her IPV experiences:

> *I thought that people were only offering help cause they thought I couldn't do it by myself...He would do something for me...but then he'd use it against me...I was scared that if I was to tell people how I was feeling...then they would like take [my baby] away...so I never spoke to anyone about it.*

Holly's experience with the council may have been further evidence against trusting others, and therefore built upon this ideology that people have ulterior motives and cannot be trusted. However, when in refuge and met with a compassionate ear, Holly shared how this made all the difference:

> *I didn't feel like some, some scared child...It was just a big weight off of my shoulders to think...I'm not gonna keep going through this life...It's not a refuge, it's a safe place...somewhere where you can call 'home'...you can grow...It almost feels like safety in numbers...I feel like they're my family. Like you just feel like one big, united unit because you're all dealing with the same shit.*

In this story, Holly named the child part of herself who had felt frightened. She talked about "going through" life, with the inference being that she had been surviving rather than living. Holly spoke about feeling at home in refuge surrounded by peers who had become her family. For Holly, this may have been her first experience of feeling as if she belonged within a family unit, whereby she felt validated and therefore able to grow. This passage contrasted Holly's earlier stories around feeling unlovable and worthless and therefore created a hopeful tone to her narrative by indicating the possibility of repairing such ruptures.

Holly finished her story of reparation by talking about not being defined by her trauma:

> *I'm not a victim, I'm a person, it doesn't define me, who I am. And actually, it makes me quite a strong person because it's a hard decision to make.*

After feeling dehumanised by her perpetrator, Holly used language that counteracted this. She also appeared to push victimisation away to acknowledge her strength. This implied that language impacts the meaning survivors attribute to their experiences and consequently how they define themselves post-trauma.

Lily's Story

Lily's interview identified one core narrative that pertained to the ascendancy of empowerment over powerlessness.

"I don't want to cry anymore no. I cried whole life already. That's enough for me now". In sharing her story, Lily began by outlining the IPV she experienced and the role of substance abuse within this:

> *I was pregnant at the time. And then he's tried to hit me...and then my face, my body, everywhere is like bruised...He's taking drugs, alcohol, everything...When he had drugs, he was completely cruel. When the drugs is over [sic], he is totally out of control...he tried to fight me...hit me...kill me, everything.*

The story encompassed a tragedy genre as it depicted Lily's suffering, particularly during pregnancy, and the distress she felt at every part of her (including her fetus) being bruised. Lily also outlined a situation in which she was continually positioned as 'the loser'. Her use of language exemplified the brutality that she experienced by inferring that when on drugs, her perpetrator was only ever cruel and arguably equally as abusive without drugs.

Lily reflected upon her Asian culture and the societal norms that she felt underpinned her attitude towards her relationship:

> *Our Asian thinking always like...when husband is hitting anyone, we have to stay with him...That's my culture...It's like our society...You have to understand him, why he is hitting you? You can't go anywhere...Maybe my husband gonna be ok one day. I will try my best...My husband's family was like, "no you can't move on, your husband's gonna be in a bad place."...Always I support my husband...I trust him blindly.*

Lily talked about survivors finding meaning in abuse, but within a socially and culturally accepted framework, i.e. that abuse may be a projection of the perpetrator's own suffering. This meaning could be employed to challenge victim-blaming narratives regarding staying within IPV relationships. Lily depicted familial, societal and cultural responsibilisation on her part to support her perpetrator into recovery.

Following recognition of the IPV, Lily recalled the police urging her to leave the relationship:

> *Police officer asks me, "why you want to give him one chance again because you suffer a lot, like too many years."...I said..."it's just like, you know, it's mistake".*

Lily's minimalisation of the abuse could be representative of her oppression within the relationship, which generated powerlessness. However, it could also be in response to the narrative around the perpetrator's suffering, which had been maximised, therefore rendering her own distress as inconsequential. Lily's account of the police interview, particularly the use of 'why' questions, could have implied a victim-blaming position, i.e. the police may have perceived Lily as not helping herself, leading to them reducing their support. This cycle may therefore cause greater powerlessness and helplessness for IPV survivors, particularly those where the intersections between culture and IPV have not been considered.

Lily reflected on the ramifications of eventually giving up her role as carer, and leaving the IPV relationship:

> *Even their family also hating me...because I didn't support him...After that everyone is blaming me.*

Her family's despair at her decision to leave may have reinforced her own guilt and shame around being perceived as an unsupportive or insensitive wife. Lily's use of the word 'blame' demonstrated an attitude that she had brought the IPV on herself. This narrative may therefore be projected onto other relationships, such as those with service-providers, or be perpetuated by services uninformed of such dynamics. It could also increase the likelihood of Lily returning to the IPV relationship to rewrite the narrative of her perceived wrongdoing.

In terms of what Lily felt facilitated her leaving, she mentioned the importance of a multi-agency approach:

> *If council, if police, everything is not getting involved in this case, I never ever move, move on.*

For Lily, it appeared that having several services involved enabled her to feel held and contained, which therefore empowered her to leave. She indicated that had this not been the case, she may have otherwise fallen through the cracks.

During the interview, Lily became tearful when expressing her pain at her children's distress:

> *I always thinking about my kids [tearful]...I suffer a lot but my kids also suffering with me...They're always crying...I don't want to show my tears in front of my kids...My biggest daughter, she knows everything, even my hit [physical abuse]...They are learning from the parents.*

The tone of this story was anguish, not only for what had passed but also for the implications of the IPV upon the children in terms of witnessing and normalising abuse. Lily implied that she attempted to stifle her tears for the sake of her children, whilst paradoxically acknowledging their exposure to it all. The inference was that Lily's tears may continue to distress her children, and therefore by suppressing them, she may feel she is a better mother. Prioritising ending others' suffering over her own at any cost may be reflected within the IPV relationship, and then transferred to her children upon leaving the IPV relationship. In terms of a coping strategy, Lily talked about looking to the future:

> *I can manage now, past is past...When I remember...it's like I feel so bad...I don't want to cry anymore no. I cried whole life already. That's enough for me now.*

It appeared that Lily was fighting between feeling empowered to move on with her life, whilst simultaneously feeling entirely disempowered by her IPV memories. The tone created by this story was therefore one of desperation to move forwards without being emotionally entrapped in the past. Lily told this story using short, sharp sentences to illustrate her conviction and intolerance of this distress. Greater cultural understanding may facilitate the re-writing of IPV narratives pertaining to blame, shame and responsibilisation.

Narrative Typologies

Table 7 shows two higher-order narrative typologies derived from the survivors' core narratives and the interview process itself. These have been outlined in further detail below.

Empowerment within Interview Processes

The majority of survivors reported experiencing the interview as empowering, which contrasted their narratives of the iatrogenic harm caused when retelling their story in various other contexts:

> *I mean, for someone to kind of ask me like how certain things have actually made me feel, it's different. You're not asked that, you're often asked what happened, you're not asked how it made you feel when it happened. So that's nice. ~ Fleur*

> *I didn't want to speak about anything where I'm a closed book, but the things I've said I think I'm still comfortable with...I've just said how I feel like I can talk to someone about it, but without saying the most horrible parts. So, it's really made me feel good about it, actually just feeling comfortable talking to you about the situation I've been through and the questions that you've asked are absolutely fine as well, I can answer them. ~ Violet*

> *It's helped me cause I feel strong...it's lovely to have somebody to take the time to want to listen. And actually want to, do you know what I mean? Not because you have to or, you genuinely want to. And it's, it's exhilarating, it's made me feel happier. ~ Olive*

These examples depicted that the interviews afforded many of the survivors the opportunity to tell their stories in their own way. For some, this may have been a nuanced experience where they did not feel pressured to retell the most traumatising parts or were able to work up to considering these at their own pace. The focus on how these experiences made the survivors feel perhaps elicited a sense of validation and feeling respected, due to centring the survivor within their story rather than the crime itself. This sense of validation appeared to be empowering for the survivors and contrasted their experiences of battling to be heard or believed, or in some cases were held to account through the judgement of others. This narrative typology drew a parallel to research conducted by the Truth Project (six thousand survivors of CSA were interviewed about their experiences; 2022), which shared that CSA survivors frequently experienced the criminal justice system as adversarial, all-consuming and retraumatising. This appeared to be exacerbated through the attitude adopted by legal systems of ‘innocent until proven guilty’, which for survivors translated to not being believed. This typology would also support the notion of transitional justice (Wright, 2018), i.e. being afforded a space to voice suffering and move towards therapeutic justice for previously silenced survivors.

Paying it forward

The second narrative typology to be identified was that of the survivors wanting to pay it forward, i.e. to use their newly acquired knowledge or empowerment to support other women. They described several ways in which they hoped to achieve this:

> *That’s all I ever ask, and if I can change something, help somebody else, then we’ve made a little difference to someone’s life, haven’t we?...So, give it a couple of years I’ll probably be working in the refuge myself now [laughs]. ~ Fern*

> *I’m gonna start a YouTube channel myself...I’m gonna definitely reach out to people...I won’t put myself in danger by doing it, but definitely share my experiences and hopefully I can help people...I’d love to work in, in the industry as well. Because it is, I am passionate towards it. Just to make sure that the people do get this help. ~ Olive*

> *It actually feels good to talk about it now cause, it means that someone else might not go through it if they know signs or signals or whatever it might just, if it helps someone else, then I would happily talk about it. ~ Holly*

The themes around paying it forward appeared to be in relation to taking part in the current research to have their voice heard to generate new learnings and support future survivors; actively disseminating knowledge through creating an IPV blog; welcoming new refuge admissions to help them settle in and join the sisterhood; or work in refuge themselves in the future to bring their lived experience and subsequent expertise to the role.

The rationale for seeking to help other survivors after living through their own IPV trauma may be linked to a drive for meaning-making. For example, feeling that if they knew what they did now they would have been better off and so they feel driven to share these learnings. It may also be that in relation to their acquired survivor identity and paying it forward, they are establishing more permanent connections to this community, or the sisterhood. This is the antithesis of the isolation they experienced in the IPV relationship. It may also be a protective and preventative coping strategy as upholding the survivor identity in this way may facilitate breaking the IPV cycle that many of the women described. Paying it forward by helping others could be a way of obtaining closure on this chapter, particularly as there seemed to be little legal justice for IPV crimes. It appeared that the survivors were beginning to author future ways of living in terms of moving towards planning and influencing something mutually empowering for themselves and others.

Table 7

Narrative Typologies derived from Survivor Core Narratives

Core Narratives	Narrative Typologies	
	Empowerment within interview processes	Paying it forward
"I just want to be a better person, a better parent"	✓	
"I was very glamorous! … Yeah, he literally killed all of that"	✓	
"I don't know what the future holds for [my son] and when I'm not here, that really worries me"		
"I don't need counselling. I need a spa break"	✓	✓
"Sometimes it genuinely feels heavy, like my body can't take the weight of everything anymore"		✓
"I was like "no I fell and hit my head on the bed"…[the words] literally just fell out my mouth"	✓	
"I don't recognise myself anymore…I'm damaged goods now"	✓	
"I was pregnant, I was taking her away because I weren't having that around her"	✓	✓
"I just kind of felt a little bit thrown out to the wolves"	✓	
"You crave it to work so much because what are the bruises for?"	✓	✓
"In main house…it's like being in with a perpetrator … when people don't get on"	✓	✓
"I feel so drained from it all. I just feel like I need a bit of a break"	✓	
"If my own mum can't love me then I can't expect anyone else to either"	✓	✓
"I don't want to cry anymore no. I cried whole life already. That's enough for me now"	✓	

Chapter Summary

In this chapter, each survivor’s story has been shared in its entirety using a narrative approach to analyse the content of the interviews in relation to themes and structural components. Illustrative quotes were provided to assist the reader to hear the stories as told in the survivors’ voices. Post-interview insights captured in a diary were shared within Appendix F to highlight the researcher’s experiences of the interviews, as well as their position and subjective interpretations. In the next chapter, themes from the survivors’ narratives as well as the narrative typologies of empowerment within interview processes and paying it forward are discussed to further reflect upon possible learnings from the survivors’ stories in relation to clinical implications.

CHAPTER FOUR: DISCUSSION

Chapter Overview

In this chapter, the main findings of the research will be discussed alongside psychological theory and extant literature on both TIC and IPV. The current research is also considered in relation to its implications for clinical practice as well as policy and legislation; recommendations are provided to facilitate this discussion. Lastly, the strengths and limitations of the research are shared so that future research may take these into account when building upon this explorative foundation. The chapter ends with reference to the researcher’s reflections on the thesis process (in Appendix G) and shares final considerations of positionality in relation to the feminist methodology adopted within this research.

Research Aim and Summary of Main Findings

The aim of this research was to explore the narratives of female survivors of IPV by interviewing women living in a refuge for domestic abuse. The intention was therefore to listen to the stories shared by the IPV survivors to better understand their experiences of finding refuge and being in refuge itself, as well as to explore the utility of TIC in offering a values-based framework for this population. A TI and feminist frame was upheld throughout the research process across every juncture of recruitment, implementation and review in order to safeguard against enquiry being trauma inducing or retraumatising. The hope for this research was that the findings may guide service development and delivery to better meet the needs of this population of survivors. Ultimately, this research embodied a microphone for these women's voices and stories to be heard, thus centralising them within the research process in both being responsive to their narratives and them collaboratively becoming influencers too.

In terms of the main findings, core narratives were identified case-by-case for each survivor that pertained to their experiences of the abusive relationship, fleeing/finding refuge and their perceptions of support from refuge. Each core narrative is discussed in depth below in relation to clinical implications. To summarise, the survivors shared experiences of the multiplicity of abuse suffered, and they reflected upon their reasons for both staying and leaving. They also talked about life inside the refuge and their relationships with peers and keyworkers. Experiences of IPV were discussed and shared in different ways, for example, stories centralised around themes such as grief and loss, survivor identity, empowerment, motherhood and countertherapeutic/maladaptive coping. Such narratives highlighted the subjective nature of IPV and trauma. IPV was also discussed in terms of reliving and re-enacting abusive relationships within other contexts, as well as naming the felt responsibilisation and reflecting on from where this attitude derived and had been perpetuated.

From the core narratives, two higher-order narrative typologies were developed, which linked to the interview process itself, as well as the unification of survivors. The interviews were experienced as empowering for many survivors, as they reflected on the meaning of the space offered to discuss their IPV experiences within the interview, i.e. being afforded an opportunity to feel heard and validated. They also talked about their desire to ‘pay it forward’ and support other women who had lived experience of IPV, particularly if they had lived in refuge too. Both typologies are discussed in greater depth below in relation to what services and practitioners may be able to harness from these findings.

Implications of Core Narratives for Clinical Practice

For each survivor, a core narrative has been reflected upon in terms of possible clinical implications and linked to existing literature and psychological theory to expand and position these novel contributions within this field of study.

Death of Former Self: Considering Models of Grief

“I was very glamorous! … Yeah, he literally killed all of that.” ~ Ivy

In further exploring the narratives that survivors constructed about their IPV trauma within the interviews, themes pertaining to the losses incurred throughout the process were shared. The interviews outlined the impact of IPV in relation to women who leave their homes to escape abuse being automatically rendered homeless and refuge ultimately affording them shelter. For many, this transition from homed to homeless was just one of many losses incurred throughout the IPV process, but a key one as research has indicated that poor housing can lead to increased helplessness and dependency, and diminished self-esteem (Evans et al., 2003). The sense of displacement experienced by many of the IPV survivors was reinforced through the processes of becoming homeless and then rehousing within refuge. Grief pertaining to such displacement, i.e. feeling bodily and socially disconnected, can have a significantly detrimental impact upon wellbeing (Robinson, 2005). IPV survivors detailed losing their family, friends, trust, personal qualities (e.g. humour and happiness), self-care, roles, jobs, routines, sense of safety, familiarity, positioning and placement. The concept of grief usually describes bereavement linked to death and dying (Kübler-Ross, 1969). However, the term 'disenfranchised grief' encapsulates less socially recognised non-death losses, whereby fewer opportunities to facilitate mourning and processing of the loss are afforded (Woodlock et al., 2022; Scott & Weisz, 2002; Corr, 1999). The impact of IPV is often measured in terms of physical injury, illness, or loss of life (Woodlock et al., 2022). Within the interviews, it was apparent that women may be more likely to experience disenfranchised grief when their IPV experiences are not quantifiable in this way, e.g. near misses, coercive control or emotional/psychological abuse. The minimisation of their IPV could therefore lead to greater disenfranchised grief due to increased silencing of survivors, thus driving shame and stigma. Sanderson (2008) described grief as being a response to incurring loss or significant change and therefore concluded that clinicians must become attuned to working with IPV survivors in terms of acknowledging a grieving process. The current research outlined the significance of these losses in adding to the accumulation of trauma, furthering the experience of distress, shame and stigma for many.

Practitioners and services should therefore consider grief models to address the impact of such losses upon IPV survivors. Concepts such as ambiguous loss (Boss, 2007) could be considered to better understand the pain experienced when there exists obscurities surrounding the loss, e.g. the psychological death of a former identity or parts of the self. For some, the development of prolonged grief disorder, whereby bereavement difficulties persist or intensify rather than diminish over time, may be particularly prevalent for IPV survivors with accumulated trauma, or C-PTSD symptoms (Jordan & Litz, 2014). Some models of grief denote grieving as a stage-by-stage process (Kessler, 2019; Kübler-Ross, 1969), and others describe a process of ‘growing around grief’ (Tonkin, 2009). The stages of grief model (Kessler, 2019; Kübler-Ross, 1969) has been critiqued for being overly prescriptive and simplistic and therefore not allowing space for the complexities of human emotions, however the model is still widely recognised and used presently (Avis et al., 2021). These six stages may be useful in helping services and organisations better understand the challenges encountered as part of the IPV journey, and how the process is not linear, much like grief. The stages may also be considered to explore the meaning the survivors made of the losses they incurred across different timepoints on their IPV journeys. During the interviews, survivors commented on withdrawing from their refuge peers or neglecting their self-care, which may be understood in terms of the ‘depression’ phase of grief (Kessler, 2019; Kübler-Ross, 1969). They also sometimes compared their IPV to others in terms of minimising their experiences, or considered returning to the IPV relationship altogether, which could be associated with a denial stage of grief, due to the desire to regain the familiarity that had been lost in the face of overwhelming displacement. Some survivors also talked about acceptance as being their overarching recovery goal, by feeling able to move on from their IPV trauma. The ‘growing around grief’ model (Tonkin, 2009) could be considered by services to understand the potential for post-traumatic growth and healing, in spite of difficult IPV memories that may remain just as poignant and painful for the survivors.

Trauma as a Subjective Experience

“I don’t need counselling. I need a spa break” ~ Rose

While some events may be deemed objectively traumatic, much of the experience and meaning made of trauma has been described as subjective (Morales-Abaroa & Moore, 2021; Boals, 2018). For this reason, the survivors' experiences of IPV, the meaning made and the implications of it differed for everyone. Survivors mentioned coping strategies employed to help them manage their IPV distress. For some, countertherapeutic/maladaptive strategies may have derived from childhood and been utilised unconsciously. For example, the defence of moving on has been described as a survival strategy when remembering or ruminating is too painful (Whiting et al., 2012; Sanderson, 2008). However for some, avoiding vital trauma processing work could lead to a re-emergence of difficulties at another time or generate repeated patterns of behaviour (Herman, 2015). Newsom & Myers-Bowman (2017) investigated the concepts of coping and resilience and subsequently found that there appears to be power in resilience as part of a personal journey, which involves healing from trauma and moving towards rediscovering and reconceptualising the self. For the women interviewed in the current research, it could be that not overtly identifying their IPV experiences as traumatic was a way of seeking to embark upon this process. In terms of the implications of this finding for clinical practice, it would be important that clinicians seek to understand how survivors make sense of their IPV experiences and for the clinician not to impose a narrative, even a traumagenic one, on them in advance. They should hold in mind that survivors may not identify with feeling traumatised by their IPV experiences, but that they may also be upholding this ideology as a survival strategy.

It must also be questioned whether adopting a TIC approach could have any detrimental implications for survivors. The argument for TIC is that it should be a minimum requirement for all care and work as a catch-all approach for those who may not disclose their trauma, as opposed to excluding those who are not experiencing trauma (Reeves, 2015; Elliott et al., 2005). However, if the trauma ethos is named it could create an illusion of a minimum threshold of distress as an entry requirement to services. Equally, if TIC is utilised as a best-practice ethos and not named, it may invalidate the very foundations of transparency and honesty in practice, upon which TIC was built (Harris & Fallot, 2001). There is also a risk of labelling survivors' subjective experiences as traumatic and then proposing a course of action based upon such assumptions (Morales-Abaroa & Moore, 2021). Further research is needed to determine the impact of TIC for populations that do not identify as traumatised by their IPV experiences.

Clinicians should note that irrespective of whether IPV experiences are categorised as traumatic, survivors may still need different forms of support and therefore access to this should not be determined by a trauma label. In the current research, survivors indicated a need for creative non-talking therapeutic support, practical and administrative support and IPV psychoeducation, as well as developing relaxation and self-care skills. This was represented by the diversity of all narratives shared throughout the research process and arguably, as TIC strives to bear witness and respond to people in vulnerable forms, it can therefore navigate nuances that relate and tailor to individual, person-centred needs (Williams et al., 2017).

The Gap between Intention and Action

"I was like "no I fell and hit my head on the bed" … [the words] literally just fell out my mouth" ~ Daisy

Nankivell & Taggart (2022) suggested that when under threat, the ability to mentalise and reflect is greatly reduced, but that this trauma response may change when safety increases. This was reflected within the interviews as survivors described the totality of the abuse, in terms of it consuming all the space within their lives leaving room for little else. It is therefore conceivable that when living with abuse, survivors may not have the capacity to consider how they tell others about the IPV, nor act upon any intentions to leave. This creates a dichotomy between intention (e.g. wanting to disclose IPV) and action (e.g. concealing the IPV). Such a paradox could lead to victim-blaming narratives if social care and health practitioners are unable to make sense of the remaining or returning actions within IPV relationships and infer responsibilisation on the survivor’s part for action.

The interviews highlighted several barriers to communicating what may feel unspeakable. In terms of the intention to disclose IPV, this could be met with resistance due to the survivor-abuser attachment. Within the interviews, survivors talked about their own childhood attachments and disruptions to this, which they felt had ramifications for how they viewed themselves within later relationships. ‘Love-bombing’, i.e. lavishing someone with adoration enabling later manipulation to meet narcissistic needs (Strutzenberg, 2016), appeared to fulfil unmet needs from childhood in relation to craving warmth, affection and closeness. However, interspersed with the gradual onset of IPV, this vicious cycle seemed to create a yearning or withdrawal, as previous experiences of warmth may have halted any action to disclose IPV in the hope of this returning. In addition to the inconsistency of affection within the IPV relationships, gaslighting e.g. rendering survivors culpable for the IPV in some way (Gass & Nichols, 1988), and threats often sought to silence the survivors into inaction. Survivors in the current research therefore described living in both hope and fear; hopeful for change and fearful of the ramifications if not actioned. Fear of the unknown consequences of disclosing IPV has been identified as a major inhibitory factor (Robinson & Spilsbury, 2008), particularly as it is known that disclosures of IPV may not always have favourable outcomes for survivors (Evans & Feder, 2016). In relation to the threat system model (Frothingham, 2021), it could be suggested that survivors move between fight and flight, but also freeze, i.e. inaction, and fawn, i.e. hopeful of further affection, or befriending as a survival strategy.

Research has shown that IPV can rapidly escalate at the onset or during pregnancy (Bohn, 1990) and that a mother's decision to stay or leave is impacted by several factors, such as family preservation, cultural practices, gender-roles, finances and perceived level of harm to children (Rasool, 2016). In the current study, it appeared that motherhood had a substantial influence over the course of IPV action. For example, survivors spoke about their fear that in light of gaslighting, they may be viewed as to blame for the IPV or perceived as mentally unfit and therefore risked having their children taken away from them. Services must therefore consider the intersections of womanhood in terms of identifying the various factors that lead to such self-stigmatisation and may be underpinning their inability to disclose what has been or felt unspeakable within their personal context. It may be that multiagency working facilitates the identification of such influential factors and that more targeted support could be offered on this basis.

De-role from the Family Narrative: Female Empowerment and Peer Support

"I was pregnant, I was taking her away because I weren't having that around her" ~ Violet

The ability to de-role from held family positions appeared to be facilitated by the peer support within the refuge for some survivors. For many, the survivor identity seemed to translate into validation and empowerment, whereby survivors were able to exist without fear of judgement, misunderstandings or tiresome explanations. Survivors talked about their relationships in refuge in relation to in-groups and out-groups, for example, those who had IPV backgrounds themselves (including peers and refuge staff) appeared to belong to the in-group (Tajfel, 1984). Within the in-group, there seemed to be a shared understanding of IPV, an unspoken language to communicate the meaning of experience and mutual respect. One survivor commented that she felt more supported by her peers in refuge than by her family of origin, and several others equated their relationships in refuge to family. Those in the out-group seemed to be perceived as less passionate and compassionate within their roles. In terms of the clinical relevance of this finding, services should consider how they are able to encourage both access and engagement to services, and whether there is scope for survivor supporters to facilitate this process. While it must be noted that peer support models bring risks of retraumatisation and responsibilisation for change being placed unfairly on the peer support workers, there are many possible benefits too in terms of increasing peer supporters' self-esteem and this enhancing their own recovery (Repper & Carter, 2011). Within mental health, peer supporters with their own lived experience are already valued, in that they appear to offer hope and instil belief in recovery (Repper & Carter, 2011). Evans & Feder (2016) proposed that 'enablers' with lived experience could offer peer support or become part of a 'buddying' system to facilitate better outcomes for IPV survivors. The survivors of IPV interviewed in this research clearly identified the value of peer support for their population. Those with lived experience in supporting positions seemed to be more readily accepted, trusted and valued by the IPV survivors based upon their own experiences and perceived understanding. This could be upheld by services to improve accessibility and encourage engagement. Women that have survived IPV have been described as being a 'hard to reach' population, which Brackertz (2007) argued disproportionality puts the responsibility for this within the group itself, rather than in how services and research approach this population. Working in this way may meet the TIC principles of establishing trust and working collaboratively (Schulman & Menschner, 2018; Reeves, 2015; Harris & Fallot, 2001), whereby IPV survivor supporters could harness their lived experiences of IPV to not only assist the development of positive working alliances but also to ensure that services are working in ways which centralise survivors to their practice. The value of this peer support may be protective in terms of women maintaining their survivor identity to break the cycle of

IPV and in women empowering other women, they may work to challenge the oppression of the patriarchy.

The Dereliction of Duty

“I just kind of felt a little bit thrown out to the wolves” ~ Fleur

The NICE guidelines (2022, 2016) recommended that if a person suspects someone is being subjected to IPV, they should sensitively question them about this in a private space and in a manner whereby the person is made to feel they will be believed. However, it became apparent through this research that not only do others appear to turn a blind eye to IPV, but also when met with disclosure their response/reaction may be triggering for survivors, leading to iatrogenic harm (Rees, 2012). In the current study, services such as the council or legal/justice systems often made the survivors feel not only re-victimised but as if the support systems were treating them less favourably than the perpetrator. Research has highlighted that attempted disclosures are frequently met with the practitioners’ own anxiety about hearing and holding trauma (Williston & Lafreniere, 2013). Similarly, such experiences within the current research may have led many of the survivors to feel unsafe or untrusting of different support or legal systems.

Survivors not being held at the forefront of care, i.e. practitioners not working in a person-centred way (Rogers, 1957), appeared to have a detrimental impact upon the experience of the many interactions with services that survivors had. For example, more often than not and particularly within the legal system, it appeared the crime/criminal was at the centre, which caused the survivor to frequently feel overlooked. Yet worse than this, were the occasions when the survivors reported feeling dehumanised, criminalised and culpable, due to a sense that systems and services were aligning themselves more with one side than the other, i.e. the perpetrator. Survivors also commented on feeling judged as manipulating the systems for their own gains. The survivors talked about this in terms of it not only feeling retraumatising, but cruel and therefore reflective of their experiences of IPV, particularly in relation to gaslighting.

Research has explored what services should offer survivors of IPV, particularly those who are contemplating leaving. Chang et al. (2005) found that healthcare providers should radiate feelings of safety, privacy and autonomy. Cluss et al. (2006) furthered this work to develop a psychosocial readiness for change model, highlighting the complex interplay between various factors that prevent leaving that may present upon a continuum of readiness. Furthermore, the research conducted by Women's Aid (2022) involving an online survey, two focus groups and one semi-structured interview, outlined what female survivors of IPV want from mental health services. This included: services responding empathically; improving accessibility and long-term support; women-only spaces including recognition of marginalised groups; practical help including support for children; access to a range of approaches; and services demonstrating IPV expertise i.e. awareness of the complex and often ongoing dynamics.

The current research has built upon these findings to suggest that female IPV survivors want to be treated with dignity and respect, for others to be passionate about supporting them and perceive them as people rather than the crime that has taken place, and for there to be tangible outcomes that support justice. Society maintains that women's autonomy should be upheld to enable them to make the decision about when and how they seek help for IPV. However, this is often a complete paradox in relation to the oppression and powerlessness in which they are living day-to-day within their abusive relationship. Services should therefore consider how they can better support women to feel both empowered and protected whilst trying to articulate what has been unspeakable regarding their IPV relationships. This study offered insights into the dynamics of abusive relationships and the impact of these upon survivors’ relationships to help.

Meaning-Making in the Face of Violence

“You crave it to work so much because what are the bruises for?” ~ Olive

During the interviews, there was a sense that some survivors utilised the space to reflect on the meaning made of their IPV, particularly in relation to their IPV reference points, e.g. normalising IPV within the family system in childhood may create a familiarity or sense of safety associated with these relationships in adulthood. The language used when communicating these ideas was often conflicted, such as the oxymoron of “best perpetrator”, which highlighted the confusion at the boundaries of safety and respect within relationships. Some survivors commented upon the passion and intensity within the relationship and equated this to feeling special or loved.

In terms of the clinical implications of this, further education within schools and colleges may be needed to educate young people about safety in relationships, particularly as this opportunity may not be afforded at home. Currently, there is statutory guidance to include safety within relationships in the curriculum for primary and secondary schools but not post-16 (GOV, 2021b, 2021a). The education around IPV is discussed further in Legislation and Policy below, however it is important that education systems are aware of responsibilisation and that any IPV education tackles preventing IPV at the source, just as much as it focuses on female safety and empowerment. Encouraging young people to learn about safer relationships would fit with the TIC construct of empowerment (Harris & Fallot, 2001), by supporting the development of self-worth from a young age, so that young people may be assertive and IPV aware within their relationships as they move into adulthood, and also so boys and men become allies in challenging the oppression of girls and women.

Reliving of IPV in Future Relationships and Experiences

“In main house…it’s like being in with a perpetrator … when people don’t get on” ~ Fern

During the interviews, survivors shared stories that depicted a re-enactment of IPV within refuge or with other services. This reliving of IPV could be in relation to trauma symptoms (Herman, 2015) or the projection/transference of previous relationships (Johnston, 2020). Practitioners should therefore consider experiences of conflict within the context of IPV and not in isolation. If IPV experiences are evoked, there may be ramifications for how the survivor perceives their environment in terms of safety and trust, which could impede their relationship to help i.e. reporting further crimes or access and engagement with services. A degree of reliving could occur and therefore have a detrimental impact upon their wellbeing if these feelings are not identified, validated and communicated so that meaningful support can be provided.

Away from the experience of interpersonal conflict within the main refuge, one survivor shared her experience of living in a refuge-run self-contained flat with her children. She likened this to regaining a sense of normality, which may therefore be a helpful stepping-stone in the process of leaving refuge altogether. However, despite its benefits, it would be important for services, particularly refuges, to have a greater awareness of the risk of isolation when living away from the main refuge house. Survivors talked about feeling more isolated within these flats, and therefore greater inclusion within social activities, whether run by refuge or locally, could help bridge the gap to returning to the community. This may also support survivors who are mothers to meet other women who could be single parents too.

Reducing their sense of isolation and bringing them into the community may reduce subsequent shame (Gilbert, 1998). Dolezal & Gibson (2022) outlined the significance and prevalence of shame post-trauma in that it can be a barrier to engagement. They also argued that TIC should incorporate shame-sensitive practice to prevent retraumatisation i.e. by recognising shame from postural, embodied or language cues and addressing the impact of this upon wellbeing. This offers further evidence for the importance of identifying the role of shame for IPV survivors in terms of their abuse experiences but also their time in refuge and the stigmatisation they may feel in relation to this.

Further to this, refuges and mental health services could develop their therapeutic offerings, e.g. by including compassion-based therapies to support survivors who from their IPV experiences may have a depleted ability to self-soothe and could therefore experience greater shame in relation to their IPV or accumulated traumas (Gilbert, 2006, 1998). The present study highlighted a need for greater therapeutic input that serves to enhance the survivors' self-worth through the identification and development of self-soothing and self-compassion skills, which may empower them moving forwards. Gilbert's (2006) Compassionate Mind Training program supported the reduction of shame, self-criticism, anxiety and depression, particularly for those from traumatic backgrounds. However, there is the risk that offering individual therapeutic support may reinforce the notion that the issue of IPV is located within the survivor in terms of it being their responsibility to resolve. In a recent study, group compassion-based therapy for female IPV survivors was effective at reducing PTSD symptoms, anxiety and depression, even when IPV was ongoing and in contexts where GBV was a social norm (Naismith et al., 2021). It may be the case that further research is warranted to explore whether matched cohort groups like this are preferential to individual or mixed-groups within compassion-based therapy.

The Enervation of Responsibilisation

"I feel so drained from it all. I just feel like I need a bit of a break" ~ Willow

Survivors commented on the process of reporting IPV in terms of it feeling laboriously repetitive, disruptive and even humiliating. One survivor talked about the police coming to her work three times to take a statement from her, but new allegations amounted in this time due to police delays. Legal processes should therefore centre around the survivor in order to be experienced as unintrusive and efficient, for example, granting survivors immediate access to an Independent Domestic Violence Adviser (IDVA) who prioritises their safety and demystifies/navigates IPV processes (SaferFutures, 2023). If this were achieved, it may make the survivor feel that their account is being managed with the gravity it deserves. This could encourage the development of greater trust within such interactions for survivors to feel safer to disclose more unspeakable abuse, such as sexual abuse which appeared to be frequently unreported within the current study. If survivors feel they are unable to report abuse and speak to their IPV experiences, there could be significant ramifications upon their wellbeing. The cumulative impact of multiple victimisations/polytraumas may increase the likelihood of C-PTSD or other serious mental health problems (Ford & Delker, 2018). It is therefore crucial that each form of abuse be addressed individually while recognising the impact upon survivors of the accumulation of IPV abuse and trauma and/or multiple victimisations overall.

Rupture and Repair within Attachment

"If my own mum can't love me then I can't expect anyone else to either" ~ Holly

Within this narrative, survivors explored their attachment with their own primary caregivers and how this perhaps set a precedence for their future relationships with others

(Ainsworth, 1979; Bowlby, 1951). For example, one survivor talked about feeling that her mother could not love her, which may have caused her to internalise this as being her own personal defect, which later laid the foundation of her romantic relationships in terms of maximising the felt sense of affection while minimising the IPV. In addition to this, the phenomenon of 'ghosts in the nursery' (Fraiberg et al., 2002) may offer insight into survivors recalling and even re-enacting memories from their own childhoods once becoming parents themselves. Part of the role of services could therefore be to acknowledge the significance of familial histories of survivors, especially where there has been greater childhood adversity (Mair et al., 2012; Felitti et al., 1998), in order to better understand the current attitudes towards the IPV relationship. This may support survivors to identify the predisposing factors that perpetuate their cycle of IPV. Armed with this knowledge, survivors may feel better prepared to repair and re-script painful narratives. Furthermore, belonging to a collective survivor identity could facilitate this process for survivors, so that they have greater points of reference to learn that they are not alone with their IPV experiences, nor to blame for them.

Ascendancy of Empowerment over Powerlessness

"I don't want to cry anymore no. I cried whole life already. That's enough for me now" ~ Lily

The NICE guidelines (2022, 2016) highlighted the need for having an awareness of diversity in IPV, such as differences in experiences based upon sexuality and/or gender or being culturally aware by recognising the need for an interpreter and choosing someone not linked to the family. In amplifying the survivor voice, this research can build upon these recommendations. For example, some survivors shared stories that portrayed the role of cultural norms, attitudes, values and beliefs within IPV and how these may therefore be used to determine the socially accepted course of action. For one survivor, IPV was described as being culturally viewed as her perpetrator's suffering, which silenced her own. She faced feeling shamed and shunned by her community upon eventually departing the relationship for her children's safety. She may have been unable to consider her own suffering based upon the perceptions and meaning made of her perpetrator's actions, not just by her, but by the wider family and community. Shame is not unique to this cultural context, but the enormity of the repercussions this survivor feared she would face could be. It is therefore essential that services look beyond the meaning they seek to make of others' experiences and instead, establish positive working alliances with women, even prior to leaving, to better understand the attitudes surrounding the IPV relationship. Where intersectionality is considered, women can be impacted by different hierarchies and multiple forms of discrimination (Josephson, 2002). Services must therefore be equipped to explore such differences so that their response is measured and appropriate rather than tokenistic, untimely or isolating.

As determined in the NICE guidelines (2022, 2016), services must recognise the survivor's practical needs, for example, ensuring that they have access to an interpreter so that their stories are heard in their own language and that communication does not become a barrier to survivors accessing support. The importance of the multiagency response was highlighted by one survivor in the research, who felt that this helped her to gather the momentum she needed to be able to leave. It could be inferred that the number of people involved countered the voices directing her to stay within the relationship and was therefore experienced as empowering. This provides evidence in support of cohesive multiagency working, which commands clear communication across different services and systems so that the survivor is central to the work and always prioritised. When survivors do not feel able to prioritise themselves, this can be modelled by services and practitioners to challenge narratives of blame, shame and responsibilisation.

Implications of Narrative Typologies for Clinical Practice

Two narrative typologies derived from the core narratives but also the interview process itself. These typologies are discussed further below to highlight the implications of these novel findings for clinical practice.

Empowerment within Interview Processes

It appeared that there was a felt sense of integrity within the storytelling process for each survivor in their interview. The interview experience was reflected on either during or after the interview and suggested that retelling the story of IPV need not be traumatic if the values of TIC (Schulman & Menschner, 2018; Reeves, 2015) are applied to the process. Below the experience of the interview process is discussed in relation to each principle of TIC outlined by Harris & Fallot (2009, 2001):

Choice. In terms of choice, this principle was established from the initial contact with the survivors during the early recruitment phase. There was flexibility in scheduling the interview around their other commitments, such as work, childcare or legal processes. This flexibility communicated respect and an acknowledgement that their lives were important and mattered. It also portrayed appreciation for the survivors offering their time to the study.

Survivors were informed that in the retelling of their story, they could say as much or as little as they felt comfortable. They could also change their mind or not answer a certain question, and even withdraw their interview entirely from the study within a seven-day timeframe. One survivor asked for some of her reflections not to be used in the analysis, which were crossed through at the transcribing phase to ensure transparency in respecting this boundary. Another survivor did not feel able to begin her narrative with the painful IPV experiences but instead chose to start from a position of hopefulness when thinking about the future. In establishing choice, the researcher hoped to communicate that they would work within the survivor’s boundaries and help them to feel able to communicate these in some way, without laborious explanations.

The survivors were also asked if they would like to opt-in to remain informed on the outcome of the study. Presenting this choice served to acknowledge that some survivors may wish to cut all contact upon leaving refuge as part of their moving-on strategy. Others may choose to remain in contact as part of maintaining their sense of belonging to the survivor community. Given the choice, all survivors within the current study expressed an interest in being informed of the research findings, which was perhaps suggestive of a need to maintain a longstanding connection with the refuge.

Empowerment. The survivors may have experienced empowerment within the interviews in terms of feeling a sense of agency and autonomy throughout the process. The research was centralised around the survivor voice while upholding feminist values and positioning (Lewis et al., 2015; Oakley, 2013), e.g. by the researcher validating the survivors’ subjective experiences, actively listening, being respectful and encouraging, and maintaining honesty/transparency throughout. Ultimately, the experience of empowerment within the research interviews may have directly contrasted the IPV relationships, in which many survivors experienced feeling controlled, manipulated and subsequently powerless.

To further empower the IPV survivors who participated in this research, their narratives were told in their entirety within the limits of the thesis research. This was a conscious decision made by the researcher to preserve the survivors’ stories, as opposed to fragmenting them on a theme-by-theme basis within the main analysis. This choice was made in line with the feminist research position (Lewis et al., 2015; Oakley, 2013; Harding, 2004), whereby there was an awareness that the survivors had already encountered pain and loss, and should therefore not have their words and voices broken apart. The research therefore aimed to empower these women through a respectful analysis of their IPV stories, which could then be considered on a wider level to think about the clinical implications of such narratives.

Safety. Safety was of paramount importance to this study. The research had to achieve a balance between exploring IPV stories to afford survivors a platform to be heard and weighing up the potential cost of this for the survivors in terms of possible retraumatisation through the retelling of distressing stories. Research has shown that professionals are often cautious when it comes to survivors retelling their stories for fear of retraumatisation, however it can be experienced as both helpful and therapeutic within the right context and setting (Williston & Lafreniere, 2013). Safety was therefore outlined through the ethics process but also communicated to the survivors to evidence their importance within this research. For example, recordings were not started until the survivors had been re-inducted to the study upon joining the video call and given the opportunity to withdraw. They were reminded of the process of anonymisation, and their safety was named within the rationale for this. If participants appeared overwhelmed during the interview, this was named and a space to reflect upon this was given, as well as considering whether to continue. Towards the end of the interview, survivors were re-orientated to their day and surroundings through grounding, distraction and relaxation, as well as checking on their need to access further support within refuge. These factors were considered in line with the reliving effects of trauma (Herman, 2015) to ensure the survivors' safety and wellbeing were considered at all times. Feedback from the survivors suggested that this was experienced in a warm and compassionate way and encouraged the survivors to feel contained and held within the interview space when discussing their painful experiences.

Collaboration. In addition to developing a sense of agency through having choice at the various stages of the interview process, working collaboratively with the survivors was essential in order to centralise their voices within the research. All survivors were asked what they felt they needed or other survivors may need from the various services encountered, or from their experiences of refuge. In voicing their opinions on this and these being disseminated through research, the survivors had the opportunity to directly contribute to service and system development so that service delivery can become more attuned to IPV survivor needs.

Trust. Trust may have been established throughout the process by a range of mechanisms. The research was supported and encouraged by the refuge, particularly by one staff member who facilitated recruitment and had lived IPV experience herself, which could have increased the study's credibility from the survivors' perspective. Research has demonstrated that relational safety and trust can be born out of giving survivors a sense of choice and control over their care (Alyce et al., 2022). In this research, a) being met with a non-exploitative compassionate ear, i.e. survivors having choice in the course of story-telling by saying as much or as little as they felt comfortable sharing, b) being reminded of their right to stop, or withdraw their story from research domains, and c) having open discussions about their emotional intensity or whether aftercare was required, all appeared to be valued factors in safely sharing their IPV stories that facilitated the development of trust.

Another principle that may have elicited trust within the survivor-researcher relationship was that of unconditional positive regard, i.e. the person-centred approach adopted by the researcher (Wilkins, 2000; Rogers, 1957). The researcher's feminist position enabled them to accept the survivor's story as just that, their story and their personal experiences not up for debate, judgement or scrutiny. One survivor remarked that she had previously not been asked how she felt about her IPV experiences, only what had happened. This appeared to be a noteworthy difference for her in terms of trust being built on the grounds that she did not feel exploited for the gory details of her story to sensationalise the research, but rather was being asked about how such experiences had impacted her, to explore what needs changing/improving in policy and practice.

It appeared that in upholding TIC within the recruitment and interview processes of this research, survivors were able to experience the interviews in more positive, validating and empowering ways, rather than feeling judged, victimised or retraumatised. Services should therefore consider these findings in terms of the impact of this upon future interactions with IPV survivors in all services and realms of care, e.g. medical, social or therapeutic.

Paying it Forward

A second typology that was identified from the core narratives and process of the research was the survivors' drive to pay it forward and support other survivors through their words or actions. The reasons for doing so when faced with their own trauma are explored in more detail below.

Protecting Other Women. From the survivor narratives within this research, there appeared to be a felt sense that justice for IPV was limited. In light of this, it may be that survivors put their efforts into supporting others as a form of obtaining closure in the absence of legal justice. For example, one survivor talked about pushing through the distressing process of giving evidence in court, in the hope that some minor conviction may be identifiable for other women based upon the principles of Clare's Law (GOV, 2016). These actions would therefore serve to protect other women from the perpetrator in the future, or at the very least, enable them to make a more informed decision about staying or leaving.

Educating Other Women. Another factor in survivors paying it forward was to educate others. Some survivors felt that they had not received such education to help them feel empowered to leave, or not having the tools to navigate such a decision. In the interviews, the survivors talked about educating others through creating an online blog or even by taking part in the current research. Some survivors talked about working in refuge themselves so that they could bring their knowledge and life experience to the role, as they had valued that from others during their time there. It appeared that the survivors felt by disseminating knowledge in different ways, they were taking a stand against the oppression they felt by helping to empower other women through education.

A Sense of Belonging. Fundamentally it appeared that for many women, paying it forward was a way of creating a sense of belonging. This belonging was perhaps in relation to a collective survivor identity, or even the establishment of a sisterhood within refuge. In creating this new identity, survivors may have been able to regain a sense of self and belonging that could have served to help them break the cycle of IPV.

While there is little research on IPV survivors' determination to support others, this has been noticed in the wider literature. For example, the Truth Project highlighted that CSA survivors often had a drive to support and advocate for one another in the hope that they may improve the lives of future children (Stubley & Taggart, 2023). It may be that this drive for helping others is part of the healing process linked to re-establishing a sense of belonging and self-esteem as well as moving towards self-actualisation in the future (McLeod, 2007; Maslow, 1943). Services may therefore be able to encourage and support this process by inviting survivors into peer supporter roles, as well as enabling them to work collaboratively on initiatives that improve the lives of others. This could be invaluable to survivors' sense of self-worth, purpose and identity and also help them to rewrite their IPV scripts long-term.

Legislation and Policy

Domestic abuse laws and legislation have changed throughout history. For example, in the eighteenth-century terms existed such as 'rule of thumb' whereby husbands were allegedly permitted to beat their wives as long as the rod was not thicker than their thumb (CentreForWomensJustice, 2022). The declaration of human rights in 1948 saw encouragement for acknowledging women's rights to security, freedom and dignity and 'Women's Aid' in 1974 brought together over 40 refuges to establish a national refuge network with the aim of women being able to escape further away from their perpetrator (CentreForWomensJustice, 2022). However, even in recent publications outlining best practice for supporting IPV survivors, some of the terminology or language used could be deemed problematic. For example, the Domestic Abuse Act that recently became law (GOV, 2022a) and the Home Office statutory IPV guidance (GOV, 2022b) reference those who have experienced IPV as 'victims' throughout the documentation. Research has shown that while some may identify with the term 'victim' from a legal perspective to highlight the crime that has taken place, it may also have detrimental connotations associated with weakness, passivity and responsibilisation (Newsom & Myers-Bowman, 2017) that could cause women to be perceived as vulnerable and therefore further their experience of victimisation (Perloff, 1983). The term ‘survivor’ has been explored and deemed to have greater positive associations with women being perceived in relation to their strength, optimism and valence (Papendick & Bohner, 2017). Being cautious with the language used when talking about those who have experienced IPV may serve to facilitate the meaning survivors make of their experiences in the context of their IPV journey stage, i.e. moving away from victimisation towards a survivor identity.

In terms of the legal frameworks that exist to protect survivors from ongoing IPV threats, the current research found that these can be experienced as excluding or insufficient in meeting survivor needs. For example, one survivor reported that her IPV experiences did not qualify for the minimum relationship duration under the non-molestation order and therefore she was not entitled to this protection. This information has since been corroborated by GOV.uk (2023); they stated that a minimum relationship duration of 6 months is required for unmarried partners to qualify for the non-molestation order. Not only does such a policy put female survivors at additional risk by withdrawing the potential for legal protection, but it also makes numerous assumptions. One inference is that relationships under this minimum threshold do not present a threat and therefore are not treated seriously. The implications of this are that the repercussions for crimes under this duration could be considered lesser. Furthermore, this narrative may then be echoed throughout society and upheld consciously or unconsciously by all services the survivor encounters. This therefore has the potential to wholly invalidate the survivor’s experience of IPV, which this research had demonstrated can lead to isolation, inaction or returning to the familiarity of the IPV cycle.

Another factor to consider in IPV policy is that of further education. Currently, educating children and young people on IPV and safe relationships is written as statutory guidance within the curriculum for primary and state secondary schools only (GOV, 2021b, 2021a). In the current study, many survivors expressed feeling that they may have left their relationship earlier had they been able to make different meanings of the abuse they suffered. For some, recognising it as abuse was not enough, particularly when IPV had been normalised within childhood and they therefore did not have healthy relationships modelled to them, and so their main points of reference were that of toxic or abusive relationships. If this education is not happening at home, then it is crucial children and young people are able to access this as a priority within the education system. A recent petition organised by the Make it Mandatory Team (BBC, 2022) are calling for the government to mandate post-16 teaching on IPV within sixth forms and colleges. They argued that this would enhance IPV understanding for young people and offer learning during young people’s formative years.

Within this research, the value of refuge as a safe haven and an opportunity to access meaningful peer support was communicated by the majority of survivors interviewed. Research by Women's Aid (2018) has however identified that there exists a discrepancy across UK refuges in terms of funding and resource. They found that some refuges were wholly reliant on fundraising after having local commissioning withdrawn, while others were still in receipt of such funds. Womensaid.org.uk (2018) hoped to offer more robust quality assurance by standardising the care offering to consistently meet the needs of IPV survivors across the UK. As refuge stays can vary from a few days to several years depending on individual circumstances (Refuge, 2023; Women’s Aid, 2023), it would be important that refuges can fund a range of activities and interventions that support women at the different stages of their refuge journey. A new arrival to refuge will undoubtedly have different needs to someone who has had a longer stay and developed their readiness to move on. In 2022, the government announced that it had secured a £257 million fund to support over 70,000 IPV survivors of domestic abuse over the next two years (GOV, 2022c). Funding should also be considered for refuge or while working concurrently with mental health services for non-talking therapies, such as arts-based therapy (Bird, 2018), or ‘bottom-up’ therapies that start with embodied sensations, such as Eye Movement Desensitisation and Reprocessing (EMDR) therapy (Tarquinio et al., 2012) to support those who may feel silenced by their previously unspeakable trauma.

Strengths and Limitations

A strength of this research was that despite the limitations of the COVID-19 pandemic and associated time constraints, as well as the transient nature of refuge, it was possible to interview IPV survivors living in a refuge. As a researcher without direct lived experience of IPV and subsequently therefore being perceived as perhaps more aligned with the ‘out-group’, this could have had a detrimental impact upon the progression of the research. However, the journey to undertaking interviews with the women in refuge was successful in relation to partnership working and possible trust-by-proxy; the researcher and research project were highly recommended by the Refuge Operations Manager and so there was the potential for trusting rapports to be developed from this platform. The relationship between the researcher and the Refuge Operations Manager was founded upon networking between the Trauma Alliance and the refuge charity. All three parties worked collaboratively to identify potential participants for the study and bring this research to life.

It is, however, important to recognise a limitation of the study in the face of the recruitment strategy, in that trust-by-proxy may not have been enough or perceived in the same way for all survivors. Some women (exact number unknown) may have been approached to take part by the Refuge Operations Manager and simply declined. Two women consented to the research but dropped out prior to agreeing an interview date, which could be due to a perceived wariness of the researcher as an unknown outsider (Bridges, 2001). Had time and COVID-19 restrictions permitted, it may have been beneficial to visit the refuge in person to establish rapport with the women before commencing the interviews. While the researcher would still have been deemed an outsider in terms of IPV experience, a relationship may have been created on the grounds of compassionate and therapeutic practice, perhaps increasing feelings of safety and trust within the process.

A feminist position was adopted within this research, so as not to simply study female survivors of IPV, but to convey passion for the importance of these women's voices being heard. This was a strength of the research because it added to only a small number of papers that have adopted a similar approach to their research (Buchanan & Wendt, 2018). Furthermore, the narrative approach given to analysing the interviews was a decision consciously made by the researcher to ensure that each of the survivors' stories remained intact to respect the women interviewed. To the researcher, it felt unethical to break these narratives apart when exploring the results of the research. Instead, out of compassion for each survivor's individual journey and courage in taking part in the research, each story was captured as fully as possible within the remit of this thesis.

A further limitation of the study may be linked to the size and diversity of the sample interviewed. While the small sample facilitated an in-depth analysis within the scope of the research, it must be acknowledged that data were collected from a small pool. Although there was much variation within the IPV narratives shared, ethnically the sample was predominantly formed of white British women. This may have limited the data somewhat in terms of the cultural richness that could be explored, and the ability to compare multi-cultural experiences of IPV was also restricted as a result. Furthermore, all the sample were recruited from the same refuge. Like any organisation, this refuge will hold its own culture, principles and values underpinning service delivery and steerage from its leadership team, which would have inevitably influenced the experiences of the survivors and their reflections upon refuge.

Further Research

As described throughout this chapter, this research has identified novel findings, which could be built upon to continue research within this field. Four key areas for further research have been identified.

Within this research, not all survivors identified with feeling traumatised or wanted to conceptualise their IPV experiences in this way. There is therefore scope for further research to explore the potential impact of TIC upon non-traumatised populations. The TIC approach denotes its application for all groups but the true impact of using this for people who in no way identify with trauma is yet to be explored. These findings could shape how services work in terms of upholding person-centred approaches, without the risk of labelling individuals' subjective experiences for them or creating false perceptions of minimum distress thresholds, which some could find invalidating and/or alienating.

As a limitation of this study was a lack of cultural diversity in the study population, future research could focus on exploring IPV within a wider range of cultural contexts. There may be learnings about the progression of IPV that are nuanced and specific to culture or religion that might otherwise remain unknown. This could also lead to more specialist support/resources being made readily available for women from different ethnic and cultural backgrounds. At the very least, it could demonstrate an awareness of intersectionality in relation to IPV, to validate all IPV survivor experiences and gain a more holistic understanding of IPV.

In the present study, all of the survivors interviewed were recruited from the same refuge, and at a similar timepoint, i.e. living in refuge. The survivors' experiences of refuge were based upon living within one refuge, with the exception of one survivor who had moved several times for safety. To explore the differences in the offering, set up and practice of refuges across the UK, data could be collected from several refuges in forthcoming studies; this may also serve to ensure the validity and reliability of any future qualitative analyses within this field. Longitudinal studies following survivor journeys may also provide insights into the experiences of leaving refuge as well as outreach work and the trajectory of their relationships. From such data, a better understanding may be gleaned from the different phases of the IPV journey post-refuge to develop learnings on how to prevent retraumatisation and iatrogenic harm (Sweeney & Taggart, 2018).

Lastly, recent research has indicated that a shift from TIC towards trauma-responsiveness may enable services to a) practice organisational leadership that effectively prioritises funding to support survivors' best interests; b) afford staff at all levels training and development with a particular awareness of vicarious trauma to prevent burnout and disengagement; c) promote policies and decision making that detail clear responsibilities for all involved; d) maintain physical environments that account for diverse survivor needs; and e) advocate for continued quality improvement for the upkeep and improvement upon these factors moving forward (Morales-Abaroa & Moore, 2021). Further research would be needed to consider the impact of trauma-responsiveness in comparison to TIC for IPV survivors.

Conclusion

This research contributes to the growing literature on IPV by utilising a storytelling approach and upholding feminist positionality. It adds to the field by qualitatively exploring individuals' experiences of IPV from a refuge timepoint, whereby survivors were able to share their journey into refuge and encounters with wider services and systems. The current research also highlighted that populations assigned stigmatising 'hard to reach' labels can be empowered to contribute to research if they feel safe and encouraged to do so. As a researcher, it felt that being met with the same passion for this topic and population helped to drive the research forward and establish trusting rapports with the survivors who participated. The survivors’ desire to be heard and to help others also gave the study momentum and meaning. This research outlined how services could simply do better to help women feel safe and supported to share their IPV experiences in a way that is empowering and validating as opposed to retraumatising. Recommendations for different ways to support IPV survivors at the various stages of their journeys into and out of refuge have been shared, as well as therapeutic interventions and support while in refuge. This research hopes to contribute to a greater awareness of the needs of survivors of IPV in the ongoing battle of ending violence against women, particularly within their own homes.

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Appendices

Appendix A: Email Invitation to Take Part in Research

Hello,

I am a Trainee Clinical Psychologist from the University of Essex and am recruiting for a piece of research that I must complete as part of my training.

I am currently interested in services being more ‘trauma informed’, which is a term used to describe anyone who tries to become more aware of how to support people who have had traumatic and distressing experiences (whether they have talked about them with anyone else or not).

I am working alongside [name] charity who have kindly agreed to send this email on to those who may be interested in taking part in the study.

I am keen to learn about your story. This may include your experiences of any services or people that might have worked with you over the years. I am aware that you might not have been asked to talk about this before, or you might not be aware of the term ‘trauma informed’ – even so, your voice will be very important to this research. This study hopes to explore your unique story in order to learn more about what can be done to better support people who have had very challenging experiences.

Your participation would involve an interview held remotely online at a time convenient to you. Interviews will last for up to one hour, and I have attached some more information for you to read if you are interested in taking part. Please note that participation is completely voluntary and will not affect your care.

I would be very grateful if you could let me know whether you would like to take part by replying to this email. I will of course be happy to answer any more questions you may have, so please do not hesitate to contact me.

Thank you and I look forward to hearing from you soon.

Best wishes,
Georgia

Trainee Clinical Psychologist

If you have any further questions or concerns, please contact the researchers:

Principal Investigator: Georgia Fuller *[email address]*
Research Supervisor: Dr Danny Taggart *[email address]*

Appendix B: Information Sheet for Participants

Title of the Project: On Becoming Trauma Informed: *Exploring the Narratives of Female Survivors of Intimate Partner Violence*

Principal Investigator: Georgia Fuller

My name is Georgia and I am a Trainee Clinical Psychologist studying in the School of Health and Social Care at the University of Essex.

I would like to invite you to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

As part of my training, I am required to complete a piece of doctoral research. The purpose of this research is to understand individual experiences of Trauma Informed Care. Over the next few months, I will be working alongside the charity [name] to interview women under their care who have experienced Intimate Partner Violence (IPV), also known as domestic abuse. From these interviews we may learn more about trauma informed care for female survivors of IPV. With this knowledge, we may perhaps be in a better position to support service-users with similar shared experiences in the future.

Why have I been invited to participate?

You have been selected to participate because you are currently under the care of the charity [name] and identify as being a female survivor of Intimate Partner Violence. You may feel you have a story to tell about some of your experiences to date. In total, approximately 10-15 women under the care of the charity will be interviewed.

Do I have to take part?

It is up to you to decide whether or not you wish to take part in this research study. If you do decide to take part, you will be asked to provide written consent. You are free to withdraw without giving a reason and withdrawal will have no impact on your access to services or taking part in future studies. You may withdraw from the study up until 7 days after completing your interview. After this time, the audio-recorded interview will be typed up into a transcript with all identifiable details removed (e.g. your name and any mention of locations or defining features) in order to maintain confidentiality. So, after this happens it will no longer be possible to identify your data in order to withdraw it from the study. Please consider taking part carefully and inform the principal investigator (details can be found at the bottom of this document) of a decision to withdraw as soon as possible, but no later than 7 days after completing your interview.

What will happen to me if I take part?

If you choose to volunteer in this study, I (the principal investigator) will arrange an interview with you remotely due to COVID-19 (either via a video call or a telephone call) at a time that is convenient for you. I will ask you some questions about your experience of services and offer you the opportunity to share your story. The interview will last for up to one hour and will be audio-recorded. The interview will be a one-off event and so following this, your participation will be complete; you will not be required to take part in anything further.

You will have the opportunity to ask questions about anything you are unsure of before signing the consent forms to partake in the research. There will be one consent form to take part in the research and another to consent to the interview being audio-recorded.

What are the possible disadvantages and risks of taking part?

We understand that having a space to talk about your experiences could be challenging. The interview questions will not directly ask about information related to difficult or traumatic experiences; however, it may be that this information is brought to mind and/or disclosed. It is important to be reminded that some people find talking about their difficult past experiences distressing, and so this should be taken into account when deciding whether to take part in the research. You will continue to be supported as usual and you will be reminded of who you can speak to at the charity for further support following the interview should you need this.

What are the possible benefits of taking part?

You may find that you benefit from having a space to talk about your experiences in as much detail as you wish, with a Trainee Clinical Psychologist. You will also be partaking in research that aims to learn more about the notion of ‘trauma informed care’ in order to better understand the needs of female survivors of IPV who enter services. By taking part in the interview, you will therefore be contributing to this field of research, which has the potential to broaden awareness and shape services.

What information will be collected?

Demographic information (i.e. age, education, marital status etc.) will be collected, but for your safety and protection all identifiable information will be fully anonymised. This will be done by changing any names given when the interview audio-recording is typed into a transcript; pseudonyms will be used. Other personal details such as locations or descriptions of defining features will be changed or removed. All data will be stored on a secure password-protected hard-drive; all documents will be password-protected and data encrypted. The data will only be accessible to myself (the principal investigator) and my supervisors (Dr Danny Taggart and Dr Kerry Mayers). The transcripts will be held for 5 years for the purposes of writing up an academic journal or practice guidelines. The audio recordings of the interviews will be held for 2 years for examination purposes, after which time they will be erased. Data will be stored in line with GDPR and the Data Controller will be the University of Essex (University Information Assurance Manager: dpo@essex.ac.uk).

Confidentiality will be upheld, unless we have a duty of care to address a safeguarding concern disclosed in the interview, e.g. if there is a chance that you or others are at risk of harm.

What should I do if I want to take part?

If you would like to opt-in to take part in this research, please inform [name], Operations Manager. She will be able to provide you with the consent forms to sign and I will then be in touch to arrange the interview.

Please inform [name] of your decision within 7 days of receiving this information sheet.

What will happen to the results of the research study?

After the interviews are completed, the themes will be analysed and written up to be submitted to the University of Essex to complete the doctoral research assignment. The results may also be written up and published as a journal article in the public domain. Some quotes from the interviews may be included in the write-ups, but all information will be completely anonymised so that no identifiable information (such as names, locations or defining features) is included. Should you wish to be informed of the research outcome after taking part, a report will be shared with [charity name], and you can ask [name] for a copy of this.

Who has reviewed the study?

Ethical approval for the research has been sought from the University of Essex Ethics Committee (ERAMS reference: ETH2021-0865).

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the principal investigator, Georgia Fuller, using the contact details below. If you feel that you cannot approach the principal investigator, please contact the research supervisor, Dr Danny Taggart (details below). If are still concerned or feel your complaint has not been addressed to your satisfaction, please contact the Director of Research for Health and Social Care, Dr Camille Cronin [email address]. If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press [email address]. Please include the ERAMS reference number ETH2021-0865).

Contact details

If you have any further questions or concerns, please contact the researchers:

Principal Investigator: Georgia Fuller	[email address]
Research Supervisor: Dr Danny Taggart	[email address]

Please keep this information safe in case you would like to re-read it at any point.

Participant Information Sheet (v.3) January 2022
ERAMS reference: ETH2021-0865

Appendix C: Consent Form for Participation

Title of the Project: On Becoming Trauma Informed: *Exploring the Narratives of Female Survivors of Intimate Partner Violence*

Principal Investigator: Georgia Fuller

Please write your initials in the box if you agree with each statement:

1. I have read the information given to me about the study and I understand what I am being asked to do. I have had time to think about the task and have been able to ask any questions I had. I am happy with the answers I have received to my questions. ☐

2. I understand that I am a volunteer in the study, which means that I can stop and leave the study at any point. I do not have to give a reason for wanting to leave the study. My care will not be affected if I choose to stop the study. ☐

3. I understand that confidentiality will be maintained at all times and any of my personally identifiable information, such as my name, will be anonymised on the transcript before being stored on a secure password-protected hard-drive. My responses in the study will only be accessed by the research team who are involved in the project. My transcript data will be held for 5 years for the purposes of writing up the research in an academic journal or practice guide. ☐

4. I agree to take part in the above study. ☐

5. I would like to be informed of the outcome of the study and so I consent to being emailed, telephoned, or written to in order to receive this information. ☐

Participant Name Date Participant Signature

Researcher Name Date Researcher Signature

If you have any further questions or concerns, please contact the researchers:

Principal Investigator: Georgia Fuller [email address]
Research Supervisor: Dr Danny Taggart [email address]

Participation Consent form (v.2) February 2022
ERAMS reference: ETH2021-0865

Appendix D: Consent Form for Permission to Audio Record Interviews

Title of the Project: On Becoming Trauma Informed: *Exploring the Narratives of Female Survivors of Intimate Partner Violence*

Primary Researcher: Georgia Fuller

Please write your initials in the box if you agree with each statement:

1. I give my permission to the interview being audio recorded and I understand that the recording will only be used for the purposes of this research including service development. ☐

2. I understand that all of my personal information will be anonymised on the transcript (i.e. names will be changed and other identifiable information, such as locations or defining features, will be removed). The audio recording and the transcript will be stored on a secure password-protected hard-drive. The audio recording will be erased after 2 years, and the transcript will be held for 5 years for the purposes of writing an academic journal or practice guidelines. ☐

3. I understand that I am a volunteer in this study, which means that I have the right to stop my interview and stop the audio-recording at any point during the interview. I am aware that I may withdraw from the study until 7 days after completion of the interview as explained in the Participant Information Sheet. I can ask for the recording to be deleted up until 7 days after completing the interview. I understand that after 7 days post-interview, it will not be possible to withdraw the recording as it will have been typed into a transcript and all identifiable details removed. ☐

Participant Name Date Participant Signature

....

Researcher Name Date Researcher Signature

....

If you have any queries or concerns, please contact the researchers:

Principal Investigator: Georgia Fuller [email address]
Research Supervisor: Dr Danny Taggart [email address]

Consent to Record (v.2) February 2022
ERAMS reference: ETH2021-0865

Appendix E: Interview Topic Guide

On Becoming Trauma Informed: Exploring the Narratives of Female Survivors of Intimate Partner Violence

The interviews will be semi-structured, and a topic guide will be used to facilitate this process. This is common practice in qualitative research in order to guide discussion while remaining flexible in the approach and style in order to enrich data collection (Ritchie & Lewis, 2003).

Research Aim: to explore the experiences of service-users within a charity that supports female survivors of Intimate Partner Violence in order to better understand trauma informed care for this population.

1. Introduction and orientation to research aims
(Recap participant information sheet, aims, right to withdraw – 7 days post-interview & provide date)

2. Demographics
(Age, ethnicity, employment status, level of education, marital status, number of children)

3. Background and contextual information
(Overview of experiences, going into as much circumstantial detail as they wish, i.e. how they came to be under the care of the charity, what happened to them)

4. Comparison of care within different settings
(If no experiences of mental health services, could be another charity, programme or GP. Check-in with Trauma Informed Care '5' – feelings of empowerment, collaboration, safety, trust and choice in relation to their experiences)

5. Discussion around care and meeting needs, feeling heard or held by services
(Thinking about earlier intervention, prevention, access to services and engagement, times when services did or didn't quite get it right)

6. Discussion around help - what has or hasn't been useful to date
(E.g. in relation to past interventions: social, financial, housing, education, employment, therapy etc)

7. Looking to the future
(Hopes for the future, recommendations, areas for development/change in practice)

Ritchie, J., & Lewis, J. (2003). Qualitative research practice: A guide for social science students and researchers. Choice Reviews Online, 41(03), 41-1319-41–1319. https://doi.org/10.5860/CHOICE.41-1319

Appendix F: Post-Interview Diary Reflections

I went into my research interviews with an open mind, not knowing who I would meet, what their individual circumstances may be or how each of their IPV journeys might compare.

In my earlier interviews, I became acutely aware of my position within the research in terms of the commonalities and stark contrasts between the participants and myself. After the first interview, I wrote in my diary the following:

> *When I asked for her marital status and she replied, "single forever", I unintentionally turned my engagement ring around.*

I remember this interview stirring feelings of guilt in me particularly because our ages were so similar and so I reflected more upon my life cycle stage in contrast to hers. I also felt hopeless and powerless to change her traumatic IPV experiences and looking back I recognise these feelings as perhaps countertransference between us in the interview, or that our connection through the sisterhood further increased my sense of injustice when bearing witness to her pain.

The third interview made me reflect on the accumulation of traumatic experiences as there was discussion of adoption, family discord, ill health, miscarriage and ultimately IPV from a very young age. I thought about how often services only get a 'snapshot' of a person, usually just the presenting problem and how this doesn't encapsulate the 'snowballing' of other traumas. This made me think about how important it is that services and professionals invest their efforts in the people and not just the problem or labels, and also afford survivors empowering spaces to be able to consider the meaning of such traumas for themselves. However, I learned that in order to cope, sometimes the ability to talk about the trauma(s) is shut down. In a later interview with another participant, I noted:

> *At the end of the interview, she seemed pleased to have had this space to talk with me. She said she hadn't really wanted to talk and described herself as a 'closed book', particularly after not being believed by her own family regarding her account of IPV.*

It seemed that sometimes shutting down from the painful experiences was countertherapeutic for some of the survivors. In light of the interview space being helpful for some survivors, I began to feel disempowered within my interviewing role, in terms of my limitations as a researcher. This felt wildly different to my position within clinical psychology, whereby I was able to work therapeutically. Here, my role was to ask questions, to listen and to elicit detailed insights. At times, this felt hard to do when I was faced with such emotional intensity and overwhelm from the survivors in response to their traumatic experiences. The role of the researcher at times made me feel helpless to change the narrative for these women and do any more than offer a validating, empathetic ear to hear their stories. Given the nature of the research topic, I was acutely aware of the potential for retraumatisation and vicarious trauma on my part. While I couldn't offer therapy, I feel I upheld my duty of care in order to practice ethically with these women. In doing this, ultimately by maintaining the principles of feminist practice and TIC, I was able to prevent retraumatisation within the research process as well as buffer my own understandable secondary stress. It felt important to me to ensure that the survivors had choice throughout the process and an opportunity to explore how it had felt talking about their IPV experiences in the interview. On completing the interviews, I compassionately reorientated survivors to their day, signposted them to their case workers/peers in the refuge for additional support when needed, reminded them of their right to withdraw and left my contact details for a further opportunity to ask questions. I felt that this afforded each of the women closure from the interview, enabling them to return to their day in a healthy headspace. While this also offered me reassurance of their wellbeing, I found supervision with my thesis supervisor, my university personal tutor and a peer support group (for those researching within the field also) invaluable spaces to help me process the emotional intensity of the interviews and maintain my own wellbeing throughout the research. Working in this way ultimately helped me to overcome the limitations I felt in my research role.

Lastly, I noticed that my choice of pseudonyms for the survivors was an attempt to reconnect them with nature. Being in nature myself has always helped me to feel a greater sense of ease and even healing at times. I subconsciously chose most of the names before realising this connection. Motivated by my initial sense of helplessness, I feel that I was driven to support these women by taking their names back to nature as my restorative and soothing way of helping them amidst their painful IPV journeys.

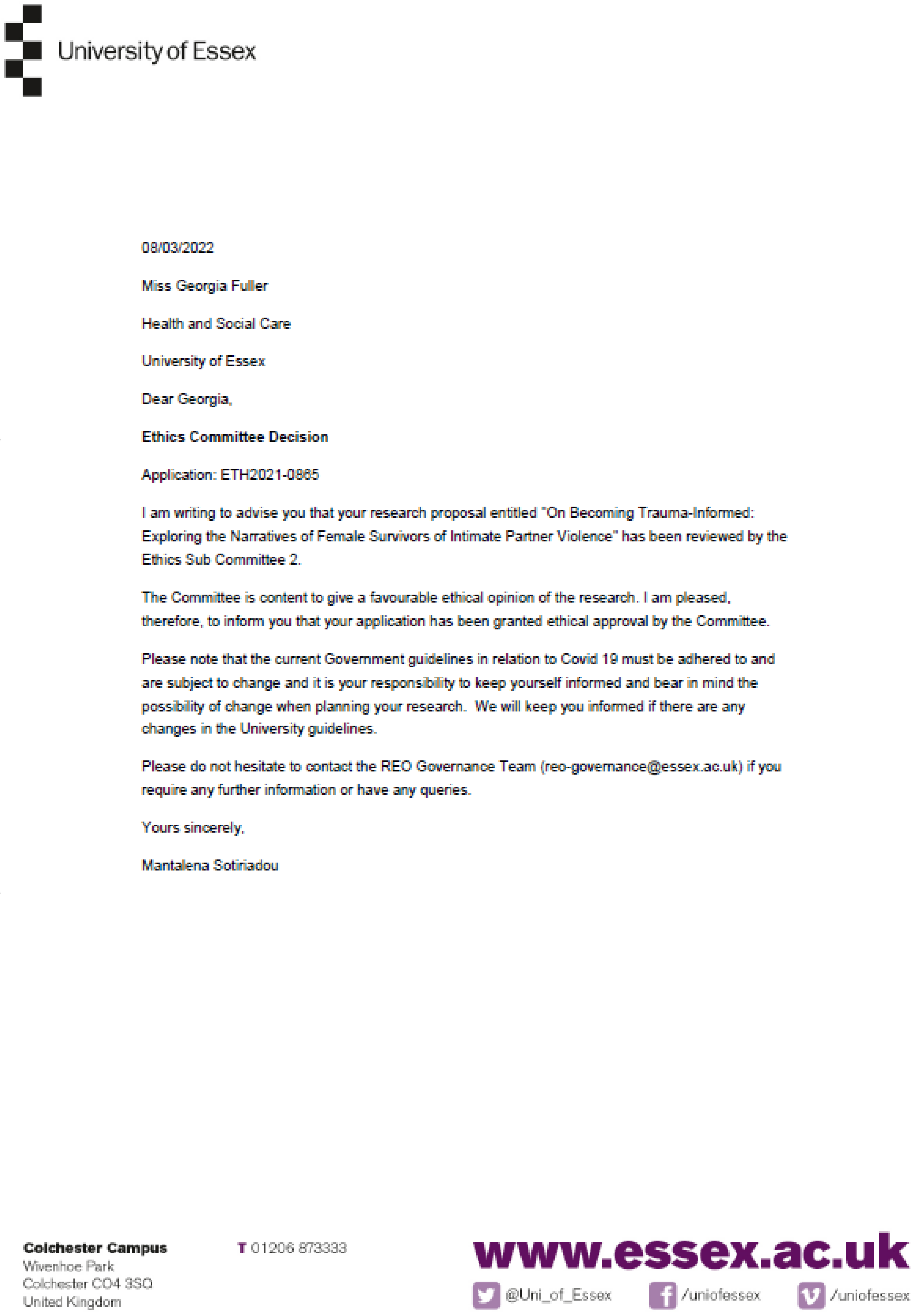
Appendix G: Final Reflections

Throughout this thesis I have worked to consider my own position within the research, and acknowledge my biases; particularly as a woman, I feel unable to present neutrally on the topic of IPV. I joined a peer support group for researchers within the field of sexual violence which helped me to consider my stance further. Starting this research, I felt I was not someone with lived experience of IPV and so I thought about my role as an outsider coming into this field. However, on finishing this research I have contemplated the many relationships I know within my wider systems and through this, I have been able to acknowledge and recognise the narratives that are not so dissimilar from those shared within this research. It has helped me to see that IPV presents on such a broad scale, and I have perhaps come into this research at a more extreme end by interviewing women who have had to flee their former lives to obtain some sense of safety, which could be jeopardised at any time. Their bravery in taking on this research has astounded me, and I hope that this study can highlight the immense courage they have each shown in the face of overwhelming adversity. I have also felt a desire to do justice to these women’s stories, perhaps in the absence of substantial legal justice for the atrocities they have experienced.

I began this process as an advocate for TIC, but I have since learned that becoming trauma informed truly means hearing the stories as told by the survivors, in order to make sense of the complex nature of IPV before attempting to intervene in some way. I have aimed to be aware of my own feelings at every stage of this research. Firstly, in conducting the interviews which I have spoken more about in my post-interview diary reflections (see Appendix F), but secondly, in considering what needs to change. I have felt anger for these women who have been degraded by the police in a busy waiting room, left to wait an entire weekend before being housed, being disbelieved by housing systems who left a heavily pregnant woman to sleep in her car, made to feel dehumanised and victimised … I could go on. I have been incensed and saddened but sometimes not surprised by the stories I heard that depicted women continually being mistreated by the powerful systems that should exist to support them. This has driven me throughout my research to continue holding the microphone for these women to be heard. My reactions within this research may have influenced the analytic frame, for example, in relation to the way in which I closed the interviews from a therapeutic stance, the pseudonyms I chose in order to take the survivors back to nature and towards healing, and the way I held the survivor voice at the heart of the research through keeping their narratives whole during analysis. I have endeavoured to evidence my stance throughout the process for transparency and to use such reflection and critique to mitigate bias.

As refuge is a transient stop-over for many women, with the duration of stay being unpredictable and person-specific, it was not possible to approach the women post-interview to gain their feedback on the study findings. However, all women who consented to take part in the interviews were informed about the findings being disseminated to the Refuge Operations Manager whom they could contact if they wanted to access the findings. The manager expressed her enthusiasm to also be informed of the study outcomes. My hope is that these women felt empowered by the experience of telling their stories in a manner that was cathartic and liberating, and that this study generates further interest in survivor-led research, particularly to explore the needs of more marginalised IPV populations.

Appendix H: University of Essex Ethical Approval



University of Essex

08/03/2022

Miss Georgia Fuller

Health and Social Care

University of Essex

Dear Georgia,

Ethics Committee Decision

Application: ETH2021-0865

I am writing to advise you that your research proposal entitled "On Becoming Trauma-Informed: Exploring the Narratives of Female Survivors of Intimate Partner Violence" has been reviewed by the Ethics Sub Committee 2.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to inform you that your application has been granted ethical approval by the Committee.

Please note that the current Government guidelines in relation to Covid 19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. We will keep you informed if there are any changes in the University guidelines.

Please do not hesitate to contact the REO Governance Team (reo-governance@essex.ac.uk) if you require any further information or have any queries.

Yours sincerely,

Mantalena Sotiriadou

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Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

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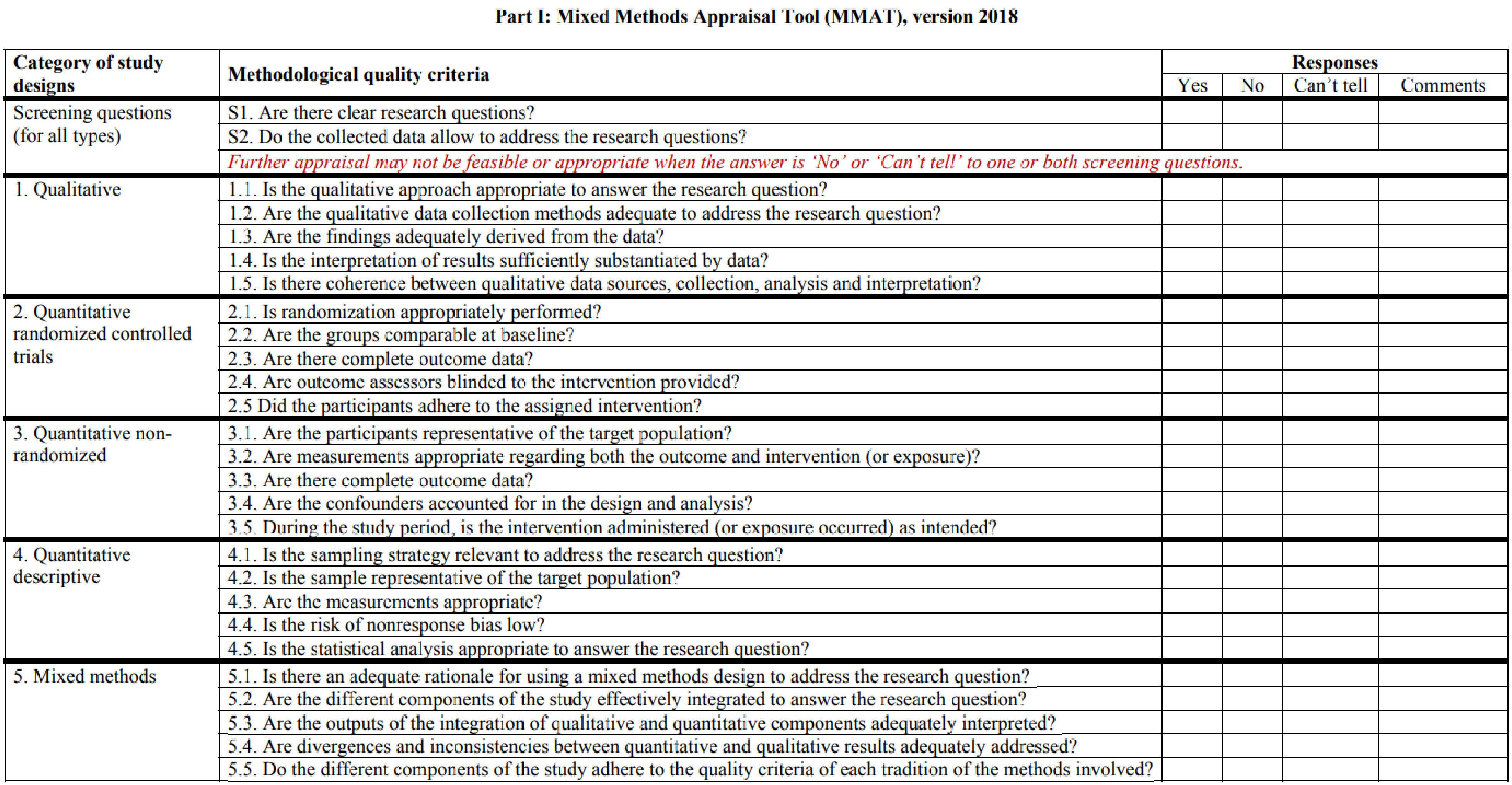
Appendix I: Mixed-Methods Appraisal Tool

(MMAT; Hong et al., 2018)



Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				