A PORTFOLIO ON RECOVERY FROM ABUSE

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Declaration

I confirm that this is all my own work and that there are no potential conflicts of interest with respect to this research. I received no financial support for this research or authoring of this portfolio.

PART A

PREFACE

‘A presentation of the components of the portfolio’

Preface to portfolio

The motivation for this research started with my own experience of finding myself in abusive relationships as an adult. Through many years, which felt like total darkness, I was constantly aware that 'somewhere there was a voice' which needed to be heard: this was, of course, my own voice. This prompted a deeper reflection on why the voice was there, what enabled it to be there, and then what I could do with the voice. These reflections were probably the starting point of a light breaking through the darkness, a potential source of hope, and the start of agentic thinking.

Throughout the relationships, I noticed that I developed my own survival strategies, and that these came from within myself; they were assisted by my increasing knowledge of psychology, and over time, an increasing knowledge about relationship dynamics and therapy. I had my own faith which was always there as a back-drop to my experiences and my own interpretation of these.

Over many years, I realised I had got myself to a place which I could call 'recovery.' This was my own interpretation of recovery, and what it meant to me was that I had got to a place where I had sufficient insight and knowledge to be able to make informed choices, and could take responsibility for my own happiness and well-being: even if I was constrained by the actions of others, I learned that I did not have to be constricted by the beliefs of others, and this empowered me. I believe it empowered me because I was able to develop a true sense of self that was not based on a value placed on me by others. This was not to say that I would never wobble, as the scars run deep, but that I had learned how to increase my resilience, how to keep on picking myself up, to draw on my strong parts, and to care for my weaker parts. I learned to (carefully) start to trust that others, sometimes, might be able to be supportive and caring, and this improved my relational recovery.

Having gone through this journey myself, always continuing, but having covered a lot of ground, I found myself working with complex trauma, notably with victims, and then perpetrators, of abuse. I realised that I was drawn to seeking a cognitive resolution of the traumas which had scarred my own life, that I had a belief that there was a way through, no matter how long it took, and that I had a hope. This prompted my academic enquiry into what was it that contributed to the recovery of those who had experienced abuse, and hence this portfolio of research.

Throughout my own journey, through the course of my professional career, and through the engagement in this research project, I learned that, although I may have a belief in the good, a hope, and a deep care for others, these things cannot be naively waved around, but must be carefully sought out and distinguished from the significant risk which is also present in society. This directed my professional endeavours into working in the Family Courts as an Expert, seeking to identify and bring out the voices of others, identifying the needs and working towards rehabilitation, but simultaneously holding some of the tension between vulnerability and risk management. With a passion for social justice, my current resting place is working with Offender Managers supervising perpetrators of violence and abuse. The final chapter of this research provides a deeper understanding of how I achieved the shift from being a victim myself, working with victims, to working with perpetrators.

This portfolio is made up of three separate, but connected pieces of work: a systematic review, an original piece of research, and an autoethnographic study. The thread throughout this portfolio is recovery from abusive relationships, but specifically looking at the recovery of different client groups.

The systematic review explores the elements which have been shown to be helpful in promoting mental health in emerging adults, both male and female, who have experienced sexual abuse.

The thesis explores the experiential and phenomenological processes involved over time for adult women in the recovery from violence, experienced as both children and as adults.

And finally, the autoethnographic study is concerned with my own lived experience of being in narcissistic relationships, and how this informs my professional practice as a Counselling Psychologist, working with Offender Managers, who supervise offenders with narcissistic presentations, who themselves have been both perpetrators and victims of violence and abuse.

Systematic review

This review answers the question: 'What elements have been shown to be helpful for improving mental health in emerging adults who have experienced sexual abuse?'

It aims to collate and synthesise primary research studies, of sufficient methodological quality, to give a narrative summary of helpful elements. These findings will then be available to clinicians in the field as well as to individuals responsible for service development.

Recent years have seen some of the highest numbers of sexual offences against children reported to the Police in England (NSPCC 2016) in addition to increasing numbers of mental health issues in children, where the main concern has been child sexual abuse. There has also been a rise in the amount of suicidal feelings and suicide rates in young people (NSPCC 2016). This gives an idea of the severity of the problem. However, there is a significant lack of primary research considering how this can be helpfully addressed within the emerging adult population.

The emerging adult population is increasingly being recognised as a new developmental stage (Arnett 2000) as there are distinct differences between adolescents and adults. It covers the age group of 18 – 30 years. This phenomenon of emerging adulthood is only being seen in the Western world and is considered to be attributable to the increasingly complex and technical environment, and the decline in normative structures: this is creating additional challenges for young people growing up.

Society is also increasingly less supportive of this age group (Cote 2002), and families are not always providing the levels of support and guidance required (Schwartz et al 2005). This suggests that this is already a difficult time for young people, however, for those who have also experienced adverse environments, such as sexual abuse, the challenges become manifold (Bynner 2005).

Services have only recently started to recognise that the needs of this client group are inadequately met, and there remains a lack of suitable provision (Allnock et al 2012).

It is for these reasons that this systematic review was considered to be imperative in order to further the understanding of the needs of this client group. By drawing together and providing a narrative of the findings of helpful elements to promote mental health, a knowledge base can be established, for clinicians already involved in service provision, and those responsible for developing it. In this way the needs of this client group can seek to be better served.

Twelve studies were considered suitable for inclusion, and this was determined through the methodological assessment of quality using an established tool developed by Kmet et al (2004). Only those studies which met the minimum threshold of being of a sufficiently high

methodological quality were included in the review. There was a high degree of homogeneity in the samples, including age, gender, and ethnicity.

The themes identified across the all-female samples and the mixed male and female samples were similar. There was one additional theme, self-compassion, noted in the mixed gender samples that was not identified in the all-female samples. Given that this finding included females in the sample it is reasonable to conclude that this was not identified in the all-female sample as a result of methodological variance. In light of this, the findings are considered relevant to both males and females.

The main findings that were considered helpful for improving mental health include the following: active strategies, such as getting involved with activities, using social and emotional support networks, asking for help, expressing emotions, and increasing the use of positive and negative emotional language; reducing avoidant strategies, such as reducing self-destructive behaviours including self-harm and substance abuse, disengagement, and denial.

Additionally, there were both external and internal factors which were found to be helpful. External factors included the following: less trauma and less severe trauma; the passing of time; interpersonal relationships, including parental, paternal, maternal, support from friends and family, peer support, intimate relationships, and relationships with children, as well as having secure attachments. A mediating variable in terms of gaining support from family was emotional dysregulation: the greater the difficulty in managing emotion, the less support was offered by family. It is not clear whether this was explained by the family also having problems with emotional dysregulation or whether the family lacked the skills to effectively provide support. Internal factors included: physical self-efficacy, self-esteem, hope, internal locus of control, greater emotional intelligence, self-compassion, and more spiritual experiences.

The findings were considered within the WHO (2014) definition of mental health. There was one noticeable difference in respect to gender: only the all-female samples identified elements which were helpful in promoting individual potential. This might point to a significant gap in terms of the identified needs for young males.

Thesis

This phenomenological and hermeneutic study seeks to explore the following question: ‘What are the experiential and phenomenological processes over time involved in the recovery from violence against women?’

The aims of this study are to explore the processes that are experienced by the women during the recovery from violence, and the meanings attributable to these, as understood within Van Manen’s (1997) existentials of lived body, lived time, lived space and lived relations. There is also a relational component to the study where the researcher adopts a dual role of practitioner and researcher in her use of self within the research process, using the Rogerian (1951) principles of non-judgmental positive regard, empathy, and congruence. Engaging in this manner, and using her own embodied experiencing as a source of reflection and additional data, offers an opportunity to further understand the role of an enabling relationship. Finally, the study aims to provide a consideration on the potential impact of the findings to Counselling Psychology, women, service development, and wider society.

The thesis starts with a consideration of relevant literature, and the context in which these stories are being told. It considers the use of terminology in respect to violence against women, and how the awareness of the problem has developed over recent years. The six women participants are first mentioned at this point in terms of situating them and their experiences of abuse in the context of attitudes and understanding in society. The purpose of this is to enable

the reader to have an insight into the depth of the need in society, and for the women participants, whilst they were growing up.

Following this, there is a short review of some of the adverse mental health complications arising from violence against women, to enable an understanding of why there is a need to consider this study. This section concludes with a short synopsis of the development of women's refuges in England, giving the reader an idea of some of the implications of having no alternative but to move there in the aftermath of violence. This is important information as this is the natural setting where the study takes place.

The study continues to provide an overview of some of the thinking around engaging with women who have experienced violence, including a critical overview of feminist theory, and provides a theoretical lens through which the findings of this present study will be considered.

In the methods section there is a discussion on the key philosophical influences which underpin this study, including phenomenology, and the use of interpretative phenomenology as analysis. This is then placed in the context of existential phenomenology which provides the framework for analysis and interpretation. The reader is provided with a summary of how the philosophical underpinnings enable the research question to be addressed.

The design of the study is reflectively considered, and the importance of including a relational focus is sought to be understood. This includes an emphasis on the role of the researcher who also adopts a practitioner role, and how the use of self is used as method but also in interpretation.

There are six adult women participants. Throughout the text they are referred to as either participants or 'the women'. The rationale for the interchangeability of these words is to seek to bring to life the experience of humanity within this research process.

The process of data collection and analysis is detailed, using the procedure of interpretative phenomenological analysis as described by Smith et al (2009). This includes the identification of emergent themes from individual transcripts, and the development of high-order themes. There is also notation on the author's own reflective process at various points as this informs the author's understanding of the emerging data, and is synthesized in the interpretation. Examples of process are provided in the text but more detailed results are in the appendices. Full transcripts are not provided due to an agreement with the manager of the refuge to protect the anonymity of the participants and to mitigate against potential future risk to the participants.

The higher order themes were conceptualized under Van Manen's (1997) existentials as master themes, which are as follows:

- Lived body: embodied; disembodied; power and control; active behaviours.
- Lived time: effects of trauma over time; time as waiting; time as persevering; ownership over time.
- Lived space: space as solitary; space as threatened; positive space.
- Lived relations: rejecting relationships; enabling relationships; identity in relationships; spiritual relationships; the research relationship.

All participants endorsed the master themes, but there was some divergence in the higher-order themes, and this is noted.

All of the emergent themes and higher-order themes are developed in the context of data from the women. This allows the reader to get an individual sense of the women but also notice the convergence and divergence of experience. There is a progression through the master themes which is not linear, but has a backwards and forwards motion, as the women are seen to

struggle with the challenge of moving forwards. However, towards the end, there is a notable shift in the women in terms of how they experience their bodies, their sense of time, their perspective on space, and on relations: the women move towards more active behaviours and agentic functioning, with an improved emotional regulation and a more positive sense of identity. The role of spiritual relationships is notable, especially for one woman, and the value of the research relationship for others; an understanding of this is sought.

The interpretation of the findings of this study is written in the first person, but as the unified voice of all the women describing the process of their recovery to date. This has been interpreted by the author from her engagement with the women and her own embodied experiencing of the data as it emerged out of the interpersonal relationship. As such it is acknowledged that it is co-constructed.

The study draws to a close with a reflection on the importance of the richness and depth of these findings, in the context of underpinning philosophies and the background literature, as well as the impact on Counselling Psychology and service provision. It closes with conclusions and final remarks.

Professional practice

This portfolio concludes with an: 'Autoethnography reflecting on working within the sadomasochistic paradigm of narcissism in the offender population.' This piece aims to connect the knowledge from my own lived experience with narcissism, with my reflections of engaging with this in professional practice, and to understand more about how this sits contextually. From the findings, there are several things which are anticipated: that the reader will be able to reflect on some of the processes involved in these complex relationships; that the knowledge base of Counselling Psychology will be informed; that the opportunity for this knowledge to be applied in practice may be further considered.

The personal section starts with a background summary of myself as author, and how I consider the foundations were laid for me to be vulnerable in relationships: this is relevant for the elucidation of the phenomenon of sadomasochistic narcissism. What follows are then excerpts from diary entries written over the years which seek to give a sense of the experience of being exposed to this dynamic, including the adverse effects, the complexity, and the emergence of hope and understanding.

This is then contrasted with the similarities that I noticed whilst supervising staff who work with perpetrators of abuse of this nature. The same processes of being overpowered and 'pushed out of metaphorical space' were noticed in the staff. Engaging with background reading enabled the development of additional understanding from the perspective of others, which served to connect theory to experience and make sense of experience in the context of existing knowledge. Creating and texturizing the understanding of the phenomenon in this manner offered an opportunity to breathe life into the complexity and convolution of these abusive dynamics, and in this way create a possibility for a shift towards democratic relating for both professionals and perpetrators of abuse. In this way, I am seeking to use my own 'voice' and my own self, to engage with academic concepts and professional practice.

References

Allnock D., Radford L., Bunting L., Price A., Morgan-Klein N., Ellis J., and Stafford A. (2012) In demand: therapeutic services for children and young people who have experienced sexual abuse. *Child Abuse Review*, 21, 318-334

Arnett J.J. (2000) Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist,* 55, 469-480

Bynner J.(2005) Rethinking the youth phase of the life-course: the case for emerging adulthood. *Journal of Youth Studies,* 12 (8) Issue 4, 367-384

Cote J.E. (2000) The dangerous myth of emerging adulthood : an evidence-based critique of a flawed developmental theory. *Journal of Applied Developmental Science,* 18 (4) 177-188

Kmet L., Lee R., and Cook L. (2004) *Standard quality assessment criteria for evaluating primary research papers from a variety of fields.* Alberta Heritage Foundation for Medical Research. ISBN (online) 1-896956-79-3

Rogers C.R. (1951) Client-centred therapy. Constable of Constable and Robinson Ltd (2003) eISBN 978-1-78033-706-7

Van Manen, M. (1997). Researching lived experience: Human science for an action sensitive pedagogy (2nd ed.) London, Ontario: The Althouse Press. (Original work published 1990)

WHO (2014) Mental health: a state of well-being. World Health Organisation

PART B

SYSTEMATIC REVIEW

‘What elements have been shown to be helpful for improving mental health in emerging adults who have experienced sexual abuse?’

Research question

What elements have been shown to be helpful for improving mental health in emerging adults who have experienced sexual abuse?

Abstract

There is a dearth of research that has been done to create an understanding and knowledge of the specific needs of emerging adults in relation to improving mental health following sexual abuse: it is increasingly apparent that mental health services are not serving this client group adequately, and families have not kept pace with the changing needs. This systematic review assesses the available evidence to identify elements which have been shown to be helpful for this client group, with a view to pointing the way for additional research and service development.

A systematic search of online academic libraries (Appendix 1) was performed independently by a single reviewer using predefined criteria (Appendix 2). Twelve studies met the selection criteria and were considered for review.

The data showed that there were four main areas which were helpful in promoting mental health, including the following: active strategies; reducing avoidant strategies; internal factors; and external factors.

Active strategies included: getting involved with activities, using social and emotional support networks, asking for help, expressing emotions, engaging in therapy, and making use of more positive and negative language when expressing emotions. Reducing avoidance included reducing the following: self-destructive / self-harm strategies; mental or behavioural disengagement; denial; and substance abuse.

Helpful external factors included: interpersonal relationships and support; secure attachments; having second chances or turning points; education and social role experiences in the workplace or school.

Internal protective factors included: physical self-efficacy, self-esteem, hope, internal locus of control, greater emotional intelligence, and more spiritual experiences. The importance of protective internal factors outweighed that of adversity, rather than the absence of adversity alone. A mediating variable was that emerging adults with emotional dysregulation received less support from families.

These findings were considered within the WHO (2014) definition of mental health. Both male and female samples identified the importance of mental health not just being an absence of disorder, but also being able to work productively, coping with normal stresses and strains, and being able to make a contribution to society. A notable deficit in terms of mental health need was observed in young males who are not achieving their potential.

The findings from this review suggest that providing supportive environments both at home and in education facilities, in the aftermath of child sexual abuse, may contribute to improving mental health in emerging adults. This implies the need for increased understanding for families and academic institutions as well as a commitment to increasing effectiveness. Specifically, promoting interventions that increase approach strategies and reduce avoidance maybe also be helpful, as well as considering how the development of resiliency and internal strengths can be fostered. The need, particularly for young males who are not achieving their potential, needs to be further explored through research, including the impact of this, not just on mental health but on wider society, and whether there are any connections with emotional

dysregulation. It is suggested that future research has an emphasis on how this knowledge could be used to bring about social change.

Introduction

Aims

The aim of this review was to collate primary research which focussed on identifying elements which have been shown to be helpful for improving mental health in emerging adults in the Western World who have experienced childhood sexual abuse.

Definitions

The World Health Organisation, (WHO 2014), defines mental health in the following way: 'Mental health is not just the absence of mental disorder. It is defined as a state of health in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'

The WHO (1999) defines child sexual abuse (CSA) as: 'the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.'

A majority of experts in the field agree that sexual abuse includes both contact (actual physical contact) and non-contact forms (e.g. exhibitionism, verbal sexual harassment) (Finkelhor 2009), and this is also supported by the WHO (1999).

Objectives

The objectives of this review were two-fold: firstly, to build the knowledge base of counselling psychology around understanding the specific needs of the client group between the ages of 18 and 30 years who have experienced childhood sexual abuse; and secondly, to make recommendations for service development based on empirical findings.

Rationale for Review

The WHO (2014) definition of mental health is used for the purpose of this review, noting that it is greater than merely the absence of mental disorder. However, there is considerable individual psychopathology related to CSA, with an elevated risk for most disorders, including post-traumatic stress disorder (PTSD), depression, anxiety, low self-esteem, obsessive disorders, dissociative disorders, substance disorder, personality disorder, and self-destructive behaviours, to name but a few (e.g. Kendler et al (2000), Nelson et al (2002), Simpson and Miller (2002) Levine et al (2017), Messman-Moore and Bhuptani (2017)).

The National Society for the Prevention of Cruelty to Children (NSPCC 2016) provides robust and up to date statistics on child protection issues in the UK. Chief Executive Peter Wanless reports that 2014/15 saw the highest number of sexual offences against children reported to Police over the past 10 years: there were 39,388 recorded offences in England of sexual activity involving a child under the age of 18, a rate of 3.4 sexual offences per 1000 children (NSPCC 2016). It is likely that increased reporting and recording have contributed to this rise, however there still remains an unquantifiable number of un-reported cases.

2015/16 also saw a 49% increase in referrals to the NSPCC about mental health issues in children, and 10,067 counselling sessions were carried out by the NSPCC where the main

concern was sexual abuse, including on-line sexual abuse. 2016 also saw a rise in the amount of low mood, suicidal feelings as well as suicide rates in young people (NSPCC 2016).

This data demonstrates something of the extent of the prevalence of childhood sexual abuse in England, and given the correlation between CSA and psychopathology, the impact on the NHS and other Public Services cannot be ignored. Allnock et al (2012) identified that the level of specialist provision is low compared with the demand for services, with less than one service available per 10,000 children in the UK. Findings from services demonstrate that the demand exceeds the resources, with limited referral routes, significant waiting lists meaning that services have to respond reactively rather than preventatively, and that services are even less accessible for sexually abused teenagers.

These problems highlight not only the great need to increase our understanding about why sexual abuse takes place in the first place, and how services can work together to prevent this, but it also points to a clear need to better understand what best helps those who have experienced sexual abuse, in order to provide a solid evidence base for commissioners of future services, so that these needs can be met. This is particularly important for young people transitioning out of childhood services such as Child and Adolescent Mental Health Services (CAMHS) into Adult Mental Health Services (AMHS), as well as young people first presenting to Adult Services, as they may well have not been able to gain access to relevant support and services during their childhood years, (Allnock et al 2012).

Scoping searches for this review identified a paucity of evidence specifically pertaining to persons aged between 18 and 30 years of age who have experienced CSA, and the rationale supporting the consideration of this as a separate developmental stage is increasingly apparent. Zacares, Serra and Torres (2015) observe that whereas the 20th century introduced the concept of adolescence, the 21st century has marked the start of a new developmental period known as 'emerging adulthood.'

It was Arnett (2000) who suggested this term 'emerging adulthood' and used it to describe the period from the late teens to the mid to late twenties. Arnett (2004, 2011) observed distinct differences during this time as compared with adolescence and adulthood. These differences centre around 'feeling in between two stages' where there are distinct features which neither specifically pertain to childhood or adulthood.

Arnett (2000) talks about the increasing demands this age group are facing, where they are required to develop greater resources to adapt to the increasingly complex and technical environment, which is challenging and has many uncertainties. The developmental outcomes at this stage are associated with educational attainment, employment, being self-sustaining, and starting a family (Shanahan 2000). Whereas events such as employment and marriage were previously normatively structured, it is now increasingly left to individuals to make their own choices, and to take the responsibilities for these choices (Beck 1992).

Schwartz et al (2005) point out that identity issues are prominent during this transition period: if emerging adults need to progress towards enduring life commitments whether in study, work or relationships, they first need to work through the task of forming a stable and viable identity that will support these commitments. Cote (2000) stated that agentic functioning is an important part in individualised identity development, where the young person can draw on positive self-concept, and the ability to cope effectively, and thus successfully adapt to emerging adulthood in post industrialised societies.

Cote (2002) also observes that society is increasingly less supportive of adolescents and young adults. Schwartz et al (2005) note that the lack of external guidance and support, both from family and society, is impacting on the identity formation in emerging adults.

Experiences of high-risk environments and adverse situations in childhood, such as CSA, only serve to increase the challenges that these young people face (Bynner 2005). Southerland et al (2009) emphasise that the functional demands of this transition stage put those who have experienced abuse or neglect in an extremely vulnerable position: there are many risks associated not only with the developmental challenges but there is also an increased likelihood that the young person cannot turn to the family for support.

Where there is a lack of family and/or social support, there is a decrease in the chances of the emerging adult being able to engage in educational and employment opportunities (Keller et al 2007), whether this is due to reduced opportunities on offer which are able to consider the additional needs of these individuals, or an inability of these individuals to make use of the opportunities.

Clark et al (2008) say that it is only now that mental health services are beginning to realise that the needs of this client group are being inadequately met, and four years later Allnock et al (2012) note that there is still a significant lack of provision for children and adolescents coming out of childhood sexual abuse, suggesting that emerging adults may be presenting at adult services not having received intervention or support from families, society, or services.

It is apparent from these preliminary searches that the prevalence and issues surrounding childhood sexual abuse continue to present a significant problem both for individuals, and within society, and indeed the need for a comprehensive public health approach is being called for (Letourneau et al 2014); additionally, there is a need to consider the age group between 18 and 30 years of age as a separate developmental stage: the needs of this group are changing and services, families, and society have not yet adapted to these changing needs.

In light of this context, this present review seeks to answer the following research question:

'What elements have been shown to be helpful for improving mental health in emerging adults who have experienced sexual abuse?'

Methods: development of the review question

Topic area

The review question was prompted by an identified service need within Adult Mental Health Services (AMHS) where the author worked as Principal Counselling Psychologist. There were increasing numbers of young adults transitioning from Child and Adolescent Mental Health Services (CAMHS) presenting with histories of sexual abuse. The first question arising out of this situation was whether these young people could 'fit into' the therapeutic options already existing in the service. At that time, these included: Dialectical Behaviour Therapy (DBT) or Mentalisation Based Therapy (MBT) for Emotionally Unstable Personality Disorders (many of whom had histories of sexual abuse), or individual trauma therapy in the form of Eye Movement Desensitisation and Reprocessing (EMDR), or Trauma-focussed Cognitive Behavioural Therapy (Tf-CBT). This primary question prompted the exploration of the most helpful way forwards for these young adults.

Scoping searches

According to guidelines developed by Boland et al (2014) in respect to carrying out a systematic review, the author engaged in scoping searches. Through these early searches, the available relevant evidence it was sought to be mapped. The function of this was firstly to identify the need for the review, but also to develop the scope of the review.

The NICE guidance (2016) for young people transitioning from children to adult services, holds the overarching principle of involving young people and their carers in 'service design, delivery and evaluation' in respect to transition between services, and to ensure that transition support is 'developmentally appropriate' taking into account their specific abilities and strengths, and with a focus on building independence. This suggested that a more tailored intervention would be recommended, one that could understand not just the specific needs of young people transitioning into the adult service, but also the specific developmental needs of this age group as well as their psychopathology, and for the purpose of this review, those who were presenting with histories of sexual abuse. This raised the question of what this service might look like, and therefore what young people were already finding helpful following sexual abuse.

There was a range of evidence of the importance of working with this age group as a separate developmental stage (Arnett 2000, 2004, 2011; Shanahan 2000), extending up to the ages of 25 years in some studies, and 30 in others, which suggested the importance of considering the needs of the whole group ranging from 18 to 30 years of age.

There was considerable evidence around the adverse impact of CSA on mental health, both in children and adult populations (e.g. Kendler et al (2000), Nelson et al (2002), Simpson and Miller (2002) Levine et al (2017), Messman-Moore and Bhuptani (2017)), but only a few studies focussing specifically on this developmental stage and the impact of CSA. A lack of cohesion and clarity between these studies meant that it was difficult to consider how services and other support might best be provided in light of the evidence.

Defining the scope of my review

Initially the research question focussed on 'interventions', but this was too broad as it also included physical interventions relating to abuse; however, reducing it down to 'psychological interventions' suggested not only a 'do-to' model, but ruled out other possible factors such as individual strengths and abilities, and social contributions: the NICE guidance was pointing to the importance of collaborative engagement so my thinking moved away from traditional psychological interventions.

The research question was thus developed with the use of the words 'elements that have been shown to be helpful' as this enabled the inclusion of external and internal factors, and in this way offered the opportunity to consider outside help and influence but also internal strengths and abilities. The question would also enable the identification of any specific interventions that had been evaluated, and a description of the designs of these studies. Enabling the inclusion of all of these aspects ensured that the research question would be both answerable and relevant.

An adapted Population, Intervention, Comparator and Outcome (PICO) table as described by Boland et al (2014) was used, including the additional sections of Setting and Study Design.

Table 1. PICO Table to demonstrate inclusion criteria

Review question	'What elements have been shown to be helpful for improving mental health in emerging adults who have experienced sexual abuse?'
Population	Young adults aged between 18-30 years. The study had to be focussing on age 18 and above, not including the adolescent phase up to 18, and not reflecting the whole adult age group. Specifically, the study had to include an upper age limit of between 25 and 30 years.

Intervention	This was understood as 'helpful element" and could include: External • something provided by another to the individual • a circumstance or situation • identifying something as 'helpful' may include considering what is 'unhelpful' Internal • something engaged in by the individual e.g. a behaviour, whether conscious or unconscious • a property of the individual e.g. a personality trait or disposition, a strength or ability
Comparator	Elements were not being compared with each other
Outcomes	Improving mental health as measured by any objective clinical outcome measure, and / or any subjective outcome measure whether by quantitative, or thematic or other qualitative data collection methods; and / or reducing psychopathology and morbidity in relation to childhood sexual abuse.
Setting	The Western World
Study Design	All

Search terms

Search terms arose out of the scoping searches and background reading and are detailed below. All articles were required to be published in English, and to be scholarly and peer-reviewed. They were specifically identified within the discipline of Psychology. The date range was all-inclusive to ensure that all relevant material was identified. Searches extending beyond the library's collection were also included.

Search terms included various combinations of: young adults; emerging adults; transitioning adults; child sexual abuse; recovery; protective factors; strategies; resilience; improving mental health; promoting mental health; coping; coping styles; adjustment; support; intervention. Exclusions included: adolescents; learning disabilities; psychosis; physical health; drugs / alcohol; suicidal behaviour; self-harm.

Inclusion criteria

Studies were included if they met the following criteria:

- They focussed on primary outcomes.
- They focussed on an element which impacted mental health either positively or negatively.
- Evaluations of the element could be quantitative, qualitative, or mixed method.

- They specified that mental health was impacted either positively or negatively.
- The study focussed at least in part on the transition period into adulthood between the ages of 18 and 30 and this was specified.
- The exclusion criteria applied.
- The studies were in English.
- The focus was the Western World.
- The studies were peer and scholarly reviewed.
- All date ranges.
- They met the minimum threshold of 70% in terms of the assessment of methodological quality according to the criteria established by Kmet et al (2004) (Appendix 3).

Exclusion criteria

Studies were excluded if any of the following applied:

- Participants had significant intellectual learning difficulties or disabilities, as it was held that their developmental needs would differ.
- Participants had active suicidal ideation as this would indicate a need to manage the risk.
- Participants had addiction to substances that presented as a primary problem.
- Participants had psychosis that presented as a primary problem.
- The study did not specify the trauma to include sexual abuse.
- Participants were outside of the age bracket 18-30.
- The study focussed on adolescence including aged 18.
- The study focussed on the general adult population.
- The study did not consider the impact of the element on health either positively or negatively.
- The study did not meet the minimum threshold of methodological quality as determined by Kmet et al (2004) (Appendix 3).

Study selection

Two methods were used to obtain relevant studies: 47 databases (Appendix 1) were searched by means of two on-line libraries extending to other on-line sources outside of these libraries; manual searching of the reference lists of selected studies.

The databases were used to access titles and abstracts under the search terms, to which the inclusion and exclusion criteria were applied, and to retrieve full articles as appropriate. It was not always clear that the full criteria were met by reading the title and abstract only, so the full article was read to determine eligibility. The inclusion and exclusion criteria were applied to all full texts retrieved. All studies were selected by the author of this review.

Data extraction

This systematic review partly fulfils the submission requirements for the qualification of Doctorate in Psychology: due to the parameters imposed by this, the author is the sole researcher.

The following data was systematically extracted from the articles which met eligibility criteria:

- Study, year, and country
- Aim of the study
- Sample group
- Design
- Data collection and analysis
- Results and conclusions

Method of quality assessment

An existing, validated tool, the 'QualSyst' (Kmet et al 2004) was used to determine quality assessment of the studies selected for inclusion: the 'QualSyst' is a standard quality assessment criteria for evaluating primary research papers from a variety of fields, and was developed as a response to a gap in the literature for a standard criteria which could simultaneously appraise the quality of a range of studies with different methodologies, with a view to extending the ability of researchers to conduct critical appraisals more effectively. Systematic review methodology has predominantly focused on collating and synthesising findings from randomised controlled trials (RCTs), (Hawker et al 2002); whereas RCTs can provide good information on differential effectiveness, limiting this review to RCT's would have missed the other evidence available for appraisal.

The QualSyst comprises a 10-item questionnaire for qualitative studies and a 14-item questionnaire for quantitative studies (Appendix 3) and the combination of both scales is used for mixed-method studies.

The scoring draws on the tools developed by Cho and Bero (1994) and Timmer et al (2003) for quantitative studies, and uses the guidelines by Mays and Pope (2000) and Popay et al (1998) for the appraisal of qualitative studies.

The questions relate to the extent that the study under scrutiny has characteristics relating to quality: reporting, internal validity, and external validity. Scores for each question are as follows: fully including the quality indicator (score of 2), partially including the quality indicator (score of 1), or not including the quality indicator (score of 0). Each study then achieves a total score which is reported as a percentage of the total potential score. The average quality is indicated by a percentage greater than 50, and a high quality is indicated by a percentage greater than 70. Only studies scoring greater than 70% were accepted for this review.

Data synthesis and analysis

The data was synthesised using a narrative approach as developed by Popay et al (2006), designed to be used for the synthesis of findings from multiple studies. Undertaking a narrative synthesis can be helpful prior to determining whether other methods are appropriate at a later stage, (NHS Centre for reviews and dissemination 2001), as well as explaining and summarising the findings of studies using a textual approach, (Popay et al 2006).

To date, narrative synthesis has not been based on reliable methods which have been tried and tested. The Cochrane Collaboration (established 1993), an independent organisation committed to promoting the search for evidence, points out that there is a possibility that the use of narrative synthesis in systematic reviews can be open to bias and thus can result in unsubstantiated conclusions. It was to this end that the guidance by Popay et al (2006) was developed, in order to describe some specific tools and techniques which can be used.

Their focus is on the synthesis of research, addressing the effects of interventions and the implementation of interventions, that have been shown to be effective in experimental settings (Popay et al 2006). Due to the lack of studies providing and measuring interventions with this client group, a narrative synthesis is being created here in order to guide the development of further research questions in this area. As such, it is a simple collation of findings from the studies which have been included in the review.

Popay et al (2006) identify four stages as a framework for conducting narrative synthesis:

1. Developing a theory of what it is that works, why, and for whom.
2. Developing a preliminary synthesis of the findings.
3. Exploring relationships within and between studies and themes.
4. Assessing the robustness of the synthesis.

It is understood that this is an iterative process rather than a linear one.

Results

Process of study inclusion and exclusion

A total of 205 studies were identified electronically. From this, 17 were identified as suitable by extract qualifying for full text review. Five duplicates were removed. A total of 12 articles met all inclusion criteria. Hand searching of reference lists from the 12 selected articles identified no further studies.

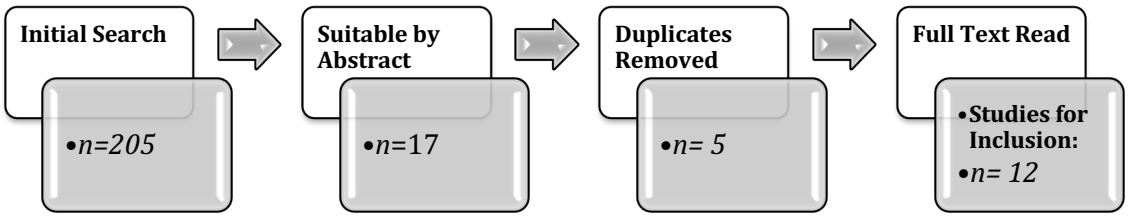

Fig. 1 Search strategy flow diagram

The 12 papers comprised quantitative studies (*n*=11), and mixed method studies (*n*=1). No qualitative studies were identified. The 12 papers included samples from 3 countries: 10 were from the US, 1 from Canada, and 1 from Spain. Gender and age were reported in all of these studies. The mean age across the studies was 19.9 years. 5 were female only, and 7 were mixed male and female samples, however, one of the mixed male and female studies was only able to analyse the female sample due to insufficient numbers of males who had experienced CSA, so this was effectively a sixth all-female sample.

Due to a word limitation in this assignment the search output is detailed in Appendix 4.

Methodological quality

Methodological quality, as measured by the QualSyst tool (Kmet, Lee and Cook 2004), was met by all included studies, each obtaining a score greater than 70, indicating that all papers were of a high quality.

Narrative synthesis - Stage 1 'What is it that helps and for whom?'

From the search output (Appendix 4) the key data in terms of content was summarised in the table below, and its effect on mental health noted.

Table 2. Table to show 'what is it that helps and for whom?'

ALL-FEMALE SAMPLES

Textual description of helpful elements	Impact on mental health
Scarpa et al (2009): less trauma, less severity of the abuse, reducing self-harm, managing anxiety, and reducing avoidance	Reduced experience of trauma psychopathology
Guelzow et al (2003): getting involved with campus activities (either at college or school) mediated by paternal support through the use of emotion-focussed coping (reducing the intensity of distressing emotions caused)	Increased self-worth
Merrill et al (2001): reducing self-destructive coping strategies and avoidance	Improved adjustment
Merrill et al (2001): less trauma, and parental support (but not if the parent was the abuser), mediated by constructive coping	Longer-term functioning
Lam and Grossman (1997): the greater number of mediating variables which were present in the individual. These mediating variables included: physical self-efficacy; self-esteem; hope; internal locus of control; socially-supportive behaviours; and an active strategy of tending to use social support networks; some of these variables also included external factors such as: parental bonding; maternal bonding; paternal bonding; secure attachment; perceived support from friends and family	Greater long-term functioning, correlated with reduced depression, reduced frequency of distress, and improved social adjustment.
Banyard and Williams (2006): resilience is stable over time. High resilience scores	Protective factors against mental health pathology. More positive and active coping later in life, giving rise to increased life and role satisfaction.
Banyard and Williams (2006): turning points or 'second chances'	Positive growth and change
Banyard and Williams (2006): relationships with others, including connections to children	Increased motivation to make positive changes

Schilling et al (2007): social role experiences: status and experience in school, work, and intimate partner relationships. Most important was having a supportive intimate relationship, over and above the school and work experiences - the ability to forge ties	Reduced the experience of a depressed mood and acting as a coping resource
Schilling et al (2007): education	Facilitating transition into adult roles including employment opportunities

MIXED MALE AND FEMALE SAMPLES

Textual description of helpful elements	**Impact on mental well being**
Haden et al (2006): perceived greater friend and family support, and use of active coping styles: using emotional and social support, expressing emotions, asking for help. Reducing avoidance, including mental and behavioural disengagement, denial, and substance abuse	Lower levels of trauma psychopathology
Haden et al (2006): increased length of time since the abuse	Reduced distress
Howell and Miller-Graff (2014): power from protective factors outweighed that of adversity and psychopathology rather than the absence of psychopathology alone	Greater resilience
Howell and Miller-Graff (2014): more frequent spiritual experiences and greater emotional intelligence	Increased resilience
Howell and Miller-Graff (2014): greater current social support from peers	Increased resilience
Barnes et al (2016): increased number of victimisations linked to reduced support from family and friends. In part, emotional dysregulation during the emerging adulthood years was significantly related to less support from family, but not friends. Managing emotional dysregulation.	Linked to increased support from family.
Tanaka et al (2011): increasing self-compassion	Linked with reducing anxiety and depression symptoms, problem drinking, and suicide attempts

Canton and Canton (2010): reducing avoidance strategies particularly in intra-familial and / or continued abuse victims. Engagement in therapy to develop effective approach strategies.	Reduced trauma pathology
Wardecker et al (2017): simply talking about the abuse experiences is less important than the language used:	
• Using more positive emotional language with severe abuse	• Significantly reduces psychological distress and depression, and less emotional and behavioural problems reported by care givers
• More use of negative emotional language	• Less reports of PTSD, (but increased reports by care givers of emotional and behavioural problems)

Narrative synthesis - Stage 2: Preliminary synthesis: thematic clusters

ALL-FEMALE SAMPLES

There were several thematic clusters in relation to the all-female groups which was identified from the information available:

Active strategies

Two studies (Guelzow et al (2003); Lam and Grossman 1997) reported that active involvement either with activities or being pro-social with others, and using social support networks, all had positive effects on mental health.

Reducing avoidant strategies

Two studies (Scarpa et al 2009); Merrill et al (2001) reported on the importance of addressing self-destructive strategies and avoidance, which had results in less trauma pathology and improved adjustment.

Internal factors

Two studies referred to internal resources, Lam and Grossman (1997) noted that physical self-efficacy, self-esteem, hope, and an internal locus of control were linked with greater long-term functioning, reduced depression, reduced distress and improved social adjustment, and Banyard and Williams (2006) noted that resiliency was stable over time; having high resiliency scores were protective factors against mental health pathology, with more positive and active coping later in life, giving rise to improved life and role satisfaction.

External factors

Five studies referred to external factors as contributing to mental health.

Two studies (Scarpa et al 2009 and Merrill et al 2001) noted that less trauma and less severe trauma were associated with reduced psychopathology and improved longer term functioning.

Four studies referred to the importance of support and relationships with others: Merrill et al (2001) noted that parental support improved longer term functioning; Lam and Grossman (1997) noted parental bonding, paternal and maternal support, secure attachment, and support from friends and family improved longer term functioning, reduced depression, reduced frequency of distress, and improved social adjustment; Banyard and Williams (2006) found that relationships with others, including children, was linked with an increased motivation to make positive changes; and Schilling et al (2007) noted that having a supportive, intimate relationship, and being able to forge ties, was more important than school or work connections, and that this contributed to the reduction of depression, and was also a coping resource .

One study (Schilling et al 2007) noted the importance of social role experiences, including the status and experience in school or work, and that these contributed to a reduction in depression.

One study (Banyard and Williams 2006) found that having second chances or turning points led to positive growth and change, and another study, (Schilling et al 2007) noted the importance of education in facilitating transition into adult roles, including employment opportunities.

Mediating variables

Guelzow et al (2003) emphasised the importance of paternal support with the mediating variable of managing distressing emotion.

MALE AND FEMALE SAMPLES

There were several thematic clusters in relation to the mixed male and female groups which were identified from the information available:

Active strategies

Three studies reported on the use of active strategies. Haden et al (2006) noted that making use of emotional and social support, asking for help, and expressing emotions, were linked with lower levels of trauma psychopathology. This is supported by Canton and Canton (2010) who noted that engagement in therapy to develop effective approach strategies led to a reduction in trauma pathology. However, this is qualified by Wardecker et al (2017) who say that simply talking about the abuse is less important than the language used: using more positive emotional language with severe abuse significantly reduces psychological distress and depression, and there are less emotional and behavioural problems reported by care givers; more use of negative emotional language is linked to less reports of PTSD, (but increased reports by care givers of emotional and behavioural problems).

Reducing avoidant strategies

Two studies (Haden et al 2006; Canton and Canton 2010) emphasised the importance of reducing avoidant behaviour and that this was linked with reduced trauma pathology. Haden et al (2006) noted that avoidance could be mental or behavioural disengagement, denial, or substance abuse, and Canton and Canton (2010) noted this was particularly helpful where there was intra-familial abuse and / or continued abuse.

Internal factors

Howell and Miller-Graff (2014) were the only ones reporting on internal factors, noting that the power from protective factors, of note more frequent spiritual experiences and greater

emotional intelligence, outweighed that of adversity and psychopathology rather than the absence of psychopathology alone, and led to increased resilience.

External factors

Four studies made reference to external elements:

Haden et al (2006) observed that an increased length of time since the abuse had occurred, led to overall reduced distress.

Three studies referred to interpersonal support: Haden et al (2006) noted that perceived greater friend and family support resulted in lower levels of trauma psychopathology; Howell and Miller-Graff (2014) noted that greater current social support from peers led to an increase in resilience, however Barnes et al (2016) noted that increased number of victimisations linked to reduced support from family and friends.

Mediating variables

Barnes et al (2016) observed the mediating variable of emotion, noting that emotional dysregulation during the emerging adulthood years was significantly related to less support from family, but not friends: managing emotional dysregulation was linked to increased support from family.

Self-compassion

Tanaka et al (2011) observed that increasing self-compassion was linked with a reduction in anxiety and depression symptoms, problem drinking, and suicide attempts.

Impact on mental health

The outcomes from all the studies were able to be understood in the context of the WHO (2014) definition for mental health. The genders for the samples are noted in parenthesis.

Table 3. Table to show the outcomes from all studies in the context of the WHO (2014) definition for mental health

'Mental health is not just the absence of mental disorder	Reduced experience of trauma psychopathology Scarpa et al (2009) (all female) Lower levels of trauma psychopathology Haden et al (2006)(male/female) Reduced trauma pathology Canton and Canton (2010) (male/female) Less reports of PTSD Wardecker et al (2017) (male/female) Protective factors against mental health pathology Banyard and Williams (2006) (all female)

	Reduced the experience of a depressed mood Schilling et al (2007) (all female) Reduced depression Lam and Grossman (1997) (all female) Linked with reducing anxiety and depression symptoms Tanaka et al (2011) (male/female) Reduced psychological distress and depression Wardecker et al (2017) (male/female)
It is defined as a state of health in which every individual realises his or her own potential,	Increased self-worth Guelzow et al (2003) (all female) More positive and active coping later in life, giving rise to increased life and role satisfaction Banyard and Williams (2006) (all female) Positive growth and change Banyard and Williams (2006) (all female) Increased motivation to make positive changes Banyard and Williams (2006) (all female)
can cope with the normal stresses of life, can work productively and fruitfully,	Improved social adjustment Lam and Grossman (1997) (all female) Improved adjustment Merrill et al (2001) (all female) Longer-term functioning Merrill et al (2001) (all female) Greater long-term functioning Lam and Grossman (1997) (all female) Greater resilience Howell and Miller-Graff (2014) (male/female) Increased resilience Howell and Miller-Graff (2014) (male/female) Increased resilience Howell and Miller-Graff (2014) (male/female)
and is able to make a contribution to her or his community.'	Less emotional and behavioural problems Wardecker et al (2017) (male/female) Less problem drinking, and suicide attempts Tanaka et al (2011) (male/female)

	Facilitating transition into adult roles including employment opportunities Schilling et al (2007) (all female)

Narrative synthesis - Stage 3 Exploring relationships in the data

There is a high degree of heterogeneity in the samples, including age, gender, ethnicity, and methods which has implications in terms of generalisability of findings to similar populations.

Ten studies were from the United States, one from Canada and one from Spain. Both North America (Canada and the United States) and Western Europe (Spain), all of which are considered to be developed, capitalist and industrial countries; eight samples were undergraduate college students or high-school seniors or navy recruits, so still engaged in a training program. There were equal numbers of all-female samples and mixed male and female samples. There were no all-male samples likely attributable to the lower incidence of CSA is males. All the studies were quantitative except one which was mixed method.

The themes identified across the all-female samples and the mixed male and female samples were similar, with the exception of self-compassion, which was not picked up in the all-female samples.

Active strategies

Five of the total number of studies supported the use of active strategies reporting their benefit on mental health, notably reducing trauma psychopathology. Active strategies included: getting involved with activities, using social and emotional support networks, asking for help, expressing emotions, engaging in therapy, and making use of more positive and negative language when expressing emotions.

Reducing avoidant strategies

Four of the total number of studies noted the importance of reducing avoidance, and this had a positive impact on adjustment, and reduced trauma pathology. Avoidance could be in the form of: self-destructive / self-harm behaviours, mental or behavioural disengagement, denial, or substance abuse. This was particularly helpful in intra-familial abuse and / or continued abuse.

Internal factors

Three of the total number of studies referred to internal factors. The importance of protective internal factors outweighed that of adversity rather than the absence of adversity alone, and led to increased resilience, which in turn was protective against mental health problems. Internal protective factors included: physical self-efficacy, self-esteem, hope, internal locus of control, greater emotional intelligence, and more spiritual experiences.

External factors

Nine of the total number of studies referred to external factors which improved an aspect of mental health: having less trauma and less severe trauma was referenced on two counts; the natural process of time, the shorter the duration the less distress was experienced, was referenced on one count.

There were seven studies which stressed the importance of interpersonal relationships and support. This support included: parental, paternal, maternal, secure attachments, support from friends and family, peer support, intimate relationships, and relationships with children.

Having second chances or turning points, the importance of education, and social role experiences in the workplace or school, were only noted in one all-female sample. This does not mean that these factors are not important to men, it might be that they have not been tested on male samples.

Mediating variables

One study from an all-female sample (Guelzow et al 2003) and one from a mixed male and female sample (Barnes et al 2016) both noted that the ability to manage distressing emotions or emotional dysregulation was important; the all-female sample noted that when the father enabled the processing of distressing emotions there was an improvement in self-worth, and the mixed male-female sample noted that when the individual was emotionally dysregulated there was less support from family, but not peers.

Self-compassion

This was identified in one mixed male and female sample, suggesting it is of benefit to both groups.

Reflection

Table 3 considers the findings in the context of the WHO (2014) definition of mental health. Given the breadth of the definition, it can be seen that there are multiple factors involved in order to fulfil this definition of mental health, which suggests a need to employ composite strategies.

There were no studies that included males in the sample which identified what may contribute to the component part of the WHO (2014) definition: 'a state of health in which every individual realises his or her own potential.' This could be interpreted as an area of need.

Assessing the robustness of the synthesis

All the studies included in this review were of good methodological quality as determined by the QualSyst (Kmet et al 2004).

The strength of the evidence was determined by the number of counts each element received in the studies:

The strongest evidence pointed to the importance of external factors, particularly interpersonal relationships and support. Increasing active strategies and reducing avoidant strategies were of similar weighting, with internal strategies receiving the least amount of counts. However, care must be taken to not draw conclusions from this due to the limited amount of studies available, and the closed nature of many of the research questions, where the researchers set out to test certain variables. As such, generalisations should not be made from these findings, but they do point to a need for more exploratory studies to specifically assess how the composite factors that have been shown to improve mental health could be further tested and developed, and incorporated into service planning.

Discussion

The impact of childhood sexual abuse poses challenges to both male and female emerging adults in all areas of mental health, and services are not meeting the level of demand. This comes at a time when these young people are already challenged by their transition into adulthood, with its new and changing demands as a result of shifts in socio-economic structure; additionally, families are not keeping pace with the changing needs of young people, and society is becoming generally less supportive.

However, the findings from this review identify that there are a number of elements which are helpful. The strongest evidence is the support provided by interpersonal relationships, particularly secure attachments, including the following: parental; paternal; maternal; support from friends and family; peer support; intimate relationships; and relationships with children. However, two studies, including male and female participants, identified that negative emotion was a mediating variable in terms of gaining family support; in particular, paternal support with managing negative emotion in females, was identified as helpful for improving self-worth. Having second chances, including in the school or work place, were also helpful, as were having social roles in these spheres.

The next strongest evidence included increasing active strategies and reducing avoidant strategies. Active strategies included: getting involved with activities; using social and emotional support networks; asking for help; expressing emotions; engaging in therapy; and making use of more positive and negative language when expressing emotions. Reducing avoidant strategies such as self-destructive / self-harm behaviours; mental or behavioural disengagement; denial; and substance abuse. All of these had a positive impact on adjustment and reduced trauma pathology.

Internal factors had the next strongest evidence, and were identified in three of the studies (25% of the total number). Internal protective factors included: physical self-efficacy; self-esteem; hope; internal locus of control; greater emotional intelligence; and more spiritual experiences. The importance of protective internal factors outweighed that of adversity rather than the absence of adversity alone, and led to increased resilience. Self-compassion was noted in one study which was a mixed male and female sample.

A number of these findings have similarities with others studies specifically on children. Bellis et al (2017) report that having access to a trusted adult as a child may improve resiliency to protect against the development of negative outcomes following childhood sexual abuse, and this is apparent across all socio-economic strata. However, the extent to which this is protective is not clear.

Parent-Boursier and Hebert (2014) note the importance of the child's perception of security in their relationship with their father, which has particular benefits in respect to internalising and externalising behaviour problems. This was only relevant when the perpetrator was other than the father. In this study the perception of security to mothers was significantly higher than the child's perception of security to fathers, however, it was the perception of security to fathers which predicted outcomes following CSA, namely, internalised and externalised behaviour problems including the following: anxiety / depression, being withdrawn, delinquent behaviour, aggression, social problems, thought problems, mothers psychological distress, and perception of security to mothers. The perception of security to father predicted all problems except somatic complaints and attention problems. Paternal supportiveness was also positively associated with emotional regulation.

Malmberg and Flouri (2011) also support this, suggesting that the positive influence of the father-child relationship may promote resilience in children.

However, Tremblay et al (1999) noted that in children aged 6-12 years, the perception of parental support was associated with less externalised behaviours, however, no association was made between parental support and internalised behaviour problems. Additionally, no distinction was made between maternal and paternal support.

In contrast to this, Rakow et al (2011) reported that children who found their mother to be more supportive were found to display less psychological distress following the abuse.

Ray and Jackson (1997) noted that children were better able to cope when the family environment was perceived as cohesive. Women who had been abused as children, but reported more cohesive families, were found to have better self-esteem and improved social and psychological adjustment. Bhandari et al (2011) support this, noting evidence that different aspects of relating to the environment, such as family functioning, had a greater impact on later psychological distress than characteristics of the abuse experienced.

The difficulty with these studies on children is that the parent-child relationship is a complex one to evaluate: samples are inevitably convenience, and measures tend to only capture one aspect of the relationship. Also, the bidirectional effect of the relationship should be taken into account. Additionally, the young age of the abuse might prevent details surrounding the abuse being disclosed, including issues around memory access, and whether threat or force where involved and the freedom to disclose now.

It is impossible to determine the temporality of intervening variables or other events which might impact recovery, for example, the involvement of the legal system. However, the findings from this review on emerging adults lends some additional support to the findings already identified in children, further drawing our attention to the importance of addressing these matters.

Taking Mguni, Bacon and Brown's (2011) interpretation of health as a psychological state which varies across time, contexts and individuals, combining psycho-social factors such as fulfilment, happiness and resilience, suggests that health and resilience are linked; the quality of an individual's life (including managing and reducing psychopathology, and being able to adapt to and function in the changing environment particularly during this transition stage), at least in part, depends on an ability to bounce back from life's adversities.

Having an understanding of what contributes to health, including the interplay with resilience, creates an opportunity to understand both current and future risks in relation to this age group. Mguni et al (2011) argue that it is necessary to take both a health and a resilience perspective together, to anticipate situations where high health may be reported in the moment, but underlying resilience to cope with a challenge around the corner is limited.

Drawing these variables together in this review creates a starting point for further research to understand not only the interplay between health and resilience, but also how these can specifically be fostered in order to promote overall mental health and to protect against future risk.

Limitations

This review is submitted in part fulfilment of a Doctorate in Psychology and thus the author is the sole researcher. As a consequence, there is potential for bias in the interpretation of the findings. This was sought to be minimised by paying attention to method and following a structured approach to the synthesis of data.

Conclusions and implications

This review identifies elements which are helpful in promoting mental health in emerging adults who have experienced sexual abuse. The main findings are within the following areas: increasing active strategies; reducing avoidant strategies; external elements such as support; and internal factors such as resiliency. No single factor is able to meet the definition of mental health that is put forwards by the WHO (2014) which includes the following areas: reduced psychopathology; being able to have resilience and cope with day to day stresses; being able to realise individual potential; and being able to contribute meaningfully to society. This suggests that in order to achieve mental health there are a range of elements which are helpful, and these include elements from the four main groups identified.

There are very few studies in this area and as such it would be unwise to make generalisations from the findings here; however, the usefulness of this review lies in the synthesis of the findings which suggest that there are four main areas that need to be considered when thinking about providing for the mental health of this client group. It is also notable that there are currently no findings which identify what is helpful for young males in terms of them achieving their potential, within the WHO definition of mental health. This is certainly an area for further research, but also there is a need to consider how the WHO definition of mental health can be conceptualised into service design in order to encourage a shift away from merely the reduction of psychopathology. There is then the opportunity to explore this in the context of how services can be developed, in conjunction with the recommendations from NICE, to include the service users and families, and to consider what this might look like.

Given the lack of current provision, and the extent of the need, it is apparent that to do nothing would have huge implications in terms of perpetuating mental health problems, of this client group, into adulthood, with the associated impact on the economy and the already scarce service resources. However, the needs of this client group are such that it is not merely going to be introducing a new service possibly including the findings from this review, there is much wider implication in terms of why families and society generally are increasingly less supportive, and given that this was the most significant finding in terms of available evidence, this is a matter that needs to be understood. Only with this understanding will we be able to consider how best to tackle this significant problem that faces us today.

References

Allnock D., Radford L., Bunting L., Price A., Morgan-Klein N., Ellis J., and Stafford A. (2012) In demand: therapeutic services for children and young people who have experienced sexual abuse. *Child Abuse Review*, 21, 318-334

Arnett J.J. (2000) Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist,* 55, 469-480

Arnett J.J. (2004) Emerging adulthood: the winding road form the late teens through the twenties. New York: Oxford University Press

Banyard V.L. and Williams L.M. (2006) Women's voices on recovery: a multi-method study of the complexity of recovery from child sexual abuse. *Child Abuse and Neglect*, 31, 275-290

Barnes S.E., Howell K.H., and Miller-Graff L.E. (2016) The relationship between polyvictimization, emotional dysregulation, and social support among emerging adults victimized during childhood. *Journal of Aggression, Maltreatment and Trauma,* 25 (5) 470-486

Boland A., Cherry M.G., and Dickson R. (2014) Doing a systematic review: a student's guide. London: Sage

Bynner J.(2005) Rethinking the youth phase of the life-course: the case for emerging adulthood. *Journal of Youth Studies,* 12 (8) Issue 4, 367-384

Canton-Cortes D. and Canton J (2010) Coping with child sexual abuse among college students and post-traumatic stress disorder: the role of continuity of abuse and relationship with the perpetrator. *Child Abuse and Neglect,* 34, 496-506

Cho M.K., and Bero L.A. (1994) Instruments for assessing the quality of drug studies published in the medical literature. *JAMA*. 272:101-4

Clark H.B, Koroloff N., Geller J. and Sondheimer D.L. (2008) Research on transition to adulthood: building the evidence base to inform services and support for youth and young adults with serious mental health disorders. *Journal of Behavioural Services and Research* 35:4. 365-372

Cote J.E. (2000) The dangerous myth of emerging adulthood : an evidence-based critique of a flawed developmental theory. *Journal of Applied Developmental Science,* 18 (4) 177-188

Finkelhor D. (2009) The prevention of childhood sexual abuse. *The Future of Children,* 10 (19), Issue 2, 169-194

Guelzow J.W., Cornett P.F., Thomas B.S., and Dougherty T.M. (2017) Child sexual abuse victims' perception of paternal support as a significant predictor of coping style and global self-worth. *Journal of Child Sexual Abuse,* 11:4, 53-72, doi: 10.1300/J070v11n0404

Haden S.C., Scarpa A., Jones R.T., Ollendick T.H. (2006) Posttraumatic stress disorder symptoms and injury: the moderating role of perceived social support and coping for young adults. *Personality and Individual Differences,* 42, 1187-1198

Hawker S., Payne S., Kerr C., Hardey M., Powell J. (2002) Appraising the evidence: reviewing disparate data systematically. *Qualitative Health Research* 12:1284-99

Howell K.H. and Miller-Graff L.E. (2014) Protective factors associated with resilient functioning in young adulthood after exposure to violence. *Child Abuse and Neglect,* 38, 1985-1994

Kendler K.S., Bulik C.M., Silberg J., Hetteman J.M., Myers J. and Prescott C. (2000) Childhood sexual abuse and adult psychiatric and substance use disorders: an epidemiological and cotwin control analysis. *Archives of General Psychiatry,* 57, 953-959

Kmet L., Lee R., and Cook L. (2004) *Standard quality assessment criteria for evaluating primary research papers from a variety of fields.* Alberta Heritage Foundation for Medical Research. ISBN (online) 1-896956-79-3

Lam J.N. and Grossman F.K. (1997) Resiliency and adult adaptation in women with and without self-reported histories of childhood sexual abuse. *Journal of Traumatic Stress* 10 (2) 175-196

Letourneau E.J., Eaton W.W., Bass J., Berlin F.S. and Moore S.G. (2014) The need for a comprehensive public health approach to preventing child sexual abuse. Public Health Reports 2014 May-June; 129(3) 222-228. doi: 10.1177/003335491412900303

Levine E.C., Martinez O., Mattera B., Wu E., Arreola S., and Rutledge S.E. (2017) Child sexual abuse and adult mental health, sexual risk behaviours, and drinking patterns among Latino men who have sex with men. *Journal of Child Sexual Abuse*, 27, 2018 issue 3.

Malmberg L, and Flouri E. (2011) Gender differences in the effects of childhood psychopathology and maternal distress on mental health in adult life. *Social Psychiatry and Psychiatric Epidemiology*, 46 (7), 553-542

Mays N. and Pope C. (2000) Quality in qualitative health research. In: Mays N., Pope C. Qualitative research in health care, 2nd Ed. London: BMJ Books, 89-101

Merrill L.L., Thomsen C.J., Sinclair B.B., Gold S.R., and Milner J.S. (2001) Predicting the impact of child sexual abuse on women: the role of abuse severity, parental support, and coping strategies. *Journal of Consulting and Clinical Psychology,* 69 (6), 992-1006

Messman-Moore T.L., and Bhuptani P.H. (2017) A review of the long-term impact of child maltreatment on posttraumatic stress disorder and its comorbidities: an emotion dysregulation perspective. *Clinical Psychology Science and Practice*. 154-169

Nelson E.C., Heath A.C., Madden P.A., Cooper M.L., Dinwiddie S.H., Bucholz K.K., Glowinski A., McLaughlin T., Dunne M.P., Statham D.J. and Martin N.G. (2002) Association between self-reported childhood sexual abuse and adverse psychosocial outcomes: results from a twin study. *Archives of General Psychiatry*, 59 (2), 139-145

NHS Centre for reviews and dissemination (2001). Undertaking systematic reviews of research on effectiveness: CRD's guidance for carrying out or commissioning reviews. CRD reports 4. 2nd Ed. York: NHS Centre for reviews and dissemination

NICE guidance (2016) Transitioning from children to adults' services for young people using health or social care services. National Institute for Health and Care Excellence. Nice.org.uk/guidance/ng43

NSPCC: Bentley H., O'Hagan O., Raff A., and Bhatti I. (2016) How safe are out children? National Society for the Prevention of Cruelty against Children

Popay R., Rogers A., Williams G. (1998) Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*. 8:342-51

Popay J., Roberts H., Sowden A., Petticrew M., Arai L., Rodgers M., Britten N., Roen K., and Duffy S. (2006) Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC Methods Programme. University of Lancaster

Rakow A., Smith D., Begle A.M. and Ayer L. (2011) The association of maternal depressive symptoms with child externalising problems: the role of maternal support following child sexual abuse. *Journal of Child Sexual Abuse*, 20 (4) 467-480

Ray K.C. and Jackson J.L. (1997) Family environment and childhood sexual victimisation. *Journal of Interpersonal Violence,* 12 (1), 3-17

Scarpa A., Wilson L.C., Wells A.O., Patriquin M.A., and Tanaka A. (2009) Though control strategies as mediators of trauma symptoms in young women with histories of child sexual abuse. *Behaviour Research and Therapy* 47, 809-813

Schilling E.A., Aseltime R.H., and Gore S. (2007) Young women's social and occupational development and mental health in the aftermath of child sexual abuse. *American Journal of Community Psychology,* 40, 109-124

Simpson T.L. and Miller W.R. (2002) Concomitance between childhood sexual and physical abuse and substance use problems. *Clinical Psychology Review*, 22, 27-77

Tanaka M., Wekerle C., Schmuck M.L., Paglia-Boak A.P. and the MAP research team (2011) The linkages among childhood maltreatment, adolescent mental health, and self-compassion in child welfare adolescents. *Child Abuse and Neglect,* 35, 887-898

Timmer A., Sutherland L.R., Hilsden R.J. (2003) Development and evaluation of a quality score for abstracts. *BMC Medical Research Methodology*. 3:2

Tremblay C., Herbert M., and Piche C. (1999) Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse and Neglect*, 23 (9), 929-945

Wardecker B.M., Edelstein R.S., Quas J.A., Cordon I.M., and Goodman G.S. (2017) Emotion language in trauma narratives is associated with between psychological adjustment among survivors of childhood sexual abuse. *Journal of Language and Social Psychology*. Vol.36(6) 628-653

WHO (1999) Report of the consultation on child abuse prevention. Geneva, 29-31, March, WHO/HSC/PVI/99.1

WHO (2014) Mental health: a state of well-being. World Health Organisation

Zacares J.J., Serra E. and Torres F. (2015) Becoming an adult: a proposed typology of adult status based on a study of Spanish youths. Scandinavian Journal of Psychology, 56, 273-282

APPENDICES

APPENDIX 1

Resources Searched

- Academic Search Complete
- ACLS Humanities E-Book
- ACP Journal Club
- Alexander Street Press
- APA Handbooks in Psychology
- Arts and Humanities Citation Text
- Athens
- Binleys Online
- British Library EThOS
- British Online Archives
- British Periodicals
- Cambridge Journals Online
- CINAHL Plus
- Cochrane Database of Systematic Reviews
- Cochrane Library
- CogPrints
- Directory of Open Access Journals
- Dissertations and theses via Proquest
- EBL Library
- EBM Reviews
- Ebscohost
- Independent Archive
- International Bibliography of the Social Sciences
- Medline Complete
- MyAthens
- MyiLibrary
- OECD Health Statistics
- Open J-Gate
- Ovid Online
- Oxford Scholarship Online Psychology
- Periodicals Archive Online
- ProQuest Databases

- ProQuest Dissertations and Theses: UK and Ireland, US and North America
- PsychArticles
- Psychological Experiments Online
- PsychINFO
- PubMed and PubMed Central
- Sage Journals
- SCOPUS (SCIRUS)
- SpringerLink
- Taylor & Francis Online
- UK Data Archive
- UK National Statistics
- UK PubMed Central
- Web of Science
- Wiley Online Library
- Zetoc

APPENDIX 2

Inclusion and exclusion criteria

Inclusion criteria

Studies were included if they met the following criteria:

- The studies focussed on primary outcomes.
- They focussed on an element which impacted health
- Evaluations of the element could be quantitative, qualitative, or mixed method.
- They specified that health was impacted
- The study focussed at least in part on the transition period into adulthood between the ages of 18 and 30
- The exclusion criteria applied
- The studies were in English
- The focus was the Western world
- The studies were peer reviewed
- All date ranges
- They met the minimum threshold of 70% in terms of the assessment of methodological quality according to the criteria established by Kmet et al (2004)

Exclusion criteria

Studies were excluded if any of the following applied:

- Participants had significant intellectual learning problems or disabilities
- Participants had addiction to substances
- Participants had active suicidal ideation
- Participants had psychosis
- The study did not specify the trauma to include sexual abuse
- Participants were outside of the age bracket 18-30
- The study focussed on adolescence including aged 18
- The study did not specify an element under consideration
- The study did not consider the impact of the element on health

APPENDIX 3

Threshold criteria (Kmet et al (2004)

Assessment of methodological quality of qualitative studies

	Criteria for assessing qualitative data	Study 9
1	Question / objective fully described	2
2	Study design evident and appropriate	2
3	Context for study clear	2
4	Connection to theoretical framework / wider body of knowledge	2
5	Sampling strategy described, relevant and justified	2
6	Data collection methods clearly described and systematic	2
7	Data analysis clearly described and systematic	2
8	Use of verification procedures to establish credibility	1
9	Conclusions supported by the results	2
10	Reflexivity of the account	1
	Total Score **(Total score divided by total possible score 20)**	18/20
	Meets minimum threshold of >70%	Yes

Assessment of methodological quality of quantitative studies

	Criteria for assessing quantitative data	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7	Study 8	Study 9	Study 10	Study 11	Study 12
1	Question / objective sufficiently described	2	2	2	2	2	2	2	2	2	2	2	2
2	Study design evident and appropriate	2	2	2	2	2	2	2	2	2	2	2	2
3	Method of subject / comparison group selection or source of information / input variables described and appropriate	1	2	2	2	2	2	2	2	2	2	2	2
4	Subject (and comparison group if applicable) characteristics sufficiently described	2	2	2	2	2	2	2	1	2	2	2	2
5	If interventional and random allocation was possible, was it described?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	If interventional and blinding of investigators was possible, was it described?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7	If interventional and blinding of subjects was possible, was it reported?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?	2	2	2	2	1	2	2	2	1	2	1	1
9	Sample size appropriate	2	2	2	2	2	2	2	2	2	2	2	2
10	Analytic methods described / justified and appropriate	2	2	2	2	2	2	2	2	2	2	2	2

11	Some estimate of variance is reported in the main results?	2	2	2	1	2	1	2	2	2	2	1	2
12	Controlled for confounding?	1	2	2	2	1	1	1	1	1	2	2	1
13	Results reported in sufficient detail	2	2	2	2	2	2	2	2	2	2	2	2
14	Conclusions supported by the results	2	2	2	2	2	2	2	2	2	2	2	2
	Total Score **(Total score divided by total possible score 28)**	20/28	22/28	22/28	21/28	20/28	20/28	21/28	20/28	20/28	22/28	20/28	20/28
	Meets minimum threshold of >70%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Search output

Data extraction from included studies

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 1 Scarpa A., Wilson L.C., Wells A.O., Patriquin M.A., Tanaka A. (2009) United States	To investigate thought control strategies or cognitive techniques used as mediators of adjustment following sexual abuse.	76 undergraduate women 18-22 years reporting CSA before the age of 14 years	Quantitative Retrospective survey	Assessment measures included: Child-abuse survey Espositos and Clum (2002); Thought Control Questionnaire Wells and Davies (1994); Impact of Event Scale-Revised (IES-R) Weiss and Marmar (1997). Data analysis: Pearson product moment correlations between all variables. Mediation analyses (Baron and Kenny 1986) were used to test the hypothesis that control would mediate the relationship between the severity of the CSA, and the results on the IES-R scale. Any mediation pathways that were statistically significant were	The greater the severity of CSA the greater the trauma symptomology, as indicated by the IES-R. The IES total was positively correlated (significant) with four out of five thought control subscales (distraction, worry, punishment and reappraisal) and negatively correlated (significant) with social control – less use of social control strategies. The severity of childhood sexual abuse was associated with increased worry. Self-punishment (e.g. self-harm) was used to try and control unwanted thoughts - anger and criticism towards self for having the thoughts,

				confirmed by the use of the Sobel test (Sobel 1982) Where there were correlations, hierarchical regression analyses were conducted to examine the relationships.	thereby increasing abuse-related distress. Reappraisal and distraction thought control strategies were significantly and positively related to trauma symptoms but there was no evidence of relationship to CSA severity so did not meet criteria for mediation. (This finding is inconsistent with some previous findings). A possible explanation is that both re-appraisal and distraction reflect a belief that avoidant strategies are helpful however they have been shown to be maladaptive following trauma e.g. Herman-Stahl, Stemmler, and Peterson 1995). Limitations – possible inaccuracies in memory relating to how abuse survivors dealt with events. Study does not address frequency or variation in CSA characteristics and how these variables impacted the thought control strategies. Sample were relatively high functioning which may impact trauma symptomology and subsequent coping.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 2 Guelzow J.W., Cornett P.F., and Dougherty T.M. (2003) United States	To examine the difference on measures of perceived social support, coping strategies, and global self-worth; to investigate the impact of victimisation and mediating factors on self-worth.	188 female undergraduate students, including 44 victims and 144 non-victims of child sexual abuse. Mean age of students was 21 years (SD 4.6 years). 81% European Americans; 3% Hispanic Americans; 0.5% African American; 0.5% Asian American; 1.6% Native American; 5.9% other; 7% unknown – gave no reply. 91% of the 44 victims reported that their perpetrators were male,	Quantitative	The "Finkelhor's perpetration and victimisation survey" (FPVS) (Finkelhor 1984) was used to determine sexual assault victimisation. Endler and Parker's (1999) Coping inventory for stressful situations (CISS) was used. This scale identifies three coping strategies: task-focussed, emotion-focussed, and avoidance-focussed using a 48-item scale. The scale has high alpha coefficients ranging from .81 to .90. Global self-worth was measured using: "The what I am like global self-worth scale", by Neemann and Harter (1986). Reliability for this scale as assessed by coefficient alpha was .89. Social support systems were measured by the "People in my life" scale by Neeman and Harter (1986), which assesses how the student feels he or she receives support from friends, the campus, mother, father, and instructors. Reliability alpha coefficients	Adjustment was defined as one's ability to maintain a positive, global self-worth. Victims of CSA were more likely to report lower maternal support than non-victims (significant difference), regarding them as less understanding and more indifferent and emotionally detached than did non-victims. Of the 40 male perpetrators, more than 52% were closely related to the victims. Victims perpetrated by a family member perceived greater maternal support than those perpetrated by a non-family member. It was theorised that this was possibly as a consequence of mother's guilt for failing to protect the child from victimisation within the family unit. Victimisation indirectly related to global self-worth through paternal support. With non-victims there were direct relations between paternal, friend, and campus support leading to global self-worth. Paternal support indirectly related to global self-worth through emotion-focussed coping indicating that paternal support and coping strategies may be important

		and of these male perpetrators 53% were closely related to the victims. 33% of the male perpetrators were fathers or step-fathers; 33% were cousins, 33% were a mixture of grandfathers, uncles and brothers.		among the four factors within the scale is greater than .80 however there are no validity measures for this scale. Analysis of covariance was performed using SPSS. Pearson Correlation coefficient and regression analyses were used to examine the impact of victimisation, social support and coping strategies on global self-worth.	for later psychological adjustment in victims of CSA. There were significant direct effects from campus support, paternal support, task focussed, and emotion-focussed leading to global self-worth, the strongest direct relation being between campus support and global self-worth accounting for 10% of the variance suggesting campus support may be an important factor for students adjustment to college life. This is interpreted as students getting involved with campus life as a means of coping with new challenges at college. Results suggest that victimisation may not be a significant predictor of global self-worth. For non-victims of CSA there were significant direct relations for friend support, campus support, and paternal support leading to global self-worth, but coping strategies were not important mediating factors. In victims of CSA paternal support had a direct influence on global self-worth when mediated through emotion-focussed coping. CSA victims' perception of their global

					self-worth is dependent on how much support they received from their fathers which in turn may signify how they cope with stressful events leading to an altered perception of self. In turn, the way in which the victims cope, predicts their perceptions of self-worth. A limitation of this study is that the social support systems included only parental support and did not provide information on other social support systems e.g. friends, co-workers, teachers. Also, the study focussed on major psychological symptoms rather than symptoms of perceived self-worth, which may influence positive achievement, positive social adjustment and improved academic and physical performance. Additionally, could also consider college students as samples to see if the effects hold true. Due to a lack of male sample it is not possible to determine why this female group placed a greater emphasis on paternal support over maternal support.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 3 Merrill L.L., Thomsen C.J., Sinclair B.B. Gold S.R., and Milner J.S. (2001) United States	To identify factors that differentiate CSA victims who suffer severe impairment from those who suffer less deleterious long-term effects; to seek to specify the mediating processes through which CSA produces negative consequences.	5226 female Navy recruits, of which 4098 met inclusion criteria. 28% met criteria for experiences of CSA. CSA victims and non-victims did not differ significantly in terms of age, ethnicity or education. They did differ in respect to income with CSA victims reporting on average a lower family income than non-victims however this effect was small. CSA victims were more likely than non-victims to be married or co-	Quantitative	Demographic and family history questionnaire; "The parental support scale" (PSS Fromuth 1986) which consists of 11 items that describe specific parental behaviour. This was performed for both parents. CSA was assessed with a modified version of the "Sexual events questionnaire" (Finkelor 1979); Coping was assessed by the "How I deal with things scale" Burt and Katz (1987). Based on a factor analysis of their original scale Burt and Katz developed 5 subscales measuring different types of coping: avoidance; nervous/anxious; self-destructive; expressive; cognitive. Factor-analysis revealed a three-factor solution: Constructive coping (including positive behavioural changes, cognitive reframing, support-seeking, self-acceptance); Self-destructive coping (e.g. behavioural acting out or escapist coping such as alcohol abuse); Avoidant coping including attempts to repress or deny thoughts and feelings	CSA victims are less well-adjusted than non-CSA victims even after controlling for negative family environment: CSA is a significant predictor of long-term difficulties, ranging from depression and anxiety to sexual problems and dissociative symptomatology. The majority of CSA victims reported abuse which included intercourse (64% n=1067) and force or threats of force (58% n=1037). Most reported only one perpetrator (71%), 20% reporting two perpetrators, and the remaining 9% reporting 3-5 perpetrators. 22% n= 1134 reported being abused by father or stepfather. The number of instances of abuse ranged from 1 (22% of sample) to more than 200 (2% of sample) with approximately half of the sample reporting 5 or less instances. Correlations among severity indicators were all positively and significantly correlated. In respect to strategies used, participants reported the greatest use of avoidance (n=961) followed by constructive (n=958) and self-destructive (n=862). Self-destructive

		habiting however this effect was also small. Mean age of CSA victims was 19.8 (SD 2.6) and mean age of non-victims was 19.6 (SD 2.6). 60% of CSA sample were white, and 19% African American, 13% Latina, the remainder were other. 59% of the non-CSA sample were white, 22% African American, 11% Latina, the remainder were other.		associated with the abuse. Internal consistencies (Cronbach's alpha) for the three sub-scales ranged from .77 (self-destructive) to .85 (avoidant). The "Trauma symptom inventory" Briere 1995 was used to assess current psychological health. Reliabilities ranged from .76 to .89. Influences of demographic difference were controlled for by use of multivariate and univariate analyses (MANCOZ and ANCOVA) of covariance. Associations between variables were analysed using MANCOVA and ANCOVA. Structural equation modelling was used to analyse factors that moderate the impact of CSA on adjustment.	and avoidant coping were significantly correlated however, neither of these negative forms was significantly associated with constructive coping. The strongest predictor of maladjustment among CSA victims was the use of self-destructive coping strategies followed by avoidant coping strategies. Constructive coping, abuse severity, and parental support was a weaker predictor statistically significant in only one of the two conditions. Conclusions: CSA victims are likely to fare most poorly when they use self-destructive or avoidant strategies. Causal relationships among latent variables identified that parental support and abuse severity influence the manner in which women cope with their abuse experience, thus the distal variables of family environment and abuse severity is indirect, mediated by coping style. Although CSA victims reported less supportive family environments than non-victims, controlling for parental support did not eliminate the effects of CSA on symptoms. However, outcomes measures were specifically trauma related rather

					than being general measures of functioning and the effects of family environment might have been stronger had additional aspects of family environment been assessed. The absence of an interaction between CSA and parental support supports that parental support was not uniquely helpful to CSA victims but equally had beneficial effects for CSA victims and non-victims. In the analysis of differences in adjustment among CSA victims, support benefitted all CSA victims regardless of abuse severity. It is possible that parental support has different effects as a function of specific aspects of the abuse e.g. identity of abuser. Regardless of whether CSA or parental support is a stronger predictor of symptoms, neither was a strong predictor in terms of absolute effect size. Coping bears the strongest relations to symptomatology because both variables assess individual differences in psychological, emotional, and behavioural functioning. The other two types of predictors (parental support and abuse severity) refer to factors external to the individual.

					Parental support predicted adjustment in the overall sample but was less consistently related to adjustment in CSA victims alone. Little is known about the interrelations among indicators and effects my combine in a non-linear manner. Parental support had neither direct nor indirect effects on symptomatology. Support was positively related to constructive coping and constructive coping was negatively related to symptoms however both relationships were weak pointing to a nonsignificant direct path. Parental support was a significant predictor of constructive coping but not of avoidant or self-destructive coping. This suggests that individuals with supportive parents may have more resources to support constructive coping and/or better role models however support did not protect against longer term pathology by reducing the use of maladaptive coping. There was evidence that long-term adjustment was mediated by coping in respect to the impact of abuse-

					severity. As the direct effect of abuse severity on symptoms was not significant this suggests that the relationship between severity and ongoing impairment / adjustment is largely mediated by coping strategies. The weaker effect of constructive coping may account for other studies identifying that coping is not significantly associated with adjustment. CSA victims perceive avoidant strategies to be the most effective way of managing abuse experiences however this is related to longer-term mal-adjustment. Limitations: retrospective self-report measures – potential issues of possible biases either deliberate or inadvertent. Retrospective measures have the potential problem of fallibility of memory.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 4 Lam J.N. and Grossman F.K. (1997) United States	To investigate the relationship between protective factors and adult adaptation in women with and without childhood sexual abuse.	264 undergraduate women ranging from 17-25 years (mean age 18.8 years); 262 were single, 1 married, 1 cohabiting. White (9 African American; 59 Asian American; 15 Hispanic; 1 Native American; 172 Caucasian; 8 other)99 Catholic, 42 Jewish, 35 Protestant, 48 Other, 39 none. two thirds estimated their total family incomes as greater than	Quantitative, correlational.	The Child Abuse and Trauma Questionnaire, which covers sexual abuse, physical abuse, emotional abuse, negative home atmosphere, and neglect, however this study only examined the responses to the sexual abuse subscale. The phrase "before you turned 15" was added to the directions. The index of severity was the total score of the six Likert-scaled items. Mediating variables were assessed using: The Physical Self-Efficacy Scale (PS-ES) Ryckman et al (1982); the Neuroticism-Extroversion-Openness Personality Five-Factor Inventory (NEO-FFI) Costa and McCrae (1980, 1985); The Rosenberg Self-Esteem Scale (RSE) Rosenberg 1965; Hope Scale (HS) Synder et al (1991); Internal-External, and Chance Scale (I-ECS) Levenson (1973) – only the Internal subscale which assessed the perceived mastery the individual had over her life was used; Parent Bonding Instrument (PBI) Parker et al (1979). Self-Report Attachment	The proportion of the sample with self-reported histories of CSA is similar to other reported figures in non-clinical female students from the college population (18%). A composite index of protective factors was created by totalling the standardized scores of the 16 protective factors. Factors analysis confirmed that 13 of the 16 protective measures were not distinct from each other and provided methodological support for the decision to create a composite index. In this study the index best reflects the essence of resiliency and this is understood to be the interaction of the 16 protective factors, and this composite index is supported by factor analysis. The composite index of protective factors was significantly correlated to depression, the frequency and intensity of distress, and social adjustment – participants scoring high on protective factors scored lower in these three scales. Women with more of the composite protective factor did better in their lives regardless of whether or not

		$40,00. The group without self-reported histories of CSA were demographically equivalent to the group with self-reported histories of CSA.		Style Prototypes (S-RASP) Bartholomew and Horowitz (1991). Only the Secure subscale was examined. Perceived Social Support – Friends and Perceived Social Support-Family Scales (PSS-FR and PSS-Fa) Procidano ad Heller (1983); Inventory of Socially Supportive Behaviours (ISSB) Barrera, Sandler, and Ramsay (1981); Network Orientation Scale (NOS) Vaux and Harrison (1985) (this assessed the tendency to use or not use social support networks; the Marlowe-Crowne Social Desirability Scale (M-CSDS) Crowne and Marloe (1960) – assesses the tendency to portray oneself in a desirable light; Beck Depression Inventory (BDI) Beck, Ward, Mendelson, Mock and Erbaugh (1961); Symptom Checklist-90-Revised (SCL-90-R) Derogatis (1983) – assesses the frequency and intensity of distress; Social Adjustment Scale Self-Report (SAS-SR) Weissman and Bothwell (1976). All tests used had adequate reliability and validity. Pearson *r* correlations explored the relationships among scores.	they had self-reported CSA. The women with histories of CSA had scores on the composite protective factor which better predicted their scores on two of the three outcome measures (SCL-90-R and BDI, but not SAS) as compared with the non-CSA group. Women with histories of CSA and higher levels of protective factors looked similar in adult adaptation to those without histories of abuse. It was supported that protective factors are beneficial to most people but they are significantly more so for those with histories of CSA (causality not inferred as the design is correlational). The results confirmed that there is a relationship between protective factors and adaptation and the multi-dimensional nature of resiliency was supported. The presence or absence of CSA did not predict functioning in terms of depression, symptoms or social adjustment. Important resiliency factors include: a sense of a secure attachment; physical self-efficacy; hope; self-esteem; internal locus of control; family and social support. Whereas these were helpful for both CSA and

					non-CSA victims they were more helpful for CSA victims. Limitations – the definition of resiliency is subject to variation and can include both physical and psychological measures. The sample may not be representative of other college populations. Self-report measures are open to bias; the decision to combine protective factors and to define cut-off points by using a median-split is based on issues debated in the literature.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 5 Schilling E.A., Aseltine R.H., and Gore S. (2007) United States	To examine social role functioning and depressive symptoms in young adults with histories of childhood sexual abuse	Wave 1: Systematic probability sample of 1578 high school seniors. Wave 2: 1093 member of wave 1 group including graduates and drop-outs. Effective sample of 1087 (572 females, and 515 males). 29.9% of total sample were ages 16-17, and 70-2% aged 18-20. 48.9% white, 21.1% black, 10.9% Hispanic, 7.05 Asian, 5.4% multi, 6.7% other.	Quantitative. Prospective study.	Dependent variable of depressed mood measured with a modified version of the 20-item Center for Epidemiological Studies Depression (CESD) Scale Radloff 1977. This has good internal consistency .81 at time1, and .82 at time 2. Structured interview was used to identify experiences of childhood sexual abuse. The prevalence rates were close to those reported by the national survey NCS using identical questions (Kessler et al 1997). Social Role Experiences included the following: Work Status and Disruption; School Status and Disruption; Relationship Status and Disruption; Work Experience (Interpersonal conflict/support deficits at work – four item measure constructed from previous research)' School Experience – Interpersonal conflict/support deficits at school, three item measure constructed from previous research); Relationships- two variables – intimate support (e.g. McLeod et al 1992),and argument frequency	Analyses could only be conducted on the women in the sample due to the low prevalence rates of abuse in the male sample. In the total sample, CSA was significantly related to increased depressed mood, controlling for gender, parental education and race. The CSA coefficient for females is strong and statistically significant demonstrating that women reporting CSA are more depressed at time 2 than time 1 even though other research suggests that there is improved psychological functioning in the immediate years following graduation (e.g. Aseltine and Gore 1993). There was a slightly greater impact of continued abuse and abuse by known perpetrators but this did not meet statistical significance due to the small numbers in each category. The extent to which the effect of CSA on depressed mood was mediated by adult role transitions was determined: women who had experienced CSA showed deficits in all social role experiences compared to non-abused women, less than half compared to non-abused women attended 4-year college courses, although it was

				and partner life events. Missing Values Imputation to capture missing data due to interview design rather than selective non-response. Missing experience data was imputed using SPSS 11.5. Analysis was by multiple regression to examine the effects of CSA on relative change in terms of depressive symptoms from Time 1 to Time 2. Social functioning variables were then added to the regression equation.	comparable at two-year courses. They reported less enjoyment at school, and slightly more conflict. Sexually abused women were more likely to work fulltime and report more conflict, and there were indicators that their personal lives were more troubled. Sexually abused women were substantially more likely to have a relationship breakup between stage 1 and stage 2, and reported lower levels of intimate support, and greater argument frequency. Abused women were more likely to have partners with drink or drug problems, or who had recently been fired or laid off from work. Conclusion – in both personal and occupational lives sexually abused women had greater hardships and risks than non-abused women, and all measures in these role domains were significantly associated with CSA. It was determined whether the social role experiences of sexually abused women mediated the impact of CSA. There was a significant decrease in the total effect indicating that status and experience in the domains of school, work, and intimate relationships during this transition

					time mediated the association between CSA and depressed mood. The relative importance of the three role domains was determined. Non-supportive intimate relationships exacerbated depressed mood over and above the influence of work and school experiences. This was as a result of lower perceived levels of emotional support from the partners; thus, the ability to forge supportive ties is an important coping resource. The lower education attainment by sexually abused women reduces employment opportunities, and is more likely to result in earlier marriage. This suggests that education can have a protective role in terms of enabling a more successful transition into adult roles, with associated psychosocial strengths for later adult years. College is identified as being an important social field for emerging adult women who have been sexually abused. Limitations – college students, thus finding not generalizable outside of this area. The conservative definition of CSA used may have missed individuals who were seriously abused but not involving rape. The

					sample size limited the ability to differentiate between factors potentially relevant to the long-term impact of CSA such as perpetrator, age of onset. some of the school and work scales have low reliability due to low numbers of items in the scale.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 6 Haden S.C., Scarpa A., Jones R.T., Ollendick T.H. (2006) United States	To investigate the relationship between PTSD symptoms and perceived injury, and to consider the moderational roles of coping behaviours and perceived support on the injury-PTSD relationship. (injury includes sexual trauma)	150 undergraduate students (50 male, 100 female), majority between 17-22 years of age (mean age 19.33). primarily Caucasian (81%). Of total sample – 24% with sexual trauma). Convenience sample.	Quantitative	Self-report measures including: the Events Scale (ES, Vrana and Lauterbach 1994) assessing exposure to trauma and severity of perceived injury; the Purdue Post Traumatic Stress Disorder-Revised Questionnaire (PPTSD-R, Lauterbach and Vrana 1996) based on DSM-IV criteria for PTSD; the COPE Inventory (Carver et al 1989) to assess coping responses - the scales were factor analysed using a principal component method of factor extraction with varimax rotation with the aim of reducing scales and obtaining more global measures. The Multidimensional Scale of Perceived Social Support (MSPSS, Zimet et al 1988) was used to assess perceived social support, with differentiation between family and friends. Gender and time since the event were controlled for.	Degree of perceived injury predicts levels of PTSD symptoms. Individuals who reported high levels of perceived injury reported lower levels of PTSD symptoms when they perceived greater friend support or interpersonal coping strategies. Active coping strategies associated with reduced PTSD symptoms / avoidant coping styles (e.g. disengagement) are associated with more PTSD symptoms. Findings emphasize the importance of survivors seeking / receiving support, and their perception of support given. Drawback – PTSD symptoms included sexual trauma but not only sexual trauma, this study did not allow differentiation between types of trauma in the findings. 62% of variance was accounted for within the COPE scales, and three orthogonal scales regarding coping styles were identified: 1) Disengagement, 2) Interpersonal, and 3) Problem focussed.

					Disengagement: mental and behavioural disengagement, denial and substance abuse (avoidant behaviour), Mean score 7.39. Interpersonal coping: using emotional and social support, expressing emotions, Mean score 11.20. Problem-focussed coping: active coping, restraining, helpful re-appraisal of events and associated growth, acceptance, and planning, Mean score 11.15 Family support Mean score 19.19, friend support Mean score 19.32. Women reported significantly higher PTSD symptoms than men, and symptoms were higher in both genders the more recent the event. Higher support from family was significantly related to less severe PTSD symptoms. Avoidant behaviours (disengagement) associated with more PTSD symptoms, even if avoidant behaviours were previously used prior to injury as a general coping style, the PTSD was greater if these

					strategies were continued to be used. Relationship between perceived injury and severity of PTSD symptoms is greater with low interpersonal styles, and stronger for individuals who perceive lower support from friends. Type of support not measures in this study, it may be useful to evaluate specific types of support that are most helpful in order to inform intervention strategies, helping to target areas that curb development of PTSD not just the cause. Active coping styles (asking for advice from others, speaking about feelings and emotions) protect the individual from emotional overload thus reducing PTSD symptomology, however, a direct effect was not observed regarding active interpersonal and problem solving focussed strategies thus it cannot be argued that intentional cognitive processing of the event is directly helpful to outcomes in young adults, however this is related to level of injury. Further research into individual differences between types of coping styles may help understand the exact mechanisms of

					coping in relation to PTSD symptoms. Friend support has a strong positive association between injury and PTSD severity becoming more influential in relation to perceived level of injury. Further research might elucidate the specific nature of friend support in relation to the prediction of PTSD severity. Limitations - convenience sample – may not be generalizable to clinical sample, need to examine these relationships with a clinical sample. Self-report measures – prone to biases. Coping and social support measures reflected general lifestyles and were not specific to the trauma, although it is most likely that participants dealt with the traumas using the specific style generally used, specific post trauma factors would warrant further investigation. Summary – high levels of injury giving rise to high levels of PTSD symptoms – protective factors against development are: perceiving strong support from friends (and family) and interpersonal coping.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 7 Howell K.H., and Miller-Graff L.E. (2014) US	To assess the associative strength of the protective factors of social support, emotional intelligence and spirituality following significant childhood trauma.	321 college students (71.3% female) ages 18 – 24 years (*M*=19.18 years) who had experienced childhood violence including: community violence, interpersonal aggression, child maltreatment, peer/sibling victimisation, and/or sexual assault. 66% Caucasian. 19% African American, 5.6% biracial/multi-racial, 4% Hispanic/Latin	Quantitative	Sample recruited through University Department of Psychology subject pool system. Demographic information was collected plus a battery of self-report measures to assess childhood experiences, as well as current psycho-social functioning, social networks, and resilience. Demographics: age, gender, family income, ethnicity and education. Juvenile Victimisation Questionnaire – Adult Retrospective – Short Form (JVQR2) 34 item self-report measure (Hamby, Finkelhor, Ormrod, and Turner 2004). The items are not related as experiences are not necessarily related, so reliability was not calculated. Connor-Davidson Resilience Scale (CD-RISC) Connor and Davidson 2003) assessing the participant's ability to respond to stress and adversity. Depression,	The average number of childhood incidents was 9.05. The most frequent from of victimisation was from a peer or sibling (endorsed by 93% of participants); 83.3% cited victimisations of being directly attacked on purpose or indirectly being exposed to violence or others getting hurt on purpose. The % of participants endorsing sexual assault was not listed, although this was included in the types of childhood experiences identified in the sample. Fewer childhood victimisations were associated with greater resiliency in young adulthood Current depressed mood contributed to the prediction of significant variance in young adult's resilience scores. It is possible that this made it difficult to predict unique effects. It is also possible that those with depressed mood may have a tainted perspective of earlier experiences. Spirituality and emotional intelligence were significant predictors of resilience with more frequent spiritual experiences and

		o, 3.7% East Asian, 1.7% other. Sample mostly affluent (31.9% reporting family income > 150,000 USD, 28.1% < 60,000 USD.		anxiety and stress scale – 21 (DASS-21) (Lovibond and Lovibond 1995). DASS-21 has good internal consistency reliability. Brief Emotional Intelligence Scale (BEIS-10) (Schutte et al 1998). The BEIS has good internal consistency and good test-retest reliability. Daily Spiritual experience Scale (DSES) assessing perception of quality of spiritual life (Underwood 2011). The DSES has high internal consistency reliability and adequate construct and discriminant validity. The Lubben Social Network Scale – Revised (LSNS-R) was used to evaluate perceived levels of social support from friends and family (Lubben et al 1001). Hierarchical multiple regression analyses was used to examine hypotheses.	greater emotional intelligence associated with greater resilience. Current social support from peers, but not family, was a significant predictor of resilience with greater support being positively correlated to increased resilience. The lack of relationship between social support from family as opposed to peers was interpreted by the nature of the childhood violence in as much as many of the victimisations occurred in the family home, including exposure to inter-parental conflict, sexual abuse by a family member, and parental neglect. In the final step of the regression model variables relating to both risk and protection, only protective factors were related to resilience: symptoms of anxiety and depression were no longer significantly linked to resilience after including spirituality, emotional intelligence and social support. This suggests that the power of protective factors outweighs that of adversity and psychopathology rather than the absence of psychopathology alone.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 8 Barnes S.E., Howell K.H., and Miller-Graff L.E. (2016) US	To examine the relationship between childhood polyvictimisation and social support in emerging adulthood, and to consider whether emotion dysregulation underlies this relationship	304 college students (71.4% female) aged 18-24 years (*M*=19.18)	Quantitative	Juvenile Victimisation Questionnaire JVQR2 (Finkelhor, Hamby Ormrod and Turner 2005) – adult retrospective short form (examines range of victimisation). Reliability statistic not calculated as items do not uniformly relate to one another. Lubben Social Network Scale – Revised (LSNS-R Lubben and Gironda 2003) – examines current level of perceived support from family and friends. (The LSNS-R has shown adequate internal consistency when subscales combined). Difficulties in Emotion Regulation Scale (DERS Gratz and Roemer 2004). Reliability for items form the 5 subscales was *a* =.95 Menas, correlations and standard deviations computed for all variable using the Statistical Package for the Social Science (SPSS). Hypothesised associations were examined using correlations. Structural equation modelling was used to assess for a mediating role of	Polyvictimisation understood as physical assault, sexual victimisation, child maltreatment, peer or sibling victimisation, witnessed or direct victimisation. No significant differences identified in terms of demographic variables. 92.4% endorsing at least one form of peer or sibling victimisation; 82.9% at least one exposure to crime; 69.7 at least one instance of indirect or witnessed violence; 42.8% reported at least one form of sexual victimisation. Significant associations were found between polyvictimisation and both support variables indicating that more experiences of childhood victimisation were negatively related to support from family and friends. The structural equation model for emotion dysregulation as a mediator between polyvictimisation and social support in young adulthood was significant. Polyvictimisation in childhood directly and negatively affects social

				emotion dysregulation. Fit indexes were evaluated using recommendations form Kline (2010)	support during the emerging adulthood years from both friends and family. Increased emotion dysregulation during the emerging adulthood years was significantly related to less support from family, but not from friends however emotional dysregulation did not fully account for the relationship between childhood polyvictimisation and social support from family. Assessing polyvictimisation rather than single episodes was considered to be a strength of this study as it argued for a more nuanced and realistic appraisal of childhood experiences and how these impact later developmental periods. Limitations – retrospective in design, risk of bias or inaccurate recollections. The correlational design does not allow for considering the study variables over time: it is likely that social support and emotional dysregulation will vary over time. The majority were white female college students from middle-class

					backgrounds so generalisability is limited.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 9 Banyard V.L. and Williams L.M. (2006) US	To examine patterns of stability and change in resilient functioning in young women following childhood sexual abuse; to examine survivors' narratives about healing.	80 women with documented hospital records of CSA. 85% African-American.	Longitudinal, mixed method	Structured and open-ended interviews. Participants were interviewed at three points in time. Wave one interviews were with 206 girls aged 10 months–12 years and their care-givers, the girls having been seen in hospital after documented sexual abuse. Wave two interviews followed up 136 of these girls, now aged between 18-31 years (*M*=25.49 years). All participated in structured interviews using standardised measures of trauma and functioning. Wave three interviews (23 years after initial report of the abuse) 80 women who had been interviewed at wave two were further interviewed, however only 61 had complete data (Age *M*=31.07 years) A further sub-set of 21 participants were contacted for qualitative in-depth interviews (Age *M*=31.52 years). Resilience – measured at wave two using a 13-item scale for	Few significant patterns of differences between interviewed and non-interviewed women in terms of demographical variables and characteristics of documented sexual abuse. Wave two resilience scores for the 61 participants was comparable to full sample of 80. Quantitative findings demonstrated that resilience was often stable over time, and a protective factor if re-exposed to further trauma, and a protective factor against mental health pathology. Higher resilience scores measured at wave two were associated with more positive and active coping later in life, giving rise to increased life and role satisfaction. Drawbacks – qualitative sample not demographical representative of all survivors of sexual abuse. Advantage – does not rely on self-report of sexual abuse rather on hospital records.

				analyses of life-course correlates of competent functioning (Hyman and Williams 2001). Wave three – scale reduced to a 12-item scale due to missing comparable data so this data was then used at wave two and three, omitting one item about having male friends. Mental Health symptoms measured by 100-item Trauma Symptom inventory (Briere 1995). Additional trauma exposure – seven questions about traumatic life experiences adapted from National Women's Study (Resnick 1996). Using age at time of interview, calculations were made regarding trauma exposure between interviews at wave two and three and a summation of trauma exposure calculated. Wave three interviews assessed correlates of resilience and growth over time: Optimism and life satisfaction (simple dichotomous question, then a Likert scale); Coping assessed using Holahan and Moos (1987) typology of coping strategies as a model of context coping; Social	

				connections – questions asked about social relationships and happiness and satisfaction in relation to these. Data was analysed at both bivariate and multivariate levels using Pearson correlations and multiple regression analyses. Qualitative analysis – coding based on methods of grounded theory.	

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 10 Tanaka M., Wekerle C., Schmuck M.L., Paglia-Boak A. (2011) Ontario, Canada	To examine the relationship between child-maltreatment and self-compassion in 16-20 year olds	117 young adults (45.3% males) from the Maltreatment and Adolescent Pathway (MAP) Random selection within an urban catchment area. Wide variety of ethnicity, white 27.0%, dual or multiple 27.8%, black 31.3%	Longitudinal quantitative study over two years.	Data collected at 6 months intervals over two years, initial ages were between 14-17 years extending to 16-20 years at the two year point. Childhood Trauma Questionnaire (CTQ Bernstein et al 1994, 2003) – 28-iten self-report measurement on physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect. No specified age range for experience of abuse. The Self-Compassion Scale (SCS Neff 2003) was used at the two year point (there were no baselines to consider change over time). The SCS is a 26-item self-report measure that assesses self-kindness versus self-judgement; common humanity versus isolation; mindfulness versus getting carried out of the present moment due to high levels of emotion. Self-compassion was distinguished from self-esteem or global self-concept. The Centre for epidemiologic Studies Depression Scale (CES-D Radloff 1977) is a	Only results relevant to this review are reported. The correlations between self-compassion scores and emotional abuse, emotional neglect and physical abuse were moderate, the correlation with sexual abuse and physical neglect were small. Emotional abuse when entered first remained significant in self-compassion score when compared with alternative entry orders of independent variables. Higher childhood physical abuse, emotional abuse, and emotional neglect were significantly associated with lower self-compassion. (Co-loading of sexual abuse and emotional abuse) Emotional abuse and emotional neglect may be seen as indicators of a broader category of maltreatment but each may have a different influence on the non-optimal development of self-compassion. Emotional abuse in childhood uniquely linked to lower self-compassion in adolescence. Significantly greater proportions of positive screen of low self-compassion with anxiety and

				20 item self-report measure of depression. The General Health Questionnaire (GHQ Golderberg and Williams 1988) used to detect psychological distress. The Alcohol Use Disorders Identification Test (AUDIT Babor, Higgins-Biddle, Saunders and Monteiro 2001) as a measure of excessive drinking. CRAFT (Knight, Sherritt, Shrier, Harris and Chang 2002) 6 item self-report for substance abuse in adolescence. Pearson correlation was used to examine binary associations among key variables. Hierarchical, stepwise regression was used to examine the relative contribution of identified child mal-treatment subtypes enabling the detection of specific subtypes associated with self-compassion. IBM-SPSS 17 was used for regression analyses and SAS v9.2 used for all other analyses.	depression symptoms, problem drinking, and suicide attempts suggesting that self-compassion can reduce negative self-related outcomes. The relationship between self-compassion and maltreatment-related impairments is cross-sectional thus a causal relationship cannot be supported. Due to a wide range of acts of emotional maltreatment it was not possible to distinguish between acts. Limitations – this study focussed on youth involved with Child Welfare. All measures used were self-report, and the amount of variance is considered modest, given possible method variance.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 11 Canton-Cortes D. and Canton J. (2010) Spain	To examine the effects of child sexual abuse on the use of coping strategies and PTSD score; to consider the interactive effect of coping strategies with the continuity of abuse and the relationship with the perpetrator	138 victims (male and female) of child sexual abuse (CSA) and 138 participants selected as a comparison group. Aged between 18-24 years	Quantitative	Specifically developed questionnaire; Coping strategies assessed with the How I deal with Things Scale (Burt and Katz 1987); PTSD scores assessed with the Severity of Symptoms Scale (Echeburua et al 1997) Drawback of this retrospective study which maintains the anonymity of participants is the single source of information to assess both adjustment and coping styles: it is possible the individuals with less psychological adjustment regardless of experiencing CSA or not, adopt more avoidant coping strategies as opposed to approach strategies. This potential bias of measuring two variables simultaneously was addressed. (See if more info required here)	Victims of CSA showed higher PTSD scores and lower approach coping strategy scores. Differences in avoidance coping strategies between groups was not consistent however the use of avoidance coping strategies was positively related to higher PTSD scores. The effects of avoidance strategies was greater in continued abuse as opposed to isolated events, and in intra-familial over extra-familial abuse, and in CSA victims over non-CSA victims. CSA is a high-risk experience which effects coping strategies and the severity of PTSD depends on the coping strategies used. The role of these strategies varies depending on whether the participant is a victim of CSA or not, and on the continuity of abuse and the relationship with the perpetrator. A reduction in avoidance-type coping strategies would appear to be beneficial particularly in intra-familial and / or continued abuse victims. The encouragement of “spontaneous” approach strategies in the absence of counselling would

					probably not lead to a reduction in PTSD symptomology however engagement in therapy to develop effective approach strategies may help reduce PTSD symptomology.

Study, year, country	Aim	Sample	Design	Data collection and analysis	Results
Study 12 Wardecker B.M., Edelstein R.S., Quas J.A., Cordon I.M., and Goodman G.S. (2017) United States		55 young adults (49 women). Aged between 16-30 years (M=23.60, SD 3.79) 69% Caucasian, 6% Black or African American, 14% Hispanic, 11% other ethnicities or mixed.	Quantitative	Interviews, mental health and legal attitude questionnaires. Brief Symptom Inventory (BSI); Young Adult Self-Report Behaviour Checklist (YASR); Posttraumatic Diagnostic Scale (PDS); Beck Depression Inventory (BDI); Those completed by primary carers include: Child Behaviour Checklist (CBCL); Young Adult Behavioural Checklist (YABCL);	Men and participants with greater legal involvement were more likely to use increased positive emotion in their trauma narratives (however the sample of men was only small). Age at the end of abuse, length of time elapsed between end of abuse and interview, and abuse severity were not significantly related to the use of positive or negative emotional language. The hypothesis that individuals who used more positive and negative emotional language in their trauma narratives reported better self and care-giver adjustments was partially supported: Behavioural problems by care givers. Individuals who used more positive emotional language showed significantly less psychological distress and less depression, and there were less emotional and behavioural problems reported by caregivers. negative Emotional language was negatively associated

					self-reports of emotional and behavioural problems and PTSD. The interaction between those who used more positive emotional language reported less psychological distress and depression, and there were less emotional and behavioural problems reported by care givers. The use of negative emotional language was negatively correlated to symptoms of PTSD (less use of negative emotional language correlated to greater report of PTSD symptoms and vice versa), however, the use of negative emotional language was positively correlated to reports of emotional and abuse severity and the use of positive emotional language was significant for all self-reported mental health outcomes, but not carer reported mental health outcomes. The interaction between abuse severity and negative emotional language was significant in respect to psychological distress and behavioural problems. Facing unpleasant emotions may be just as important in respect to healing after severe trauma, and greater use of negative emotional

					language was associated with less report of PTSD and behavioural problems. They conclude: simply talking about the experience maybe less important that the language used.

APPENDIX 5

List of articles included in the review

In total, 11 studies were included in the review:

1. Scarpa A., Wilson L.C., Wells A.O., Patriquin M.A., and Tanaka A. (2009)
2. Guelzow J.W., Cornett P.F., and Dougherty T.M. (2003)
3. Merrill L.L., Thomsen C.J., SinclairB.B., Gold S.R., and Milner J.S. (2001)
4. Lam J.N. and Grossman F.K. (1997
5. Schilling E.A., Aseltine R.H., and Gore S. (2007)
6. Haden S.C., Scarpa A., Jones R.T., and Ollendick T.H. (2006)
7. Howell K.H. and Miller-Graff L.E. (2014)
8. Barnes S.E., Howell K.H., and Miller-Graff L.E. (DATE)
9. Banyard V.L. and Williams L.M. (2006)
10. Tanaka M., Wekerle C., Schmuck M., and Paglia-Boak A. (2011)
11. Canton-Cortes D. and Canton J. (2010)
12. Wardecker B.M., Edelstein R.S., Quas J.A., Cordon I.M., and Goodman G.S. (2017)

PART C

THESIS

‘What are the experiential and phenomenological processes over time that impact recovery from violence against women?’

SECTION ONE

ABSTRACT AND

INTRODUCTION

SECTION ONE

Abstract

This study introduces an epistemological and methodological framework based on the foundations of Interpretative Phenomenological Analysis (Smith 1996), rooted in hermeneutic phenomenology, as a means to disclose the experiential and phenomenological processes over time involved in adult women recovering from violence. It has a relational element where the researcher adopts a dual role of practitioner-researcher, using the key Rogerian (1951) principles of non-judgmental positive regard, empathy, and congruence. This was considered a prerequisite due to the traumatic nature of the experiences the participants had been exposed to, and the aim to explore their recovery processes without causing them further harm.

The existentials described by Van Manen (1997) of lived body, lived time, lived space and lived relations, enables an understanding of the individual experiences, but also an appreciation of the phenomenon of recovery. Bringing recovery from violence into focus in this way, enables a fresh perspective on recovery, and a consideration of how others may respond to this knowledge.

In this study, six adult female participants were purposively selected and invited to share their experiences of their recovery journeys to date. Interviews were carried out weekly for up to six months, but with the option of continuing up to 12 months if the woman chose. Sessions typically came to a natural conclusion when the woman moved on from the refuge.

The participants' accounts provided insights into the embodied experience of recovery, how they experienced time and space, and the significance of relationships, including the research relationship.

The participants moved at their own pace from experiencing the body as threat, to experiencing the body as strength. Some of the processes involved in this included: managing fragmentation and destruction of the self; managing power and control; negotiating negative emotion; creating thinking space; finding positive emotion, and the emergence of positive activities and agentic functioning.

The embodied experience of recovery overlapped with the existentials of lived time, lived, space and lived relations. Trauma was noticed to have a pervasive effect over time; time was experienced as waiting, but also as a need to persevere. There was a move towards taking ownership of time where new beginnings could be made.

Space was experienced as solitary and threatening during the violence, and continuing after the abuse had ceased. Over time, participants were able to enjoy and create a positive space which contributed to positive emotion.

There were perspectives on historical rejecting relationships, including overt rejection, perceived rejection, and absence of relationships, and the negative impact this had on the women's identity. The benefit of supportive and enabling relationships was acknowledged by all participants. The research relationship was experienced positively by all the participants, with two women noting it was their first experience of an enabling relationship. Four women acknowledged a positive change in their sense of identity over time.

Recovery was conceptualised as involving multiple areas, including: a spiritual relationship; facing and accepting the past, and creating a sense of meaning; knowing joy and happiness; engaging in positive friendships, as well as intimate and sexual relations; engaging in

meaningful activities; having clear boundaries; being able to manage emotion; feeling safe; and being independent.

Participants unanimously found the research relationship helpful, with an emphasis placed on the researcher being genuine and having depth of understanding, listening, and placing a value on the participant, being caring and taking time, and holding and accepting everything brought to the encounter.

It is suggested that the importance of the spiritual, as well as the nature of the therapeutic relationship, should be given high consideration when engaging with women with similar presentations. This may have clinical significance when considering service design for women who have experienced chronic violence from childhood into adulthood.

Introduction and overview of chapters

In the field of Counselling Psychology, this thesis aims to contribute to the body of knowledge on the experiential and phenomenological processes that impact on recovery from Violence Against Women (VAW). It aims to bring an understanding of the nature of being an embodied human within this process, to give a temporal understanding to stories being told, to consider the context of space and environment, and to consider the contribution of the relational. It is grounded in hermeneutic phenomenology, existentialism, and relational theory.

Chapter one sets the scene in terms of outlining the incidence of violence against women, as well as the increasing awareness over the years, and provides a contextual background for each participant. It also gives a brief overview of some of the mental health repercussions following violence, and demonstrates the need for this research. This chapter concludes with an overview of the service development of the women's refuges in England, as this is the setting for the present study. This chapter aims to give the reader a context within which the stories of the participants are being told.

Chapter two talks through some of the current thinking around engaging with women who have been subject to violence. Provided is a brief overview of relational-cultural theory, and a critical review of feminist theory. Religion and spirituality, and healing, are also considered in this chapter, and the benefits and potential risks associated with this are outlined. This chapter aims to provide the reader with some of the relevant theories on which the study draws on.

Chapter three focusses on the underpinning assumptions and philosophies. It gives an overview of phenomenology, interpretative phenomenological analysis (IPA) as described by Smith et al (2009), and existential phenomenology. IPA is the method of analysis used in this study, and this is understood within existential phenomenology using Van Manen's (1997) existentials of: lived body; lived time; lived space; and lived relations. This chapter concludes by considering the dual role of the researcher in the study, the relational nature of engagement, and how the data is co-constructed out of this.

Chapter four looks at method. It considers the original design according to the proposal, but how this needed to be amended in order to safeguard the interests of the participants, as well as to be better able to answer the research question. The six adult women participants are detailed, as well as the procedure, including data collection and analysis.

Chapter five covers the data analysis with examples of emergent themes, and the process. The development of the higher-order themes are demonstrated here, including the emergent themes that they incorporate. There is then a cross-case analysis to demonstrate convergence and divergence of themes, and also how these sit within the master themes of lived body, lived time, lived space, and lived relations.

Chapter six considers the findings of the study, and starts with a first impression of the women participants as was detailed in the author's reflective journal. This provides a textured understanding from which the data emerged.

Chapters seven and eight look at interpretation and discussion. The interpretation is written in the first person as the unified voice of the women participants, co-constructed with understanding from the embodied experiencing of participants, and the author's own reflections. This single voice seeks to elucidate the phenomenon of recovery for these women in a textured presentation. This is then considered in the context of underpinning theories.

The final short chapters, nine and ten, of this thesis, consider the impact of the findings, including the implications for Counselling Psychology and for service provision.

The thesis concludes with chapters eleven and twelve which are conclusions and final remarks.

Aims

This study has the following aims:

- To explore the experiential and phenomenological processes over time that are involved in the individual recovery from violence against women.
- To understand these processes in the context of Van Manne's existentials of lived body, lived time, lived space, and lived relations, including the research relationship.
- To consider the impact of the findings for Counselling Psychology, women, service development, and wider society.

SECTION TWO

CONTEXT AND

REVIEW OF RELEVANT LITERATURE

Chapter one

Culture and Context

This chapter seeks to understand the present-day context in which these stories are being told, with an explicit awareness of the social and cultural context of the research. In addition, it summarises some of the literature on the adverse effects of abuse against women, and considers the transition from the family home to a women's refuge.

VIOLENCE AGAINST WOMEN

There is a prevailing international consensus that the abuse of women and girls, regardless of where it occurs, should be seen as 'gender-based violence' as it mostly arises from the subordinate status of women to men in society. In 1993, the United Nations presented their definition of gender-based violence, and passed the 'Declaration on the Elimination of Violence Against Women' (United Nations 1993), which included behaviours specifically directed at women because of their gender: sexual abuse of girls; selective mal-nourishment of girls; female-genital mutilation; sexual assault; marital rape; and dowry-related murder.

Heise, Ellsberg, and Gottmoeller (2002) define gender-based violence as any act that involves the subordination of women through physical or verbal force, or other form of coercion, that results in humiliation, physical or psychological harm, or deprivation of autonomy. It includes sexual assault, intimate partner violence, and human trafficking. This study refers to a range of sexual, physical, and psychological acts against the participants that come under both of these definitions.

There are various terms used to refer to gender-based violence, and they tend to mean different things in different regions in the world. For the purpose of this study, I am predominantly using the term Violence Against Women (VAW), although some specific definitions refer to this as Gender-Based Violence (GBV), and some studies refer to it as Domestic Violence or Intimate Partner Violence; the term used will be keeping with the source that is being referenced.

In the early 1970s, the fear of women who were exposed to violence was starting to be acknowledged at a local level, and women's refuges began to be set up. However, Hanmer and Leonard (1984) note that it was not until 1975 that violence against women started to become a public issue.

Despite this, it was not until the 1980's that violence against women was considered to be a sufficiently significant concern that was worthy of the investment of resources, or of featuring on international agendas (Ellsberg and Heise 2005). Women's groups, both nationally and at an international level, started to focus public attention on the abuse of women, including physical, sexual, psychological, and economic abuse. As a consequence of these actions, violence against women is increasingly being recognised as a human rights matter, (Ellsberg and Heise 2005).

This is the contextual background in which the participants sit. Martha was born in the mid 1950s which was 20 years before violence against women was even being considered as a risk to health.

Amanda was born in the early 1970s when the risks of violence against women were only starting to be considered at a local level, and it was not yet considered to be a public issue. Martha had already experienced 20 years of abuse by this time.

Chloe, Tessa and Kirsty were born in the mid 1980s when there was the start to thinking about these concerns as worthy of investment; however, Chloe spent most of her childhood years in Africa, where developments have not kept pace with the Western world.

Sara, the youngest of the participants, was born in 1999. Despite the relative recency of her birth, and the proportionate increase in knowledge and awareness, she was still subject to childhood abuse and abuse as an adult.

The background data suggests that as a nation there is still a long way to go in terms of public awareness and intervention for this problem, plus there are still women who have suffered from violence prior to and during the increase in awareness over the years, and are still reaping the consequences; it is these reasons that emphasise the salience and pertinence of this present study.

Prior to 2005, research into violence against women largely focussed on non-representative groups, and had diverse methodology. As such, it was difficult to gain helpful information in terms of the overall incidence as well as the impact of this violence. The International Research Network on Violence Against Women (IRNVAW) pioneered a multi-country study on Women's Health and Domestic Violence, seeking to overcome methodological issues, and facilitate collaboration amongst researchers. These findings are reported on by Ellsberg and Heise (2005) and those relevant to the nationalities of the participants in this present study are reported here.

Martha was of Indian origin who came over to the United Kingdom as a young child. An example of the incidence of violence against women in a National study in India between 1998-1999 (Kishor and Johnson 2004), with a sample size of 90,303 women between the ages of 15 and 49, all having been married or partnered, showed that 10% had been physically assaulted by a partner in the last 12 months, and 19% had been assaulted in the past. This data is around 30 years after Martha's birth but gives a sense of the continued prevalence in the thinking around the acceptability of abuse in this culture.

Chloe was of African origin, and spent her childhood in Africa, and had an African partner as an adult but in England; Kirsty was British but was previously married to a man of African origin.

In Zambia in 2001-2002, (Kishor and Johnson 2004) a National study of 3792 women between the ages of 15 and 49, all of whom had been partnered or married, a total of 27% had been physically assaulted in the last 12 months, and 49% at some point.

A national study in Kenya (Central Bureau of Statistics 2003) with a sample of 3856 between the ages of 15-49, all women having been partnered or married, a total of 24% had been physically assaulted in the last 12 months, and 40% at some point.

The remaining three women, Amanda, Tessa and Sara, were of British origin, and had British partners as adults. In 2001, in the United Kingdom (Fischbach and Herbert 1997), a national study of 12,226 women between the ages of 16 and 59, a total of 3% reported being physically assaulted in the last 12 months, and 19% reported this to be since the age of 16. In London this was 12% within the last 12 months, and 30% since the age of 16; however, this sample group also included women who had never been in a relationship, suggesting that the incidence may have been higher. Many women across the samples also reported first non-volitional sex at a young age, (Ellsberg and Heise 2005; Macdowall, Gibson, Tanton et al

2013). This gives an idea of the social context in which the women in this study were growing up.

The Office for National Statistics reported findings for the year ending March 2016 in the Crime Survey for England and Wales on adults between the ages of 16-59, and identified that over 26% of women had experienced domestic abuse since the age of 16, equivalent to an estimated 4.3 million female victims. There have been small, non-statistically significant changes from year to year since March 2009, but the cumulative effect of these changes suggest a lower prevalence in March 2016 as compared with March 2012, suggesting a longer-term downward trend. Despite these reports of a possible downward trend in England and Wales, these figures only include those which have been reported, and, given the criminal nature of abuse, it is reasonable to assume that much goes unreported and thus undocumented. What is concerning is that, despite reported advances in awareness and recognition in the issues around violence against women, there are still attitudes in the multi-cultural Western World where it is legitimised, minimised or hidden, and denied (Lloyd and Ramon (2017); As Chartier, Walker and Naimark (2010) point out, these are acts that if directed at a neighbour, employer or other, would be challenged, but when directed at women, particularly in the context of family, appear to go unnoticed.

It is recognised that violence can be perpetrated by both males and females, however, the violence typically committed against men differs from the characteristics of violence committed against women (Ellsberg and Heise (2005): men are more likely to be attacked on the street by a stranger, killed in wars or gang-related activities; men are more frequently the perpetrators of violence regardless of gender of the victim.

On the other hand, women are more likely to be a victim of violence by someone they know, frequently a partner or ex-partner or other family member. They are also more at risk of being sexually assaulted in childhood, adolescence and as an adult, (Watts and Zimmerman, 2002 in Ellsberg and Heise 2005). All of the participants in this study were subject to early abuse by family members and by partners as adults. Chloe was slightly different, she was neglected and psychologically abused by her aunt who was her carer in the absence of her parents, but the sexual and physical abuse was perpetrated by the men in the village community.

In the research by Valentine (2001), it is argued that the most common place for violence against women is in the home, and by a man who is known to her. Domestic violence is seen within virtually all cultures (Heise, Pitanguy and German (1994) and across all social classes, age groups and ethnicities (Hall 1998).

The cultural context can contribute to both the risk of violence against women, but also to resiliency (O'Brien and Macy 2016), who say that unequal gender norms persist worldwide, where the roles of men and women are imbalanced, with cultural and social pressure for women to be chaste and passive, but few expectations for men to either practice self-control or treat their partners respectfully, (Heise et al 2002). O'Brien and Macy continue to say that it is these differences in expectations which impede the development of equitable and healthy relationships, with community and religious values maintaining and normalising violence against women (Garcia-Moreno et al 2005). This is particularly pertinent to Chloe who was subjected to Tribal abuse.

Unequal gender norms within the cultural context, including expectations and belief systems, impact women's ability to make autonomous choices, as does the fear of rejection and abandonment by their partners and communities; a consequence, they frequently suffer in silence, (Garcia-Moreno et al 2005). Martha, a Muslim, endured over 55 years of abuse in silence before being able to leave the family home.

Hooks (1984) defines oppression as being the absence of choice. In Western society, it could be argued that there are many choices available to women that weren't previously there, such as greater equality in employment which now supported in law, (e.g.The Equality Act 2010);control over reproduction, such as use of the Contraceptive pill (first commercially available contraceptive pill was in 1960). With these significant changes it could be argued that women are not discriminated against in the Western World; yet the impact of violence against women can still be seen to be a considerable problem both at an individual and societal level, and the maintenance of difference, as a result of, for example, gender, continues to be very important in many cultures within the Western World.

The next section provides an overview of some of the adverse mental health complications as a result of violence against women.

MENTAL HEALTH REPERCUSSIONS FROM ABUSE

There is now a substantial body of research that identifies that childhood adversity, and adult abuse, can have serious deleterious consequences for women, both physical and mental (e.g. Afifi et al 2008; Kessler et al 2010; Chapman et al 2004).

There are strong links between cumulative exposure to childhood abuse giving rise to diminished health-related quality of life, (Corso et al 2008).

Posttraumatic stress disorder is one of the most common disorders among women who have experienced intimate partner violence (Campbell 2002), with associated depression, dissociation and substance misuse, (Hebenstreit et al 2015), and anxiety (Lindert et al 2013).

Many suffer life-long adverse effects from either childhood abuse, abuse in adulthood, or both, with physical and mental consequences and the impact on Health Services and Government resources is substantial, (Bellis, Hughes and Hardcastle 2017)

Given the high and enduring impact of violence against women on their mental and physical health, plus the economic cost to the nation, it is vital that there is a good understanding of what is involved in the recovery from such traumas so that services can work in the most effective way. Increasingly, efforts by women's action groups are starting to have an impact, and service providers and policy makers are recognising the need to provide for this health problem.

The next section considers more of the contextual aspects for the participants, and looks at the background to the setting where this study takes place, the women's refuge.

FROM HOME TO REFUGE

Warrington (2003) talks about the fear experienced by women who are subject to violence in the home, and describes this as frequently being a very private fear, not even shared with family and friends. Warrington continues to say that this silence around the experience of violence is often driven by shame, and / or additional fear that family and friends may intervene and make the situation worse. Kirkwood (1993) discusses how this fear can extend through time and space, so that even when a woman takes the step to leave a violent relationship, the fear continues.

All of the participants in this study remained in abusive relationships for long periods of time, the longest, Martha, was at least 59 years, and the shortest, Sara, was at least 15 years.

Warrington (2003) describes how women can be trapped by a number of possible factors including: economic; a sense of personal failure; fear that the violent family member will find them and punish them further; and sometimes a belief that the violence will stop. For all the women in this study there was an episode of extreme violence that forced her to leave her home and seek shelter elsewhere, and it was to a women's refuge that they turned in search of safety.

Women's refuges have been providing temporary accommodation in the United Kingdom since the 1970's (Bowstead 2015). They are services which enable women and children to relocate to a place where they have no other connections, in order to escape the violence. There are a range of support services provided (Warrington 2003) with the view to assisting women in the recovery from abuse (Abrahams 2010).

Dobash and Dobash (1992) identified three goals in the early refuge movement, which included assisting female victims, challenging male violence, and improving women's position in society. Whereas refuges were originally set up to provide a place of safety, it was soon recognised that a more extensive service was required, and more consistent support from staff (Warrington 2013). Refuges today are working more closely with other agencies including the police, and a number are now funded by the government. However, the increase in professionalism has not been entirely good, as Schechter (1988) points out, that while government funding has brought advantages, some of the key principles have been undermined, where increasingly refuges are managed by social service agencies, and violence against women is being viewed as a mental health issue (Warrington 2003). Unfortunately, with the need to get money and maintain the service, something of the original vision has been lost. Additionally, despite government input, there continues to be challenges to funding, which in turn challenges the ability to provide a service in a way that meets the need, and much of the time of workers is necessarily spent on fundraising activities.

It is recognised that violence against women forces them to geographically relocate for their own safety. All of the women in this study were able to find a place at a refuge, however there is a lack of national planning and funding to ensure that refuges are in sufficient numbers, and also having enough capacity, around the country, (Quilgars and Pleace 2010). This can make it very difficult to access a place of safety at a time when the woman is already very distressed. For those women who choose not to relocate it is not always possible to remain safe, even with additional security measures and support (Jones et al 2010).

Bowstead (2015) reports that around three quarters of women make relocation journeys within their area, suggesting that women prefer to stay where they are if they can, only moving beyond this if they have no alternative. Four of the participants in this study moved a relatively short distance from their family home, and two moved out of area.

Additionally, specialist services are increasingly being cut (Coy et al 2009), which means there can be a reduced access to practical and emotional support at this time of crisis. Regardless of whether they had to move to a new area or remained in the local area, the common factor with all of the women is that all had to leave their own home and uproot into temporary accommodation in order to seek safety.

Bowstead (2015) notes that there is a limited evidence base on the experiential nature of women's relocation journeys to escape domestic violence, and it would be easy to lose sight of this contextual aspect to this present study. Women relocating as a result of violence are not only new arrivals to an area and community, but are also a minority group (Parvin 2009). Although this study does not specifically focus on this transition journey, it is against this backdrop that these stories of recovery are told.

Chapter two

Review of relevant literature

SUMMARY OF FEMINIST THEORY

Feminism is a multi-disciplinary voice which advocates for social change, and essentially is a lens for thinking about wider issues, (Lak and Daley 2007). For a number of years, considering feminism as a lens rather overshadowed the focus on developing theory, but there have been a number of developments in recent years.

Feminist theory developed out of a large feminist movement which sought to challenge traditions, hierarchies and priorities of life, and called for a major reassessment of theories and methods in use in the academic world (Hesse-Biber, 2002). Feminist theory specifically focuses on the female viewpoint and experience as opposed to other perspectives. In this way it can illuminate social problems and issues that have perhaps been overlooked or ignored, and that may have a historically patriarchal perspective on social theory, (e.g Crossman (2018).

Particular areas within feminist theory include discrimination and exclusion on the basis of the following: sex and gender; gender roles and stereotypes; inequality within society, e.g. the wage gap between genders for doing the same work; objectification. From this starting point, research which operated within a feminist framework started to draw attention to matters around social power and difference, with a commitment to pursuing social justice.

To say that feminist theory merely focussed on the rights of women would be reductionist: there are specific epistemological and ontological assumptions, and this are summarised below:

Flax (1999) identified three key assumptions to feminist theory:

- The worlds of men and women are not the same, essentially they have different experiences. There is a call to consider how gender differences impact human behaviour, and to consider how oppressions are gender based.
- The oppression of women is a unique combination of social problems which require understanding in their own right. Flax goes onto say that oppression it is not just 'bad attitudes" (p10) or backward traditions, but is a patriarchal structure deeply rooted in the socio-economic and political structure of society.
- There are 'power differentials between men and women' (p10)

The nature of the oppression of women has sought to be understood, and the understanding and analysis of this are central to feminist theories. It has been identified that in respect of oppression, there can be a lack of education, financial dependence, and (especially historically) unequal political rights, as well as a need for control over sexuality. Some of the causes of these things have been identified as cultural order, biological differences, politics, economic relations and also how women understand themselves.

Feminist theory would argue that there is a need for us to critically examine what is happening in the social world, and provide strategies for amelioration. Some of the principles behind this include placing a value on women and their experiences, and seeking social change through advocacy.

Andermah et al (1997) note that feminism has developed in different arenas, including: 'black feminism, radical feminism, cultural feminism, lesbian feminism, liberal feminism, Marxist

feminism, materialist feminism, and socialist feminism.' There are key similarities, but also some specific emphases in the different domains. Some examples, which are relevant to the study here, include the following arenas:

- Black feminism seeks to understand what it is to be a black woman in a historical context of 'racist patriarchy' (Johnson 1983), where individual transformation entails understanding the how institutions of domination have been structured. The differences between men and women seem much more visible in particularly black cultures, (Collins 1991), and the intersection between race, class, gender, religion, and sexuality provide a context that is not so strong in other feminisms.
- Radical feminism places men as causal in the oppression of women, and holds that it is not reducible to other explanations. It criticises cultural feminism for providing a grounding that men cannot help being oppressive, and women cannot help being submissive (Ferguson 1996).

This study does not have the scope to acknowledge all the different types of feminism, except to acknowledge the diversity within feminism.

A criticism of much feminist research is that it frequently does not focus on the development of theory, either asserting the key components or testing these. This present study does not seek to do this either, but rather uses feminist theory as a lens, creating an opportunity for the reader to understand some of the difficulties that the women faced in relation to their cultures and context, in particular, some of the pathologizing discourses about women, and behaviours of men that maintain inequalities and oppression.

This study seeks to understand the phenomenon of recovery as socially constructed knowledge, and Van Den Bergh (1995) emphasises the importance of this. She notes the feminist concern of consciousness-raising as a type of knowledge production, which includes women's life experiences. She states that putting the experience into voice, and naming the reality, is empowering, and in this way, knowledge and power become linked. There is a need for voices which have been marginalised by 'expertness' to be heard.

RELATIONAL CULTURAL THEORY

It is an important observation to make that all traumas occur within a sociocultural and historical context, but also within a relational context (Kress, Haiyasisi, Zoldan, Headley and Trepal 2017), and this is especially relevant for these six participants where the traumas were initiated within the interpersonal relationships family, partners, and in Chloe's case, the village men in addition to inter-partner violence.

Relational cultural theory (Miller 1976) is a developmental theory based on feminist and psychodynamic theories, and focuses on the centrality of relationships with others as opposed to psychological individuation and separation (Jordan 2000). This is relevant to this study as it considers the impact of relationships on the women and how this impacts their recovery.

Kress et al (2017) suggest that the use of relational-cultural theory may be useful when working with victims of interpersonal violence. Jordan (2010) explains the main tenets of relational-cultural theory as operating on the premise that all people require a connection with others throughout their life, and that it is through healthy relationships which promote individual growth, that a sense of safety and wellbeing can be experienced, and that it is through this that healing can take place. This study specifically considers relationships both historically and in the present including, but not exclusive to, reflection on the relationship between the participant women and the practitioner-researcher.

Walker (2005) observes that deep and meaningful connections with others is central to psychological development and it is held that the research relationship can contribute to this. Within this, women can experience a sense of belonging and develop a sense of self-worth, and from this can see how they can contribute to and positively affect others in society (Miller 1976).

Miller continues to say that times of disconnection are necessary to relational development, but when the woman experiences interpersonal violations, such as verbal humiliation or physical abuse, the openness and desire for these relationships is impaired; when the interpersonal violence persists, the disconnection becomes chronic, and the woman experiences the imbalance of power, and in this way prioritises the expectations and desires of the abusive person. These experiences can impact on the woman's ability to form new and trusting relationships, including with therapists and other professionals, and in this study, the practitioner-researcher. Banks (2006) suggests that women's disconnection not be seen as resistance and should not be pushed against; rather he practitioner-researcher seeks to be aware of the self-protective strategies of disconnection that may be at play.

Miller and Stiver (1997) explain that strategies of disconnection are seen as safe alternatives to the traumatised woman when faced with repeated humiliation, neglect and violation, but behind these is both the desire for and fear of connection. Due to the woman's difficulties in tolerating feelings of vulnerability, there are likely to be abrupt disconnections, emotional dysregulation, destructive behaviours, and hypervigilance (Jordan 2010). Given that relational support is integral (Miller and Stiver 1997) in this study the practitioner-researcher's goal is to explore and notice this paradox between connection and disconnection. Through the process of the interviews, the women have the opportunity to give attention to disconnection and connection processes in the context of a safe and healthy relationship, and in this way gain relational competence, confidence, and resiliency (Jordan 2010).

This approach is pertinent to this study as it has a concept of humanity as being whole, whilst simultaneously recognising that there are disparate parts, but yet each part is valued and considered within the whole person. The women are seen as such but also as part of a relational and contextual system, and it is within these that she can grow and develop. Although the change is largely at the individual level this will necessarily also impact her context.

RECOVERY AS A CONCEPT

The process of 'recovery' suggests 'the idea of action that moves one from disordered states to states more conducive to balance, harmony, growth, and health,' (Ashford, Brown, and Brown et al. 2019). Many definitions exist for the concept of recovery, definitions that are arguably necessarily guided by the field in which they are to be applied, with epistemological and ontological differences giving rise to varying recovery paradigms.

In their systematic review, Ellison, Belanger, Niles, Evans, and Bauer (2016) focussed specifically on Mental Health Recovery. They note that over recent decades a new paradigm for describing the process of overcoming the detrimental effects of severe mental illness has emerged. An early example of a national consensus approach to a definition of mental health recovery is that of the Substance Abuse and Mental Health Services Administration (SAMHSA), which stated that 'Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of the person's choice while striving to achieve his or her full potential' (Substance Abuse and Mental Health Services Administration, 2006, cited in Ellison et al. 2016).

However, the term ‘recovery’ is an ambiguous concept that is used inconsistently as an amalgam of treatment practices, cultural beliefs, and ideas about mental illness (Davidson and Roe (2007), cited in Ellison et al., 2016). The concept of recovery, like mental illness, represents a multidimensional set of phenomena, and the selection of any one definition of recovery opens the possibility of over-emphasising minor components, or even dismissing key ones.

Aimed at guiding future research on recovery, the Ellison et al. (2016) systematic review assessed the concordance of policy-based and scientific definitions, and operationalisations of the recovery concept. Ellison et al. examined 67 articles and found that although literature contains various overlapping and ambiguous definitions of recovery, their findings suggest that there is a consensus on at least four aspects of recovery: it should be ‘person centred’, and centrally connected to the construct of ‘hope’, ‘purpose’, and ‘empowerment.’ They suggest that as organisations struggle to define recovery in order to provide services that are recovery orientated, the application of these four aspects would align policy with the consensus on how recovery is understood in the international field.

Ellison et al.(2016) noted that while there was a broad consensus on the dimensions and components of recovery, there were two outliers, those of ‘addresses trauma’ and ‘culture’. The omission of ‘addresses trauma’ in most articles is arguably due to the growth and appreciation of trauma informed mental health care, or possibly that it was intentionally omitted because not everyone who has mental health challenges has experienced a traumatic event. Whereas they suggest the omission of ‘culture’ may reflect a Euro-American ethnocentrism to recovery literature, their review also noted components of recovery that were missing from SAMHSA definitions, such as ‘skill building’, ‘quality of life’, and ‘ecology.’ Whilst these components can be closely linked to other SAMHSA components like ‘purpose’ and ‘hope’, they suggested that further explication of recovery should attend to these specific components.

Ellison et al. acknowledge that they could only speculate on what the drivers are for changes in recovery definitions over time and raised the question as to whether it evolves through changes in political direction, changing cultural values, or maybe a growing crystallisation born out of practice and experience. They also acknowledge limitations to their review, for example basing it on the SAMHSA defined components of recovery, only one of several other frameworks for recovery they could have used. They also note that although the SAMHSA definitions were informed by literature, and represent a best effort to capture the essence of each concept, the lines that distinguish concepts from each other can still be blurry.

A more recent study by Ashford et al. (2019) led to a collaboration on behalf of the Recovery Science Research Collaborative (RSRC). The RSRC has a mission, as an independent panel, to support the expansion of the science of recovery, and its support systems. At the centre of their endeavour, the RSRC considered a number of definitions from stakeholder entities, such as SAMHSA. They evaluated their relative strengths and weaknesses using the most current supporting data, with the aim of producing a synthetic, independent recovery definition that could be operationalised for recovery science and research (so that recovery can be more effectively investigated). From leading definitions, Ashford et al. surmised fundamental elements, the first being the role of the individual in actively seeking wellness, and the second being the paradigm of recovery as a multidimensional state of wellness, including psychological, physical, and spiritual factors. They also anticipated an importance of engagement with a community that upholds prosocial values, and suggested that ‘quality of life’ seemed to be the central operant in the recovery process.

Ashford et al. (2019) noted that the explicit recognition that contexts, systems, and people involved in recovery, was absent from existing definitions, and that these factors may change between individuals and across segments of similar groups of individuals. Other examples that

impact the cognisance and establishment of recovery processes, and the motivation and ability to maintain them include the following: community factors, socio-economic factors, stigma, ethnicity, recovery pathways, degrees of pathological severity and organic impairment. It can be argued that any definition of recovery that does not account for individual experiences, or the role of contexts, would be incomplete.

Ashford et al. (2019) go on to explain that the RSRC began constructing their definition using linguistic analysis of key terms and concepts relating to specific components of recovery. They concluded that, firstly, recovery is a relational process, with a multiplicity of trajectories; secondly, there are overlaps which exist between recovery paradigms (e.g. between substance abuse disorder and mental health); and finally, that cultural and ecological factors influence the scope and context of recovery.

The RSRC consensus definition of recovery is:

"*Recovery is an individualised, intentional, dynamic, and relational process involving sustained efforts to improve wellness*." (Ashford et al., 2019)

Ashford et al. (2019) note that a limitation of any attempt to define terms within research, is that a degree of inclusion and exclusion takes place along dialectical perimeters. Language is constantly evolving, with changes in meanings, values, and assumptions. Limits to this definition might also develop as treatment, medication, public health, political, and social realities evolve. Although an arduous process, a field-wide consensus on the definition of recovery will require continued engagement with the process to push forwards.

RECOVERY: CONTRIBUTING FACTORS

Whalen (1996) researched various counselling models which were being used to promote the recovery of women who were victims of violence. She came to the conclusion that the counsellors she interviewed had a lack of understanding of the ideological foundations which underpinned their counselling, but she was even more concerned that the primary ideology was not one of social change, as would be in keeping with the ideology of the 'battered women's movement' (p105). Rather, the emphasis of counsellors was based on their understanding of the role of counselling in helping women become free from the abusive relationships. In this way there was a separation of counselling practice and politics. Whalen was concerned about this apparent compartmentalisation: it seemed as if there was a shift away from the collective empowerment of women to individual empowerment.

A specific finding in relation to this was the training programs of counsellors, which were frequently linked to program standards and also confidentiality statuses. Whalen explained the compartmentalisation in terms of the lack of integration of component parts within the training, which seemed to be reflected in the practice of counsellors, and this was supported through her interviews with the counsellors.

Two further issues identified by Whalen were how basic counselling skills can be implemented in a model that enables social change activities on the part of the client, as well as considering empowerment as a concept.

Many counsellors and psychologists engaged in programs relating to violence against women are first taught Rogerian-style engagement skills, including empathic listening and responding, and holding a non-judgemental position whilst simultaneously remaining true to oneself. Whalen acknowledges the centrality of the Rogerian principles in terms of engagement, however, argues that this emphasis on connecting with the woman can easily become the goal in itself, as opposed to a means of achieving social change, and in this way

compartmentalisation persists, and the endeavour remains focussed on the individual. Grounding the skills in an ideology which also focusses on social change does not limit it to the benefit of the individual, rather offers a contribution to changes on a bigger scale. She stressed that there also needs to be a recognition that this is a social problem which requires a corporate response.

This research identifies how counselling can view the individual in a compartmentalised way and that this concept of compartmentalisation is unhelpful. This is not only because the woman is already likely to be experiencing herself as fragmented, but also because it does not place this in the context of social change. This present study does not set out to be a counselling endeavour however it employs the key tenets of Rogerian theory due to the traumatic nature of the phenomenon under study. The practitioner-researcher engages with the women at an individual level, which seems of paramount importance, given the considerable distress of the women having just come into the refuge.

It is held that gaining a greater understanding of the recovery process will enable a greater reflection on the wider social context, thereby increases the potential of social change over time.

Jayasundara, Nedegaard, Flanagan, Phillips and Weeks (2017) discuss the importance of religion and spirituality in people's lives in their journey towards recovery after violence, but note that although it can be a source of comfort, it can also be a barrier to victim's seeking help. In their paper, they discuss five major religions and highlight how each one can be misused to justify abusive behaviours.

The authors support the work of O'Brien and Macy (2016) and stress the importance of cultural competence, considering religion and spirituality as cultural forms of diversity.

Domestic violence impacts families regardless of socioeconomic status, age, or religious background (NCADV 2007) and it is important to understand the role of religion and spirituality in a client's life (Jayasundara et al 2017).

Religion can be a protective factor: trust in a higher power, and support received from other members of a faith community, have been shown to be significantly helpful in the reduction of depression of many victims of domestic violence, in addition to contributing to their general wellbeing (Gillum, Sullivan and Bybee 2006).

However, religion is not always a protective factor (Anton 2007) and can be used as a weapon of abuse to perpetuate abusive thinking and behaviours, justified by the distortion and misuse of sacred texts (Pournaghash-Tehrani 2009). These beliefs can also be adopted by victims of violence, resulting in them feeling even more powerless and vulnerable, (Jayasundara et al 2017).

Knott (1996) identifies how religious views can impact help-seeking behaviours as a consequence of beliefs about what is and is not acceptable. Zastrow (2010) observes that not acknowledging the importance of religion in a client's life can prevent the understanding of how the client's belief system supports or inhibits help-seeking behaviours, and also change.

Three women in this study had religious or faith beliefs: Martha was Muslim; Chloe and Kirsty were Christian. The other three women reported no religious or faith beliefs. The importance of observing the impact of faith or religion on the women's recovery not only has a concept of humanity as being able to transcend the everyday into the realm of the spiritual, but also provides additional texture to the findings of this study including the meanings ascribed to them.

Stenius and Veysey (2005) in their ethnographic study of a largely white population, (one woman was Latina), carried out semi-structured interviews at three monthly intervals for one year, examining the healing and recovery process of the women. All women had experienced childhood abuse or adult abuse or both.

Stenius and Veysey observed that women recover from violent experiences in a number of different ways.

They found that most of the women had informal resources and supports which they used to help take care of themselves. The women who had difficulty taking care of themselves reported the need to see themselves as worthy of being cared for, over and above caring for the needs of others.

All the women relied on connections with others. Professional intervention was a support for some, and at times this was the only support; however, it was the means of delivery that mattered most. Others reported that connections with friends and family provided a level of trust and understanding that was not always available in professional relationships.

72% identified that a spiritual connection helped their ability to regulate their emotions, and this varied from formal religious practice to more general beliefs; however, the commonality was the source of support, a sense of hope, and a feeling of inner peace.

Walking and enjoying nature were cited as helpful, as were pets, because of their unconditional love; activities such as volunteering which enabled a sense of having something to give to others, was also viewed positively. Some women focussed on self-care in the form of healthy eating, ensuring adequate sleep, and exercise. Others enjoyed massages, relaxing baths, and other mindful and relaxing activities.

78% pointed to the importance of making decisions and setting limits. Having choice was crucial, choosing the pace at which they healed, when to work on things and with whom, establishing a safe place, and setting and maintaining boundaries. In sum it was about making helpful choices.

During their time of recovery, a number continued to use strategies such as numbing and dissociation, including having different identities with different memories. The authors noted the degree of control the women had over these symptoms, and how much understanding these women had over their mind and body to be able to prevent deterioration.

No specific formal intervention was identified as uniformly helpful or unhelpful. It was not the service per se, as much as it was the means of delivery, and the characteristics of those offering the care. What was identified as helpful included the therapist's skills and relational style, availability and responsiveness, shared empathy and experience, female therapists, and women-only groups.

This chapter has considered some of the relevant theories of working with this client group, and will be re-visited in conjunction with the findings from this present study. The following section focusses on the underpinning assumptions and philosophies of this present study, and provides details on method.

SECTION THREE

METHODOLOGY

Chapter three

Underpinning assumptions and philosophies of this present study

ASSUMPTIONS

There are some general assumptions which underpin the research question, which are as follows:

- The assumption that the experience of recovery from violence against women is significant and relevant to the discipline of Counselling Psychology.
- The assumption that time is involved in the process of recovery. The method will focus on both past experiencing of the participants, and present experiencing within a relational context between the participant and the practitioner-researcher.
- The assumption that the recovery process is significant to the participant.
- The assumption that there are multiple truths in relation to this experience, and that these truths can be shared if they can be translated into language.
- The assumption that this process of translating experience into meaningful language will have a resonance with others, even if those others have not directly experienced violence against women themselves.

Further to these general assumptions pertinent to the research question, this study sits within a research paradigm, which is a context for framing the research (Morrow et al 2012), and includes both beliefs and assumptions around ontology (the nature of reality and being) and epistemology (the acquisition of knowledge).

ONTOLOGICAL BELIEFS

This study takes the perspective that there is no single and objective truth, rather there are multiple and equally valid versions of reality, and in this sense it embraces the constructivist-interpretivist paradigm, (Ponterotto 2005). It is concerned with the subjective and meaning making processes of the women, and also of the researcher in the context of her relationship with the women. The researcher seeks to explore the participants' individual lived experiences of recovery from violence considering both convergences and divergences.

EPISTEMOLOGICAL ASSUMPTIONS OF INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

In respect to epistemology, this study seeks to capture the lived experience of participants but also holds that meaning is hidden and it is through reflexive interpretation that is comes to the foreground (Willig 2013). It is underpinned by the following assumptions pertaining to interpretative phenomenological analysis:

- To understand the world, it is necessary to understand experience
- Researchers engage with individual accounts of people immersed in a relational, linguistic, cultural and physical world

- This idiographic focus enables detailed attention on the particular
- Experience is not directly accessed through individual accounts but rather through the process of meaning making in the context of relationships.
- To be able to engage with the experiences of other people, the researcher needs to reflect on her own assumptions and experiences.
- The researcher cannot escape her role in producing these interpretations but maintains a commitment to grounding them in the views of the participants.

(Larkin and Thompson 2011)

ORIGINS AND INFLUENCES

Phenomenology

Phenomenology is the study of being in terms of existence and experiences. There are two key historical roots: the transcendental, and the hermeneutic or existential (Larkin and Thompson 2011).

Edmund Husserl, according to Todres (2007), is considered to be the founder of phenomenology. He paid great attention to understanding the epistemological concerns of how reflections on what appears in consciousness can give rise to knowledge about life. He was mindful about reducing the gap which was appearing in the Western world between mind and body, and object-subject relations (Todres 2007). Empirical phenomenologists inspired by Husserlian ideas (e.g. Giorgi 1985), attempt to study structures as they appear in consciousness.

Transcendental phenomenology arises from Husserl, and seeks to identify the essential core structures of experiences through methodological reductions. For Husserl, this involved identifying the researchers assumptions (history, context, culture) then bracketing these off in order to identify the essence of a phenomenon. The objective was to transcend everyday assumptions, and seeking to describe everyday experiences in their richness and complexity, and then to analyse these, with the aim of understanding what it is to be human (Larkin and Thompson 2011). This was a significant move away from the scientific ideal of positivism.

Ponterrotto (2005) points out that psychology has long been dominated by positivist and post positivist research, and this is reflected in the quantitative research available. He argues that such a limited focus in terms of epistemology and methods has restricted the profession's overall development. He goes on to say that the inclusion of post-modern perspectives with the associated qualitative methodology will take the discipline of counselling psychology to new heights.

Phenomenology makes the assumption that a person supersedes the sum of her parts, is affected by relationships with others, is aware, has choice, and is intentional. There is no split between mind and body. Phenomenology offers the researcher the possibility of accessing the phenomenon "as it is given in experience" (Finlay 2006 p44).

Martin Heidegger (1962) focussed more on ontology in respect to the kind of being that is able to understand and know, and what we can learn about the nature of being and the context within which being is situated. Heidegger considered existential and hermeneutic (interpretive) dimensions e.g. Ashworth (2003), looking at a person's sense of self, space, time, embodiment, and relationships, in an interpretive manner. Heidegger questions even the

possibility of knowing in the absence of interpretation. Heidegger emphasised our personal involvement in the lived world, and saw this in the context of our relationships with others, and to the world.

This understanding results in the inextricable relationship between language and understanding, as it is only through language that our being can be shown and thus understood (Heidegger 1962). Each being is always amidst the pre-existing world of people, relationships, language, history and culture, and material objects, thus each being is always in relation to something else. Therefore, paramount to any phenomenological enquiry, is this interpretation of individual meaning making.

Heidegger sought to increase texture to understanding by considering how understanding is situated existentially. He suggested that the "pre-reflexive" (cited in Todres 2007) consideration of things before us is never neutral, but rather is coloured by mood. Todres (2007) suggests the need for us to find a language that is able to convey the situated-ness of mood within a given experience. This emphasis on the worldly, the embodied, and thus situated-ness of experience is often termed hermeneutic phenomenology, and is always interpretive in nature (Larkin and Thompson 2011).

Merleau-Ponty (1962) also considered the importance of the interpretation of knowledge but particularly sought to describe the embodied nature of our relationship to the world. Merleau-Ponty saw the embodied way of being as the world and body being within each other and intertwined. This view that our embodiment shapes our perspective of experience has come to be recognised within Interpretative Phenomenological Analysis (Smith et al 2009), and embodied interpretation seeks to convey the meaning of a phenomenon with the richness of its texture and complexity, facilitating not just a cognitive understanding but also an emotional cognisance. Although this may go some way into translating experience into language and also a felt-sense, it is also recognised that whilst one may feel empathy for another, their experience belongs only to them and their own situatedness.

Amos (2016) proposes that this embodied interpretation can be successfully incorporated into IPA. As the researcher attends to her bodily response to the research data, an additional understanding is offered in terms of 'words that work' (Todres and Galvin 2008, p576) for the researcher, participant, and the reader. There is this sense that lived experience is more than words can say (Amos 2016p307). Using this philosophy as an approach to interaction in this present study provides an opportunity to slow down and 'dwell' (Finlay 2011) in the specific and individual experiential processes pertinent to recovery. There is the chance to participate in the richness of the experiencing, using language to test out with the women things which are tacitly but not explicitly know, and as Seamon (2000) suggests, typically go unnoticed or unquestioned.

Interpretative phenomenological analysis

Interpretive phenomenological analysis (IPA) is the method of analysis chosen for this study due to the opportunities it affords to explore the experiential and individual meaning-making of the participants, drawing on the developments by Heidegger and Merleau-Ponty.

First introduced by Johnathan Smith (1996), IPA holds ideographic and hermeneutic phenomenology as its key tenets (Smith, Flowers and Larkin 2009; Larkin and Thompson 2012). It is specifically concerned with meanings and processes, and the participant's version of reality, as opposed to what actually occurred and possible causal relationships. This is particularly relevant to a study such as this present one, which does not seek to engage with a fact-finding mission to establish exactly what happened in the episodes of violence, but rather seeks to explore the experiencing of the recovery from these events, accepting that the participants' accounts of the experiencing is their reality, and valid as such. Meaning is

considered at the level of each woman as they are in their context, in their personal and social worlds, and to the things that pertain to them, and the individual meanings that they make (Smith and Eatough 2006) in respect to them and to themselves.

As an ideographic approach it is concerned with the detailed and nuanced examination of the individual participants (Shinebourne 2011) and as such does not seek to identify general patterns of behaviour and generate laws across groups (Smith et al 2009) as in nomothetic research.

IPA adopts a phenomenological attitude which is characterised by openness, curiosity and reflexivity (Finlay 2014). This allows the practitioner-researcher to engage with the participants in a way that enables a caring and supportive environment but creates the space for things previously not considered to be noticed and reflected upon within both the participants and the practitioner-researcher, and within the interpersonal space.

IPA acknowledges that self and experience are contextual, embodied, and embedded in relationships with others and the world and the nature of our engagement with them, and that meanings are intersubjective and relational (Smith et al 2009). It is recognised that the narrating of experiences relating to recovery is also influenced by the nature of the engagement between the participant and the practitioner-researcher.

Within the IPA approach the researcher is required to collate first-person, detailed and reflective accounts from participants and to provide a phenomenologically-focussed interpretation to these accounts, (Larkin and Thompson 2012). The role of the researcher is acknowledged within the data collection and the interpretation (Smith et al 2009), and this is mediated by prior experiences, existing knowledge, and is also embedded in the socio-cultural context of the researcher (Smith et al 2009). In this way there is a 'hermeneutic circle' (Smith et al 2009) which involves a dynamic dialogue between the past and the present, the researcher and the participant. IPA therefore has a 'double hermeneutic' (Smith 2007) referring to the researcher's influence in the construction of knowledge.

Due to the relational nature of engagement in this study, here is a specific focus on the relationship between the participant and the practitioner-researcher and this is viewed as additional data. The researcher seeks to empathically interpret, seeking to understand from the subjective perspective of the participant, but simultaneously adopts hermeneutics of suspicion' (Ricoeur 1970), asking critical questions to reveal what is hidden, (Willig 2013).

The emphasis in terms of data collection is the quality of data gathered as opposed to the quantity, and therefore small sample sizes are required (Smith et al 2009). Small groups are homogenous, and purposively selected for their situated context in the phenomenon under consideration. This study uses repeated interviews with participants over time, as well as diaries where available, seeking to gain a depth and breadth of understanding as well as observe changes over time.

EXISTENTIAL MATTERS

Existential phenomenology

Existential phenomenology is concerned with returning to the embodied life-world experience (Finlay and Evans 2009), or the embodied reality.. Merleau-Ponty (1962*)* calls our attention to the human body which is in relationship with others in the world. For him, the body is full of implicit meanings and relational understandings. Applying these ideas to research, existential phenomenologists argue that it is this shared embodiment and understanding that allow for

the possibility of empathy and understanding. Engaging with existential analysis involves examining one's own embodied self in relation with others.

Rich, Graham, Taket and Shelley (2013) describe how in qualitative research there is a tension between having open and fluid interviews which allow the researcher to stay true to the participants lived experiences, and being able to discover key structures and meanings of those experiences. They suggest that a way of resolving this is Van Manen's theoretical framework of the four lifeworld existentials.

Existential refers to the experience of existence, and of being human. The idea of a lifeworld refers to this lived experiences (Van Manen 2002 in Rich et al 2013)

Van Manen (1997 in Rich et al 2013) uses four terms to describe "existentials." These include:

- Lived Body (corporality);
- Lived Time (temporality);
- Lived Space (spatiality);
- Lived Human Relations (Relationality).

Lived Body

Lived body includes all we feel, reveal, conceal and share through our lived body and through which we communicate and interact with others and the world (Rich et al 2013). Merleau-Ponty (1962) was familiar with the works of both Husserl and Heidegger and held that embodiment is not independent of knowing and being. The woman's embodiment is central to her being a person, and is the vehicle through which she experiences (Stevens 2000). The way it does or does not function can alter her experience and her perception of her experience. It is also a medium for her vulnerability, for example pain, whether physical or emotional.

Whatever embodied experience, emotion, thought or behaviour that is brought by the woman, even if confused and conflicting, is sought to be understood within the interpersonal space; this includes experiences that are not presented obviously in language, but may just be a physical feeling or behaviour or an unconscious process. Engaging with the woman's bodily experiences in this way enables a textured understanding that exceeds a detailed assessment or formulation of it (Todres 2007) and is associated with bodily-relevant meanings pertaining to the experience of violence and the recovery thereof. This enables a move away from the purely cognitive, and allows the woman to experience herself in a way not previously conceptualised.

The way in which the woman experiences her body and her sense of belonging in the world are the same thing, and the understanding from her sensory and 'felt sense' (Finlay 2011) of bodily experience is held in mind by the practitioner-researcher alongside the emotional, cognitive and relational aspects of the woman. This is also reflected back to the woman.

Lived Time

Lived time can be understood as how the woman experiences time subjectively as opposed to actual time (Rich et al 2013). The way the woman feels can impact how she experiences time and vice versa. In keeping with IPA which focusses on individual meaning-making, (Larkin and Thompson 2012), so the meaning of the experience to each woman is focussed on, and its significance to her at that given point in time. It is recognised that the meanings and level of significance may have changed over time and may continue to evolve, and these changes are sought to be noticed in the context of data collection.

Within each woman's human existence there is always the concept of time, involving her past memories, her current experiences, and anticipation of future experiences, but what is notable is that all of these are held within the present moment. Phenomenologically, time is understood as the continuous flow of experience (Stevens 2000 *p185*) which includes past memories, and anticipated future experiences.

The woman's ability to remember provides some sense of continuity of her experiencing, a sense of 'biographical flow' (Stevens 2000 p23). By noticing patterns and consistency the woman is able to make sense of her experience as it presents in her conscious awareness, which is perceived through her lens of cognitions. This can offer the woman a way of coping and having some sense of control, (Stevens 2000)

Lived Space

Lived space is felt space, the woman's subjective way in how she experiences the space in which she finds herself, and this also affects the way she feel. Additionally, how she feels also affects the way she experiences the space and this is sought to be understood across time during the recovery process.

Lived human relations

This refers to the relations the woman has with others in the world, and how she communicates and experience them in her reality (Rich et al 2013). This includes issues of transference and counter transference, which are seen as aspects of communication and are handled as such, rather than as the mainstay of the relationship. Violence against women and the recovery from it, are distinctly personal, and involves judgments about herself, her relationships with others and her place in the world. The relationship with the practitioner-research is also within this existential and is discussed further in the next section.

The research relationship

Finlay (2002 a and 2002 b) recognises that the relationship the researcher has with each woman will influence the responses the woman gives and thus the findings. The outcomes are therefore relative and co-constructed between the woman, the practitioner-researcher and the interpersonal relationship between the two. By attending to the dimensions between practitioner-researcher and the participants this study adopts a relational component, (Finlay and Evans 2009). Having this relational component enables the exploration of the meanings attributed to this potentially sensitive experience of recovery, but also enables understanding as to how the interpersonal space can be used as a reflexive medium to potentiate new possibilities.

It also enables the practitioner-researcher to reflect on her own role within the process, and allow her own perceptions, understandings, and experiencing to be challenged.

The practitioner-researcher accepts that her prior experience of abuse and her understanding of her own experience, will affect how she sees the phenomena and how this is constructed in terms of language, emphasis, and meanings (Finlay 2002a). in order to promote an awareness of this a reflective diary is maintained by the practitioner-researcher throughout.

The practitioner-researcher and each woman actively engage in an interactive encounter, and as such there is a constantly evolving and dynamic relationship, which is jointly constructed (Evans and Gilbert 2005); data emerges out of this relationship. Within the relationship each affect and impact the other (Finlay and Evans p29) and this impacts how the research unfolds. Evans (2007) says that much of what can be learned about another, (and possibly ourselves)

is within the inter-subjective space, and it is in this way that the method of this study offers an opportunity for growth for all involved.

Chapter four

Method

DESIGN

Following the approval of the proposal, the original research was planned to be an in depth phenomenological study which used participatory action research as a design frame; it was planned to be more structured and with the possibility of groups, making use of clinical measures to evaluate ill-health and well-being. However, on entering the refuge, it became immediately apparent that the women were emotionally volatile and not in a place where they could engage in the study in the manner originally thought.

Some of the clinical measures were started to be used with one participant, but it was noticed that she was very emotionally distressed, and was bringing so much material that to use the measures and the structure as originally planned, seemed not only irrelevant and reductionistic, but possibly might cause harm. In light of this, the design frame was modified, but the core tenets, as per the approved proposal, were maintained.

The objective of the revised design was to ensure that the findings would be as valid as possible, and would adequately answer the research question, with the understanding that they may, in time, have an influence on service development and social policy in respect to violence against women. In a time where resources are scarce, it is vital that any changes or developments are not just identified as plausible, or of doing no harm, but are actually worth investing the resources in, because, theoretically, the ideas should work in wider practice (Gorard 2013 pp 2-12).

The present study uses a phenomenological approach within a relational design, where a value is placed on the research relationship, and data emerges, at least in part, out of this. It is held that the embodied, dialogical encounter offers the opportunity for real empathy and understanding, the researcher attending to her own authentic presence whilst also being in the relational space between participant and researcher, (Evans and Finlay 2009 p31), with an opportunity to explore the meaning-making in relation to this over time.

The design enables the values of Counselling Psychology to be applied to research, with an emphasis on creative, compassionate and collaborative engagement, continued reflection throughout the process, with a view to increasing the knowledge base for ethical and effective working, (Division of Counselling Psychology 2018)

The study takes place in a real life setting of a women's refuge, seeking to capture the participants' experiences in context, looking at the meanings the participant brings, (Denzin and Lincoln 1994 p2 in Finlay and Evans 2009) and the meanings arising out of the intersubjective relationship. The findings are both descriptive and interpretive

PARTICIPANTS

The participants were purposively sampled specifically because of their situated-ness of being in a women's refuge in the aftermath of violence: this was in the form of being a victim of violence as an adult, but additionally all had also been victims of childhood abuse. In this sense the group was relatively homogenous, and all had an understanding of the phenomena under consideration.

There were six female participants aged between 19 and 63 years, see Fig. 2 below:

Pseudonym	Approximate Age (years)	Religion	Ethnicity	Ex-partner
Amanda	46	None	White British	White British
Chloe	32	Christian	African	African
Tessa	34	None	White British	White British
Sara	19	None	White British	White British
Martha	63	Muslim	Asian	Asian
Kirsty	33	Christian	White British	African

Fig. 2 Details of participants

Only two (Kirsty and Tessa) had achieved any secondary school qualifications, the most being equivalent to six GCSEs. Chloe was illiterate. Amanda, Sara and Martha dropped out of school prior to any formal exams. None had progressed to further education.

REFLEXIVITY AND THE DUAL ROLE OF THE RESEARCHER

As a Chartered Counselling Psychologist, I came to this study with both training and experience of working with complex trauma and recovery; in addition, I had my own experience of abusive relationships, which served as a backdrop to my understanding. A synopsis of my own journey is provided in the preface, and also further expounded, in relation to my clinical practice, in the autoethnography which concludes this portfolio.

It could be argued that having my own experience of abuse and recovery could act as a bias to this research. Whereas this might be true, this research considers this to be a positive, and embraces my own subjectivity, seeking to use this in a way that adds to the knowledge of the phenomenon under consideration.

I would argue that my own experience provided me with a depth and breadth of understanding that has a very tangible expression, that others without this experience may struggle to grasp from more academic forms of learning. It enabled an increased perception of what is unseen and unspoken, a greater awareness of the felt-sense of embodiment, and an attunement that bridged the interpersonal space in a way that words would struggle to cross. The circularity of knowledge from my own experience, and that arising out of the relational encounter, and how they both relate, is reflected on in the research journal, and thus becomes part of the data. The way the research is designed and carried out is in keeping with the core values of Counselling

Psychology: being a reflective scientist practitioner, working creatively, compassionately, and collaboratively, as well as working ethically and effectively.

Given the nature of the study, it was paramount that I was able to engage with the participants in such a way as to not re-traumatise them, and to be sufficiently skilled in interpersonal relationships to be able to promote a safe and therapeutic space through my attention to the core conditions laid out by Rogers (1957). These core conditions include: maintaining a non-judgemental positive regard for each participant; being empathic yet recognising that only they could truly know their own situatedness; and being congruent with my inner experiencing as I engaged with them, simultaneously being aware of how my own experience identified or differed with that of the participant, and maintaining an openness to new information.

My intention throughout the engagement with the participants was to be authentic and empathic with each woman, seeking to create a connection, and not merely be curious about the content they brought. In this way I was balancing my role as a researcher, but also using myself as a practitioner, holding both positions simultaneously. I sought to be transparent in my reflections with participants, and reasonably direct in order to avoid ambiguity. In my personal reflections, after the sessions, I strived to be curious, to notice similarity and difference between myself, and other participants, to notice where I might inadvertently seek a validation, and seek to understand this for what it might be. The importance of the research journal was crucial in me being able to objectively and subjectively move between the roles of practitioner, researcher, and myself as an experiencing human being, and noticing in myself the constant attendance of moving between the objective and subjective during my engagement with the participants.

Reason (1988 p219) sums this up nicely, noting: “I have that quality of attention so that I may be with you, alongside you, empathising with you; and yet not losing myself in confluence with you, because the dialogue between us both bridges and preserves our differences.”

Finlay and Evans (2009 p37) point out the importance, in research with a relational focus, of maintaining honesty throughout the engagement, accepting participant responses as their truth at that time but not needing to agree, and being open to challenging and disagreeing. I sought to maintain congruence through the iterative process of reflexivity, aided by my research journal and extensive personal reflection, throughout the research process.

Due to the depth of this engagement, there was an inevitable emotional toll on myself. The research was all-consuming and emotionally exhausting, both during the face-to-face interactions, but particularly during transcription and the write-up process, as I strived for a greater level of analysis and reflection. This was managed through the reflective process of the research journal, mindfulness of my own experiencing and embodiment, and supervision.

I noticed that my own experiences increased my resonance with the material, and my ability to engage at depth with the participants. I was aware of my own integral involvement with the data collection, selection and interpretation, and acknowledge that it is co-constructed. My role in the relationship was sought to be explored with the participants.

In addition to listening carefully and attending to what was brought by the participants, I also used to my own experiencing in the moment to increase my understanding of what the participant might be projecting into the interpersonal space, and reflected on this with the participant. This was then open to confirmation, qualification or discounting as required. This was a key part of my role as practitioner. The contribution that this made was evaluated each session, where at the end I would ask how she had found the session, and what she found helpful or not in relation to how I had engaged with her, and what this meant to her.

The other part of my role was that of researcher, however this part was kept as unobtrusive as possible, because the emphasis was on gaining access to data that may not typically be available by other methods. It was for this reason that no direct questions were made about my role as researcher, until the end of the engagement, although there were more subtle reminders of process, as indicated by the presentation of the participant; for example, she may be reminded that she did not have to continue, that there would be no penalty should she choose to stop at any point. At the end of the engagement, there was a more general discussion about how each participant experienced the interactions, focussing specifically on any attributes which were significant or meaningful. My role of researcher was coupled with my role as practitioner as all of the interactions became part of the data.

Descriptions of my own personal reflection and experiencing during data collection and analysis have been used to synthesise and elaborate on the implicit meanings, including reflections on the relational component of the encounters.

Etherington (2004 p32) supports this dynamic process and states that reflexivity is more than self-awareness, it involves the reactions within oneself as well as the interactions between researcher and participant. Maintaining the research journal helped me to monitor the process and interactions and also to be aware of any potential unhelpful processes within the encounters such as abuse of position or power.

PROCEDURE

Following approval of the proposal by the Senate Research Ethics Committee (see Appendix 3), steps were taken to gain access to participants. This included approaching the manager of the refuge, meeting with her and discussing the proposal, and gaining her consent for the study to be carried out within the refuge. It was agreed that the participant's privacy and confidentiality would be respected, and that the maintenance of safety was a higher priority than continuing with the study. Participants were free to withdraw from the study at any point, and alternative referrals made to other services would be made as required.

It was acknowledged that should there be any disclosure of risk that this would be discussed with the manager of the refuge and appropriate action taken according to the situation presented. Risk was to be monitored on a session by session basis.

The women had already left their homes to seek the physical security of the refuge. It was agreed with the manager that should a woman choose to return to her former partner or leave the refuge then she would no longer be able to continue with the study. Due to the level of risk the women could face, all the data has been anonymised, including the location of the refuge: all names are pseudonyms, and the ages are approximate.

It was acknowledged that due to the nature of the work, an emotional dependency from the participants to the researcher might occur. It was emphasised that the researcher would be monitoring the relationships and interactions through the research journal and also supervision, and that the emphasis was not on providing a direction for the participants, or making decisions for them, rather it was exploring with them their current experiences as they sought to move on from the violence. Clear boundaries in respect of time, location and session length would be adhered to at all times, and it was made clear from the start that the sessions would be for an hour each week up to a maximum of one year.

The criteria for inclusion in the study was that they were female, over the age of 18 years, and had been subject to violence. This violence was understood to include all forms of abuse, whether as a child or adult or both. They needed to be able to attend the sessions free of

intoxication from either substances or alcohol. Specific learning difficulties were included. The participants needed to speak English at a reasonable level of fluency to be understood.

There were certain exclusion criteria: the women could not be actively suicidal, from the point of view of ensuring their safety; they could not be psychotic because they would require direct intervention; or be thought to have global learning difficulties, as there would need to be adaptations made to meet their level of need.

The manager was involved in the selection of women, by identifying to me those who showed an interest in being involved, following which an informational letter was given to potential participants describing the nature of the study. This is detailed in Appendix X. There were no rewards or incentives offered, except that they would receive an empathic engagement with the researcher for an hour a week up to one year, who would reflect with them on their journey.

Following verbal agreement to partake in the study, written consent was sought, and a statement signed where they acknowledged they could withdraw at any point without penalty, and that alternative referrals would be made as indicated. It was noted on the consent form that all sessions would be recorded in a discreet manner, that sessions would be transcribed, and that the study would include verbatim quotations from the participants and at times from the researcher. It also stated that they would be anonymised as would be the location of the research. It was agreed with the manager and the participants that full transcripts would not be detailed in the research, they would be destroyed following completion of the research, and they would not be used for any other purpose.

INTERVIEWS AND DATA COLLECTION

A life history interview guide was used to guide the sessions, (see Appendix 1 for full details). Some examples of the questions used are:

- Is recovery something that you have thought about? What does it mean to you?
- Are there any significant events, relationships or turning points that have impacted your recovery or ability to cope? Additional prompts include: early years; adolescent years; young adult life; adult life.
- Thinking about these specific things, can you tell me more about why they are significant for you? Additional prompts: what do these events mean to you? What thoughts or feelings do you have in relation to these events? Have these affected you / do they continue to affect you, and if so how?

Additionally, there were diaries available from two of the participants (Amanda and Kirsty).

The interviews with the participants were semi-structured in order to allow the participants to describe their experiences in as detailed a way as possible. Additional curiosity was used to encourage participants to expand and reflect further on their experiences. This was often along the lines of:

‘I wonder what that feels like?’

The researcher sought to be flexible and responsive to the situation as it presented itself. In practice, this meant ensuring that the participant could lead the conversation in such a way as she chose, to allow for the unveiling of additional material that might not otherwise have been discovered. Responsivity also meant an emotional responsiveness, whereby the researcher was also in the role of practitioner, and could respond empathically to the participant. The

interaction itself also became part of the data, and was noted at the end of each session.

Latent meanings were probed, where the researcher would adopt a stance of curiosity, wondering what something might mean, and giving the participant opportunity to explore her own ideas of meaning. Patterns of meaning were noted over time, during the interviews, the transcribing and analysis, and where possible, these were drawn together in reflective summaries with the participant, again offering the opportunity for these to be confirmed, amended, or discounted. This was to ensure that the data collected was as accurate as possible to the phenomenon under investigation.

The relationship between the participant and the researcher was considered at each interview, with a direct question at the end of the interview, asking what the participant found helpful or not, but also noticing projections and transferences within the interview, and reflecting these back to the participant in order to gain additional sources of data, but without engaging in in-depth psychoanalytic interpretations.

There was a significant amount of data produced during the research process. Each interaction was recorded, and transcribed as soon after the interaction as possible, as well as noting my own experiencing in the research journal. The importance of transcribing the material soon after the event was two-fold: a considerable amount of data was being generated, and if transcribing was not maintained throughout the process, this could have created a daunting challenge at a later stage in the research; more importantly, transcribing close to the experience meant that I was still aware of my own reactions, experiences, and mental processes in relation to the interaction, which I could then express in writing. This not only allowed me to be aware of the impact of the contents and process, and to be mindful of how it was similar or different form my own experiencing, but also enabled reflection on how I was simultaneously holding two roles of being researcher and practitioner, all the time seeking to connect with the participant, but also objectively monitoring this. As the sessions were recorded, few notes were taken in the session, but were made in relation to observed emotion, body language, and expression, as well as movement around the room. The aim of minimal note taking was with the aim of not disrupting the engagement and connection, but it also meant that I needed to develop the notes that were made, soon after each session, so as not to lose the embodied expression of the content.

Critical reflection was sustained throughout the research process by means of the research journal, focussing on the researcher's own social context and positioning, cognitions including values and beliefs and unconscious processes, and associated feelings.

The researcher sought to act as witness in as much as the participants' experiences are sought to be represented as accurately as possible, and author in the way that the experiences are interpreted. The interpretation connects with the reflexive process that the researcher is engaged with.

DATA ANALYSIS

The analysis followed the guidelines for Interpretative Phenomenological Analysis as laid out by Smith et al (2009) however, the organisation of the interpretation was also informed by Van Manen's (1997) existentials.

The transcripts were analysed using the procedure as outlined by Smith et al (2009), as demonstrated in Fig. 3 below. Step one involved a verbatim transcription of recorded interviews, which was subsequently read and re-read. Multiple pages of the texts were open simultaneously on an extra-large screen, which enabled the use of highlighters to identify

themes and concepts, and map these onto a key. The key developed over time, as the themes emerged.

Information identified in this way from the transcripts were then moved onto a new document, and divided into four columns. The first stage involved noting the excerpt in column 2, see the example below:

1	2	3	4
Emergent themes	**Transcript excerpt. Identify participant (lines / page)**	**Checking/clarifying core content. Looking for underlying issues and meaning.**	**Process notes / author's reflections on the relationship and her own embodiment**

Fig. 3 Example of structure according to Smith et al (2009)

There was then a free-flowing process of noting thoughts, feelings and ideas as they manifested themselves when reading the transcripts: these were captured in column 3. Column 1 included early development of themes. Finally, reflections on process including the relationship between participant and practitioner-researcher, and the author's own experience of embodiment, were noted in column 4. This data in column 4 was used to inform the understanding between the practitioner-researcher and the participant, and was at times reflected back in order to put a language around the experiencing in a more textured, and embodied way, and at other times was mindfully held by the practitioner-researcher, and was reflected on in a curious way, observing if additional information came to light at a later stage.

Following the first interview for each participant, and throughout the subsequent interviews, a validation of emergent themes was carried out. This was an iterative process which involved member checking with individual participants to ensure that what the researcher considered was an emerging theme was a suitable representation for what they were experiencing, and any amendments or clarifications were noted. Following this, there was a move towards a higher order conceptualisation of themes, and the same iterative process of member checking was employed throughout. These higher-order themes were then conceptualised using Van Manen's (1999) existentials.

The cross-case analysis entailed a comparison of higher-order themes identified across all of the participants' transcripts. Convergences and divergences were noted, (see Fig. 4 below) and from this, master themes were created, under which the already created sub-themes were represented.

Master themes	Higher-order themes	Convergence	Divergence

Fig. 4 Example of table to show cross-case analysis

VALIDITY AND VERIFICATION

The key quality indicators in qualitative research as described by Smith (2010) have been sought to be upheld throughout this research process, including:

- Collecting appropriate data from appropriately selected participants: all participants met the inclusion criteria for the study, and the semi-structured interviews were guided by the Life History questions. Having said this, in keeping with the epistemology of this study, each participant's capacity for agency and self-direction in terms of what they brought to the session was upheld throughout, and at no point were they influenced in any possible decision-making.
- Contextual details are provided on each participant to facilitate an understanding of their situated-ness.
- An idiographic focus was maintained through a stance of curiosity throughout the data collection phase, balanced against what was common across the participants as identified during analysis.
- Although participants inevitably brought events which had happened, the focus remained on how things were understood and what meanings were derived from these. This also included a reflection on the relational engagement between myself and the participant and what meanings were ascribed to this.
- The analysis transcends the structure of the data collection method, and draws on a hermeneutic approach in the form of interpretative phenomenological analysis, as well using an existential framework for synthesising interpretations and meanings.
- The analytic and reflective component was maintained throughout data collection and analysis by means of a reflective journal, focussing on my own embodied experiencing which was used to inform the understanding of the participant experiencing.
- The credibility of themes developed was reflected back to individual participants as a means of credibility checking. These themes were also discussed with my supervisor in order to achieve trustworthiness.
- Extracts and commentary was used throughout the research process in order to achieve transparency, and claims made are referenced to data.
- The phenomenological detail and interpretative work was understood in the context of existing knowledge, seeking to develop psychologically relevant accounts of the participants' experience through their journey of recovery.

It is accepted that the researcher is a central figure who is involved in the active construction of data, including collection, selection and interpretation. This researcher subjectivity is seen as an opportunity, rather than a problem, (Evans 2009), and this research is a joint product between the researcher, the participants, and also the readers.

It is accepted that the meanings portrayed here are fluid, are subject to interpretation by the reader, and understood within the reader's own experiencing of the lived world. Thus, it is recognised that multiple meanings can be inferred, and that interpretations are according to varying frames of reference. It is acknowledged that the researcher has her own frame of reference and although she has sought to be aware of her own interpretations and ascribed meanings, the cross-communication not be ruled out due to the confines of being human.

It is recognised that there are limitations to the generalizability of this study, however, the purpose is not to generalise findings but rather to form an interpretation of experiences. It is held that there will some ecological validity to this study whereby it will have a resonance with others who have experienced violence against women, professionals and volunteers who work in this area, and to the general population because they are all human. It is hoped that this

study will also evoke an emotional cognisance of recovery from violence with those who have not previously had any experience of this phenomenon.

SECTION FOUR

RESULTS

Chapter five

Data analysis

The details of emerging themes are listed in Appendix 2. An example of how this process evolved is found in Table 1 below, in a section from Amanda's transcript where she describes her experiencing in the first interview, and in Table 2 in respect to the higher-order conceptualisation of themes.

Example of process

Table 1: An example of analysis of emergent themes (Amanda)

1	2	3	4
Emergent themes	**Transcript excerpt.** **Identify participant (lines / page)**	**Checking/clarifying core content.** **Looking for underlying issues and meaning.**	**Process notes / author's reflections on the relationship and her own embodiment**
Being in her body Not being comfortable in her body Expectations of others Attempts to communicate	'I am like a clown that doesn't smile'	It is as though she is wearing a mask, pretending to play the part and yet there is this discrepancy between what she looks like and what she feels inside. I wonder about the expectations of others – do they think she should be smiling? Who are these others? Where have these expectations come from? What are the consequences of not meeting these?	There is this sense that there is something between us that is not clear yet she is telling me clearly. I experience the confusion and remain engaged and curious. I do not want to challenge her because I am sensing that she needs to protect herself from something or someone, so I mindfully hold this at this stage. I am sensitive to her needs to ensure that she feels safe with me.

Emergent themes	**Transcript excerpt.** **Identify participant (lines / page)**	**Checking/clarifying core content.** **Looking for underlying issues and meaning.**	**Process notes / author's reflections on the relationship and her own embodiment**
Being in her body Trapped Not ready Defensive / separate	'I am an adult who is a child'	There is a sense of being trapped; not being ready; unprepared; developmental arrest. There is something about her that is very childlike and engaging but in an adult body that comes across as defensive and 'prickly.' Something about needing to protect?	I notice the conflict within myself as I try and hold both these experiences of her as an adult and as a child in my mind, and notice the physical tension it creates, like an anxiety, and a fear.

Table 2: Higher-order conceptualisation of themes

Higher-order themes	**Emergent themes**
Embodied	<u>Embodied as threat</u> Not comfortable in her body Trapped in her body Rape Trapped in body of pain Using the body to try to manage emotions Physical limitations Body as mask Just doing (like a robot) <u>Negative emotion</u>

Higher-order themes	Emergent themes
	Loss Confusion Guilt Anxiety Difficulty coping Self-blame Emptiness Shame Confusion Anger Aggression Fear of exposure Hopelessness Fear Despair Humiliation Disappointment Anxiety Lack of trust Bitterness Controlled <u>Positive emotion</u> Happiness from within Fullness of joy <u>Body as strength</u> Self-care – eating, sleeping, exercise Resilience

Higher-order themes	Emergent themes
	Resilience helped by children Thinking Blocked by pain Difficulty thinking Moral conflict Thinking new (positive) thoughts
Disembodied	Fragmentation Fragmented Bits missing Destruction of self Shattering of hope Fear and threat of fragmentation Loss of life force Burning in the sun Reduced life-force Tired of coping Overwhelmed / consumed By negative emotion Feeling out of control
Power and control	Survival / Power – but in a negative way (fire setting) Power Need to be seen to be coping / in control / powerful Need for power and control Lack of agency Lack of knowledge to be able to make informed choices

Higher-order themes	Emergent themes
Active behaviours	Agentic functioning Choosing to think differently Making positive choices Creativity Writing Poetry Managing suicidal urges Changing unhelpful behaviours Perseverance Getting back up after failure Not berating self Organising Synthesising Art Education Dressing dolls Holiday Sewing Martial arts Wishing / fantasy Thinking more clearly through writing Employment Self-help books Positive self-talk Sorting things out in her head
Effects of trauma over time	<u>Intrusions</u>: • Emotions • Images • Thoughts

Higher-order themes	Emergent themes
	• Feelings Build-up of trauma over time
Time - waiting	Waiting for life to begin Time not a healer, just blocking out the pain so she can cope day to day
Time – perseverance	Taking time to find positive feelings Process over time – keep on going Recovery taking time Helpful relationships over time helping perseverance Enduring – over a long time
Time - ownership	Time for everything – to talk about the abuse and not to talk Taking ownership over time Going through past events to gain understanding and perspective
Space as solitary	Alone in a space Independence Being different – set apart Not fitting in Alone Dark abyss
Space as threatened	No place of safety Physical space full of fear Disconnect between physical space and the mind Exposure Not time and space for herself Being watched

Higher-order themes	Emergent themes
	Unsafe / threatened
Positive space	Retreat to safe space within herself Getting a different perspective on the world from others Being with others on a regular basis Animals Needing to be with other people Going on holiday with a friend Nature Education Shifting focus from the past to the present Accepting the present Use of art Noticing positive things especially in relationships particularly with children Employment
Rejecting relationships	<u>Demands of others</u> Fear of judgment from others Shamed Blamed Judged <u>Lack of relationship</u> Lack of meaning in relationships Lack of care and support Lack of protection in relationships Let down by friends Testing out relationships Lack of trust

Higher-order themes	Emergent themes
Enabling relationships	Supportive relationships Support of friends Encouragement Not having friends but knowing she wants / needs some Practical help and advice, practical support Someone to talk to when needed Friends Loving / caring relationships Acknowledging own need for love and care Need for synthesis and holding – accepting the whole person Desire for love and closeness Importance (but absence) of maternal relationship – desire continuing over time Love – not sure what it is but knowing what it isn't Love – the feeling for her son Children and happy times Children – positive relationships, help with resilience Approving relationships Validated Being accepted and wanted Need to feel valued
Identity in relationships	Humanity as defective Gratification of others Confusion about identity Disgust at self

Higher-order themes	Emergent themes
	Self as weak Caring for others over self Self as nothing Female gender as object Internalisation of shame Female gender as cause of problem Internalisation – negative identity Positive identity Identity in God Choosing to believe and know who she is in God Positive self- perception, liking self
Spiritual relationship	Focussing attention on God Direction Sense of purpose Sense of meaning Realisation of extent of love of God Gratitude Significant relationship - God Assurances of God's love Holding - being held Faith in God God as someone to talk to and being available Being heard by God, helps her to be strong Being cared for by God
Research relationship	Gratitude Positive value

Higher-order themes	Emergent themes
	Holding Listening and remembering stuff Safety Genuine interest Can relate to researcher

Cross-case analysis

The cross-case analysis entailed a comparison of higher-order themes identified across all of the participants' transcripts. Convergences and divergences were noted. From this, master themes were created using Van Manen's (1999) existentials, under which the already created sub-themes were represented.

Table 3: Master themes and the constituent sub-themes

Master themes	Higher-order themes	Convergence	Divergence
Lived body (corporality)	Embodied	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
	Disembodied	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
	Power and control	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
	Active behaviours	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
Lived Time (temporality)	Trauma over time	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
	Time-waiting	Amanda. Kirsty.	Chloe. Tessa. Sara. Martha.
	Time-perseverance	Amanda. Tessa. Sara. Martha. Kirsty.	Chloe.

	Time-ownership	Amanda. Chloe. Martha.	Tessa. Sara. Kirsty.
Lived Space (spatiality)	Space as solitary	Amanda. Chloe. Sara. Martha. Kirsty.	Tessa.
	Space as threatened	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
	Positive space	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
Lived (Human) Relations (Relationality)	Rejecting relationships	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
	Enabling relationships	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	
	Identity in relationships	Amanda. Chloe. Sara. Martha. Kirsty.	Tessa.
	Spiritual relationship	Chloe. Kirsty.	Amanda. Tessa. Martha. Sara.
	Research relationship	Amanda. Chloe. Tessa. Sara. Martha. Kirsty.	

These themes represent the main findings of this present study and are reported in the following chapter, in addition to the two additional questions which focussed on ‘recovery’ and ‘moving forwards’.

Chapter six

Findings

Given the relational focus of this study, this chapter starts with an introduction to each of the participants at the first meeting. Then follows a narrative representation of the analysis of the data arising out of this and the subsequent interviews.

The process of analysis resulted in the creation of 4 master themes, comprising 16 higher-order themes. Each master theme is described, followed by a description of its constituent sub-themes. These are supported by corresponding quotes from participants.

MEETING THE WOMEN

'I arrived at the refuge full of hope and expectation. I had this naïve idea that this would be a positive time where the women could move on from their past difficulties to find pastures new. My first time out of the manager's office and into the rooms occupied by the women was so very different. Some children were playing with the play equipment, others were crying and nobody seemed to be responding, there was shouting and banging, and then a wail; women were bustling to get out of the door with buggies, a food delivery arrived from a local retailer, and someone had come to fix the boiler which had broken. It felt chaotic. I gingerly walked down the corridor as if it were made of eggshells, and into the kitchen where staff could take a break and have their lunch. No-body was there so I breathed a sigh and made myself a cup of tea, taking a few moments to gather myself. I felt conspicuous in my smart clothes, and consciously decided to be more casual next time I visited. I was aware that I might be perceived as white, middle class, 'successful' and 'having it easy.' I challenged this thought there and then, because I knew that abuse affects all strata of society, and it was easy to make assumptions about others. I myself had had eighteen years of abuse as an adult so this had to be a false perception. Yet somehow it still mattered. Why was I anxious? Was it because I was no longer in the middle of my journey? Did I somehow feel bad that they were still suffering the trauma and chaos, feelings I knew all too well? So perhaps it wasn't about dressing down next time, perhaps it was about me being me. I wondered who 'me' was in relation to the women here, and whether I would find parts of me that I hadn't explored before. I hoped so.' (Author's reflective journal: 'First day at the refuge'.)

'I first met with Amanda. She shuffled along, looking at the ground, and then looked at me suspiciously. She made certain demands about how she would like the room, the window had to be open, the door ajar, and she needed to sit by the door. I made efforts to accommodate all her requests, and ensured that our privacy could be maintained by closing a second door. She sat down and looked at me again. I felt anxious for her. The space between us was pregnant with unspoken questions, anxieties, hopes and fears. Her first question came:

'How long are you going to be here then?'

I was pleased this was a question I could answer, and reiterated the information in the sheet she had been provided with, saying that I could meet with her for an hour each week for up to a maximum of one year. She seemed somewhat satisfied with this answer. And then we began.' (Author's reflective journal: 'Meeting Amanda'.)

'When I met Chloe, she filled the air with noise, most of it a joyful exuberance which marked much of her conversation. She greeted me in broken English with a thick African accent, and

expressed her pleasure at being able to come and talk with me. She called me ‘my sister’ and I felt there was a solidarity between us before we had even started. There was something about her that drew me towards her. She had a warmth and a presence that commanded respect, but one that belied a certain frailty. I was immediately intrigued and found myself sitting on the edge of my chair, expectant.’ (Author’s reflective journal: ‘Meeting Chloe’.)

‘Tessa came into the room dragging one leg. She wobbled coming through the door and I found myself jumping up to assist her lest she fell. She thanked me and smiled fleetingly, and explained that her fibromyalgia was ‘very bad’, and that ‘most days she could hardly walk’, and indeed ‘some days all she could do was to rest in bed’. I nodded, thinking that perhaps I didn’t really have fibromyalgia myself as it wasn’t as bad as that, before noticing that I had been caught up with a thought about myself, so turned to her and said: ‘That sounds really difficult. I wonder how you manage?’ The conversation instantly flowed.’ (Author’s reflective journal: ‘Meeting Tessa’.)

‘Sara – well. Sara is angry. She spent the first 20 minutes pacing up and down like a caged lion. I watched her, partly anxious and partly curious – anxious because I didn’t know what she was angry about, and curious that she had agreed to come and talk with me. She expressed her frustration with the lack of support in the refuge, how ‘nobody seemed to know what was happening’ and ‘everybody kept asking her stuff’ and ‘how was she supposed to know everything?’ I nodded and acknowledged that ‘that must feel very difficult’ and ‘wondered if she would like to sit down and talk?’ Sara sat, apprehensively, and asked me ‘what I wanted to know?’ I explained that it wasn’t so much about wanting to know ‘stuff’ as it was wanting to know ‘her’, (believing that the ‘stuff’ would become apparent over time.) She quite liked this response, given away by a small smile, but met it with a grunt, and announced: ‘I don’t have many friends ya know.’ I felt a mild anxiety that she might think this was about us becoming friends, but didn’t want to push her away, at this time which felt so crucial to us getting to know each other, but was grateful that I was clear in my own mind where the professional boundaries lay. I noticed how easy it would be to be drawn into her world and get completely lost in it, possibly never to emerge. I observed the two parts of myself, the part that was able to engage with the person in front of me and the part that ‘looked on’ and observed what was happening. I was glad I had some experience of working with vulnerable people, and thought that this work should not be done by a novice. This was by no means an arrogant statement, but I acknowledged ‘this is like walking through treacle’.’ (Author’s reflective journal: ‘Meeting Sara’.)

‘Martha shuffled through the door in worn and faded gold slippers, and furry pyjamas, despite it being two in the afternoon. I was struck by the incongruity of her slippers typically worn by Asian women, and the very Westernised pyjamas. Her hair was straggly and looked unwashed. She made little eye contact, and mostly looked at the floor. I immediately found myself feeling concern for her. I felt a heavy weight of shame which seemed to push her further and further down. She did not smile, and spoke in soft, almost inaudible tones which I had to strain to hear. She thanked me for seeing her. I found myself wondering at this, as if she was expecting something from me. I felt that I had come empty handed, that I had nothing of any value to give. I wasn’t sure if this was me or her. I brought myself to our meeting, and enquired how she was. She reached out and grabbed my hand, and I felt the dryness of her skin against mine. She peered into my eyes. I was so glad that I had abandoned any measures at my first meeting with Amanda: there were no questions which could even begin to capture what this woman brought to our encounter: it could only be felt.’(Author’s reflective journal: ‘Meeting Martha’.)

‘Kirsty brought with her an anxiety and a desperateness that was evident in her strained demeanour. I observed her conflicted presence of trying very hard to do everything she needed to do but simultaneously not allowing herself to fall apart under the pressure. I noted the tension that this caused in her and sensed the heavy burden on her shoulders: a burden of

responsibility wrapped up in a fear and an anxiety that at any point might spill over into panic. She looked at me mistrustfully, as if questioning my ability to understand. 'This is a tough time for you, isn't it?' I started. The tears welled in her eyes which she quickly brushed away. It was some ten minutes before she was able to reply. I sat with her.' (Author's reflective journal: 'Meeting Kirsty'.)

It was apparent from those early sessions that we would not be able to consider the journey of recovery until we had a shared understanding of where they were coming from. It is summed up nicely in this variation of a quote by George Santayana:

'You can't know where you're going until you know where you've been' (variant of 'Those who are unaware of history are destined to repeat it,'). I knew then that we would have to start at the very beginning – the present moment.

LIVED BODY

In the existential of lived body, there were four higher order themes including: being embodied, being disembodied, agency and power, and active / avoidant behaviours.

EMBODIED

The experience of being in the body was perceived in a number of ways, including experiencing the body as threat, where there was an incongruity between the inner experiencing and the external presentation, and the inner experiencing not being noticed or cared for either at the time or in the present; there was the experience of being trapped inside of the body and unable to communicate with the outside world, whether this was through a lack of language or by not being heard; there was a physical entrapment where the body experienced pain during the abuse and this caused psychic pain which lived on after the abuse had ended; and there is the matter of the female gender which was attributed to being casual for the abuse by some of the women.

Additionally, there was the experience of being trapped in the body as a result of ongoing physical pain, and how this intertwined with historical and present psychic pain. This also connected with felt negative emotion. The experience of negative emotion was at times so extreme that it seemed to suck the life force out of the woman, but also served as a paralysing agent which prevented the woman from thinking clearly. At times, the body was sought to be used as a physical means to try and manage the negative emotion, for example, through risky sex or self-harm although this only had short-term gains. There were some cultural aspects relating to shame that were a source of additional negative emotion for one woman.

With five of the participants it was noticed, over the time of the interviews, that the negative emotion lessened and there was a move towards rational thought and agentic functioning, including engaging in positive activities, and the body was able to be considered as a source of strength and healing. The other woman, Chloe, appeared to have already travelled a long way down her recovery journey and was already able to think clearly, and was engaging in positive activities.

All the women in this study had experienced childhood abuse as well as violence as adults: for all of the women their early experiences contained sexual and emotional abuse; Amanda, Chloe, Tessa, Martha, and Sara had also been physically abused, and were neglected. The

onset of abuse for all participants was before the age of 5 years old and continued throughout childhood. All participants were sexually, emotionally, and physically abused as adults.

It goes without saying that all of the women were embodied, but there was a sense that the bodies they had been born with, equipped with their senses, expectations and hopes, had become bodies which housed a continued sense of threat.

Embodied as threat

All of the women identified with there being something very uncomfortable about their embodiment, and this was not just experienced during the abuse but continued into the present time.

For Amanda and Sara there was an incongruity about their inner experiencing and their outer presentation. As Amanda said:

> *'I am like a clown that doesn't smile'*

There was this sense that she felt that that she looked a certain way but that her inner experience was quite different, and this also linked with a sense of not being ready for the world, when she went onto say:

> *'I am an adult who is a child'*

There was a feeling of being trapped in her body, with possible expectations from others that she should be able to negotiate life's challenges as an adult, but being unprepared for this, and in this way the external body was experienced as a threat. It is possible that this was an unconscious reflection of her childhood sexual abuse where she was emotionally and developmentally unprepared, but was unable to communicate her need to others, for example:

> *'I am screaming but can't make a sound'*

Martha identified with this sense of others expecting something, but the inside experiencing was not heard, not noticed, or not cared about,

> *'It was like I had to be the person she wanted, they did not know that inside I was screaming to get out'*

and conveyed this picture of being frozen in a glass cube, powerless, unheard, uncared for. Sara talked similarly about her embodiment as being trapped, but one which continued into the present moment, not being able to express the feelings of early abuse:

> *'Sometimes I can't say the things which happened, I don't even have the words. It feels like these things are trapped inside of me not able to escape. It's like I was a child again and feel all the feelings, but I don't know how to tell you.'*

There was this sense of not having the language to describe her experiences, the experiences were trapped inside her; it felt as if language was the only way they might be able to find a way to escape, but she was frustrated and powerless without the words.

Tessa and Kirsty expressed their embodiment during the abuse as wearing a mask, living a pretence, and just continuing to try and function, but Tessa emphasised that others wouldn't understand even if they did know:

'I couldn't talk to anyone about what I was feeling, I just smiled and pretended everything was fine. They wouldn't understand.'

And Kirsty was unable to consider an alternative reality:

'I felt I lived a lie every day. I just did the stuff I had to do because I had no choice. I didn't think, I just did.'

Kirsty and Tessa identified with Amanda, Martha, and Sara's historic experiencing where there was a feeling of 'not being able to get out' but for Kirsty and Tessa this was the continued physical pain (possibly a physical expression of emotional pain) that kept them trapped:

'I am lying in the bed, paralysed. My body is like lead, but inside the pain darts around like stabbing knives, over and over'

Tessa continued to experience her mental pain very physically with her fibromyalgia:

'My legs hurt so much I can hardly walk. Every time I try and sort things out in my head my fibro (fibromyalgia) *flares up, and the pain takes over so it's hard to think. It's like my body controls me, it takes away from the pain in my head, but I know the pain is still there. I just have to try and sleep until it gets better then I can start to think again'.*

There seemed to be this separation of the mind and the body, and although the abuse had stopped, the body continued to express the pain of the mind or the emotional, so that the physical experience in the body became the focus. It is suggested that there is an inability to process the mental pain. The physical pain prevented Tessa thinking clearly. She was very preoccupied with her body and how it was feeling, and for a long while there was this sense of disconnection between body and mind.

Amanda supported this sense of on-going disconnection saying:

'Sometimes I freeze on the spot and am unable to move. It's as though I am paralysed'.

She was unable to explain what was happening mentally for her at these times.

Chloe seemed to acknowledge the physical entrapment but mentally separated herself from her body as a means of survival, similar to the disconnection experienced by Amanda, but in a more conscious way: she was aware that she was escaping into an alternate reality, a suggestion that she could control the level of pain in her mind even if she could not control the pain to her body:

'I learned not to feel the pain. It was like I escape into another world'

This sense of being embodied as a threat continued with Chloe and Tessa expressing a sense that it was because of their female gender that their bodies themselves became the threat, as Chloe said:

'I am half lying, half sitting against the hut. I am burning in the sun and my mouth is so dry. My dress is torn and dirty and I am bleeding from down there (points to her groin*). I am four years old. All the men of the village they use me for sex'*

Chloe endured years of repeated rape from the age of four, giving rise to her experience of herself as an object for the desire and gratification of men. Her body was a constant source of physical suffering and distress to the extent that her very existence was threatened, where she was left for dead in the heat of the African sun.

Tessa's experience of being human was similar to Chloe's in some ways, of being 'done to' and that this was 'because of her body'. She was the perceived inanimate object that had to receive the desires of another: it was as if she had to resign herself to the limitations of her body and had no choice.

> *'I don't know how to have sex any more. To me it is just about the hole, they can do what they want coz you've got a hole, haven't you? This is why women are weaker than men and men can take advantage of them. They can do stuff to you, but it's harder to do stuff to a man'.*

And:

> *'It feels like I don't have any choice over my body. People can do stuff to me coz I'm a girl and can't stop them. If my body was different it wouldn't happen.'*

Martha experienced something similar, blaming her gender for her abuse experiences:

> *'My children they don't respect me. I did all that I could to care for them and love them, I took them on outings, I bought them things, I played with them, but they don't respect me because I am a woman'.*

And:

> *'My son has hit me lots of times, and it got worse, and when I told his father he say nothing, he do nothing. It is hard when it is your own child that hits you. He say: 'get away from me, I hate you, I hate you'. I have tried my best. There is nothing else I can do to make this better'.*

<u>Negative emotion</u>

Negative emotion was endorsed by all the women in the study both historically by all women, and during the early weeks and months by five women. Being in a body full of fear and anxiety, pain and sadness, emptiness, confusion, shame, anger and despair, are just some of the emotions that not just passed through but often dwelt within their bodies. It was noticeable that negative emotion lessened as the data collection proceeded.

Some of the emotions were described in the following ways:

> Amanda: *'Fear spreads through my body, I can feel it, it's like a virus. It's unseen but all consuming, showing me all things which are unspeakable'*

This gave an indication of the fearful memories which were evoked by the emotions, and how these became all-consuming, and how the focus was always looking backwards to some unresolved trauma. Kirsty also endorsed fear as a dominant emotion, finding it indescribable and powerful, as if a tangible force:

> Kirsty*: 'There are no words to describe the fear. It's like something that is so powerful it's as though you can touch it. I have lived for many years with that fear'.*

And:

> *'It* (fear) *is all consuming, all-powerful, and eats away at you until there is nothing left. I woke up afraid and I went to bed full of fear. It was like the house was possessed, there was a sort of presence in the house, an oppression, a heaviness. I believe it was fear.'*

Amanda described experiences of negative emotion which were so powerful that to the extent that they were sapping of her life force, as suggested by the following:

> *'Pain and sadness flow through my body until I am gripped in a strangled hold'*

And:

> *'The memories seep into my body and crawl up my back, travelling along every vein, until I am drowning'*

And:

> *'All my feelings of anger and hate were soaked up in a sponge of fear'*

As a result of this fear, she also described being in a constant state of hyper-alert, as she said:

> *'I listen with every one of my senses, trying to make out any unusual sounds, as I tiptoe downstairs to the kitchen. It is not worth my life to get caught. I am looking for food'.*

The idea of 'listening with every one of her senses' conveyed the enormity of the threat she experienced just to get life-sustaining food.

Chloe described a craziness which was born out of the negative emotions:

> *'I was crazy with the feelings. I was running into the street, I did not know what I was doing.'*

This suggested the challenge she was faced with when trying to think rationally, supporting the idea that strong emotion got in the way of her thinking. This is endorsed by the other participants whose descriptions are all focussed on feelings as opposed to thoughts. Sara experienced a dominant emotion of anger:

> *'When I get angry now I just can't stop. It's like something comes over me. Someone spilt hot chocolate on my jacket here and I nearly flashed out, but I ended up just going for a walk and kept hitting things. I don't know what makes me angry, I really don't know. But she knows now that she can't walk all over me, she won't do that again'.*

And:

> *'Relationships are meant to be equal, not one person taking advantage of the other – if someone does that to me I would kick them big time. That's why I've taken up kick boxing and martial arts. I can go to that real angry place'.*

Sara mostly expressed anger, and there was a sense that this was hiding a range of other negative feelings, but she was not comfortable getting close to these. Her anger was partly

directed towards herself and partly towards others, suggesting a confusion and a difficulty thinking about and making sense of the traumas. This confusion was evident when she said:

> *'He always punished me, punished me for being bad, even though I never knew what I had done wrong. He punished just by things he said sometimes, like it was always my fault. He had full control, he kept me in his fear. I kept thinking: "Is it something about me? I've had this shit all my life, why have I got to have more?" I don't see how people like this can get away with stuff'*

Tessa found negative emotion particularly difficult and used the act of cutting as a means to exert some control over the feelings. This was particularly when there were so many emotions that she felt numb and could not distinguish between them, then the cutting served to waken her sense of being alive in her body:

> *'I just cut, it takes away the feelings. Sometimes I just feel numb and then when I cut I feel alive again'.*

This suggests that Tessa was trying to using her physical body to try to meet her emotional need.

Martha particularly struggled with the emotion of shame and this was set in the context of her cultural background of being Muslim and leaving the family home, which is considered shameful:

> *'My husband tell me how much shame I bring on the family. I am so ashamed'.*

Kirsty struggled with anxiety and fear, and this prevented her ability to think and get an alternative perspective:

> *'For so long I have been anxious and fearful that I can't think straight, I just keeping doing things to try and make it better'*

What was noticeable about the negative emotion from the women was that emotion from the childhood experiences of abuse were merged similar to those experienced as adults, and it was not uncommon for all the women to move freely between child and adult experiences when talking about their journey. In this way the distinctions between isolated events were often not made, and the trauma floated freely over time.

The idea of strong emotion getting in the way of clear thinking emerged as a theme on multiple occasions, an example is in Sara's words:

> *'It was like I was a robot, doing stuff without thinking, getting the kids out the way before dad came in and gave us all a good hiding'.*

It feels like there is this disconnection between mind and body, and this was a result of the constant fear and threat. When asked whether there were any experiences which prompted her to stop and think, and she replied that it was when she and her siblings were taken into local authority care when she was 10. She was removed from the situation but also separated from two of her siblings, so although this might allow her time to think about her own needs it was also a massive challenge to her as she lost her sense of identity as a mother figure, and this confusion continued into the present day, noted by the use of the present tense.

'I can't bring all my thoughts together, there's too many of them and they're all jumbled up'

And:

'Sometimes I am so angry I don't know what's happening around me anymore.'

And:

'I've lost my words'

Sara really struggled with a lack of narrative. It was clear that so much had happened and that this was causing her great distress, but she could only tell me things in short sentences. I didn't press her but stayed with her and reflected her feelings of confusion, being out of control because she couldn't 'place' everything, finding herself experiencing emotions but not being able to make connections with things. Although she said 'I've lost my words' it was as if she had never had the words, and in her mind there wasn't the sense to be made. Then at other times there was the dilemma of wanting to be able to stop thinking because the thoughts and associated feelings, were too distressing, as Sara noted:

'I try and forget but I can't forget coz it's everywhere. Especially in this place. I walk down the street and all I see is paedophiles'

And Martha experienced something similar, when she commented:

'The memories come back as if they were yesterday. It's as if they come from no-where and when I least expect them, and vooom! I am back there. I am pulled all over the place'

Kirsty notes that there is a chronic impact of abuse over time which makes it harder to recover, describing this as abuse becoming part of her thinking:

'I think the longer you have been abused the harder it is to recover, coz it's like it becomes part of you, part of your thinking.

What she meant by this was that the continued experiencing of abuse impacted how she thought about many things, including herself, her relationships, and her world around her, and due to the enormity and complexity of this it was harder to move towards recovery.

<u>Using the body to try to manage emotion</u>

Tessa was the only one who reported using her bod to try and manage her feelings. She showed this in her reference to cutting, to make herself feel less numb and more alive

'I just cut, it takes away the feelings. Sometimes I just feel numb and then when I cut I feel alive again'

but also continued to use one of the things which had caused so much distress as a child and as an adult, namely sex, as an attempt to manage her on-going emotional need for love and affection, shown here when she says:

'Sex hurts, it's not a nice thing, it's just bloody painful if you ask me. But I still want it! I need to be close to someone. I want someone to hold me and sex is as close as it gets. I know it doesn't work like that but somewhere I think that'

Sex it is the closest thing Tessa has had to anything that might equate to love and affection. She knew that it didn't quite add up but a part of her thought that the sex she had was love, and she craved love: as a consequence, she would sacrifice her body to unwanted and unpleasant sex from another because of her need for love. It seemed that this strategy of continuing to expose herself to traumatic sex maintained the sense of threat and her experience of trauma in her body, and left her struggling to process the past. In this way her coping strategy of trying to meet her underlying need was getting in the way of her moving towards recovery.

Emotion and thinking

The difficulty being able to think in the presence of strong, negative emotion, has already been noted, but over time, a period of five months for Tessa, thinking was identified as an important component of recovery, when she said:

> *'I am thinking: 'What must I do to get sorted? I am trying to be rational but I'm confused'*

And:

> *'I need to have clarity of thought'*

And:

> *'To move on from here I need to keep sorting out my thinking, putting everything in the right order where it needs to go so I know I've got everything'*

but it was recognised that this was fraught with difficulties. Pain was a particular difficulty experienced by Tessa and Kirsty, as Tessa said:

> *'My legs hurt so much I can hardly walk. Every time I try and sort things out in my head my fibro (fibromyalgia) flares up, and the pain takes over so it's hard to think. It's like my body controls me, it takes away from the pain in my head, but I know the pain is still there. I just have to try and sleep until it gets better then I can start to think again'.*

There seemed to be this separation of the mind and the body, but the body took over the pain of the mind so that it became the focus. The physical pain prevented her thinking clearly. Kirsty also had fibromyalgia and experienced something similar:

> *'I am lying in the bed, paralysed. My body is like lead, but inside the pain darts around like stabbing knives, over and over. My thoughts are racing. I cannot think straight, I don't know which way to turn or what to do'*

Emergence of thinking, and positive emotion

Despite years of what can only be described as horrific abuse, Chloe had a very clear perspective on thinking, since she had become a Christian during her relationship with her abusive husband:

> *'Take control of the mind. Have a mind that bears witness with the Spirit. My smile now comes from the inside, my eyes are fixed on the cross'*

Chloe made many references to the battle for the mind, the battle against her desires to self-harm / take her own life, to be full of rage and bitter, the trauma images, thoughts and voices

intruding into her conscious and subconscious awareness, and how she chose to let her mind be transformed, keeping her focus on God. She added:

> *'I ask God to search me, change me, take my mind, take control of my mind, the Spirit is saying something else, renew our minds daily, not monthly not weekly but daily'*

Chloe identified this as one of the most important things in her recovery, and that it was only through this that she was able to experience the positive emotion of being able to move past the abuse:

> *'We can make all the excuses we like but it is only ourselves which stop us moving forwards'*

And:

> *'Take control of the mind. Have a mind that bears witness with the Spirit. My smile now comes from the inside, my eyes are fixed on the cross'.*

There was a real sense of positivity and hope, as well as an acknowledgment that the mind played an important part in her ability to move forwards, supporting the earlier references to the other participants struggling with their ability to think clearly.

In the final weeks, after a period of six months, Amanda acknowledged:

> *'Happiness can be found but you have to have a lot of patience'*

And:

> *'With each new relationship I always hoped: 'This time it will be different'. I thought that somehow, I would be who they wanted me to be, and they would like me. I hoped I could be accepted and valued for who I was. But it never worked out that way and I always retreated. But now I am hoping again'*

She, too, referred to hope, but suggested that it can come and go, that is was something which could be crushed. She was able to identify that hope was creeping back as she started to see potential ways of moving through her struggles, but this took time. This hope emerging again was said in the context of acknowledging the role of supportive professionals, including the research relationship.

Sara noticed the positive influence of her grandparents over time, and that thinking of positive experiences helped her to be able to cope better on a day to day basis:

> *'They used to have me some weekends.* (Thoughtful) *Good times. Sometimes it helps me when I reflect on the good times'*

And:

> *'Sometimes I just think to myself: 'What do I want to do? And I just do that. My sisters are getting older now so they have to take responsibility. I've tried to teach 'em that. I can't always be there for 'em, being the mum ya know. I've gotta live my life too'*

Her identity growing up was as 'mum' to her siblings and this carried on into adulthood, putting the needs of others above her own. She had some anxiety that she would always think like

this which suggested she realised it was unhelpful, but she was also hopeful when she recognised her own ability to make choices, and entertained the idea that she could do things that she wanted to do and that she had her own life to live.

Kirsty found that getting a sense of physical space as well as writing things down helped her to be able to think things through more clearly:

> *'I do take time to try and think, and the writing helps. If I can get a space to myself, like when the children are playing, I do most of my thinking then, trying to sort things out in my head'*

Tess also used extensive writing to help her process her thoughts and to try and organise them. What was noticeable was that the more she organised her thinking, her self-harm also stopped.

This section of the findings represents each woman's experience of being in her body, where even though the body is currently safe in the context of being in the refuge, the body is still experienced as a source of threat, whether that is thoughts and feelings which persist in the body, or whether it is being trapped in a body full of physical and emotional pain, or using the body as an attempt to meet emotional needs, either through risky sex or cutting. The importance of thinking was observed but thinking was not easy particularly in the context of negative emotion and physical pain.

Positive emotion was experienced by a few of the women, and both Amanda and Chloe saw this as a by-product of progressing through their recovery journey. Chloe, Sara and Kirsty were all able to recognise the importance of helpful thinking, which is reasonable to conclude contributed to more positive emotion.

Over time, the body was seen as a source of strength by some of the women, with adversity contributing to resilience, and the development of an inner strength. Coping was also supported by caring for the physical needs of the body in terms of eating, sleeping and exercise.

<u>Body as strength</u>

There was some descriptions of the body being as a container or source of strength by Amanda and Kirsty:

> Amanda: *'I haven't had another relationship since. I think I want one but I need to know that I am strong enough to be able to do things more my way and not just letting him walk all over me'*

There were also references to knowing where her own boundaries were, and this was linked to her ability to be strong.

Kirsty talked about her body as strength, but emphasised the importance of self-care in helping her to cope each day:

> '*I look after myself a lot, I always try and eat healthy, and get enough sleep, and take walks and stuff. It may not be much but it helps me cope a bit better on a day to day basis'*

There was a connection with resilience here with reference to an inner strength developing as she was able to overcome each battle, suggesting that progressing steadily through each

situation that arose was a means of developing inner strength. Amanda described this as the 'ultimate power':

> *'I think that the more experiences you have, even if they are good or bad, can give you a sort of inner strength, but you have to find a way to overcome each battle. Then there are no limits to what you can do, it is the ultimate power'*

It was six months from the start of the research interviews that Amanda was able to recognise that she had not just survived thus far but that there was a strength which had grown within her alongside adversity, and it was through this that she felt stronger and more powerful:

> *'Resilience is about being strong, having an inner strength that doesn't let you give up'*

This resilience was important as it connected with the sense of hope that she had previously expressed.

In addition to their embodied experiences, there was also a sense of being disembodied. The findings from this are detailed in the next section.

DISEMBODIED

The higher-order theme of disembodied sits in the existential of lived body, and was endorsed by all participants. Although there is not the literal disembodiment, there is a metaphorical sense of not feeling totally connected with the body. This included a sense of fragmentation where parts of the body, particularly memories, were missing, and there remained a sense of incompleteness. Additionally, there were nightmares that were unable to be recalled but clearly resided in the body. In this way there was a sense of being disconnected from what the body was experiencing, as it could not be understood in conscious awareness.

The fragmentation was so extreme for some women, both literally and metaphorically, that it threatened the continued existence of the psyche as a whole, as well as the physical body. The memories from these events also fed into this sense of continued psychic destruction. All of the fragmented parts were held in the interpersonal space between practitioner-researcher and each woman, were accepted and not judged, and wondered about together.

Fragmentation

Tessa, Martha, Kirsty and Amanda all had a sense that they were not whole in their bodies, and that parts were missing. The importance of these missing parts was very significant for all of these women and was a focus of conversation for a number of weeks. Tessa summed it up like this:

> *'The problem is, I come from the starting point of something being missing. And I don't know what it is that's missing. I am holding onto things which give me comfort, which give me security'*

This was a significant obstacle for Tessa, and it was many months of writing and organising her past that helped her to be confident that all the parts of her were being discovered. The importance of this was that she seeking to make sense of the past. Whereas Tessa was actively searching to find bits that were missing, suggesting that this was a process she was in control of, Martha was more chaotic in her experience of being fragmented, and there was a sense the trauma continuing to control her:

'The memories come back as if they were yesterday. It's as if they come from no-where and when I least expect them, and vooom! I am back there. I can see out of the window people cutting the grass with a machete, a curved knife. But it made me frightened that they would cut me up too'

And:

'The staff tell me that often in the night I am running to the front door, screaming, I am half naked, and am trying to get out into the street. When they talk to me they return me to my room and I take a shower. I then go back to bed.'

Martha was experiencing nightmares which she was unable to recall, suggesting they were not accessible to her conscious awareness at that time, and it was this not knowing that maintained her sense of disconnection. This is similar to Tessa, she felt she needed to know what all the memories were in order to be able to synthesise them, and also to know the different parts of herself, which then enabled her to be able to look after these different aspects.

It was notable that Amanda also endorsed this idea of part of her being missing, but it was as if she noticed they were missing but that was all she was able to do, there was a feeling of powerlessness attached to this:

'My thoughts are in in empty houses and lonely alleys'

And:

'My thoughts are all scattered in dark places

Kirsty identified with parts of her being missing, and this continued after the abuse had ended:

'I just never feel like I am a whole person, there is always something missing.'

And also, a sense of on-going destruction and fragmentation:

'I have this recurring dream. I am lying in bed, and I am watching the walls of the house falling into clouds of dust around me and into a big hole all around. Even the floor boards start disintegrating, until the bed starts to drop through the boards…then I wake up and my heart is racing.'

The loneliness and emptiness that Amanda felt was profound, and there was a sense of the missing parts being uncared for. It was noticeable at the time how important it was that all the different aspects of the participants were accepted equally, they were not sought to be avoided, but were all acknowledged as being a part of the woman.

<u>Destruction of self</u>

There was a sense from both Amanda and Chloe that fragmentation had a consequence that could pose a threat to life, metaphorically and literally; Amanda described herself as being totally fragmented, as if she had been cast into outer darkness and dispersed in the wind:

'I am in complete darkness, gone in the wind'

This felt like the ultimate fragmentation for Amanda, as if ashes that were scattered after death. It is was if there was total loss of life, except her eyes still perceived the darkness, a sense of being dead but not dead: the thoughts are still her thoughts. She continued with:

> *'I am dull and lifeless, shrivelled and powerless, baked hard in the scorching sun'*

There was still an 'I' and not a 'thing over there.' She had an awareness of the effects of what had happened to her, but there was something about her that was still present. Amanda experienced starvation yet she continued to pursue life:

> *'I listen with every one of my senses… It is not worth my life to get caught. I am looking for food'.*

Chloe also identified with near death as she was left to die after repeated rape at the age of four, and also due to the severity of the beatings:

> *'I am half lying half sitting against the hut. I am burning in the sun and my mouth is so dry. My dress is torn and dirty and I am bleeding from down there*'(points to her groin*)*

And:

> *'I learned not to feel the pain of the beatings, it was as if I escaped into another world, but at the same time I was twisting and turning to escape her, strangled for air'*

The severity of the threat of actual destruction of the body was overwhelming for Chloe and Amanda, but there was also a sense of a mental destruction, when Chloe described her current experience:

> *'The pressure alone is just too much, it felt like I was falling apart'*

And Amanda:

> '*The memories seep into my body and crawl up my back, travelling along every vein, until I am drowning'*

And:

> *'Fear spreads through my body, I can feel it, it's like a virus. It's unseen but all consuming, showing me all things which are unspeakable'*

It was as though she was forced to watch scenes of horror from her life played out in front of her, but played with no sound track or narrative, but yet there was this insidious force which silently overcame her, and which she was unable to communicate. The role of negative emotion came back into play here in Amanda's sense of destruction:

> *'Pain and sadness flow through my body until I am gripped in a strangled hold'*

Total fragmentation was also entertained as a desire by Amanda, as if this total destruction was a better alternative to her current existence:

> *'I wish I could evaporate into the air and be gone forever*'

This suggested a conflict of emotion, both fearing it yet desiring it as the only way out of the desperateness of the situation. This idea powerlessness is further elaborated on below.

POWER AND CONTROL

The sense of powerlessness arising out of the violence was tangible and there were reports of attempts to gain a sense of power and control through unhelpful strategies such as fire setting and suicide attempts. There were also efforts to appear to be powerful and in control as a means of protecting the self against further damage. The lack of knowledge about alternative realities served as a disempowering agent which made the consideration of making choices out of the question.

The concept of being able to feel powerful or having a sense of control, were identified by Amanda, Chloe, Sara and Tessa. Amanda described the powerlessness as:

> *'I cannot escape my mind. My memories of the pain from my father's belt. The lashings I got which left me in searing pain as though I had been dipped in and out of boiling water. His threats to kill me. I quiver and shake at the thoughts of these and I cannot escape these feelings. Sometimes I freeze on the spot and am unable to move. It's as though I am paralysed'.*

I noticed that she clutched at her head as if trying to extricate the thoughts therein, but she was trapped inside her body with these memories. The emotional and physical pain felt like they were still present, with a paralysing hold over her.

Both Sara and Chloe sought to gain a sense of power and control, albeit through negative means, and this was used as a means of coping:

> Sara: *'Sometimes I would light a fire. Anywhere really. There was an excitement that gave me a thrill all over. I would sit and watch the fire and feel it's warmth. It was a warmth that I had created. I could also feel its power, and think of it as my power. I don't do that no more but it helped me cope at the time'.*

Sara used fire to feel strong and powerful and in control, but also making her environment better with the warmth, and this helped her to survive at a time when she had little ability to control her environment. Chloe, on the other hand, sought to try and gain control over her situation by making the ultimate agentic decision:

> *'There was no other life for me, I could do nothing'*

And:

> *'When I tried to take my life, it was three times, I was imagining my life was so bad, it was what people had done to me and my body'*

Her only perceived way of gaining control over her life and her feelings was to try and take her life.

It was also important to Sara to be seen to be powerful, as if this somehow had an impact on the level of threat to herself when she showed me her walking with her arms crossed:

> Sara: *'I walk with my arms crossed over my chest, I feel more powerful like this'*

Tessa drew the attention to her ignorance at the time, of not being aware of alternative realities, and that this lack of knowledge contributed to the feelings of not having any control over her situation:

> *'It just happened didn't it* (as a statement). *We didn't know any different'.*

Tessa also used self-harm as an effort to exert control over her feelings, although this subsided over time. It was noticeable that the sense of powerlessness and the need to gain a sense of control continued after the traumas had ended. This was understood as a need to gain control over the emotional sequelae.

ACTIVE BEHAVIOURS

Active behaviours played an important part in all of the participants' journeys towards recovery. These included any decision or active process that the woman either engaged with consciously or unconsciously, or activity engaged with. Some active behaviours were already in action prior to the start of data collection, and this included the first step of leaving the adult abusive relationship and coming to the refuge. All of the women reflected that the violence had got to such an extreme level that they felt they had no alternative except to leave. However, it was also noticed over the duration of data collection that the level of active behaviours increased. There was no definitive point, this was a gradual process.

Agentic functioning

Over time, for all of the participants, there was a noticeable shift towards agentic functioning, whether this was directly making the acknowledgement of taking a control over her life, or whether this was through making the choice to engage in different positive activities. For Amanda it started with a conscious decision:

> *'My future is mine to own'*

And:

> *'I am searching for a sense of unity, togetherness'*

This was a very significant shift for Amanda, as she was no longer grieving her fragmentation in a powerless way, she had shifted towards making a positive step to actively pursue this. This was similar to a process that Tessa engaged in when she was searching for memories:

> *'Boxes store memories, memories need to be safe. That's why I'm still searching for memories as I have so many and they're not safe. Some memories I've found but I don't have a place for them. It's like I only have part of the picture and I can't find the missing pieces, and when I find pieces I don't know if they're real or true. I am separating everything out in my head, trying to remember everything so I can order it and put it all together in one place'*

And:

> *'I am searching for a place to put my memories of each precious child so that they are safe. Everything needs to be in its proper place'* (grieving the loss of her children).

Tessa was seeking to manage her difficulty with thinking by compartmentalising things in her head, realising that for her this was a precursor to being able to synthesise the past as a whole. She made the decision to actively look and to keep searching. Both Amanda and Tessa took ownership and responsibility about their past but also their future, making choices to pursue a sense of unity.

Making positive choices

Martha made a conscious choice to manage without the help and support of her family, even though culturally this would have been counter to what a woman might typically do in the Muslim religion:

> *'I will work for as long as I can and then I will live off my pension. I try and do as much as I can for myself'*

Her rationale for this was that the abuse was in the family setting and she realised that she would need to move forwards independently from them in order to recover. It is suggested that given the cultural implications relating to the family home and the role of women, this was a particularly bold decision.

For Chloe, the positive choices she made were about stopping previous behaviours which were harmful, including suicide attempts and anger. Chloe accepted that she was choosing to live her life by a higher order and that to do this she had to allow changes to take place both mentally and behaviourally:

> *'When I ask Jesus to come into my heart He want to transform so changes have to take place. Things that I do before I have to now ask myself if that is ok. I have to make different choices'*

Writing

The act of writing for significant for three of the women. As Tessa explained:

> *'I do lots of writing. Every time we have met I write down everything to try and sort through stuff, what my feelings and thoughts are, and I try and put everything in its right place, coz then it's done and I haven't lost anything and I can move onto something else'*

Tessa found writing a means of organising and expressing her thoughts and feelings and also of holding onto important parts which might otherwise 'go missing'

Kirsty endorsed this:

> *'I always keep a notebook and write everything down. It helps me to be able to think more clearly, especially when I go back and read it a few weeks later, it helps me to think 'is that really true' or 'do I still feel like that?' It's also a way of knowing if I've moved on or not, or whether I am still saying the same sort of things as before.'*

Amanda also used writing:

> *'I write a lot, I do a lot of poetry. I went to a poetry class and that was good coz I got to meet people too.*

For Amanda, particularly, there was an emphasis on positive interactions with others contributing to helping her feel accepted.

Arts and crafts

Arts and crafts were positively experienced by three of the women. For Amanda and Tessa it served a function of conveying inner experiencing and by bringing it to the interviews they were able to be heard in a way that they had been unable to put into language. As Amanda said:

> *'No-one knows the depth of the pain that is my reality, it's like it goes untouched and unnoticed. It's graphic stuff you know. Sometimes I feel I just need to give a shape to all this. Sometimes this is a bit gruesome, like when I paint my dolls and their arms and legs are all in the wrong place. Sometimes I paint them and they have no face, or no eyes, or no mouth. This is the one with no mouth'.*

'Amanda showed me her picture. It was a beautiful painting of an old-English china doll – with a completely black hole for a mouth. It was quite shocking, and I felt the vastness of the silence that had been. But in her art she had also communicated that silence, those lack of words or inability to speak for whatever reason.' (Author's reflective journal.)

'Amanda brought another picture today. It was of another china doll, but there was a leg coming out of the mouth, the arms were twisted and out of place, and the other leg was missing. It created in me a feeling of dislike and compassion at the same time – dislike because it was quite gruesome, as if it belonged to some horror movie, and compassion because I thought how fragmented and disrupted the doll was – and Amanda was. But yet she had successfully managed to communicate this to me, and we were able to accept this into our encounter. So, although it was still fragmented, it felt like a voice had started to speak,' (Author's reflective journal).

Tessa was able to notice the change in her own expression of emotion, and in this way observed her progress in her journey

> *'I have started painting again. For years I could only paint pictures of black, stormy seas. I have painted a different one.'*

And:

> *'I quite like doing the painting now, and sometimes I can feel the creative me coming out a bit. I still paint seas but the last one had a beach in it too! And a palm tree!'*

Tessa began painting more and more, using it to express her emotions and to create new things. It was as if her emotional world was changing and she expressed this in a physical space that she painted.

Martha enjoyed cross stitch and making clothes for her dolls, and this not just gave her a sense of achievement but there was an appreciation for creating something beautiful:

> *'I make clothes to dress my dolls, I use lace and silk to make them beautiful. I like to see that they are beautiful'*

There was an importance for all three of the women for expressing something of themselves through art and craft, expressing both negative and positive emotion.

Martial arts

Sara brought with her an energy and a determination to move forwards. She didn't always seem to do much thinking but was determined to be moving forwards. She got a place in college to study sport, and joined a martial arts class. She seemed to be driven by her anger and shame about what had happened, and was determined to not go back there.

> *'I keep myself busy. If I'm not out with my mates them I'm busy doing my college course or martial arts. If I'm busy I don't have to think about the bad stuff, like what's my life's like'*

Wishing / fantasy

Both Amanda and Kirsty used fantasy and dreaming to maintain a sense of hope and perspective, as Amanda said:

> *'I dream of how I want to be and how I want my life to be just so that I can stay sane. It helps me cope'*

There is a sense of escaping into another world as a means of coping. It also is about creating something in her mind, attending to the detail of the characters and the events, noticing things about herself that she likes and dislikes, things she chooses to have and chooses not to have. There is a degree of agency in this.

Kirsty also endorsed this:

> *'I dream about my life how I want it to be, about the man I want to be with and what he would be like. This gives me hope that life could be different.'*

What is important about this is the ability to conceptualise a different future, whereas for many weeks they were only able to look at the past and the present. This idea of time is explored more in the next existential, 'lived time.'

LIVED TIME

Within the subjective experience of time, four themes were identified: the experience of the continuity of trauma over time, and how this existed outside of the confines of the actual boundaries of the violence; a sense of waiting, where there was a passive experience of time with an expectancy that life would change if one just waited long enough; and the need to persevere over time, which was connected to resilience. As time passed, there was a sense of ownership over time, and active engagement with time, in conjunction with an active pursuit of the woman's recovery and own happiness.

TRAUMA OVER TIME

'Lived body' and 'lived time' ran hand in hand. The persistence of the trauma, the difficulty in thinking, the negative emotions, and the physical pain, all extending over time was noticeable in the descriptions above under the embodied experiences. This is depicted here in the

interaction between the practitioner researcher and Amanda, as a means of reminding the reader that the subjective experience of time was very much controlled by the past:

> Amanda: *'When I think of those evenings, and I would have to climb the stairs to bed…'*

She stopped mid-sentence. Her eyes were staring, she was motionless. I filled in the narrative using my 'felt sense' all the time watching her to ensure my accuracy:

> *'I am cold all over, it's like it's just at the surface of my skin, and every hair is standing on end. The cold spreads deeper and it's like I cannot move. I feel a weight of heaviness descending on me like a leaden cloud, it wraps itself about me like a cloak of death. I am gripped, motionless, my very breath is frozen: my old enemy, fear'.* Amanda nodded

It seemed like there was no place to express the anger and the hate and these got devoured by the fear, yet they remained present. A sense that the feelings become inextricable and unresolved persisting over time.

Chloe and Sara also reflected on the persistence of trauma over time, and also space, taking up residence in her body, having such a hold that it was inescapable, as Chloe said:

> *'I suffered with the trauma, going over and over what had happened. I had all the nightmares, I kept living it over and over, I could not get away from it'*

And Sara notes:

> *'I try and forget but I can't forget coz it's everywhere. Especially in this place. I walk down the street and all I see is paedophiles. Everywhere. I can't get the pictures out of my mind'*

Amanda's experience of the loss of life force, and her subjective experience of time, noticing a time when she used to be more alive, but now resorted to just an echo of something former. There was this painful suggestion of the extensiveness of the trauma continuing over time:

> *'My heart has been dragged out of me, my heart beat is just an echo of something that used to be'*

It felt like the abuse was this devouring monster that had painfully extracted the very essence of life: a feeling of still being in her body, but yet her life was but an echo, as though a flicker of life left in a corpse. There was a concept of time where it was implied that the heart beat used to be stronger, possibly at birth, when the world was yet to be explored, and an idea that a life force was extracted slowly and painfully, in the use of the word 'dragged'.

Chloe suggested that although the trauma had troubled her greatly, over time this had also shifted, suggested by her use of the past tense:

> *'I used to be so fearful, I used to see her, my aunty, in my dreams, I used to see her all the time and could hear her calling me. I changed my name so I couldn't hear her calling. I went through a lot of things with my husband also'*

He trauma had continued from childhood and into adulthood for all of the women, but there was also a sense of subjective time passing more slowly as a result of the free-floating nature of the trauma.

TIME - WAITING

Amanda experienced time as something which was almost running as a parallel world, as if she wasn't really in it and experiencing it, but just noticed when it had passed:

> *'I spend a lot of time just waiting, waiting for my life to begin. It makes me feel anxious every day that goes past because my life has not begun. Sometimes I don't notice the waiting, I just notice the years that have gone past. It feels as if everything is on hold'*

There was a sense of her experience of time being distorted, not real, a sense of watching, and waiting for someone else to do something, or something to happen outside of her control. For Amanda this connected with her feelings of helplessness.

TIME - PERSEVERANCE

Chloe had developed a perseverance where she kept getting back up on her feet, after a 'fall' and not berating herself for failing. She described the importance of learning from experience and saw that this could only happen over time.

> *'Through your failure do not be afraid from your failing, your failing will get you through because you will know next time. Don't sit there and think 'oh no I have done it twice', get up and keep on going. You need to get to that place. It takes vision and faith. For me to receive that, I ask God to search me, change me, take my mind, take control of my mind, the spirit is saying something else, renew our minds daily, not monthly not weekly but daily'*

Similar to the process that Amanda and Tessa had engaged in where they were actively pursuing fragmented parts of themselves, Chloe also went through a process of working through the past events, but engaged in an additional activity of allowing God to show her His presence throughout, and the meaning of this in the broader scheme of things. She explains this when she said:

> *'I woke up the next morning and I was rejoicing, but then the battle came, I said: 'If this is how it is then I don't want it anymore', and God started bringing my past to me, and showing me all the times I was there. And I was angry: 'But how did you let that happen?' And He say to me: 'I wanted you to know that they were doing that to Me, what they done to you is as if they have done this to me. You share in my suffering and you will share in my glory'*

Chloe was able to grow in understanding about the abuse and to make a sense of it, allowing God to show her His perspective, with assurances of His lasting love, and the change that resulted from this working in her heart and mind:

> *'I knew a lot of things was of God coz He was working thing out in my life. This can only be God. When we are serving the enemy, we give him everything. I never had this wisdom. Stop saying 'I wish, I want to be in that situation'. I will be discouraged.'*

Chloe described a process whereby God helped her to process and make sense of the abuse. When she talked about the 'enemy' she referred to him being pleased that she was angry, bitter, confused, and wanting to take her life, and how when she went over and over the trauma

it was like giving glory to the enemy, as his goal was to cause destruction. She learned to stop regretting the past, saying 'I wish…' as this caused discouragement, and instead chose to accept the present.

TIME - OWNERSHIP

Amanda observed the value of there being a time to talk about the abuse and a time not to talk and in this way used time to exercise a sense of control over her own feelings:

> *'I met people through arts and crafts group and small groups where we could have a cup of tea and chat. It helped to not always talk about the problems but do normal things with normal people'*

She also took ownership of her subjective experience of time:

> *'Time is mine now'*

There was a shift in Amanda, she seemed more determined, she was actively taking 'time' rather than watching her life go by, waiting for things to happen. There was a sense of a new beginning, a positive feeling of hope when she said:

> *'I am allowed to start again'*

This theme includes the concept of trauma floating freely over time, the sense of waiting, the importance of persevering, and moving to place where there is a taking ownership of time.

LIVED SPACE

Lived space as a master theme was endorsed by all of the participants, but with differing emphases. For all of the participants, the physical space that they occupied both in the past during the traumas, and the present space when the actual traumas had ceased, had a negative impact on their mood and feelings, and vice versa, but as their feelings became more contained, the present space was able to be experienced differently, and more positively.

During the time of the on-going abuse, space was experienced as solitary, and threatening, but over time there was a reflection on space as being safe, shared, and an ability to enjoy positive space.

SPACE AS SOLITARY

Four of the participants talked about their experience of space as solitary. Amanda experienced this especially during the early years of trauma, and recalled:

> *'I am out in the street. I have been playing with some boys. They are called into tea by their mums and run off happily. I drag my feet along the road and notice the dark evening creeping in. I sit on the pavement outside my house. No-one calls me into tea. I wait there for some time until eventually my dad appears as an almighty hulk in the door way and tells me to get in. He clips me round the ear as I pass and sends me to bed without any supper because I had been out playing. I feel the*

sides of my stomach gnawing at my bones I am so hungry. It is like a ravaging beast within. I have not eaten all day. I creep into my bed and curl myself up to try not to think about the pain'.

Her experience of humanity at this point was of being uncared for and not even provided with physical requirements such as food. It was noticeable how much Amanda craved company as an adult, and how much she disliked being on her own.

Amanda described being physically separated from other people, where being solitary was used as a punishment, which served to reinforce her belief of her own badness:

'There was little notice taken of me. I ate separately, I was not allowed to play with the other children. I was told I was promiscuous and stupid. I believed I was evil, a liar, the devil's child.'

For Chloe, it was the physical absence of caring people that made for the space experienced as solitary:

'I was so alone, I had no mother or father, and my aunty she did not care for me'.

In Amanda, this sense of a solitary space that is external to the body, also seemed to present itself inside the body at the time of the abuse:

'Silence creeps into my mind, spreading like a virus'

But also continued into the present day when the abuse had ended:

'Silence pushes me out of my mind'

The silence and solitude felt to be all powerful and consuming, to the extent that there was no place for herself in her own mind and body, there was just this silence. But yet she was still in her body as she heard and experienced the silence, a sense of being fragmented yet still present. It was still 'her mind' suggesting there was still some ownership over her embodiment: there was an overlap between the master themes of lived body, and lived space.

Kirsty described her space in the following way, and noticed the similarity between the past and the present:

'There was no-one, no-one to talk to, no-one who seemed to notice or care. It was just me. Even now, I still feel kind of locked into a space that no-one else knows about'.

This was significant for Kirsty because of the pain of the solitude, this sense of experiencing the traumas in a way that no-one else seemed to care about of understand, which maintained her feelings of insignificance and of being solitary.

Sara presented a little differently, describing her experience of space in the present time. She had developed a fierce sense of independence through her adversities, but still had this need to be with people:

'I just get on with life on my own. I always have to have company though, I hate being on my own. That was why it was so hard to leave my partner. I knew it was bad what he was doing but I couldn't face being on my own. Especially when me and my sister drifted apart when she got her new man. Even now, I need to be with people, I don't like being on my own'

SPACE AS THREATENED

All the women endorsed the experiences of space as being threatened both during the abuse and when it had ended. As Amanda said:

> '*Wherever I run I am always chased, wherever I hide I am always found'*

Amanda was talking metaphorically but it felt like there was nowhere that she could go, 'the other' seemed to be all-knowing and all-powerful, a feeling of being exposed and unsafe. She was talking in the present time, but there was a sense of her referring to the time when the abuse was ongoing, again making connections between the master themes of lived body, lived time and lived space.

Chloe's experience was a reference to the physical space at the time of the abuse, and her use of the present tense suggests that this was an on-going experience at the time of retelling it:

> *'I am half lying half sitting against the hut. I am burning in the sun and my mouth is so dry'*

There is this sense of being left almost to die in the hot sun, after being repeatedly used by the men of the village for sex, but this feeling continued to reside in her. This suggested that trauma could continue to occupy a space in her head even though the event had ceased. This is also endorsed by Martha, who said:

> *'I am running, screaming to the door* (of the refuge) *trying to get out, I do not know where I am'*

For Kirsty, Amanda, and Tessa the sense of present space felt threatened because they felt exposed and watched by others, as Amanda described:

> *'I had this image of my life being a bit like washing on the line, but I don't want anyone to see it. I am ashamed because I have so many things wrong with me, it's as though I am like faulty goods, I don't quite work properly. I'm afraid that other people can see this, and that I will be found out'.*

Kirsty was similar:

> *'I feel that people are always watching me, thinking that there is something wrong with me or I'm not quite right'*

And Tessa:

> *'I hardly ever go into town, as when I walk down the street it's like everyone can see straight through me and know what's happened to me and the things I've done and are judging me.'*

It is noticeable that their perception of the world around them had changed as a consequence of the trauma, that they seemed to have internalised the 'badness' of the trauma as their own, whereby the space experienced as 'bad' came to occupy a 'bad' internal space, and it was through this lens that they perceived others and the space around them. There was a strong sense of guilt and shame wrapped up in the perceived or anticipated judgement of others and

that this was adding to the accumulation of negative emotion that restricted their ability to move away from their continued experience of abuse.

Sara experienced it differently because the space was always filled with the needs of others, and her own space for herself was threatened:

> *'Every day when I was 8 or 9 the only thing I could think of was where I was gonna get food from that day for the kids'.*

As the women progressed along their recovery journey, the experience of space changed. For Chloe she had already travelled this path, for the other five women the next section describes their experiences.

POSITIVE SPACE

Positive space was endorsed by all of the women whether this was reflecting on positive space at the time the traumas were continuing, or whether it was about creating a positive space in the present and the future.

Amanda found that her pursuit of gardening enabled the creation of a physical space in the present where she could experience it as safe. This overlapped with the concept of time, and also relationships, as it reminded her of the space enjoyed with her grandfather in his garden, which brings all the master themes together in a unified whole.

> *'I sit outside. I notice the sun which is bright in my eyes. I sit on the grass and pick the daisies. Sometimes I make them into a daisy chain. I plant vegetables like my grandad did. I can be outside all day, it's as if I escape to somewhere safe'*

And:

> '*We used to do things together, plant seeds in the garden, sit outside in his shed and just talk while he smoked his pipe. He helped me to feel that there was something different to my world.*

The act of sharing a space together and creating something gave rise to a sense of positive meaning and placed a value on her existence.

Sara reflected on some positive space she had enjoyed growing up, and how this contributed to her ability to cope at the time:

> Sara: *'My Nana and Grandad helped me when I was growing up. They used to take me to the beach. Perhaps it was coz they saw I had a hard time at home. They knew for a fact what was going on and that I was not coping. They used to have me some weekends. (Thoughtful) Good times. Sometimes it helps me when I reflect on the good times. I would take the younger kids to my big sister who was already married then I would go to Nan and Grandad's'*

Sara talked fondly of her grandparents, and some of the positive times she had with them. This meant a lot to her and was a great source of comfort and strength growing up. It was important to her that her grandparents had been there over time.

Positive space for Sara in the present also involved thinking about the world and its occupants in a different way to one she was used to:

'I try and think about the other things I see, about nature, people's gardens. Sometimes I look at people's gardens' and even in their windows, ya know, just as I'm walking past like, not peering in, and wonder what their lives are like. What's going on behind that closed door? Sometimes I see people just watching telly and stuff or just being together. Once I saw this mum playing ball with her little girl and I wondered what that was like. They didn't even have a big garden or anything, they was just playing ball on a little patch of grass. I liked that'.

Animals played a role in creating positive space for Tessa and Sara, in the present for Tessa and in the past for Sara. For Tessa it was important that she was able to care for something, especially after the loss of her children, and to prove to herself that she could do this. Her dog was always responsive and that contributed to her feelings of being acceptable:

'I love playing with my dog, he always wants to play'

Sara recalled further positive memories with her Grandad, and how taking the dog for walks brought a bit of happiness into her world:

'My Grandad had a trainset and we would sit and watch it for hours. They also had a dog, and I would take him for walks. That was fun'

For Martha she actively created positive space by planning a holiday with a friend:

'we will just stay in a little house by the seaside, you know, to get away from everything for a while'

This sense of being able to choose to go to a physical space which felt safe and free from the hassles of everyday life, not that it wold change anything, but it was important to her to be able to enjoy physical space. This is similar to her own, and Amanda and Kirsty's appreciation of nature:

Amanda: *'I sit outside. I notice the sun which is bright in my eyes. I sit on the grass and pick the daisies. Sometimes I make them into a daisy chain'.*

And:

Martha: 'The beauty of summer, the feel of the breeze, the smell of the grass, the song of the birds. I just sit and listen. And feel. It is a breath of sanity'.

For Martha it was soaking up nature will her senses, her vision, touch, smell, and hearing, and just taking time to be mindfully still and notice her surroundings which were pleasant.

Kirsty expressed something similar when she said:

'I love being outside with nature, just sitting in a field, or looking at flowers. Seeing something beautiful helps me not to think of all the disgusting and horrible things that are often in my head'.

This theme includes the progression from experiencing space as solitary and threatened to being able to enjoy and create a positive space, and with it the opportunity for positive emotion.

LIVED RELATIONSHIPS

All of the participants endorsed the master theme of lived relationships as being relevant in the recovery from violence. There were perspectives on historical rejecting relationships, whether this was overt rejection, perceived rejection, or absence of relationships. This impacted five of the women in their present day experiences, with continuing difficulties of low self-esteem, lack of confidence, fear of judgment from others, and giving rise to beliefs of badness about herself. It was noted that some of the women continued to relate to others in similar ways that they had done during the abuse, and this continued to have a negative effect on their ability to engage caring relationships.

The importance of enabling relationships was endorsed by all of the women, and was considered integral to the recovery process. The impact of negative relationships on identity was present for all women, but four women were able to acknowledge positive changes in their sense of identity over time. The presence and importance of a spiritual relationship was incorporated into this theme as this was a major factor in the recovery for Chloe. The research relationship was experienced positively by all the participants, with two women noting it was their first experience of an enabling relationship.

REJECTING RELATIONSHIPS

All of the women experienced the rejection through abuse, but several also noticed how this continued to impact them into the present day, negatively affecting their mood, self-confidence and esteem, their identity in on-going relationships, and a continued lack of trust and for some a lack of reciprocity in relationships.

Kirsty experienced herself in relationships as being disliked or humiliated, and also the lack of loyalty in relationships:

> *'I always felt I was different from the other children, I was very self-conscious and thought everyone was looking at me all the time. I had a few friends but they always seemed to like each other more than they liked me. As an adult, my 'friends' just seemed to disappear. If they did come round my husband would humiliate me so much in front of them I wished that they wouldn't come round coz I was so embarrassed by his sexual behaviour. After a while I realised I didn't have any friends to ask round anyway'.*

For Kirsty, it was fearing that others would not understand, that they would apportion blame. The meaning she derived from this was that she was unimportant, but also different, a sense of 'being apart' from others, that she didn't quite fit in. She had become very self-conscious, and lacked confidence much of the time, in the way she looked, the way she dressed, and how she behaved. This has continued to impact her in her present relationships, and her ability to move forwards, as much of her focus continues to be on what others might think about her.

> *'Even now, I am always really conscious about what I am wearing, and even if I have clothes, I am always doubting my decision, always thinking that I am different, and even odd. I keep changing my clothes and hair and find it hard to make decisions that I am confident in.'*

Chloe was also concerned with what others might think but did not seem to compensate in the same way as Kirsty:

> *Chloe: 'I have been worried about being judged the way I have been treated. I am worried that they judge me for my past, them seeing it as my fault or I am bad person'.*

There is suggestion that Chloe had also had a time when she felt it was her fault and that she was a bad person, and that this might be a natural conclusion for others to come to. This caused considerable fear and anxiety

Tessa also experienced this perceived rejection, and avoided others because of her fear of being judged or exposed by others. This behaviour of avoiding people kept the shameful feelings going, and maintained her perception that others could see through her:

> *'I hardly ever go into town, as when I walk down the street it's like everyone can see straight through me and know what's happened to me and the things I've done and are judging me'*

All three of these women had a distorted perspective of themselves as a consequence of their current perception of others. Given that 'the rest of the world' were not the perpetrators of violence to these women, suggests that there may have been a generalising effect from direct experiences of rejection and that the past was affecting their perception in the present.

The lack of relationship connects with the theme of being solitary in space, again supporting the idea that the existentials overlap. All of the participants noted the lack of primary relationships growing up:

> Chloe: *'I was so alone, I had no mother or father, and my aunty she did not care for me'.*
>
> Sara: *'We never had no friends round, and I didn't get to go to school much so didn't have friends there either. Mum was always drunk and dad was out'.*
>
> Tessa: *'It was just me and my brother, and I had to look after him coz my Mum didn't'.*
>
> Amanda: *'There was little notice taken of me. I ate separately, I was not allowed to play with the other children. I was told I was promiscuous and stupid'.*
>
> Martha: *'For so long I tried to get close to my mother, but I was pushed away. She would hit me across the face, round the head, anywhere, and kick me like a donkey. How do you repair that? Because it is hugs and love that she did not give, she did not touch me unless she was hurting me. When it is your mother that rejects it is the most painful things. As I grow older I would say 'but she's still my mum.'*
>
> Kirsty: *'I just didn't feel very noticed or important, and I didn't feel there was anyone to talk to. No-body understood. I grew up feeling mistrustful of everyone, and so I was very lonely'*

Martha also talks about the danger in her adult relationships and how rejecting these were:

> Martha: *'When my son beat me, my husband he just turn the other way, he did not even tell him to stop. It was not until I got out from there that I can see how bad it*

was. I would shut myself in my room all day in the end and not come out even for food, I was so frightened to be around them'.

And:

Martha: *'I was like an outsider in my own home. It was not like a home to me it was just a place where I was. No-one noticed if I was there or not, they just noticed when the work was not done. I would not even use the toilet while they were there, I would wait until they had gone out.*

And Sara refers to the lack of reciprocity in adult relationships, suggesting that the impact on relationships continues over time. Sara is observed to repeat her childhood pattern of doing everything for everyone and getting little back, and continues this into adulthood. This suggests that she continues to have very low self-worth, as there is frequently no equality on the relationships, and others do not respond in a way that looks after her:

Sara: *'I am always doing things for other people but when I need something no-one ever returns the favour. My best friend did that for me once, you know, returned the favour. But I do favours for her all the time. That's how you know who your friends are, they give something back. That means you are important enough in their lives'.*

Her experience of others was that they were not available for her, except rarely, but when they were she felt valued and important to them and this was significant for her.

<u>Mis-trust in relationships</u>

Sara: 'Sometimes I stole things with other people. Just people I knew, in the street. That's how you really find out who you can trust. Whether they would tell anyone. But I also noticed how they coped with stuff, how they reacted. And if they would ever use things against me in the future'

Sara needed to test others out to know if they were trustworthy or not, and whether she could rely on them if she needed to. She also learned how to survive in a challenging world where there was no-one else looking out for her

Amanda: *'I thought you cared, you used to pick me up when I fell over or hurt myself. But when it was bedtime I used to dread having to go upstairs, knowing you would come and lie on me. Do you love me? I asked myself; but we could never talk about this. The door was always locked and I was plunged into silent pain, alone, terrified, breaking. I am red and raw and burning inside'*

This confusion about believing that she was cared for and loved but not being able to make sense of the hurt and paint hat was caused by the same person. The trust that she wants to be there, the belief that he might be there to care for her, but the turmoil caused by the sexual abuse.

Amanda: *'I still find it hard to trust people, like knowing whether they will hurt me or not'*

Kirsty: *'I don't trust anyone, just myself. I do keep trying to trust, but they have to prove that they're trustworthy.'*

ENABLING RELATIONSHIPS

Relationships that were enabling covered a number of areas, including: people who had been consistently there, those that were supportive or just friendly, and those that were loving and approving.

For Sara, her Grandparents played an important role, creating positive space and time away from the trauma:

> *'My Nana and Grandad helped me when I was growing up. They used to take me to the beach. Perhaps it was coz they saw I had a hard time at home. They knew for a fact what was going on and that I was not coping. They used to have me some weekends. (Thoughtful) Good times. Sometimes it helps me when I think on the good times. I would take the younger kids to my big sister who was already married then I would go to Nan and Grandads'.*

For Amanda, it was about her Grandad being there, just creating a feeling that life could be different:

> *Amanda: 'My grandad was there for me. He had a special way of making me feel wanted and cared for. He used to cheer me up when I was sad. We used to do things together, plant seeds in the garden, sit outside in his shed and just talk while he smoked his pipe. He helped me to feel that there was something different to my world'.*

But despite this, she continued to experience considerable trauma over time. Going to the Police and being believed was an important turning point:

> Amanda: *'The policeman was gentle and caring and believed me, he listened to every word'.*

For Chloe, it was her friends who helped to get a perspective in the chaos of her anger:

> Chloe: *'Through all the personal experience of my life I was angry with God: why did you let me go through this? I have been abused, you don't understand what I went through!'*

And my friends at church would say to me:

> *'but God is able',*

and I would tell them to

> *'be quiet!''*

Chloe was struggling with a sense of injustice, with her focus on the past, but her friends were drawing her attention to the present and the future and to what God could do. Chloe grew to value her relationships with the friends at church, recognising that they were helping her to be strong and grow, they provided encouragement and support:

> *'I have brothers and sisters in Jesus and they give me encouragement so I can be strong. We pray together and share the Word together so we can grow'*

She got to a place where she said:

> *'My relationship is Jesus'* (smiling)

Kirsty acknowledged that there had been some key friends throughout her life which had helped, but like Chloe acknowledged that it was knowing that God was always there and that He cared which helped her to feel stringer:

> *'There were some key people at different times in my life, no-one as a child, but I didn't really know that what was happened was wrong then, or that it was affecting me. I can see now. I had a good friend when I was a teenager, she was an adult, but that helped a lot. And another couple of friends after I left home. I think that helped me through the teenage years. It was after I got married that the friends sort of dropped off. It was my faith in God which kept me surviving all those years, I didn't see things clearly, I couldn't understand things like I do now, it took such a long time to understand, it was like I was just clutching on. But it was knowing that God was always there, and I could talk to Him and that He cared.'*

Tessa and Martha were unable to identify anyone significant in their early lives that had helped or supported them, but Tessa placed a value on the research relationship and Martha had made a friend through work which was positive:

> Martha: *'There was nobody. My grandmother sometimes she would sit and put her arm round me but that didn't comfort me as much as if it were my mother. I needed my mother. I didn't trust her (grandmother) because what was happening was right in front of her'.*
>
> Tessa: *'You're the first person who's really listened and cared'.*
>
> *Martha: 'I have made a friend at work. She does not know everything but she is a still a friend. We are going to go on a holiday together to the seaside.'*

The on-going support and love of others was recognised as important by Amanda, Tessa and Martha:

> Amanda: *'Having friends that at least seemed to care was really important. It also helped to know where to find these friends. I met people through arts and crafts group and small groups where we could have a cup of tea and chat.*

It was important to be accepted by others, validated and heard, but there was also something positive about engaging in shared activities,

However, there is a suggested deeper depth of relationship that still felt missing for Amanda, Tessa and Martha:

> Amanda: *'I need to be loved, wanted, and missed'.*

And:

> Tessa: *I don't have any friends yet but I really would like some. I wish you could be my friend but I know you can't. I need someone normal not messed up like me, and everyone in here is messed up as well, it's like a disease that spreads. I want to find somewhere that I can make friends as that will help me get better'*

Tessa placed a valued on making friends but she had never really had any one but she placed a value on finding friends that had clear boundaries about their emotions.

Martha expressed her desire to learn about what love is, recognising that this was something which had been missing all of her life:

> *Martha: 'I do not know what love is, but I want to know'*

IDENTITY IN RELATIONSHIPS

The importance of relationships in the construction of identity, both positively and negatively, was identified in all participants. Historically, identity was constructed in a number of ways: self as unimportant, shameful, weak, faulty, defective, loathsome, and a sense of being lost. Chloe, in her journey towards recovery, had discovered a new identity in God, where she no longer worried about the judgment of others, she felt accepted, and had a sense of purpose which placed a meaning and value on her identity.

Over the time of the data collection there were some other changes observed in Martha, Tessa, and Kirsty. Martha started taking more care over her physical appearance and dress, suggesting she was more proud of herself and her body, whereas previously she had attended in pyjamas, scruffy clothes, with no attention to hair washing or appearance; Kirsty, who had always presented as coordinated, with evidence of much effort going into her appearance, felt able to not wear makeup for going out, suggesting that she was less worried about the judgment of others, and more comfortable with herself. Kirsty was also able to acknowledge that she was a 'good person' and Martha, she was 'beautiful' suggesting a shift towards a more positive self-concept. Tessa was also observed to pay increasing amounts of attention to her appearance over the course of the data collection, from the early days when she would attend in very casual clothes, to caring for her hair, and clearly making an effort with her clothes. The process of noticing these changes was important to all women, suggesting the liking for positive affirmation from another. Sara was able to reflect on her identity and notice positive aspects of herself which she previously had given little thought to.

With Amanda, there was this sense of the other (her mother) being the most important, her mother's desires, interests, goals, and Amanda getting left behind, but also having no identity apart from her mother, which suggests that Amanda did not see herself as separate from her mother in respect to identity:

> *'She lost me in pursuit of herself'*

Sara picks up on this in her adult relationships, where she seems to internalise the shame of her abuser, as if she was not separate from him:

> Sara: *'That makes me angry now though because I was weak. I hate myself for that. Ugh, I despise myself for letting him do those things, like when he wanked all over my face and told me to open my mouth. I can't believe I let him do that. That's just the most disgusting thing ever. I feel myself all screwing up inside now every time I think of it'*

Chloe echoes this idea of her identity being constructed by the abusers, but not having a sense of a separate identity:

> Chloe: *'I am four years old. All the men of the village they use me for sex. That is all I do'*

Chloe: *'I was lost, so lost'.*

Tessa endorsed this idea of her identity being wrapped up in the abuse:

'I was just a whore, wasn't I?'

But this identity continued over time, and in conjunction with Sara and Kirsty, they seem to have internalised the abuse and views it now as their own defectiveness:

'I am ashamed because I have so many things wrong with me, it's as though I am like faulty goods, I don't quite work properly'.

And:

Sara: *'I am ashamed to have anything to do with that life. It's like we are all bad because of them'.*

Kirsty: *' I feel just a total failure and that somehow it's my fault'*

Martha placed a strong emphasis on her identity as nothing, not worthy of respect, on her female gender. This does not feel like an identity constructed as a result of an internalisation of the abuse, it suggests that her identity was nothing from the start, due to her gender:

Martha: *'My children they don't respect me. I did all that I could to care for them and love them, I took them on outings, I bought them things, I played with them, but they don't respect me because I am a woman'.*

And:

'I was an outsider'.

And:

'I am nothing to my family'.

There was a noticeable difference in Chloe from the start of the interviews, she had already come a long way in her journey towards recovery, and had developed a positive identity in God:

'Coming to trust God is a challenge, is a challenge of fighting with the mind. Jesus say 'let the man who has no sin cast the first stone. I know who I am in Jesus and that is the most important'

Chloe explained that this was a verse from the Bible meaning that people should not be judging others because everyone has done wrong. There was this sense of her being fearful about others judging her but at the same time trying to hold onto how God saw her, and this was a mental struggle.

'I got to that point where there is nothing in this world that can be there for me, for me to have this understanding that God created the earth, and all that is it. We are created to be in an intimate relationship with God to worship Him'

Chloe had struggled with the fear of judgment for a long time, suggesting that she had doubts about her own level of involvement in the past abuse and whether she was responsible or

culpable in some way, but she wrestled with this and her new-found identity in God and found that her purpose was to be in a relationship with Him.

Martha suggested a change in her self-concept, which was recognisable by the way she started to dress. In the early interviews she would often wear pyjamas or very casual jogging bottoms and top, but one day she looked completely transformed: she had dyed her hair and had it cut, and she was wearing traditional dress from her cultural heritage. She came in and said:

> *'My husband say I am old and ugly, but I know I am beautiful woman!'*

Kirsty was able to recognise a respect for herself:

> *'I do think I'm a good person, I do try and do the right thing, even if I don't always get it right'.*

Sara also had a sense of liking herself:

> *'I do quite like myself now coz I think I'm funny. I love to make people laugh. I like people who have humour in them. I also like that I'm caring about others'*

SPIRITUAL RELATIONSHIP

Three of the participants reported faith or religious beliefs, Martha, Chloe and Kirsty. Martha was a Muslim, and talked very little about her religious beliefs either in the past or the present. Kirsty had been a Christian during the time of the abuse and attributed to God her ability to be strong, be heard, and feel cared for. Chloe had become a Christian following her abuse as a child and during the abuse with her husband, and attributes her healing to the development of her relationship with God, where she experienced acceptance, love, understanding and being cared for.

Chloe's experience of God seems to have been transformative for her where she felt accepted and comforted as a child would in the arms of loving parents. Chloe was an orphan so this had an additional depth of meaning for her.

> *Chloe: 'The sun was out, I could remember the light shining very bright, and I stood at the front* (of the church) *there, and it was as if something was coming into my life, I have never had a mother or a father, and when I accepted Jesus I got the biggest hug, I felt I was being wrapped, wrapped, wrapped as the most delicate thing, and I wept with rejoicing'*

Chloe was aware of her huge need to be loved, and came to her (former) husband with the hope that he would be able to fulfil the gap that was so painfully there in her life. The extent of the disappointment when this did not happen is unfathomable, to find herself in a sexually and physically abusive relationship. The overwhelming and heart sinking feeling of being in another 'hell'. Chloe turned to God to meet her need realising that this was something that held a deeper meaning and value

> *Chloe: 'I hoped my husband would give me all the love that I needed, the love I had never had. I went from the hug of Jesus to my husband and then back to God. When you understand the love of Jesus, God drew me back. I hoped my husband would fulfil everything as a child I never got but that did not happen, it was another*

hell. Only God can fulfil my need for true love and acceptance. What the world offers is empty in comparison'

Kirsty also acknowledges the importance of her faith:

'I do pray to God, and tell Him all my feelings. He's the only one that actually listens I think, or cares. I've always prayed and this helps me to be strong'

RESEARCH RELATIONSHIP

The research relationship was integral in the design of the study, and all participants placed a value on this, to greater or lesser extent. Being genuine with a real sense of caring was important for three participants; having the time was important to one participant; remembering and holding onto things which have been said, and being able to notice these at later stages was important to thee participants; listening was important to all participants, and understanding what it is like to be abused was noted by two participants. For Chloe it was valued because she was able to share her experiences and the joy associated with that.

Amanda shares her thoughts in this way:

'I find I can talk to you and you seem to understand. Sometimes when I meet professionals I just feel like they are doing their job but don't really care, and so long as I tick the boxes then that's all that matters, but you have taken the time to listen to me and that makes me feel important. I know I wouldn't normally have got this much time if it wasn't for this project but if you told me we just had six sessions together I would never have talked to you. I feel like I am putting my life back together – not there yet, but I have started'

There was a real emphasis on not being restricted to a set and short number of sessions. Amanda knew that the maximum time I would meet with her was one year but this seemed long enough for her to feel safe enough to talk to me and share her journey.

I felt privileged to have been able to walk this journey with Amanda, honoured that she shared with me her traumas and struggles and that she trusted me to hold and value all aspects of herself. It wasn't something that I did, it was something that Amanda was enabled to do as we shared a physical space and time together over the eight months that we met, and created a relationship that was accepting, non-judgmental, and very importantly holding.

Chloe placed a value on being able to share life with another. I had spent some amazing weeks with Chloe, just listening to her story, noticing her joy and her inner strength. There was a sense of a shared joy in her journey.

Chloe: 'What I have found is that we have shared life together, and we have known the love of Jesus'

Tessa placed a value on the respect and humanity in the research relationship but also the depth of understanding and empathy.

'Thank you for being there. You are different to all the rest. You treat people as people, not numbers. I know that you really know what it's like, being abused and stuff, and that makes a difference, you haven't just read it in a book'

In my curiosity and reflection Tessa seemed to have been enabled to hold onto bits that she might otherwise have 'lost' and this seemed to help her to synthesise and make sense of things.

> *'You kept challenging me not to avoid stuff coz you always remembered what I'd said. This helped me to keep finding bits that I was losing'*

Sara seemed to have created a life for herself, she got herself a new partner 'who she wasn't having any shit from' and moved out of the refuge and in with him. She seemed stable enough, but I often wondered about her anger and how 'wobbly' that made her. We were able to have a brief chat about what recovery was for her before she left the refuge:

> *'It's good, yeh, to have someone to talk to like, coz you just listen but you remember stuff too, and the staff are helpful especially with benefits and stuff, and they helped me sort my college course out. Practical stuff is what you need at times like this as it helps you get back on your feet again'*

I felt there was still a child in her that 'needed to get out', and also a loneliness, and this was mixed with needing to be independent and survive in an adult world. I don't think she had sorted out her feelings of shame and badness at that time, but I do think she was too busy to think about them.

Martha expressed her feelings about the research relationship in the following way:

> *'You are the first person who has really listened to my story. I had counselling before but they made it much worse. After 11 sessions he said I was better. It was like they opened up all the boxes and then left me. I did not know what to do, I couldn't sleep, couldn't think, I was running screaming to the door at night just trying to get out. I did not know what I was doing'*

Kirsty emphasised the importance of the research relationship being genuine, but also that I was interested in her:

> *'I like the fact that you seem interested in me, and what my story is, and that you seem genuine, not just trying to get stuff down for your project, but that I can relate to you'*

She talked about feeling that I had placed a value on her by taking the time to listen to her story.

RECOVERY

The direct questions about resilience and recovery were asked in the early interviews with all the participants, but only Chloe was able to answer at that time:

> *'We can make all the excuses we like but it is only ourselves which stop us moving forwards. It was the grace of Jesus that got me from that place of being so angry to knowing how much God loved me. Sometimes the enemy come, and I see myself as I was, and for a second I go back in there, then I say*
>
> *'Jesus!'*

And I am able to come out! It is funny to say it but my past has made me more a conqueror. I went to the depth of hell and that is how far His love and grace have reached down towards me. Out of that, there is the gratitude of heart, pulling me out of despair. The worse the situation I have been in the more we know His love, and we love Him. If I had an easy life I wouldn't ned Him. People who have comfortable lives they cannot see their own need'.

Chloe was talking about recovery. She very much saw herself as getting in the way of her own recovery in the past, and was referring to her own lack of understanding and her own desires, and the emotional conflict. She described the 'enemy' as pulling her back emotionally, with images of herself during the abuse both as a child and an adult, and how she started to get lost in this but would refocus on God. She got to the point when she could say:

'Recovery is when you have faced all the past stuff that is bad, and can accept what has happened to you, and received the healing power of Jesus Christ so that you will know fulness of joy'

As time progressed, the other women were able give their understanding. Amanda's started off being dismissive, but she was able to qualify this:

'Well, I'm still 'ere, aren't I? (Thinking) *Resilience is about being strong, having an inner strength that doesn't let you give up. I have always hoped there would be a different life for me and that kept me going, kept me searching, even though I nearly gave up so many times'*

There was something important about persevering and not giving up hope, as well as holding onto the idea that life could be different.

'I don't know what defines recovery for me but I think it would be when I feel like I've got a life. I'm getting there, I have activities on most of the time now and this helps me. I go to the coffee mornings at the church and get to meet people there, even though they're mostly old folk it's nice that they speak to me and always make me feel very welcome'

And:

'I haven't had another relationship. I think I want one but I need to know that I am strong enough to be able to do things more my way and not just letting him walk all over me. I still crave to be loved and wanted so I know I will find another relationships but just want to make sure it's the right one'

There is this suggestion of recovery being in multiple areas. Although she can feel better when she is accepted by others there is still the area of intimate relationships which are unchartered waters, and there is an anxiety and fear about this.

Tessa described resilience as a strength that was present throughout, and like Amanda, suggested the importance of perseverance:

'I don't think recovery is the same as resilience, resilience is about being strong all the way through, and not giving up. Recovery is about getting past the bad stuff and having a life – having friends, being able to go out and do stuff, being able to be calmer and help other people'

Tessa identified the importance of being more functional, able to go out, managing emotions and being able to contribute to the lives of others.

Sara's understanding of recovery was focussed on independence but also acknowledging the importance of social relationships:

> *Sara: 'Recovery yeh, it's about being able to stand on yer own two feet, innit? And having mates and stuff'*

Martha was unclear on recovery, but emphasised the importance of physical safety, and a sense of happiness:

> *'I do not know what recovery is but I think it is being happy and not being hit and beaten; and feeling safe'*

Kirsty identified with this idea of being physically safe, and also happy:

> *'I think I've got quite a long way to go to really 'recover'. I'm not sure what it is or what it looks like. I think it would be that I was happy, that I could just feel safe and happy in my own place with the kids, that I didn't have to worry who was coming through the door, what mood they might be in and what they might do'.*

MOVING FORWARDS

All participants were asked what they considered to be the next steps in terms of their recovery.

All women identified the importance of good relationships, Chloe was focussing on developing her relationship with God, Tessa felt she needed to be able to have intimate sexual relations, and Amanda, Sara, Martha and Kirsty all placed a value on positive friendships with others. Tessa placed a valued on continuing to make sense of her past experiences, and Kirsty recognised the need to focus on developing her self-esteem; Chloe and Kirsty stressed the importance of not worrying about the judgment of others.

Amanda wanted acceptance in relationships as this is what determined her acceptability and feelings of being cared for and wanted:

> *'I need to make some good relationships, people to talk to, who actually want to see me'*

Chloe stressed the importance of not worrying about the perception of others, focussing her attention on God, and allowing God to renew her mind:

> *'If I remove my eyes from the cross. I am going down. When I am seeking validation from others, I am struggling. I do not need to check with people 'am I ok?' I just know what my heavenly Father thinks of me. I choose to believe Jesus'.*

And:

> *'Take control of the mind. Have a mind that bears witness with the Spirit. My smile now comes from the inside, my eyes are fixed on the cross'*

Chloe made many references to the battle for the mind, the battle against her desires to self-harm / take her own life, to be rage full and bitter, the trauma images, thoughts and voices intruding into her conscious and subconscious awareness, and how she chose to let her mind be transformed, keeping her focus on God.

Tessa described her ongoing journey of recovery as continuing to synthesise the past and make sense of it, but also being able to have intimate sexual relations:

> *'To move on from here I need to keep sorting out my thinking, putting everything in the right order where it needs to go so I know I've got everything. I need to be able to have sex and it not be a bad thing'*

Sara identified that what she needed in the moment was to have a place of her own where friends could visit, and not thinking about the past.

> *'I just need to get me own place and to have mates round and stuff, and just forget about the crap and make my own life'*

Martha also endorsed this idea of needing her own place, and valuing friends:

> *'I think I need to find my own place, you know, and get comfortable with my life. I enjoy being with my friend, that is important to me now'*

Kirsty stressed the importance of improving her self-esteem, having friends, and not worrying so much about the perception of others:

> *'What I need to do now is to feel better about myself. I feel that people don't like me much and that upsets me. I don't have many friends and I would like friends. I do try to be friendly and help people. I need to not care so much about what other people think, but I do, I worry about it'*

It was recognised that all of the women were continuing on their recovery journeys and that they all had an idea about what was important to them in respect of the next steps. This is in stark contrast to how five of the women presented at the start of data collection.

SECTION FIVE

INTERPRETATION AND DISCUSSION

Chapter seven

Interpretation

‘I step over the threshold and into the refuge. It’s as if I enter another world, like stepping through the wardrobe and into Narnia. In that moment, my former existence seems to slip behind me as I dare to hope that I might be safe. Hesitantly, I step down the linoleum floor and into the office. It’s bustle and business, phones ringing, women coming in with children crying. The noise rings in my ears like the shrill of a never-ending whistle. I am closing in on myself and feel my anxiety like a deep churning in my gut which consumes my attention. The office scenes pass in front of me as if slightly unreal, I am watching from a distance. I am shown to my room. The door shuts. I am alone. I wake from my trance with a start. I’ve made it. I’m here. Space. The relief breaks from my eyes with streams of tears and I fall face down on the bed. Time passes. And passes. Silence. Distant banging, a shout and a cry, but in myself is silence. Emptiness. Nothingness.

My eyes are stinging, straining from peering through the darkness. My shoulders are screwed up like rags, every hair on my body stands on end and I feel the cold chill run down my spine. My room that was safe when I entered is now full of horror. Darting. Creeping. Stifling. My face is frozen, and my head is full of sponge. The child in me writhes and twists, gasping for air, yearning– words, frozen. No one sees me, no one cares, I shrink back inside my body, hiding in the darkness. Alone. Silence again.

Sometimes I pretend. I smile and nod, and agree with everything. It’s easier that way. Sometimes. Then they can’t reject me, they can’t tell me I’m wrong, or that I’m not good enough, coz I say everything they want me to say. The slap on my cheek stings like acid and I am falling against the table, stumbling, as the boot reaches my behind and I feel the cold floor. I’m still wrong. ‘Liar! Whore!’ Ringing in my ears. I find myself shrinking smaller and smaller. It’s as if something is dying inside me. I consider death as a viable way forwards.

I am still in my room. With that gut-sinking feeling I realise I’ve brought my past with me. I find myself wrapped up in myself. I struggle with the confines of my body, feeling trapped with the pain that contorts me yet paralyses me. I am this writhing mess of darkness and despair, unreachable, untouchable. I find myself running, desperate, banging on the door to escape, only to find myself escorted back to my room. Confusion. What am I? I cannot live within myself for the pain is too great, the past is ever before me, floating freely across time and space, a power of its own. Fear possesses me. I am drowning.

I draw the razor over my skin, feeling the silky sharpness of the blade, watching the light catch the silver metal, entertaining the possibility of piercing - deeper, deeper. Blood flowing. Instant – relief. Dripping. Sharply awake now… but creeping inside me, all over me, distorting me – guilt. Shame. Self-loathing. Inadequacy. I despise myself. My body is killing me.

Quietness. The little brown bird hops from one branch to the next. The copper beech shines in the light of the afternoon sun. Listening. Eyes – soft, focussed. Quietly – talking. The neatness of the room. Space. The knitted scatter pillow in the shape of a heart. The box of tissues. Time passes. Gently. Quietly. Noticing. Caring. I’m holding the little heart pillow, hands gently stroking, almost caressing, feeling the warmth, the softness, the presence of another human being. Sharing. I see my past – before me. I experience time as if it is frozen, but in the stillness I look at it. And look at it. The ugliness, the brokenness, the sadness, the horror. I’m holding the cushion more firmly – tense now, tears streaming, panicked lest she despise me. The moment passes. We are both still here. Eyes – soft. Gentle. Another day.

Searching. Writing. Thinking. Praying. Making space. Being held. Why me? What did I do? What did they think of me? Who am I? Friends sharing, supporting, listening. Getting through another day. Putting things in boxes – memories, parts of me that mustn't be lost. If I cannot find them all, I will lose – me. And I'm still trying to find - me.

Being accepted. Jesus, friends from church. Staff at the refuge. You. I like the crafts – and the coffee, and making dresses for the dolls. Sometimes painting – dark seas and stormy clouds – now softer, lighter, a beach maybe.
Entertaining – ideas, hopes, aspirations – could life be different? Needing relationship, craving – love, holding. Being – wanted, for being me. Maybe. One day.'

Chapter eight

Discussion

This section aims to sit the findings of this phenomenological study in the context of the underpinning philosophies but also the wider context of current trends in practice.

It was noted that all of the master themes were interconnected, however in order to understand the phenomenal of recovery more fully in this thesis they are also considered independently.

This study utilised interpretative phenomenological analysis as it enabled the exploration of each woman's experience and meaning-making process as individuals and their realities following their experiences of violence and how they moved towards recovery. It focussed on their personal and social worlds during the time of the data collection and this included a temporal aspect of how the past continued to be experienced in the present, and how the meanings they attributed to the past were able to be reflected on in the context of a supportive, relational space in the present. The non-judgemental, supportive, and empathic holding within this interpersonal space between practitioner-researcher and participant, and for some women in the spiritual dimension, enabled an opportunity for reconceptualising experience and the attribution of new meanings, as the woman was able to become aware of new conceptualisations of herself within an enabling relationship. It is recognised that the nature of the engagement between the practitioner-researcher and the participant influenced the nature of the relating of experiences and thus the data collection, and this was understood by specifically focussing on the role of the research relationship as an additional source of data.

This study also embraced existential phenomenology with a focus on the embodied experience. It is held that this was especially useful given the violence against the body to each woman, and enabled an appreciation of the implicit meanings and how they impacted her experience of herself in time, in space, and in relation to others.

LIVED BODY

Experience

The master theme of lived body reflected on the woman's experience of the centrality of her body which was the vessel of violence and vulnerability, but also healing. The way in which her body functioned affected her perception of her experience, and the interconnection between body and mind was very strong, for example, the impact from the presence of both emotional and physical pain influencing her ability to think clearly and make choices.

As Stevens (2000) notes, others react to the physical body as they see it, and the sense for the woman of being an underdeveloped child in an adult body, emotionally unprepared for adult life, was apparent. Feelings of not being heard or understood by others, as well as not being able to find the words or narrative, maintained a sense of being locked into the adult body, trapped by negative emotion and physical pain, and unable to reach out to others. This maintained a feeling of being rejected and solitary in relation to others, and this was a feature in the past during the violence, but one which continued into the present. In this way the violence continued to live on in the woman's body even after the actual events had ceased.

Finlay (2011) notes that the body is the vehicle in which we do, experience, and be, and observes how both mind and body are intimately intertwined in our relationship with others.

This connected with the relational where others had been rejecting and unavailable, and have not seen or responded to the need both at the time of the abuse or in the present.

The woman's emotions were a constant backdrop to her experience of recovery, and in the early weeks and months this backdrop was seen to have a continuity of anxiety and fear, which at times became central and volatile, such as when reminders of the past intruded into the present. These reminders were at times overt, but also subconscious and not available to conscious awareness. In this way there was an experience of fragmentation and a need to synthesis 'bits that were missing.' The emotions arising from these experiences were held within the interpersonal space, and were reflected on in a non-judgemental but curious way. It was observed how much the emotional feelings were wrapped up in the experience of physical and psychic pain and the woman's perception of herself and the world, as well as her experience of relating to others.

Ratcliffe (2008) makes reference to these emotions as existential feelings, and says they are more than emotions, in as much as they are not directed to something, rather they are enmeshed into perception and our bodily being in the world. It was noticed over time that the volatility of emotions lessened, and that each woman was able to move from a place of overwhelming emotion to one where she could reflect and think more clearly about her past, her present, the journey to date, and also consider what she might need for the future. In this way there was an altered perception of time, where she could envisage alternative realities and opportunities, as well as conceive of new ways of being and doing. This freedom of choice created a sense of ownership over time, but also space, which was noted to be experienced more positively as the emotions lessened.

Process

In the early weeks of the recovery journey, each woman was absorbed in her bodily experiences. Finlay (2011 p31) observes that it is at times like this that her body can be a kind of 'existential setting.' Drawing attention to the bodily experience of emotion and thought through the researcher-practitioner curiosity and reflection offered an opportunity for greater reflection on the woman's experiencing and brought previously intangible processes into conscious awareness.

Finlay (2011) observes that in this way her body can become figural for example, when the way of being in her body becomes more self-conscious. Noticing these processes whilst simultaneously holding the cognitive and relational aspects of the woman, offered an opportunity for conscious reflection on the synthesis of the whole, as well as being able to consider alternatives, and therefore choice was increased.

Merleau-Ponty (1962) considers explicitly how her body participates in the experience to the point of having a bodily sense which can be re-activated or re-lived at a later time, and this was seen in the continuity of trauma over time, where trauma continued to exert a power over the woman's body and mind. One client experienced a spiritual relationship with God where she was enabled to consider her past and her identity and come to a place of being loved and accepted for who she was. This enabled her to find joy and happiness and move on from the abuse. Other participants experienced a holding and sense of containment through the research relationship, where all parts of the woman, including experiences of being fragmented and destroyed, overwhelmed and consumed, were engaged with through non-judgmental acceptance and curiosity by the practitioner-researcher. This enabled the creation of thinking space and an alternative conceptualisation of the past experience and bodily reactions, and the woman was able to move from a place of being controlled by the body to a place of agentic functioning and engagement in positive activities.

LIVED TIME

It was observed that there was continuity of time for all the participants but it was differentiated by the physical surroundings and social contexts, from the time when the violence was continuing to how this experience continued to be held in the present time in the relative physical safety of the hostel.

In the early weeks, trauma seemed to travel independently through time, and exerted an influence over the mind and body of the woman, and in this way time and space were connected, where trauma floated freely over time and created a mental space that was unsafe in the presence of a safe physical space; the frequency and extent of negative emotion was seen to get in the way of clarity of thought, but also the experience of time as passing the woman by added to feelings of powerlessness. The subjective experience of lived time was impacted by levels of emotion, the greater the negative emotion the slower the experience of time. This is supported by Rich et al (2013) who notes that it is not actual time it is the perception of time.

It was only when the negative emotion lessened, through the process of the woman's past experience and meaning making being heard and reflected upon, validated, accepted, and valued, whether this was through spiritual relationships, engaging in other activities, expressing emotion, and building new relationships, or through the process of engaging in the research relationship, that the construction of the past could be subject to change.

Stevens (2000) explains this continuity of time as a succession of phases, saying that while the woman holds her experience of the past in the present, the construction of the past is open to change. In this study it was observed that the reduction in negative emotion in addition to a validating and containing relationship, enabled a sense of personal control by the woman: this was seen in her ability to take ownership over time, and enabled the understanding that perseverance through time was important in order to move towards more positive emotions. In this way, time and relations were intertwined.

It is also observed that the wishful thinking engaged in by some of the women allowed for a concept of the future, what she might become or how she might relate to others. Stevens (2000) notes that this in turn may also influence her memory of what has been, and overlaps with her experience of space and relations.

LIVED SPACE

Lived space was endorsed by all of the participants, but with differing emphases. For all of the participants, the physical space that they occupied both in the past during the traumas, and the present space when the actual traumas had ceased, had a negative impact on their mood and feelings, and vice versa, but as their feelings became more contained, the present space was able to be experienced differently, and more positively.

During the time of the on-going abuse, space was experienced as solitary, and threatening, but over time there was a reflection on space as being safe, shared, and an ability to enjoy positive space.

Lived space is felt space, the woman's subjective way of how she experiences the space in which she finds herself, and this also affects the way she feels. Additionally, how she feels also affects the way she experiences the past and present space. Time and space are thus connected.

LIVED RELATIONS

All of the participants endorsed lived relations as being relevant in their recovery from violence. The women experienced historical rejecting and abusive relationships, including overt rejection, perceived rejection, and an absence of relationships. This intertwined with lived time and lived body where the impact on their concept of self and identity, and their relations with others, continued after the abuse. The continuing difficulties included problems with low self-esteem, a lack of confidence, fear of judgment from others, and a negatively sense of identity. It was noted that some of the women continued to relate to others in similar ways that they had done during the abuse, and this perpetuated a negative effect on their ability to engage caring relationships.

The importance of enabling relationships, including spiritual relationships, was considered integral to the recovery process, and some of the women were able to acknowledge positive changes in their sense of identity over time.

The women placed a value on the genuine and caring engagement of the researcher, and her ability to relate empathically with understanding. Additionally, it was important that there were not short time constraints placed on the women as this may have prevented them from sharing what was really important to them. The process of holding whatever was brought to the interpersonal space was considered important in the process of recovery, and this held considerable meaning to the women; being able to contain thoughts and feelings from being overwhelmed by the past, and what this meant to them in terms of their experience of being fragmented and destroyed, to moving towards agentic functioning, improved self-esteem, and being able to think clearly about her own needs and the future, not only enabled a reconceptualization of the past and the present, but it also carried significant meaning for the women: it meant that she had worth, as another had placed worth on her; it meant that she was respected and therefore able to be respected, which impacted her sense of identity as a human being; it meant that she was responded to appropriately with care and compassion, which meant that she was loveable, that her experiences were valid, and therefore *she* was valid . Two women place great importance on their spiritual relationship with God, one woman identifying that this was transformative in terms of her healing and being able to move forwards and the other recognizing the strength and love she was able to draw from this. Particularly for one woman this meant that she was not responsible for her past, she did not have to carry the guilt and live in fear of the judgment of others, she was free to move past the trauma and experience a loving relationship with Jesus.

This study was not intended to be a counselling endeavour but rather to explore the processes involved in recovery and what meanings were attributed to these by the women. However, the practitioner-researcher sought to maintain the core tenets of Rogerian theory (Rogers 1951) including empathic listening and responding, holding a non-judgmental and positive regard, whilst continuing to be genuine and true to herself. Whereas this is a therapeutic intervention it was considered appropriate to use this within this research process due to the nature of the phenomenon under investigation, and the risk that the women would otherwise be exposed to in respect to their existing levels of trauma. It was noted that one participant had already travelled a long way down her recovery journey as a consequence of her relationship with God. This was not known prior to the start of the data collection however some of the processes she engaged with were similar to that of the other women, notably being held and feeling secure in a relationship, feeling loved and cared for, facing and accepting her past and finding a new identity. The meanings attached to this, of being acceptable and cared for, were also similar.

Context

Whalen's (1996) research looked at various counselling models for women who had experienced violence, and criticized them as being focused on freeing the woman from abusive relationships and not having a political focus in line with the 'battered women's movement' to effect social change. She argued that many forms of training maintained this sense of compartmentalization which was unhelpful given the already fragmented nature of the woman's presentation. This experience of being fragmented was supported in this present study and the importance of this being synthesized into a whole carried considerable meaning to the woman in terms of her perception of recovery, and it is suggested that adopting the Rogerian principles served to augment this for most of the women.

Banks (2006) notes that sometimes a disconnection with others can provide a false sense of security and control, and this was noted in one participant, Sara, who engaged in the process for the shortest amount of time (six weeks). One strategy which can be used by women in order to try and protect themselves is to withhold some aspects of themselves in order that they might be accepted (Jordan 2010), however, with this lack of authenticity they are never truly able to achieve a real connection, and in this way can continue to be isolated and lonely.

Whalen (1996) acknowledges the centrality of the Rogerian principles, but said this should not be the limit of the engagement. This present study draws the benefits of the Rogerian principles into focus, from which women were seen to be able to move forwards in their recovery.

The importance of the wider social and political context is not ignored however, but it is argued that as the woman changes in terms of her experience of herself, her relationship with time and space, and her relationship with others, there will inevitably be an impact on others around her, with a move towards more democratic relating. The findings of this study are supported by those of Walker (2005) who notes that it is the ability to form a meaningful relationship which is central to psychological development, within which the woman can develop a sense of self-worth, and it from this place that she is able to positively affect change in society (Miller 1976).

This is not to suggest that this alone is sufficient, but it has to be the starting point, because this I where the immediate distress and fragmentation are experienced. The breadth of addressing the needs in society and social policy are not within the scope of this study, however it is suggested that the integration of the woman's recovery into the context of wider society is an issue for further consideration.

This study supported the observation by Kress et al (2017) that all traumas occur in a sociocultural and historical context but also a relational context. The findings of this present study emphasize the importance of the sociocultural and historical context but also the centrality of relationships. The damage which occurred in relationships, often with perpetrators who assumed positions of trust, was extensive in terms of the continuity of the trauma for the women, the destructive and fragmenting nature of the abuse, and the negative impact on identity; it also impacted the way in which the women continued to try and elicit care in future relationships. Miller (1986) identifies five things which are found in growth-fostering relationships, including: zest; understanding of self and the relationship; a sense of worth; a sense of agency and empowerment, and a desire for further connection. It is held that the research relationship provided a sense of this which was experienced as enabling and conducive to growth.

As the women's engagement in the research progressed, and Chloe found a secure and holding relationship with God, they were all able to move to positions where they could think, and make positive choices about their time, their space, and their embodied experience in terms of agentic functioning and positive activities. This fits with Jordan's (2010) observation that everyone requires a connection with others through their life, and that it is through the

establishment of healthy relationships that individuals can grow, a sense of safety and well-being can be experienced, and through this healing can take place.

Some of the participants used self-harm, suicide attempts, and risky sex as efforts to cope with feelings directly associated with traumatic events, especially during the early stages of recovery, however all of these reduced over time. Banks (2006) suggests that with this focus on the relational, with attention to increasing self-awareness and empathy towards self, women may be able to restore the relationship with themselves. This was seen in the stopping of destructive behaviours in some of the women.

The research structure offered an opportunity where women were able to learn about forming and maintaining a healthy relationship. Kress et al (2017) observe the importance of this structure as an opportunity for new ways of learning about relationships. This was significant given the women's histories of interpersonal traumas where they had little experience of healthy relationships. Banks (2006) says that this is especially important when it comes to seeking to promote healing and recovery and this present study supports this.

There were three participants who expressed religious or faith beliefs, and Zastrow (2010) stresses the importance of acknowledging this in relation to the abuse they had received. Martha, who was Muslim, did not talk about her religion very much and it was understood that she was not actively practicing. Kirsty and Chloe found faith in God to be a protective factor, and Chloe described it as 'transformative' as well as acknowledging the importance of support from Christian friends. This is supported by the work of Gillum et al (2006) who found that trusting in a higher power, and support forma religious community was significantly helpful in the reduction of depression for victims of domestic violence, and also contributed to their general wellbeing. This is also supported by Stenius and Veysey (2005) who identified that 72% of their sample identified that a spiritual connection helped regulate their emotions, provided a source of support, a sense of hope, and inner peace. As a constant presence it was considered more reliable than friends. The three main benefits identified included: women were able to believe that they were good; they were not held responsible for what had happened to them; and that justice would prevail. Chloe certainly endorsed all of these findings.

The engagement in positive activities, including agentic functioning, was a finding that is also supported by Stenius and Veysey (2005). In their ethnographic study of women recovering from abuse they also found that animals were a positive experience due to their unconditional love, self-care in the form of healthy eating, adequate sleep and rest, and exercise was beneficial, and engaging in activities with other people.

They also noted that having choice was crucial, as was the pace at which they healed. This was something identified in this study, where it was noted that had there been a short restriction then they would not have engaged, but equally there was no pressure to do anything as it followed the pace and expression of each participant. Stenius and Veysey (2005) had a similar finding as this present study noting that it was the means of delivery and the characteristics of those involved which were important, including relational style, availability and responsiveness, as well as shared empathy and experience. This is considered to be a key finding from this present study.

This section concludes by acknowledging that the findings from this present study are supported by other findings which adds to the validity and credibility of this research. Although the findings in terms of experience and meaning are not considered to be generalizable, they hold an ecological validity. The emphasis on the importance of enabling relationships and the style of relating is well documented in this study and elsewhere and is a point of clinical importance when considering working with this client group.

SECTION SIX

IMPACT

Chapter nine

Implications for counselling psychology

This study considers some of the important implications of this phenomenological analysis of the experiential journey of recovery for practice and for the body of Counselling Psychology. It considers this in relation to the existing knowledge base, with special reference to therapeutic engagement and relational style.

The empathic engagement with the first-person account of the participants' journey towards recovery, and the expounding of meanings attached to this, meanings ascribed by the individual but also co-constructed within the interpersonal space between researcher and participant, offers the reader an opportunity to reflect on the multiple versions of truth within the experiencing of these participants, and also the dynamics within the relationship. This has the potential to go beyond mere findings and outcomes (Finlay 2011), it has the capacity evoke a sense of the experiencing in the reader. Finlay (2011) claims that the process of engaging in this type of research has the capacity to be transformative for both researcher and participant, and to offer the opportunity for new understandings. This enabling brings additional knowledge to Counselling Psychology as a profession, not just in terms of the benefits of research in this manner, but the importance of the therapeutic relationship style and manner of engagement.

It is anticipated that this research, although modest, offers an opportunity to encourage personal reflection in the reader, about what is important in our relationships with others, and what it is that we as Counselling Psychologists bring with us to therapy and research.

I have used my training, knowledge and skills as a Counselling Psychologist to carry out this research and it has been confirmatory to me as a person and as a professional as to the importance of the Counselling Psychology values but also my own personal values, the most important of which being empathy and compassion, understanding and sensitivity, and holding the individual experience as valid and significant. This is something I take back to my place of practice, working with the tensions of performance expectations and lack of resources, recognising that amidst the pressure the importance of the individual must not be forgotten.

Chapter ten

Implications for service provision

In this study, the women were seen as part of a relational and contextual system, and it is within these that she can grow and develop. Although the change is largely at the individual level this will necessarily also impact her context. This understanding of what matters to the individual as well as the wider context needs to be considered in terms of service provision for this client group.

What was identified as helpful included the researcher's skills and relational style, availability and responsiveness, shared empathy and experience, and time.

Stenius and Veysey (2005) n their ethnographic study on women recovering from violence noted things that were identified as harmful, including system barriers, a lack of professional cross-training in dual diagnosis, and individual trauma therapist's lack of sensitivity, and trauma sensitivity. They noted that the exclusionary practices within mental health service provision and substance misuse served to contribute to the fragmentation of women's care, focussing on service-specific symptoms rather than addressing women with their complexity and wholeness.

Stenius and Veysey observed that women recover from violent experiences in a number of different ways, and noted that although professional interventions can be helpful, they may not be sufficient, and can in fact be re-traumatising. They noticed that the *means* of service delivery may be more important than the service, finding that caring individuals and a safe environment gave rise to the greatest benefits

This present study endorses these findings and recommends that they be considered in terms of designing service provision for this client group.

SECTION SEVEN

CONCLUSIONS AND FINAL REMARKS

Chapter eleven

Conclusions

This thesis seeks to convey a textured understanding of the journey towards recovery as experienced by the women. It is not intended to be a series of isolated events or stages, rather it is designed to create a sense of flow, which is not linear, but rather has a backwards and forwards motion to it, as each woman continues to negotiate and make sense of herself and her world.

Recovery is not so much considered to be a fixed end point that the woman 'arrives' at, rather it is conceptualised as making sense and determining meaning out of the past traumas by being able to think more clearly; it is about persevering through time and being able to recognise her individual growth, and how the adversities have shaped her; it's about accepting this; it's about entertaining possibility and future plans of what or who she could be, what she could do, and how she could relate to others and the world around her; it's certainly about being safe, and being able to enjoy the space she occupies, being able to engage with people around her and create reciprocal relations, about being able to choose how to spend her time and have a sense of ownership over her decisions, her life, herself.

There is much more to each individual woman and her recovery than the mere development of ideas and integration of theory can possibly capture, however by exploring the data under the existentials of lived body, lived time, lived space, and lived relations it is hoped that not only the individual experiences have been explored, but the phenomenon of recovery has been understood in an integrated way, where experiences overlap and intertwine. It is hoped that the reader can shared in something of the lived experience of this journey.

This thesis acknowledges that the entirety of the women's recovery cannot be summed up in words, and it seeks to texturize the phenomenon, inviting the reader to engage not just cognitively or academically, but experientially, reflecting on their own interpretation and process of extracting meaning. It is hoped that this thesis has meaning and matters, just because we are all human.

Chapter twelve

Final remarks

This thesis provides a phenomenological grounding for therapeutic work. It brings into focus the importance of the therapeutic relationship, and the centrality of engaging with women who have experienced violence in a way that is not reductionist or distant, not measured or forced, but one which embraces humanity at its weakest, with compassion and understanding, without judgement, holding all things speakable and unspeakable, seeking to explore ‘being human’ together.

SECTION EIGHT

References

Appendices

References

Afifi T.O., Enns M.W., Cox B.J. (2008) Population attributable fractions of psychiatric disorders and suicidal ideation and attempts associated with adverse childhood events in the general population. *American Journal of Public Health,* 98, 946-952

Amos I. (2016) Interpretative phenomenological analysis and embodied interpretation: integrating methods to find the 'words that work.' *Counselling and Psychotherapy Research*, December 2016. **16**(4), 307-317

Ashford, R.D., Brown, A., Brown, T., Callis, J., Cleveland, H.H., Eisenhart, E., Groover, H., Hayes, N., Johnston, T., Kimball, T., Manteuffel, B., McDaniel, J., Mongomery, L., Phillips, S., Polacek, M., Stsatman, M. and Whitney, J. (2019) 'Defining and operationalizing the phenomena of recovery: a working definition from the recovery science research collaborative', *Addiction Research & Theory* [online]. Available at https://doi.org/10.1080/16066359.2018.1515352

Bellis, M., Highes, K., and Hardcastle K. (2017) The impact of adverse childhood experiences on health service use across the life course using a retrospective cohort study. *Journal of Health Services Research and Policy*. 2017, Vol 22(3), 168-177

Campbell J.C. (2002) Health consequences of intimate partner violence. *Lancet*, 359, 1331-1336

Central Bureau of Statistics (2003) *Kenya Demographic and Health Survey 2003.* Ministry of Health (MOH) [Kenya], and ORC Macro.

Chapman D.P., Anda R.F., Felitti V.J., Dube S.R., Edwards V.J., and Whitfield C.L. (2004) Epidemiology of adverse childhood experiences and depressive disorders in a large health maintenance organisation population. *Journal of Affective Disorders,* 82 (2), 217-225

Chartier, M.J., Walker, J.R, Naimark, B. (2010) Separate and cumulative effects of adverse childhood experiences in predicting adult health and health care utilisation. *Child Abuse and Neglect.* Vol.34 (6) 454-464

Corso P.S., Edwards V.J., Fang X., and Mercy J.A. (2008) Health-related quality of life among adults who experienced maltreatment during childhood. *American Journal of Public Health,* 98 (6), 1094-1100

Division of Counselling Psychology (DCoP) Strategic Plan 2017-2020. February 2018

Eatough V. and Smith J.A. (2008) Interpretative phenomenological analysis. In C.Willig and W.Stainton-Rogers (Eds), The Sage Handbook of Qualitative Research in Psychology in Psychology (pp179-194) London: Sage

Ellesberg, M. and Heise, L. (2005) Researching violence against women: a practical guide for researchers and activists. Washington DC, United States: World Health Organisation, PATH;2005

Ellison, M.L., Belanger, L.K., Niles, B.L., Evans, L.C. and Bauer, M.S. (2016) 'Explication and Definition of Mental Health Recovery: A Systematic Review', *Administration and Policy in Mental Health and Mental Health Services Research* [online]. Available at https://link.springer.com/article /10.1007/s10488-016-0767-9

Etherington K. (2004) Becoming a Reflexive Researcher: Using Our Selves in Research. Jessica Kinsley Publishers.

Finlay L. (2006) 'Going exploring': The nature of qualitative research. In Finlay L. & Ballinger C. (Eds.), *Qualitative Research for Allied Health Professionals: Challenging Choices,* pp 3-8. John Wiley & Sons Ltd.

Finlay L. (2011) Phenomenology for therapists : researching the lived world. Wiley-Blackwell.

Finlay L. (2014) Engaging phenomenological analysis. *Qualitative Research in Psychology*, 11, 121-141. doi:10.1080/14780887.2013.807899

Finlay L. And Evans K. (2009) Relational-centred Research for Psychotherapists: Exploring Meanings and Experience. Wiley-Blackwell.

Fischbach R.L. and Herbert B. (1997) *Domestic violence and mental health: Correlates and conundrums within and across cultures.* Social Science and Medicine, 45, 8, pp 1161-1176.

Gorad S. (2013) Research design: creating robust approaches for the social sciences. Sage Publications Ltd. Doi: 10.4135/ 9781526431486 pp 2-12

Hebenstreit C.L., Maguen S., Koo K.H., and DePrince A.P. (2015) Latent profiles of PTSD symptoms in women exposed to intimate partner violence. *Journal of Affective Disorders,* 180, 122-128

Kessler R.C., McLaughlin K.A., Green J.G. (2010) Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *British Journal of Psychiatry,* 197, 378-385

Kishor S. and Johnson K. (2004) Domestic Violence in Nine Developing Countries. Macro International.

Larkin M. and Thompson A. (2012) *Interpretive phenomenological analysis.* In Thompson A. and Harper D. (eds), Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners. John Wiley & Sons, pp. 99-116.

Lindert J., Von Ehrenstein O., and Weisskopf M. (2013) Long term effects of abuse in early life on depression and anxiety over the life course. Comprehensive Psychiatry, 54 (8) 24-32

Lloyd, M. and Ramon S. (2017) Smoke and Mirrors: U.K. newspaper representations of intimate partner domestic violence. *Violence Against Women*. 2017. Vol.23(1) 114-139

Macdowall, W., Gibson, L.J., Tanton, C., Mercer, C.H., Lewis, R., Clifton, S., Field, N., Datta, J., Mitchell, K.R., Sonnenberg, P., Erens, B., Copas, A.J., Phelps, A., Prah, P., Johnson, A.M., Wellings, K. (2013) Lifetime prevalence, associated factors, and circumstances of non-volitional sex in women and men in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). Lancet November 26th, 2013; 382:1845-55

Morrow S.L., Castaneda-Sound C.L. and Abrams E.M. (2012) Counselling psychology research methods: qualitative approaches in N.A. Fouas (ed) APA Handbook of Counselling Psychology (93-117). Washington DC: American Psychological Association

Office for National Statistics (2016) Crime Survey for England and Wales, March 2014 – March 2016

Ponterotto J. G. (2005) Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. Journal of Counselling Psychology, 52, 126-136. doi: 10.1037/0022-0167.52.2.126

Rogers C.R. (1951) Client-centred therapy. Constable of Constable and Robinson Ltd (2003) eISBN 978-1-78033-706-7

Rogers C.R. (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, (2), pp.95-103

Rich, S., Graham, M., Taket A., and SHELLEY J. (2013) Navigating the terrain of lived experience: the value of lifeworld existentials for reflective analysis*. International Journal of Qualitative Methods*.

Shinebourne P. (2011) Interpretative phenomenological analysis. In N. Frost (Ed) Qualitative research methods on psychology: combining core approaches. Pp44-65. London: Open University Press

Smith J.A. and Eatough V. (2006) Interpretative phenomenological analysis. In G. Breakwell, S.M. Hammond, C.Fife-Schaw, and J.A. Smith (Eds) Research methods in psychology (3rd ed.) pp. 322-341. London: Sage

Smith J.A. and Osborn M. (2008) Interpretative phenomenological analysis. In J.A. Smith (ed) Qualitative psychology: a practical guide to methods (2nd ed) pp53-80. London: Sage

Smith J.A., Flowers P., and Larkin M. (2009). Interpretative phenomenological analysis: theory, method and research. London: Sage

Todres, L. (2007) Embodied enquiry: phenomenological touchstones for research, psychotherapy and spirituality. Palgrave Macmillan

Van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.) London, Ontario: The Althouse Press. (Original work published 1990)

Van Manen, M. (2007) Phenomenology of practice. *Phenomenology and Practice*, Vol.1 pp11-30

Willig C. (2013) Introducing qualitative research in psychology (3rd ed.) Berkshire, UK: Open University Press

Appendices

APPENDIX 1

Life history interview guide

Information was collected regarding ethnicity including any former partner, and religion.

- What does abuse or violence mean to you in general?
- What age were you when the trauma started?
- What age were you when the trauma ended?
- Have you undergone any counselling or therapy in relation to the trauma? Can you tell me about this?
- Is recovery something that you have thought about? What does it mean to you?
- Is coping or surviving the same as resiliency or recovery in your opinion? Explore.
- Are there any significant events, relationships or turning points that have impacted your recovery or ability to cope? Additional prompts include: early years; adolescent years; young adult life; adult life.
- Thinking about these specific things, can you tell me more about why they are significant for you? Additional prompts: what do these events mean to you? What thoughts or feelings do you have in relation to these events? Have these affected you and if so how?
- Can you tell me about any strategies which helped you cope or survive both at the time and now?
- Were there any changes that you noticed that helped you feel that you were coping or not?
- Where do you consider you are now in terms of recovery?
- How would you know when you got there – what would need to happen?
- Have any specific events contributed to you feeling that you were moving towards recovery or do you feel that your progress has been hindered? Tell me about this.
- To what extent did you see your life or your recovery as your responsibility? And now?
- To what extent did you consider it to be the responsibility of others? And now?
- Are you able to identify any specific times when you were able to sit and reflect on yourself and your life? Did you have thoughts about the future? Prompts: tell about these times. tell me about anything which helped or hindered your thinking.
- Were there any other people you were in contact with who played a significant role in your life or currently do. How did you feel when you were with this person? What does this mean to you?
- What do you consider needs to happen for you to reach your own definition of recovery?
- What do you feel you need to be able to change or needs to change to enable you to recover?

APPENDIX 2

Examples of emergent themes and author's reflections

(not exhaustive due to volume)

1	2	3	4
Emergent themes	**Transcript excerpt**	**Checking/clarifying core content. Looking for underlying issues and meaning.**	**Process notes / author's reflections on the relationship and her own embodiment**
	AMANDA		
Being in her body Not being comfortable in her body Expectations of others Attempts to communicate	'I am like a clown that doesn't smile'	It is as though she is wearing a mask, pretending to play the part and yet there is this discrepancy between what she looks like and what she feels inside. I wonder about the expectations of others – do they think she should be smiling? Who are these others? Where have these expectations come from? What are the consequences of not meeting these? There is a feeling of anxiety and frustration surrounding this.	There is this sense that there is something between us that is not clear yet she is telling me clearly. I experience the confusion and remain engaged and curious. I do not challenge her because I am sensing that she needs to protect herself from something or someone, so I mindfully hold this at this stage. I am sensitive to her needs to ensure that she feels safe with me.

Being in her body Trapped Not ready Defensive / separate	'I am an adult who is a child'	There is a sense of being trapped; not being ready; unprepared; developmental arrest not fit for purpose. There is something about her that is very childlike and engaging but in an adult body that comes across as defensive and 'prickly.' Something about needing to protect?	I notice the conflict within myself as I try and hold both these experiences of her as an adult and as a child in my mind, and notice the physical tension it creates, like an anxiety, and a fear.
Powerless Unable to communicate needs Unheard	'I am screaming but can't make a sound'	There is this disparity between the inner and outer experiencing and the sense of being within her body yet cut off from the outside, as if she were in a glass cube. Feeling powerless and ineffectual.	I feel the powerlessness and the silent struggle and want to reach out and break the glass but understand it is this glass which is currently keeping her safe. I notice my urge to rescue. I focus my attention on being with her in the best way that I can. I want her to know that I am there and will hear her.
Being done to – powerless. Overwhelming. Consuming.	'The memories seep into my body and crawl up my back, travelling along every vein, until I am drowning'		I feel the sensation of things crawling all over me, inside me, silently devouring me until I am overpowered. It is as though I have no choice but to succumb to its force. I find myself wondering how she has held it together for so long, and

			marvel at her strength.
Being done to. Consuming Lack of agency	'Fear spreads through my body, I can feel it, it's like a virus. It's unseen but all consuming, showing me all things which are unspeakable'	It is as though she is forced to watch scenes of horror from her life played out in front of her, but played with no sound track or narrative, but yet there is this insidious force which silently overcomes her.	I find myself feeling very small and helpless as I sit with her in that moment. I feel the fear as if it is a cancer and my hairs on my body feel like they are standing on end. I am cool all over as if ready, waiting, watching.
Loss of life force Lack of agency	'Pain and sadness flow through my body until I am gripped in a strangled hold'	Life-sapping pain and sadness.	I feel empathy that these feelings of pain and sadness have been so great it is as if she were constantly dying. I feel inadequate to respond to this, but I stay with her in the moment. I feel helplessness
Alone Alone with her pain and suffering	'I am out in the street. I have been playing with some boys. They are called into tea by their mums and run off happily. I drag my feet along the road and notice the dark evening creeping in. I sit on the pavement outside my house. No-one calls me into tea. I wait there for some time until eventually my dad appears as an almighty hulk in the door way and tells me to get in. He clips me round the ear as I pass and sends me to bed without any supper because I had been out playing. I feel the sides of my	Not even life-sustaining food is made available. There is this view of her humanity as an inanimate object, with no needs or desires or choice. No-one cares or seeks to try and meet her needs.	I think of my own children, how important it is to me that I make sure they are fed regularly and always know where the next meal is coming from. I struggle to imagine a parent that would not do this for their child and feel angry and disgusted. I notice but hold onto my feelings and refocus my attention on being with Amanda, imagining the searing pain that grips her little body for right now she is as if a child in front

	stomach gnawing at my bones I am so hungry. It is like a ravaging beast within. I have not eaten all day. I creep into my bed and curl myself up to try not to think about the pain'.		of me. I want to wrap a blanket around her shoulders and hold her securely so that she knows she is wanted, acceptable, and that somebody cares. I am mindful of my desire but stay focussed on being with her in her desperation, noticing how she holds herself together. There is a certain strength in this and I don't want to take this away.
Threat and hope mixed together	'I listen with every one of my senses, trying to make out any unusual sounds, as I tiptoe downstairs to the kitchen. It is not worth my life to get caught. I am looking for food'.	There is a capacity to survive, to keep trying, to find life-sustaining nourishment. There is a hope. There is this desperation to stay alive but it is an all-consuming desperation, it takes everything she has got.	I smile inwardly as I consider how one listens with all their senses before understanding the gravity of the situation, that every sense has to be on high alert for danger, because not only is starving life-threatening but also is looking for food. I feel struck by the level of risk.
Powerless Fear	'I cannot escape my mind. My memories of the pain from my father's belt. The lashings I got which left me in searing pain as though I had been dipped in and out of boiling water. His threats to kill me. I quiver and shake at the thoughts of these and I cannot escape these feelings. Sometimes I freeze on the spot and am	I notice that she clutches at her head as if trying to extricate the thoughts therein, but she is trapped inside her body with these memories. The emotional and physical pain feel like they are still present, with a paralysing hold over her. I think about how there is no space to be	I notice my own humanity that feels weak in the face of such threat and wonder what can be done about the society we live in. I notice my urge to 'fix'. I notice how easy it is to become absorbed in her world of despair, and consciously remind myself that I in this

	unable to move. It's as though I am paralysed'. 'Whatever I did was wrong, even when I told the truth. I had to say what she wanted me to say'.	anything other than a victim at this point.	yet still outside of this.
Powerless No agency even over her own body Unwanted yet trophied	Talking about her ex-partner: 'I feel I am chained to him but don't belong'	This sense of being used by another, not wanted but held onto, possibly because of the 'function' or 'service' she provides.	I feel disgust at being 'attached' to another who seems to cause such harm and pain. I feel like there is a growth that can't be removed. I feel angry and sad.
Fragmented Bits missing	'My thoughts are in in empty houses and lonely alleys' 'My thoughts are all scattered in dark places	There is this sense of fragmentation, bits of her are missing, and in places where they are less likely to be found, but the sense of emptiness and loneliness that parts of her experience feel huge.	I experience Amanda as fragmented, she has different names for different parts of her life, and each part is compartmentalised, and they don't seem to have much communication with each other. I am consciously holding all the different parts, and noticing with her that she separates them off. I enquire whether all of these are parts of a whole and I bring this to our relationship, that each part is acceptable. She appears grateful and emotionally needy at the same time. I feel warm towards her and accepting. I feel she needs me to

			accept all the parts of her.
Powerless Lack of agency Alone Unheard Unable to think All consuming	'Silence creeps into my mind, spreading like a virus' 'Silence pushes me out of my mind'	There seems to be no place for thinking or talking because there is this overwhelming silence, a lack of words to express what she is experiencing, and a lack of communication with others to test out her thinking. The silence feels to be all powerful and consuming. There is no place for herself in her own mind and body, there is just this silence. But yet she is still in her body as she hears and experiences the silence, a sense of being fragmented yet still present. It is still 'her mind' suggesting there is still some ownership.	I notice that she brings this silence to the interpersonal space, and at times demands of me that I find the answer, that I fix the problem. This seems an unreasonable expectation of me, but I notice with her the anxiety about not having the answer or solution, and that this is very difficult. I put a narrative around this difficulty, and she seems accepting of this.
Fragmentation Bits missing Alone	'My thoughts are all scattered' 'I am in complete darkness, gone in the wind'	This feels like the ultimate fragmentation, as if ashes that are scattered after death. It is as if there is total loss of life, except her eyes still perceive the darkness, a sense of being dead but not dead; the thoughts are still her thoughts, a sense of ownership	I am mindful of the difficulty in not knowing what all these thoughts are that she is trying to hold onto, and the need to 'find them' and almost pin them down. I feel the despair at the challenge. I feel the disorganisation and chaos, and the uncertainty of

			whether this is ever achievable.
Fragmentation Hope autonomy	'I am searching for a sense of unity, togetherness'	There is this need to bring the fragments together, to get the best fit, to feel like a whole. She is making a decision to keep searching, there is a strength in this.	I am struck by an image of a blind person searching in a dark room for something, but she doesn't know what it is or if it is even there. I wonder how she will know when she finds the something, and whether that will be enough, or will there always be more?
Loss of life force Concept of time – length of trauma – linked with fragmentation	'My heart has been dragged out of me, my heart beat is just an echo of something that used to be'	It feels like the abuse is this devouring monster that has painfully extracted the very essence of life. A feeling of still being in her body, but yet her life is as but an echo, as though a flicker of life left in a corpse. There is a concept of time where it is implied that the heart beat used to be stronger, possibly at birth, when the world was yet to be explored. An idea that a life force was extracted slowly and painfully, in the use of the word 'dragged'.	I have this feeling similar to when I have had a dental extraction, and know how jaded I feel. Even though it's 'just a tooth' somehow it affects the whole body, the whole body is traumatised, and feels shaky. The heart would be so much worse. I feel compassion towards Amanda, and have this feeling of being with something very fragile.
Loss of life force Powerless	'I am dull and lifeless, shrivelled and powerless, baked hard in the scorching sun'	There is still an 'I' here, and not a 'thing over there.' She has an awareness of the effects of what has happened to her, but there is something about her that is still present. I	I am aware that she brings this fragmented and desperate part of herself to our engagement, in the form of her diary. She encourages me to read the diary, and asks me

Hopelessness and despair Sense of ownership, 'being a being'	'I wish I could evaporate into the air and be gone forever'	notice this, and then notice her desire to be gone, as if it is all too much to make sense of being fully present.	to make sense of it. I fell she is asking me to hold or 'collect' all of the bits.
Powerlessness No place of safety Disconnect between the physical space and the mind. Embodied threat?	'Wherever I run I am always chased, wherever I hide I am always found'	There seems no-where that she can go, 'the other' seems to be all-knowing and all-powerful, a feeling of being exposed and unsafe. Being physically safe enough to reflect upon feeling unsafe in her mind A disconnect between the physical safety in the refuge and in this room and the lack of safety in her mind, like the trauma roams free across boundaries, space and time	I feel there is a huge expanse but even in the vastness there is nowhere that is safe and containing. I am aware of the four walls about us, the safety of being able to notice these feelings within, and mindful of holding this and the sense of being unsafe in her mind, as if there is a separation of mind and body, or is the body still partially threatened.
Exposure No place of safety Judgement of others shame	'I had this image of my life being a bit like washing on the line, but I don't want anyone to see it. I am ashamed because I have so many things wrong with me, it's as though I am like faulty goods, I don't quite work properly. I'm afraid that other people can see this, and that I will be found out'.	This sense of being exposed and unacceptable at the same time, afraid of what others will think and do. It feels like a very painful exposure, that it is humiliating, and that this is a constant presence.	This feels uncomfortable in my body, almost like an embarrassment. I am not embarrassed by her but for her, but notice this is likely to be a transference of her feelings onto me. I question my own judgments to make sure I am not judging her as 'faulty' or lesser in anyway.
Identity	'I don't know who I am'	Sense of not knowing who she is as a person,	I feel the confusion and the weakness. I have this urge to

Physical space – being overwhelmed and fear of being consumed	'I am a tiny spec in an immense desert'	thinking of previous comments about 'bits being missing' – how could you know who you are if you didn't know what all the parts were. Feeling very insignificant in her sense of physical space	look up towards the sky as if this would help me capture a different sense of space. I notice the different perspective and reflected that we can all feel very small in a vast expanse, but somehow there is a need to feel confident and strong in this place.
Consumed Lack of agency Powerless	'I felt the hate grow in me like a poisonous plant spreads through my body like a virus, it is unseen but all consuming, showing to me all things which are unspeakable'	A sense of being out of control, the horrors being forced upon her simultaneously destroying her.	I have this image of a black tar like substance making its way through the body, clogging up everything in its path.
Overwhelmed by emotion, sense of lack of agency Unheard / lack of voice Emotions playing out over time. Lack of narrative / words / voice Paralysis	'All my feelings of anger and hate were soaked up in a sponge of fear' 'Now I jump from extreme fear to intense anger' 'When I think of those evenings, and I would have to climb the stairs to bed…' (she stopped mid-sentence. Her eyes were staring, she was motionless. I filled in the narrative using my 'felt sense' 'I am cold all over, it's like it's just at the surface of my skin, and every hair is standing on edge. The cold spreads deeper and it's like I cannot move. I feel a weight	Seems like there was no place to express the anger and the hate and these got devoured by the fear, yet they remained present. A sense that the feelings become inextricable. Unresolved – they persist over time	I feel the enormity of the muddle, the lack of voice to express and work with the feelings at the time, the ensuing confusion. I use my narrative to help her put feelings into words. This enables her to move out of the motionless place and look at me, engage with me, and we are able to share an understanding. This seems to create a 'freeing up' of some space between us.

	of heaviness descending on me like a leaden cloud, it wraps itself about me like a cloak of death. I am gripped, motionless, my very breath is frozen: my old enemy, fear'		
Alone in a space Judgement of others Lack of relationships	'There was little notice taken of me. I ate separately, I was not allowed to play with the other children. I was told I was promiscuous and stupid. I believed I was evil, a liar, the devil's child. She said I was stupid, a pain, a burden'	Being a nothing, humanity as the lowest of the low, and inherently evil at that	I thought of the projection of badness onto Amanda and how she soaked it up like a sponge, what else could she do? I notice that I am mindful of her vulnerability, and her need for acceptance and holding.
Loss of identity	'She lost me in pursuit of herself'	Sense of the other (her mother) being the most important, her mother's desires, interests, goals, and Amanda getting left behind, not able to keep up	I feel angry at the mother. I notice my desire to protect.
Positive relationships A different perspective on the world	My grandad was there for me. He had a special way of making me feel wanted and cared for. He used to cheer me up when I was sad. We used to do things together, plant seeds in the garden, sit outside in his shed and just talk while he smoked his pipe. He helped me to feel that there was something different to my world.	Feelings special, by another Another bringing cheer and care Another wanting her Doing shared activities Being creative	I noticed Amanda was happiest when talking about her grandad and in turn talking about her own garden

Positive relationship Being heard. Validated Being believed	The policeman who was gentle and caring and believed me, listened to every word	This seemed to bring a sense of hope, and confirmation that her experiences were valid, and important. However, this was not 'enough' in itself but it seemed to be an important component, as if a start to something.	I felt glad. I felt hopeful. Amanda was more positive, and it felt as if she had reached out and someone had responded and this was important. Amanda adopted an unusual behaviour at this time – she was almost defiant in her look but searching at the same time, a sort of desperateness. I felt she was telling me how important it was for her to be heard and believed, and that the 'story' mattered, that she mattered.
Positive relationships Being cared for Time for everything	Having friends that at least seemed to care was really important. It also helped to know where to find these friends. I met people through arts and crafts group and small groups where we could have a cup of tea and chat. It helped to not always talk about the problems but do normal things with normal people.	Important to be accepted by others, validated and heard, engaging in shared activities, not always talking about 'bad stuff' but engaging in 'normal' things with 'normal' people.	I noticed the difference between wanting to be heard and to tell the story, but also not always wanting to talk about it. I thought about there being a 'time for everything' and how important it was to be sensitive to that.
Betrayal Confusion Fearful space Pain	I thought you cared, you used to pick me up when I fell over or hurt myself. But when it was bedtime I used to dread having to go upstairs, knowing you would come and lie on me. Do you love me? I asked myself; but we could never talk about	This confusion about believing that she was cared for and loved but not being able to make sense of the hurt and paint hat was caused by the same person. The trust that she wants to be there, the belief that	I noticed how we would swing back and forth between seeming to move forwards and then being right back in the midst of the trauma, and the importance of me not leading this but noticing how there

	this. The door was always locked and I was plunged into silent pain, alone, terrified, breaking. I am red and raw and burning inside.	he might be there to care for her, but the turmoil caused by the sexual abuse.	was a need to be responsive to the woman whichever part of herself and her experiencing she brought to the session, a need to not judge or criticise but to hold and be with.
Humiliation Shame Confusion Destruction	Love and sex are fine, until you realise that when you are looking up at the person you thought loved you and is having sex with you, that it hurts, and you feel ashamed and humiliated. It destroys all the feelings you have about love and sex and it doesn't make sense.	There is some understanding that the type of love she was hoping to receive didn't fit with the sex, and that this sex was not in line with expectations either. There is a sense that expectations and desires are shattered, and end in confusion, destruction, pain and shame.	I have this picture of a beautiful rose, which gets torn off the bush and trampled underfoot. I don't have the words to say to Amanda, so I share my image.
Fragmentation Destruction Hope and the shattering of hope Disappointment Living to please others Desperation to be loved Retreat to a safe space inside herself.	It's not a feeling that just goes away, it feels more like a cancer, it eats away at you all the time until it destroys you. I feel so unnoticed. I always hoped: "This time it will be different." I thought that somehow, I would be who they wanted me to be, and they would like me. I hoped I could be accepted and valued for who I was. But it never worked out that way and I always retreated.'	There is this sense of being destroyed, eaten, until there is nothing left, nothing that anyone can see or relate to. This hope that new relationships would be different but not understanding her own depth of need to be liked and loved and basing a relationship on the 'chance' that they might love and accept her. This seemed to end in disappointment time and time again, and she felt the only option was to retreat. In practice this played out in being defensive,	I noticed a conflict in myself in my relationship with Amanda, because I could see the depth of vulnerability but it was shrouded in some very prickly behaviour, she could be very scornful and derogatory of others, there was what appeared to be a selfishness where she was unable to think about the needs of others, she could be demanding and critical. At the same time she was very fragile. I started to see the extent of the prickly defence

		prickly, hostile and intolerant.	as being in equal measure to the extent of the vulnerable person underneath, and that I needed to relate to both these parts of Amanda.
	'No-one knows the depth of the pain that is my reality, it like it goes untouched and unnoticed. It's graphic stuff you know. Sometimes I feel I just need to give a shape to all this. Sometimes this is a bit gruesome, like when I paint my dolls and their arms and legs are all in the wrong place. Sometimes I paint them and they have no face, or no eyes, or no mouth. This is the one with no mouth.		Amanda showed me her picture. It was a beautiful painting of an old-English china doll – with a completely black hole for a mouth. It was quite shocking, and I felt the vastness of the silence that had been. But in her art she had also communicated that silence, those lack of word or inability to speak for whatever reason.
Fantasy and hope	'I dream of how I want to be and how I want my life to be just so that I can stay sane'	This sense of escaping into another world as a means of coping. It also is about creating something in her mind, attending to the detail of the characters and the events, noticing things about herself that she likes and dislikes, things she chooses to have and chooses not to have. There is a degree of agency	I feel respectful of Amanda, and sense an inner strength that keeps hoping. There feels to be a connection between us, almost as if we are watching the stars together – we can't reach them but we can share our looking at them. Amanda showed me another picture: it was of another doll, but there was a leg coming out of the mouth, the arms were twisted and out of place, and the other leg was missing. It created in me a

			feeling of dislike and compassion at the same time – dislike because it was quite gruesome, as if it belonged to some horror movie, and compassion because I thought how fragmented and disrupted the doll was – and Amanda was. But yet she had successfully managed to communicate this to me, and we were able to accept this into our encounter. So, although it was still fragmented, it felt like a voice had started to speak.
Reflection Inner strength developing out of adversity Being creative and seeking to overcome each battle Strength Space Process over time	'I think that the more experiences you have, even if they are good or bad, can give you a sort of inner strength, but you have to find a way to overcome each battle. Then there are no limits to what you can do, it is the ultimate power'	Amanda seems to have space to think, and she is able to recognise that she has not just survived thus far but that there is a strength which has grown within her alongside adversity, and it is through this that she feels stronger and more powerful	I notice myself smiling. Our times together have shifted from feeling like we are stemming the bleeding, to a place where there is space to think
Time lost waiting for life Lack of agency	'I spend a lot of time just waiting, waiting for my life to begin. It makes me feel anxious every day that		

	goes past because my life has not begun. Sometimes I don't notice the waiting, I just notice the years that have gone past. It feels as if everything is on hold'		
Time - ownership Agentic functioning	'Time is mine now'	There is a shift in Amanda, she seems more determined, she is actively taking 'time' rather than watching her life go by, waiting for things to happen.	
Time to find positive feelings / experiences Hope	'Happiness can be found but you have to have a lot of patience'	Time seems to have played an important part, and happiness has an elusive quality, it is something to be discovered rather than landing in front of you	
Agentic functioning	'I am allowed to start again'	Permission given by another or permission taken, as if a choice? A sense of a new beginning, a positive feeling, a hope	
Agentic functioning	'My future is mine to own'	Taking ownership and responsibility, about making choices and determining her own happiness rather than relying on others to provide this.	
Nature	'I notice the flowers, the birds and the trees. I feel the warmth of the sunshine'	Looking outside of herself, noticing the physical space and the beauty in it	
Nature	'I sit outside. I notice the sun which is bright in my eyes. I sit on the	Enjoying being outside, creating something in a	

Taking time Physical space	grass and pick the daisies. Sometimes I make them into a daisy chain. I plant vegetables like my grandad did. I can be outside all day, it's as if I escape'	physical space, reminiscent of a positive relationship from childhood. Taking time to be.	
Nature	'The beauty of summer, the feel of the breeze, the smell of the grass, the song of the birds. I just sit and listen. And feel. It is a breath of sanity'	Sense of vision, touch, smell, hearing, and taking time, using her senses to just 'be'	
Education Agentic functioning Trying out options, ideas	'I kept trying and trying to make things different. Like I went to college and stuff'	Amanda joined an art class at a local college. Starting to make choices, a real sense of persevering, but this is tempered by other occasions where she is just waiting. A suggestion that things go in stages of action and less action. There may be something about trying options to see what works and if it does gaining some strength from this.	
Supportive relationships	'Having friends that at least seem to care is really important. It also helps to know where to find these friends. I've met people through arts and crafts groups and small groups where we could have a cup of tea and chat. It helps to not always talk about the problems but do normal things with normal people'	Sense of being cared for by others, and being able to engage in activities and conversations that were not always about the traumas.	

Writing and poetry Supportive relationships and positive interactions	'I write a lot, I do a lot of poetry. I went to a poetry class and that was good coz I got to meet people to. It helps to be with normal people and not have to talk about all the bad stuff all the time. You know when it's ok to talk about past stuff, but sometimes it's nice not to, and just to enjoy having a bit of a life'	Positive interactions with others contributing to help Amanda feel accepted and able to enjoy being in the company of others.	
Meeting people Positive relationships Being accepted and wanted Different constructive activities	'I don't know what defines recovery for me but I think it would be when I feel like I've got a life. I'm getting there, I have activities on most of the time now and this helps me. I go to the coffee mornings at the church and get to meet people there, even though they're mostly old folk it's nice that they speak to me and always make me feel very welcome'	Sense of creating a life which has meaningful activities and relationships in it. Feeling accepted and wanted, and that people are pleased to see her. Treating her as a somebody rather than a nothing.	
Anxiety about being hurt Difficulty trusting Need to be loved in an intimate relationship	'I still find it hard to trust people, like knowing whether they will hurt me or not, and I haven't had another relationship. I think I want one but I need to know that I am strong enough to be able to do things more my way and not just letting him walk all over me. I still crave to be loved and wanted so I know I will find another relationships but just want to make sure it's the right one'	Suggestion of recovery being in multiple areas. Although she can feel better when accepted by others there is still the area of intimate relationships which are unchartered waters, and there is an anxiety and fear about this.	

Research relationship Being heard Taking time Sharing physical space on a regular basis Relationship that was enabling	'I find I can talk to you and you seem to understand. Sometimes when I meet professionals I just feel like they are doing their job but don't really care, and so long as I tick the boxes then that's all that matters, but you have taken the time to listen to me and that makes me feel important. I know I wouldn't normally have got this much time if it wasn't for this project but if you told me we just had six sessions together I would never have talked to you. I feel like I am putting my life back together – not there yet, but I have started'	There was a real emphasis on not being restricted to a set and short number of sessions. Amanda knew that the maximum time I would meet with her was one year but this seemed long enough for her to feel safe enough to talk to me and share her journey.	I felt privileged to have been able to walk this journey with Amanda, honoured that she shared with me her traumas and struggles and that she trusted me to hold these for as long as she needed me to and that gradually she was able to take bits back and start piecing things together. It wasn't something that I did, it was something that Amanda was enabled to do as we shared a physical space and time together over the eight months that we met, and created a relationship that was accepting, non-judgmental, and very importantly holding.
Recovery	'Well, I'm still 'ere, aren't I? Resilience is about being strong, having an inner strength that doesn't let you give up. I have always hoped there would be a different life for me and that kept me going, kept me searching, even though I nearly gave up so many times'		
To progress	'I need to make some good relationships, people to talk to, who actually want to see me'		

	CHLOE		
Helplessness Pain and suffering Lack of care and support Humanity as an object Gratification of others Embodied as threat	'I am half lying half sitting against the hut. I am burning in the sun and my mouth is so dry. My dress is torn and dirty and I am bleeding from down there (points to her groin). I am four years old. All the men of the village they use me for sex. That is all I do. My aunty, she know, but she do nothing'	There is this sense of being left almost to die in the hot sun, after being repeatedly used by the men of the village for sex. Humanity is an object of utility for the gratification of others. Her only meaning is to be there for others and there is nothing she can do to change this.	This image of a young African girl who is suffering so much pain. I feel this desire to protect, huge empathy. I notice how strong she looks, and how 'together' she comes across. I have a curiosity.
Trauma repeating over time, invasive and intrusive, powerful	'I suffered with the trauma, going over and over what had happened. I had all the nightmares, I kept living it over and over, I could not get away from it'	This sense of the trauma being free across time and space, taking up residence in her body, having such a hold that it was inescapable.	I feel this sense of wanting to reach out to Chloe, I am taking in something of the extent of the suffering
Power and control – trying to gain - powerlessness	'When I tried to take my life, it was three times, I was imagining my life was so bad, it was what people had done to me and my body'	There is something about the utter desperation, that the only way she believed it could be better was to end her own life. The emphasis was on what others had done to her as a person and to her body. The traumas that Chloe talked about are the worst I have encountered face to face, and can only be described as torture and horror. The power and control of others -her only perceived way of gaining control over	But as I sit with her I feel her strength, I feel her unity of mind and body. I notice how ashamed she seemed when she talked about trying to take her own life.

		her life was to try and take her life.	
Pointlessness Hopelessness Despair Lack of agency Humanity as an object	'There was no other life for me, I could do nothing'	Her options as a child were non-existing, she was at the mercy of men who saw females as objects for their own gratification. Humanity as an object	I feel a sense of helplessness and huge sadness
Survival – dissociation Physical space versus mental space	'I learned not to feel the pain. It was like I escape into another world'	Attempts to survive and have some control over her mind if not her body	I identify with the survival strategy and seek to convey my understanding with my empathic but focussed eye contact and my attentive listening, and quiet nodding. We cannot get away from the depth of the suffering but we acknowledge it by letting it be heard to some degree
High expressed emotion – bitterness, anger, frustration Humanity as object	'When I was a few months after when I left the house with my husband, that month if you came and met me there I was talking with such bitterness and anger and: 'this person (her husband) cannot see what he has done, and all he can see is the material things'	Chloe was describing how bitter and angry she was when she finally was able to leave her husband, her frustration with him for how he could only see 'things' as important and not her as important. The sense of her being so devalued, as if less than objects, not dissimilar to her early years.	
Disappointment	'And I was crying with disappointment, then the more I started	This overwhelming sense of loss, not just her childhood years but her expectations from	

Searching Asking questions, thinking	crying out to the Lord He started saying: 'Don't worry, and trust in Me' and I started thinking: 'How am I going to manage with the kids? Where I am going to live?	marriage, the rejection from multiple others, the lack of humanity. The sense of aloneness and struggle with every day pressures, being overwhelmed with life events, a sense of falling apart.	
Fragmenting Focussing attention on God Direction	The pressure alone is just too much, it felt like I was falling apart. But you know, one day I went to sleep and I have visions, and I woke up and I say: 'Thank you Jesus', and you know when God is *in* something in your life and you hear all the voices in your ears, everyone is talking in your ears telling you this and that, and I say: 'I am listening to that still small voice, just listen to that voice', If I didn't listen to that still small voice I would have been blown in all directions'.	Confusion of being pulled in multiple directions, being pulled apart and unable to cope. The focussing of her attention on God and listening to Him, and the calming effect from this. Taking direction from this to manage the confusion	
Love Holding - being held	The sun was out, I could remember the light shining very bright, and I stood at the front (of the church) there, and it was as if something was coming into my life, I have never had a mother or a father, and	Chloe's experience of God seems to have been transformative for her where she felt accepted and comforted as a child would in the arms of loving parents. Chloe was an	

Grief reaction Hopes dashed, overwhelming disappointment	when I accepted Jesus I got the biggest hug, I felt I was being wrapped, wrapped, wrapped as the most delicate thing, and I wept with rejoicing. I hoped my husband would give me all the love that I needed, the love I had never had. I went from the hug of Jesus to my husband and then back to God. When you understand the love of Jesus, God drew me back. I hoped my husband would fulfil everything as a child I never got but that did not happen, it was another hell. Only God can fulfil my need for true love and acceptance. What the world offers is empty in comparison'	orphan so this had an additional depth of meaning for her. Chloe was aware of her huge need to be loved, and came to her (former) husband with the hope that he would be able to fulfil the gap that was so painfully there in her life. The extent of the disappointment when this did not happen is unfathomable, to find herself in a sexually and physically abusive relationship. The overwhelming and heart sinking feeling of being in another 'hell'. Chloe turned to God to meet her need realising that this was something that held a deeper meaning and value	
Going through past events and gaining understanding and perspective Assurances of love Allowing perspective of love to change her heart and mind	'I woke up the next morning and I was rejoicing, but then the battle came, I said: 'If this is how it is then I don't want it anymore', and God started bringing my past to me, and showing me all the times I was there. And I was angry: 'But how did you let that happen?' And He say to me: 'I wanted you to know that they were doing that to Me, what they done to you is as if they have done this to me. You share in my suffering and you will share in my glory. The	Chloe growing in understanding about the abuse and making a sense of it, going through many things in her past, allowing God to show her His perspective, with assurances of His lasting love, and the change that resulted from this working in her heart and mind	

	world has rejected me, but I have chosen you. I have suffered losing my children but I have love you with an everlasting love, and as much as you have suffered, that same amount and more you will know of my love.' And slowly, slowly, little by little, God worked at things in my head and in my heart.		
Fear of judgment from others	'I have been worried about being judged the way I have been treated. I am worried that they judge me for my past, them seeing it as my fault or I am bad person'	Fearing that others would not understand, that they would apportion blame. There is suggestion that Chloe had also had a time when she felt it was her fault and that she was a bad person, and that this might be a natural conclusion for others to come to. This caused considerable fear and anxiety	I felt a connection with Chloe and identified with her fear, and acknowledged this fear can be so overwhelming that it can be a barrier to forming new relationships.
Alone Despair Confusion	'I was lost, so lost'	There was this sense of total isolation	I had this double image of Chloe – seeing her as a small child, so alone, and seeing her as an adult, so vulnerable, and yet the lady before me seemed so strong it was almost paradoxical
Fear of judgment from others versus identity in God	'Coming to trust God is a challenge, is a challenge of fighting with the mind. Jesus say 'let the man who has no sin cast the first stone. I know who	Chloe explained that this was a verse from the Bible meaning that people should not be judging others because everyone has done wrong. There was this	

	I am in Jesus and that is the most important'	sense of her being fearful about others judging her but at the same time trying to hold onto how God saw her, and this was a mental struggle.	
Fear of judgement from others Finding a new identity and purpose in God, finding a meaningful relationship in God	'I first thought that Christians were about judgment, I grew up in a church where I had to go to confessions, and if I don't then these bad things would happen, but that's not my God. I got to that point where there is nothing in this world that can be there for me, for me to have this understanding that God created the earth, and all that is it. We are created to be in an intimate relationship with God to worship Him'	Chloe had struggled with the fear of judgment for a long time, suggesting that she had doubts about her own level of involvement in the past abuse and whether she was responsible or culpable in some way, but she wrestled with this and her new-found identity in God and found that her purpose was to be in a relationship with Him	I was struck by Chloe's warmth, and by her joy. She was very excited to share her experiences to a willing listener.
Fear Intrusions from the trauma	'I used to be so fearful, I used to see her, my aunty, in my dreams, I used to see her all the time and could hear her calling me. I changed my name so I couldn't hear her calling. I went through a lot of things with my husband also'	The trauma being invasive and persisting over time, unable to escape from it, changing her name to stop hearing it being called, feeling of being pursued	
Mental and spiritual conflict Support of friends	'Through all the personal experience of my life I was angry with God:	Difficulty making sense of the abuse, angry and apportioning blame, being calmed by friends but not	

	‘why did you let me go through this? I have been abused, you don’t understand what I went through!’ And my friends at church would say to me: ‘but God is able’, and I would tell them to ‘be quiet!’’	tolerating this, being frustrated with this	
Anger getting in the way of recovery Confused about identity getting in the way of recovery Realisation of extent of love of God Growing in strength through adversity Gratitude Acknowledging her own need for love	‘We can make all the excuses we like but it is only ourselves which stop us moving forwards. It was the grace of Jesus that got me from that place of being so angry to knowing how much God loved me. Sometimes the enemy come, and I see myself as I was, and for a second I go back in there, then I say ‘Jesus!’ And I am able to come out! It is funny to say it but my past has made me more a conqueror. I went to the depth of hell and that is how far His love and grace have reached down towards me. Out of that, there is the gratitude of heart, pulling me out of	Chloe was talking about recovery. She very much saw herself as getting in the way of her own recovery and was referring to her own lack of understanding and her own desires, and the emotional conflict. She described the ‘enemy’ as pulling her back emotionally, with images of herself during the abuse both as a child and an adult, and how she started to get lost in this but would refocus on God.	I spent most of my time with Chloe just sitting in admiration of her, and listening to her story.

	despair. The worse the situation I have been in the more we know His love, and we love Him. If I had an easy life I wouldn't need Him. People who have comfortable lives they cannot see their own need'.		
Focus on God Choosing to believe and know who she is in God	'If I remove my eyes from the cross. I am going down. When I am seeking validation from others, I am struggling. I do not need to check with people 'am I ok?' I just know what my heavenly Father thinks of me. I *choose* to believe Jesus'.		
Significant relationship - God	'My relationship is Jesus'.	There were no other relationships reported as being significant except Jesus	
Choosing positive behaviours	'When I ask Jesus to come into my heart he want to transform so changes have to take place. Things that I do before I have to now ask myself if that is ok. I have to make different choices'	Chloe was talking about changing unhelpful behaviours, including suicide attempts and anger. Chloe accepted that she was choosing to life her life by a higher order and that to do this she had to allow changes to take place both mentally and behaviourally	
Battle for the mind Happiness from within as opposed to	'Take control of the mind. Have a mind that bears witness with the Spirit. My smile now comes from the inside, my eyes are fixed on the cross'	Chloe made many references to the battle for the mind, the battle against her desires to self-harm / take her own life, to be rageful and bitter, the	

smiling to please others		trauma images, thoughts and voices intruding into her conscious and subconscious awareness, and how she chose to let her mind be transformed, keeping her focus on God	
Changing unhelpful behaviours Shifting focus from the past to the present and accepting the present	'I knew a lot of things was of God coz He was working thing out in my life. This can only be God. When we are serving the enemy, we give him everything. I never had this wisdom. Stop saying 'I wish, I wanted to be in that situation'. I will be discouraged.	Chloe described a process whereby God helped her to process and make sense of the abuse. When she talked about the 'enemy' she referred to him being please that she was angry, bitter, confused, and wanting to take her life, and how when she went over and over the trauma it was like giving glory to the enemy as his goal was to cause destruction. She learned to stop regretting the past, saying 'I wish…' as this caused discouragement, and chose to accept the present.	
Perseverance Getting back up after failure Not berating self Challenging and renewing the mind daily Focus on God	'Through your failure do not be afraid from your failing, your failing will get you through because you will know next time. Don't sit there and think 'oh no I have done it twice', get up and keep on going. You need to get to that place. It takes vision and faith. For me to receive that, I ask God to search me, change	Chloe had developed a perseverance where she kept getting back up on her feet, after a 'fall' not berating herself for failing but getting back up and moving forwards. She described the battle as one of the mind and the need to change the old ways of thinking on a daily	

	me, take my mind, take control of my mind, the spirit is saying something else, renew our minds daily, not monthly not weekly but daily'	basis, listening to God's perspective	
Supportive friends Encouragement Faith	'I have brothers and sisters in Jesus and they give me encouragement so I can be strong. We pray together and share the Word together so we can grow'	Chloe described friends at the church which were encouraging and supportive and also helped her to grow in her faith and be strong	
Education	'I study English and Math. Before I come here I could not read or write'	Chloe was completely illiterate before she came to the refuge. She wanted to learn how to read and write so she could support her children	
Fullness of joy	'What I share with you, my sister, is LIFE, so that you will know and have life abundantly'	Chloe was joyful, and this flowed from her. She had found something precious and wanted to share it.	
Recovery	'Recovery is when you have faced all the past stuff that is bad, and can accept what has happened to you, and received the healing power of Jesus Christ so that you will know fulness of joy'		
Progress	'What I need to do now is continue to grow in relationship with Jesus, to let Him renew my mind every day, to be encouraged by my friends, and to bring my children up well. What will get in the way is if I take my		

	eyes off Jesus and let the enemy remind me of the past and what happened'		
Research relationship	'What I have found is that we have shared life together, and we have known the love of Jesus'		
	TESSA		
In her body, external presentation different from internal experiencing	'I couldn't talk to anyone about what I was feeling, I just smiled and pretended everything was fine. They wouldn't understand.'	Sense of wearing a mask, not being understood	
Trapped in her body of pain Pain blocking her thinking (mental and physical)	'My legs hurt so much I can hardly walk. Every time I try and sort things out in my head my fibro (fibromyalgia) flares up, and the pain takes over so it's hard to think. It's like my body controls me, it takes away from the pain in my head, but I know the pain is still there. I just have to try and sleep until it gets better then I can start to think again'.	There seems to be this separation of the mind and the body, but the body takes over the pain of the mind so that it becomes the focus. The physical pain prevents her thinking clearly, it seems to be a permanent obstacle to Tess sorting out what is happening in her head. Tess was very preoccupied with her body and how it was feeling, but for a long while there was this sense of disconnection.	At first, I felt frustrated with this preoccupation until I reflected that this was also her safety mechanism for controlling the recovery process and managing herself safely.
Female humanity as an object by physical design. Body as threat	'I don't know how to have sex any more. To me it is just about the hole, they can do what they want coz you've got a hole, haven't you? This is why women are weaker than men and men can take advantage of them. They can do	Tessa's experience of being human was 'to be done to' and that was 'because of her body'. She was the inanimate object that had to receive the desires of another. There was this anger and resentment about	I remember feeling repulsed at this image, and angered, because I thought it might be true. As a woman I identified with her vulnerability. This was a connection between the two of us, and she

	stuff to you, but it's harder to do stuff to a man'.	her, and there had been mutual interpersonal violence in her previous relationship. But it was as if she had to resign herself to the limitations of her body and had no choice.	expressed that she was glad because I would 'know what she meant'. It was important for her that I could understand and relate to her and her experiences.
Sex and love boundaries blurred Using the body / sex to try and meet emotional needs	'Sex hurts, it's not a nice thing, it's just bloody painful if you ask me. But I still want it! I need to be close to someone. I want someone to hold me and sex is as close as it gets. I know it doesn't work like that but somewhere I think that'	Sex has been a significant part of Tessa's life, starting from a young girl, and generally has been less than pleasant. But it is the closest thing she has had to anything that might equate to love and affection. She knows that it doesn't quite add up but a part of her thinks that the sex she has is love, and she craves love. She would sacrifice her body to unwanted and unpleasant sex from another because of her need for love.	There is a sense of confusion because not all of her thinks this, and it is as if a part is fragmented from the rest of her body.
Powerless Humanity as object Lack of agency Physical limitations	'It feels like I don't have any choice over my body. People can do stuff to me coz I'm a girl and can't stop them. If my body was different it wouldn't happen.'	Being female is a powerless and vulnerable place.	I feel angered at the injustice of the imbalance between male and female and am curious about what caused this imbalance but also what maintains it. I feel like Tess and I are in this together, there is a sense that we are walking this tricky path, but neither of us knows where we are

			going. The only thing that mattered was that we were in it together.
Lack of agency Lack of knowledge	Tessa: 'It just happened didn't it (*as a statement*). We didn't know any different'.	Lack of choice and control but also no reflective thinking due to lack of knowledge	
Fragmentation Attempts to synthesise and organise Loss Confusion Guilt Self-blame	'I am searching for a place to put my memories of each precious child so that they are safe. Everything needs to be in its proper place. I am still searching for memories as I know they are there but I can't find them and I need to put them in their place too. Some memories I've found but I don't have a place for them. It's like I only have part of the picture and I can't find the missing pieces, and when I find pieces I don't know if they're real or true'	Tessa had her children removed from her care when they were young. She has struggled to come to terms with what happened and grieves the loss of her children. She feels this loss like part of her body has been amputated, and struggles with what is real and what she experiences as real but is not sure about. There is very much a discomfort with what has happened and Tess experiences a lot of guilt and self-reproach.	I am mindful to accept all parts of Tessa as equally valid, and convey this to her. She thanks me and shakes my hand when we come to an end, and says how important it was to her that I was human, emotionally available, caring and sensitive, and accepting of all of her.
Fragmentation Threat Attempts to synthesise, organise, contain	Boxes store memories, memories need to be safe. That's why I'm still searching for memories as I have so many and they're not safe'. 'I am separating everything out in my head, trying to remember everything so I can order it and put it all together in one place'.	There is this sense of being in danger with parts of her in different places, and she is searched for all these parts to put in a box where they can all be together. There was an overwhelming feeling when I was with Tessa that she did not feel safe. Tess bought actual boxes and put specific things in	At first I noticed I was frustrated by this, but then became curious about it and took a step back and understood that she needed to be on control, she needed to direct her own recovery and a pace that she could manage, and it wasn't about what I could or couldn't do, what

		each to try and help herself sort out her head. She was externalising the containing of these memories, which had a sense of already being 'out there' trying to make senses of her experiences. At different times she chose to talk about the contents of some of the boxes. This pace was very much controlled by her fibromyalgia and sometimes weeks would pass and we would only talk about her physical pain and how she was struggling to cope with this on a day to day basis.	was important for her was that I was there, I was sensitive enough to recognise her need for time and space, and that I had an understanding of what she was experiencing. Tessa and I spent 12 months meeting for one hour each week.
Blurred boundaries Emotional contagion Fragmentation Need for synthesis and holding	'I need to have clarity of thought. I need to be able to separate my needs from everyone else's needs. At the moment I feel like I am dismembered – there are pieces of me all over the place and I don't know what is where. I need to bring them all back together again'	Tess struggled to not get caught up in everyone else's experiencing and emotions and would get confused between trying to help someone else and trying to sort out her own feelings at the same time. She struggled to contain her emotions which would often leak out in anger and aggression. There was this huge sense of loss with bits missing. This was a large part due to the loss of her two children and this was a very real struggle. But there was also the loss of her own childhood, and her lack of	

		positive relationships with parents.	
Loss Emptiness Lack of meaningful relationships Fear and threat of fragmentation	'The problem is, I come from the starting point of something being missing. And I don't know what it is that's missing. I am holding onto things which give me comfort, which give me security'	Tessa very much came from the position of being threatened, and this created a neediness in her relationships where she would hold onto them even if they were abusive until it was so desperate she had no choice but to leave. She had this sense of loss and emptiness which was with her all the time	I was mindful that Tessa was potentially emotionally dependent so ensured very clear boundaries of time and space and also end points. Tessa demonstrated that she was really able to work with this and although she was sad when our time came to an end she was able to successfully negotiate it.
Gratitude / value Research relationship	'Thank you for being there. You are different to all the rest. You treat people as people, not numbers. I know that you really know what it's like, being abused and stuff, and that makes a difference, you haven't just read it in a book'	Tessa placed a value on the respect and humanity in the research relationship but also the depth of understanding and empathy	There was a connection between Tessa and I, an understanding. She knew that I had experienced abuse although this was never discussed. I did acknowledge that I had fibromyalgia when she asked me if I knew what it was. Although I talked very little about myself, just responding honestly to questions, there was a genuineness in the relationship and Tessa particularly valued this.
Fear of judgement from others	'I hardly ever go into town, as when I walk down the street it's like everyone can see straight through me	Tessa carried a great shame about her past particularly about her children.	

Shame	and know what's happened to me and the things I've done and are judging me'		
Humanity as defective Judgment of others Exposure	I was just a whore, wasn't I? I am afraid to go out because people will see me and they will know things about me. I had this image of my life being a bit like washing on the line, but then I thought I wouldn't want everyone to see it. I am ashamed because I have so many things wrong with me, it's as though I am like faulty goods, I don't quite work properly. I'm afraid that other people can see this, and that I will be found out'	Tessa was so afraid of being judged, being seen for the defective person she believed she was, a huge fear of exposure. Her sense of inadequacy as a person	She hardly ever went out, but when she came to see me she had always made a big effort with her appearance.
Confusion Difficulty thinking Anger and aggression	'I am thinking what must I do to get sorted. I am trying to be rational but I'm confused, I am not safe to be around, I am angry and hostile, and I hurt people. I am not good to be with. I don't know why I am not sorted'	Trying to think but struggling with negative emotion	Tessa worked so hard to try and sort things out in her head, and would often bring large spider diagrams with so much crammed onto the paper it was hard to read the contents, but she kept trying
Feeling understood, listened to, heard, cared for, supportive relationship	'You're the first person who's really listened and cared. You make me feel like a person and not just a number. I had counselling before but couldn't really talk to her coz I don't think she knew what she was talking about. It's different	Tessa placed a big value on the times we spent together, she valued being listened to, heard, understood, and this helped her to feel cared for. She valued being treated	I felt a warmth towards Tessa.

	when you know that someone *knows* like you do'	with respect as a human being.	
Art	'I have started painting again. For years I could only paint pictures of black, stormy seas. I have painted a different one'	Tessa showed me several pictures which all looked the same, very dark and black stormy seas. The page was mostly black. Today she painted one navy blue. She showed me with pride.	It felt like Tessa had taken a big step forwards. I felt happy.
Animals	'I love playing with my dog, he always wants to play'	Tessa bought a dog for company and something to care for	
Time taken for Recovery Build-up of trauma over the years Research relationship - gratitude	'I still feel I've got a long way to go before I can say I've really recovered, there is so much to sort out. It's years of crap that needs sifting through to try and make sense of it all so it's not going to happen quick. But I know I've come a long way, the furthest I've ever come before, thanks to you, and I know we've had more time than I would normally get with anyone'	Tessa placed a value on the time we had together but time was an important factor – the time the abuse had lasted giving rise to multiple traumas, and the time Tessa needed to try and unravel this.	
Holding	'You kept challenging me not to avoid stuff coz you always remembered what I'd said. This helped me to keep finding bits that I was losing',	In my curiosity and reflection Tessa seemed to have been enabled to hold onto bits that she might otherwise have 'lost' and this seemed to help her to synthesise and make sense of things	

Art Physical space	'I quite like doing the painting now, and sometimes I can feel the creative me coming out a bit. I still paint seas but the last one had a beach in it too! And a palm tree!'	Tessa began painting more and more, using it to express her emotions and to create new things. It was as if her motional world was changing and she expressed this in a physical space that she painted.	I felt excited about the developments in her artwork
Writing and organising	'I do lots of writing. Every time we have met I write down everything to try and sort through stuff, what my feelings and thoughts are, and I try and put everything in its right place, coz then it's done and I haven't lost anything and I can move onto something else'	Tessa found writing a means of organising and expressing and also of holding onto important parts which might otherwise 'go missing'	
Friends To progress	'I don't have any friends yet but I really would like some. I wish you could be my friend but I know you can't. I need someone normal not messed up like me, and everyone in here is messed up as well, it's like a disease that spreads. I want to find somewhere that I can make friends as that will help me get better'	Tessa placed a valued on making friends but she had never really had any one but she placed a value on finding friends that had clear boundaries about their emotions	
Recovery	'I don't think recovery is the same as resilience, resilience is about being strong all the way through, and not giving up. Recovery is about getting past the bad stuff and having a life – having friends, being able to go out and do		

	stuff, being able to be calmer and help other people'		
To progress	To move on from here I need to keep sorting out my thinking, putting everything in the right order where it needs to go so I know I've got everything. I need to be able to have sex and it not be a bad thing'		
	SARA		
Controlled Humiliated Disgust at self Angry Self as weak	'I always carried a condom with me, as a teenager, I'm not really sure why. But that made Malcom think that I was sleeping with other men and that made him jealous. He got into a real rage when he was jealous. That's when he started checking me, you know, inside, when I'd been out, to see if I'd slept with another man. I couldn't handle the conflict so I let him do it. I hated the arguments. It was just easier to give in' That makes me angry now though because I was weak. I hate myself for that. Ugh, I despise myself for letting him do those things, like when he wanked all over my face and told me to open my mouth. I can't believe I let him do that. That's just the most disgusting thing ever. I feel myself all	Tessa described some of her humiliation and how she felt disgust and self-loathing about her own perceived weakness and the anger she felt towards herself. Th emotion of disgust was turned on herself rather than on him.	I often felt on edge when I was with Sara, possibly because she rarely sat down, and paced the room much of the time.

	screwing up inside now every time I think of it'		
Anger Confusion	'He always punished me, punished me for being bad, even though I never knew what I had done wrong. He had full control, he kept me in his fear. I kept thinking: "Is it something about me? I've had this shit all my life, why have I got to have more?" I don't see how people like this can get away with stuff''	Sara was confused and angry about the abuse and there was a sense that she questioned herself and whether it was something about her but also the injustice of life that people can 'get away with it'	
Survival Power Moral conflict	'I knew that stealing was wrong, but when I stole things I felt clever, because I got away with stuff. 'Til the anxiety came in and I was dreading being found out. But I had to steal just to survive mostly. It was just food, and sweets and things. Sometimes clothes. I would get things for my little sisters too'	Sara was forced to steal for physical survival and had the conflict knowing it was wrong but also needed the goods. There was also a sense of power about 'getting away with stuff' at a time when she felt she had little control over life or what happened to her.	
Testing out relationships Lack of trust Survival	'Sometimes I stole things with other people. Just people I knew, in the street. That's how you really find out who you can trust. Whether they would tell anyone. But I also noticed how they coped with stuff, how they reacted. And if they would ever use things against me in the future'	Sara needed to test others out to know if they were trustworthy or not, and whether she could rely on them if she needed to. She also learned how to survive in a challenging world where there was no-one else looking out for her	

Power Need to be seen to be coping / in control / powerful	'I walk with my arms crossed over my chest, I feel more powerful like this'	Sara showed me her walking with her arms crossed. There was this sense that she was telling me she could look after herself and that she was coping	I noticed Sara's need to be seen as powerful and strong and how uncomfortable she was at being anything other than this.
Need for power and control Creating something positive in her environment	'Sometimes I would light a fire. Anywhere really. There was an excitement that gave me a thrill all over. I would sit and watch the fire and feel it's warmth. It was a warmth that *I* had created. I could also feel its power, and think of it as *my* power. I don't do that no more but it helped me cope at the time'.	Sara used fire to feel strong and powerful and in control, but also making her environment better with the warmth, and this helped to survive at a time when she had little ability to control her environment	
Lack of words. Trapped in her body Trauma present over time	'Sometimes I can't say the things which happened, I don't even have the words. It feels like these things are trapped inside of me not able to escape. It's like I was a child again and feel all the feelings, but I don't know how to tell you.'	There is this sense of not having the language to describe her experiences, the experiences are trapped inside her, and it feels as if language is the only way they might be able to find a way of escape, but she is frustrated and powerless without the words.	I empathised and was curious, and reflected her feelings, and the words she chose. I used the feelings within myself to start a narrative, and thought about these with her as possible feelings within herself, and together we put a language around this.
Humanity – focus on survival No time and space for herself	'Every day when I was 8 or 9 the only thing I could think of was where I was gonna get food from that day for the kids'.	Her experience of her own humanity was survival – but her focus is on others. There is this sense that all that mattered was the survival of her siblings, and there was no thought to her own wellbeing. I	

		wondered if there was no time or space to think about herself because no-one else gave her time and space, and whether this contributed to her feeling unworthy of receiving anything for herself.	
Not able to think Fear and threat	'It was like I was a robot, doing stuff without thinking, getting the kids out the way before dad came in and gave us all a good hiding'.	'It feels like there is this disconnection between mind and body, and this as a result of the constant fear and threat. I was curious about whether there were any experiences which prompted her to stop and think, and she replied that it was when she and her siblings were taken into local authority care when she was 10. She was removed from the situation but also separated from two of her siblings, so although this might allow her time to think about her own needs it was also a massive challenge to her as she lost her sense of identity as a mother figure, and she did not know how to be a child'	
Overwhelming emotion Lack of words / narrative	'Sometimes I am so angry I don't know what's happening around me anymore.'	Sara really struggled with a lack of narrative. It was clear that so much had happened and that this was causing her great distress, but she	

	'I've lost my words'	could only tell me things in short sentences. I didn't press her but stayed with her and reflected her feelings of confusion, being out of control because she couldn't 'place' everything, finding herself experiencing emotions but not being able to make connections with things. Although she said 'I've lost my words' it was as if she had never had the words, and in her mind there wasn't the sense to be made.	
Confusion Lack of narrative fragmentation	'I can't bring all my thoughts together, there's too many of them and they're all jumbled up'	The confusion of not being able to think clearly and sort out all the thoughts and emotions	
Shame Caring for others over self -identity	'I am ashamed to have anything to do with that life. It's like we are all bad because of them. I always look after people before myself, because of the situation I was in. You know, being the mum coz mum was always high or hung over. It was like she wasn't there. I would open the cupboards and there wasn't even any plates or stuff in them' I share my food sometimes here, if someone hasn't got any. Sometimes I cook	Sara struggled with feeling ashamed of the way she had been brought up, and how she had had to care for her siblings. Her identity was as 'mum' to her siblings and this carried on into adulthood, putting the needs of others above her own. She had some anxiety that she would always think like this which suggests she realised it was unhelpful. She was able to entertain the idea that she could do things that she wanted to do and	

Thinking new thoughts – possibility of caring for self	for some of the others. I'm always being the mum. If I get to 30 I think it will be hard to get out of it, never thinking of myself. Sometimes I just think to myself: 'What do I want to do? And I just do that. My sisters are getting older now so they have to take responsibility. I've tried to teach 'em that. I can't always be there for 'em, being the mum ya know. I've gotta live my life too'	that she had her own life to live.	
Helpful / supportive relationships Animals	My Nana and Grandad helped me when I was growing up. They used to take me to the beach. Perhaps it was coz they saw I had a hard time at home. They knew for a fact what was going on and that I was not coping. They used to have me some weekends. *(Thoughtful)* Good times. Sometimes it helps me when I reflect on the good times. I would take the younger kids to my big sister who was already married then I would go to Nan and Granddad's My grandad had a trainset and we would sit and watch it for hours. They also had a dog, and I would take him for walks. That was fun.	Sara talked fondly of her grandparents, and some of the positive times she had with them. This meant a lot to her and was a great source of comfort and strength growing up. It was important to her that her grandparents had been there over time. Sara enjoyed having a physical space that was positive, whether going to the beach or walking the dog.	

Physical space as positive Relationships over time	My grandparents knew everything about my childhood so they tried their best to help me. I do still speak to them. They sent me a card at Christmas.		
Independence Need to be with people Lack of meaningful relationships Doing for others but not receiving much care. Need to feel valued	'I just get on with life on my own. I always have to have company though, I hate being on my own. That was why it was so hard to leave my partner. I knew it was bad what he was doing but I couldn't face being on my own. Especially when me and my sister drifted apart when she got her new man. Even now, I need to be with people, I don't like being on my own' 'Every day I just go out and hang with people coz I don't like being alone, but they're not really there for me. 'I am always doing things for other people but when I need something no-one ever returns the favour. My best friend did that for me *once*, you know, returned the favour. But I do favours for her all the time. That's how you know who your friends are, they give something back. That means you are	Sara was fiercely independent but at the same time was very lonely and needed people about her. Her experience of others was that they were not available for her, except rarely, but when they were she felt valued and important to them and this was significant for her	Sara engages less, she seems to have a different way of coping. She is very focussed in pursuing goals and quickly moves herself away from any reminder she may have about her past. She seems steadier the more activities she has in her life, but I feel there is more of a silence between us, she was evasive about questions, so many things went unsaid and it did not feel right that I should say them, so I just noticed it'

	important enough in their lives'.		
Keeping busy College Martial arts Avoidance	'I keep myself busy. If I'm not out with my mates them I'm busy doing my college course or martial arts. If I'm busy I don't have to think about the bad stuff, like what's my life's like'	Sara brought with her an energy and a determination to move forwards. She didn't always seem to do much thinking but was determined to be moving forwards. She got a place in college to study sport, and joined a martial arts class. She seemed to be driven by her anger and shame about what had happened, and was determined to not go back there.	It was harder to build a relationship with Sara because she was often defensive, and of all the women she was the one that would miss sessions, and attended for only a few weeks. It felt like there was more of a distance between us. I respected this as her choice, and understood it as possibly not being able or not wanting to be able to think about trusting another with matters that were too difficult to understand, that she didn't have the words for, or just didn't want to go there.
Anger Boundaries aggressively defended	'When I get angry now I just can't stop. Someone spilt hot chocolate on my jacket here and I nearly flashed out, but I ended up just going for a walk and kept hitting things. I don't know what makes me angry, I really don't know. But she knows now that she can't walk all over me, she won't cross that boundary are meant to be equal, not one person taking advantage of the other – if someone does that to me I would kick them big time. That's		

	why I've taken up kick boxing and martial arts. I can go to that real angry place'		
Positive self-perception, liking self	'I do quite like myself now coz I think I'm funny. I love to make people laugh. I like people who have humour in them. I also like that I'm caring about others'	Sara was able to think about herself in a positive way	I felt I had been with her for a part of her journey, and it seemed like any progression from being stuck in the past happened in stages, as if it was too difficult to happen as a nice linear progression. It felt like some steps forwards, some standing still, and at times some steps back
Avoidance Pervasiveness of trauma Nature Noticing positive things especially in relationships particularly with children	'I try and forget but I can't forget coz it's everywhere. Especially in this place. I walk down the street and all I see is paedophiles. Everywhere. I can't get the pictures out of my mind. But then I try and think about the other things I see, about the nature, people's gardens. Sometimes I look at people's gardens' and even in their windows, ya know, just as I'm walking past like, not peering in, and wonder what their lives are like. What's going on behind that closed door? Sometimes I see people just watching telly and stuff or just being together. Once I saw this mum playing ball with her little girl and I wondered what that was like. They didn't		

	even have a big garden or anything, they was just playing ball on a little patch of grass. I liked that'		
Research relationship Practical help and advice, practical support Someone to talk to when needed	'It's good, yeh, to have someone to talk to like, like you coz u just listen but u remember stuff too, and the staff are helpful especially with benefits and stuff, and they helped me sort my college course out. Practical stuff is what you need at times like this as it helps you get back on your feet again'		She seemed to have created a life for herself, she got herself a new partner 'who she wasn't having any shit from' and moved out with him. She seemed stable enough, but I often wondered about her anger and how 'wobbly' that made her. We were able to have a brief chat about what recovery was for her before she left the refuge. I felt there was still a child in her that 'needed to get out', and also a loneliness, and this was mixed with needing to be independent and survive in an adult world. I don't think she had sorted out her feelings of shame and badness at that time, but I do think she was too busy to think about them.
Recovery Friends Independence	'Recovery yeh, it's about being able to stand on yer own two feet, innit? And having mates and stuff'		

To progress	'I just need to get me own place and to have mates round and stuff, and just forget about the crap and make my own life'		
	MARTHA		
Humanity as object Internal experience in body different from outer expression – mask Unheard	'When I think of my mother I was like a slave to her. I would do all the cooking and cleaning, while my brothers they did nothing. I used to make and mend the clothes, and she would say to me: 'go and sit at that machine and do your work.' She didn't care if I went to school or anything about me. She knew if she had friends round the cleaning would always be done by me, and I would bring cups of tea or coffee to her and her friends. It was like I had to be the person she wanted, they did not know that inside I was screaming to get out'	There is this sense of being trapped in a body and in a role, with meeting the expectations of others as the only thing that was privileged. Her identity had to be determined by another, but this imposition of another served to imprison the real her. She was not able to be true to herself and so had to live with this constant conflict of what she felt inside and the imposition of another. The only logical explanation that a child could come to was that the 'other' was more important, had more worth, and therefore she had to take the counter position of being unimportant, and of no worth.	
Humanity as object	'I remember my mother, she dragged me by my hair across the kitchen for something I had done wrong. I do not even know what it was that I did wrong. She hit me with a wooden spoon so hard that it broke in	The pain and damage to the body cause me to cringe. The futility of it all, as Marth didn't even know what she was being punished for, but also the power held over her, with the 'weapon' kept as	I felt the powerlessness of the situation, but also the inherent shame and humiliation in this. I had this image of a rag doll.

Self as nothing	two, and she kept it on the shelf as a sort of trophy. It was like I was this *thing*'. 'I was nothing to her. It was like I didn't exist except to be punished.'	a trophy, as if it continued to wield some malevolent force. I struggled with the idea that one human could do this to another, that someone could be so inflated in their own mind that they had the audacity to inflict punishment and control over another.	
Female gender as object Shamed and blamed Unheard	'My children they don't respect me. I did all that I could to care for them and love them, I took them on outings, I bought them things, I played with them, but they don't respect me because I am a woman. When my son beat me, my husband he just turn the other way, he did not even tell him to stop. It was not until I got out from there that I can see how bad it was. I would shut myself in my room all day in the end and not come out even for food, I was so frightened to be around them'. 'My husband tell me how much shame I bring on the family. He see it as all my fault and he tell me off and look sad. I say to him to tell his son to leave and not hit me but he do nothing. They do not listen to me'	Certainly in her own mind, Martha tried to be the good mum to her children, and I saw her searching her own mind to try and understand where it all went wrong. She had brought from her childhood a belief that she could only be worthy by what she did, rather than who she was.	It was very cold in the refuge that day because the boiler had broken. I was sitting in my coat, and Martha was wearing her house coat. She stood up, smiled, and told me to 'wait there' a moment. Curious, I waited. She returned with a large woollen blanket that she had knitted. I admired her handiwork and she beamed at me. I said I would make us some tea. We sat side by side on the sofa, drinking our tea, with her blanket over our knees. Not much more was said that day, we just sat together. She was the happiest I had seen her. It was as if she was grateful that I would want to be with her, and this placed a worth on her.
Mask	'I remembered particularly that I was	Martha's humanity is perceived as an	I am feeling the tension in my body

Lack of words Trapped in silence Humanity as object	with grandmother, and my grandmother knew what had been happening all night, that my grandfather and uncle would have sex with me, but she sent me to school, and I hadn't got any sleep and when I went to school I put my hand on the face and fell asleep and the teacher sent me to wash my face with cold water. I could not tell them'.	inanimate object who has things 'done to' without thought or care given to how this might affect her, she was there purely for the benefit of others, yet still expected to go to school that day. I am struck by the degree of suffering that young child had, with no-one to empathise or help her in her plight. There is also this sense that these things happened 'without word' and there are no words to describe them, that either the language isn't there or an understanding or ability to make sense of them isn't there. Either way the net result is that the experiences remain trapped inside.	as I picture the suffering of that small child. I am horrified at humanity.
Desire for love and closeness Continuing over time Importance of maternal relationship	'For so long I tried to get close to my mother, but I was pushed away. She would hit me across the face, round the head, anywhere, and kick me like a donkey. How do you repair that? Because it is hugs and love that she did not give, she did not touch me unless she was hurting me. When it is your mother that rejects it is the most painful things. As I grow older I would say 'but she's still my mum.'	It does indeed feel like this is the greatest injury, that the mother who bore you cannot bear to be near you in a way that wasn't violent or hostile. It almost feels like a rejection of a part of herself, but is certainly a rejection of Martha. I am thinking that if one's mother does not love the child then who will? As a mother myself I am thinking how impossible it would be for me to not love one of my children. I	We both had tears in our eyes.

		feel the desperation in the interpersonal space between us, when she says: 'but she's still my mum'. I am curious as to how she makes sense of this, and she acknowledged that her mum 'shouldn't have done those things' and that's why she would never have treated her own children like that. But the confusion remains, because although she treated her children well, the tables were turned, and her children abused her. It is hard for her to not come to the conclusion 'it must be something about me.' I leaned forwards and held both her hands, and held her eye contact in a caring way.	
Trauma persisting over time Powerless Feeling out of control Fear of fragmentation	'The memories come back as if they were yesterday. It's as if they come from no-where and when I least expect them, and vooom! I am back there. I am pulled all over the place' 'I can see out of the window people cutting the grass with a machete, a curved knife. But it made me frightened that they would cut me up too'.	Martha was pulled in many directions, and experienced this as chaotic and confusing.	When I first met her and she agreed to be part of this study, the staff at the hostel said to me: 'Please speak to Martha, every night she is running screaming to the front door trying to get out. She is half naked, and then sits by the door and sobs. She then goes back to her room and showers. We don't know what to do with her. Mental Health

			Services have discharged her, she's had 12 weeks of therapy, but we don't think she's right.'
	KIRSTY		
Confused Blurred boundaries about right and wrong Difficulty coping, anxiety Agentic functioning	I think the early stuff made me vulnerable because I never felt good enough. It was really soon after I got married that the violence began, and the sexual coercion. The problem was I didn't know what 'normal' sex was because I wasn't taught, and my early experiences clearly shouldn't have happened. I was confused and I things this was why I tolerated things for so long. It wasn't until it got so bad that my life was at risk and I just couldn't cope any more, that I decided I had to go, come hell or high water'		
Fragmentation Consumed Unsafe / threatened	'I have this same dream over and over. I am lying in my bed, when the walls of the house start falling down around me, disappearing into clouds of dust; and then I watch the floor boards being engulfed into a big hole, until finally my bed starts to break up and I am falling. Then I wake up.'	Kirsty had years of domestic violence where she tried to hold everything together, including her family, but at the same time it seems that everything around her was crumbling, everything she hoped for in a home and family were falling apart before her eyes. Kirsty very much saw herself as a family person and to admit that things	I had this sense that Kirsty was working really hard to hold everything together

		were beyond her control and were falling apart was a very difficult step for her. The pain and loss over her ideal were enormous.	

APPENDIX 3

Senate / Psychology Research Ethics Committee

Application for Approval of Research Involving Human Participants

Please tick the box for which Committee you are submitting your application to

☐	Psychology Department Ethics Committee (Light Touch or Standard)
X	Senate Research Ethics Committee
☐	Cass Business School
☐	School of Arts & School of Social Sciences Research Ethics Committee
☐	School of Health Sciences Research Ethics Committee
☐	School of Informatics
☐	Learning Development Centre

Psychology Department. Please submit to [redacted], ccing to [redacted]

For **Senate** applications: return one original and eight additional hardcopies of the completed form and any accompanying documents to [redacted], Secretary to Senate Research Ethics Committee, University Research Office, Northampton Square, London, EC1V 0HB. Please also email an electronic copy to [redacted] (indicating the names of those signing the hard copy).

For **School of Arts & School of Social Sciences** Research Ethics Committee submit a single copy of the application form and all supporting documentation to [redacted] (Social Sciences) and [redacted] (Arts) by email.

For **School of Health Sciences** applications: submit all forms (including the Research Registration form) electronically (in Word format in a single document) to [redacted], followed up by a single hard copy with signatures.

For **School of Informatics** applications: a single copy of the application form and all supporting documents should be emailed to [redacted]

For **Learning Development Centre** a single copy of the application form and all the supporting documentations should be emailed to [redacted]

Refer to the separate guidelines while completing this form.

PLEASE NOTE

- Please determine whether an application is required by going through the checklist before filling out this form.

- Ethical approval **MUST** be obtained before any research involving human participants is undertaken. Failure to do so may result in disciplinary procedures being instigated, and you will not be covered by the University's indemnity if you do not have approval in place.

- You should have completed every section of the form

- The Signature Sections must be completed by the Principal Investigator (the supervisor and the student if it is a student project)

Project Title:
What are the experiential and phenomenological processes over time in the lives of adult female survivors of gender-based violence that impact on recovery?
Short Project Title (no more than 80 characters):
What processes are involved in recovery from gender-based violence?
Name of Principal Investigator(s) (*all* students are required to apply jointly with their supervisor and all correspondence will be with the supervisor):
Katharine Craib (Researcher) Internal Supervisor: [redacted] External Supervisor:
Post Held (including staff/student number):
Katharine Craib is a Chartered Counselling Psychologist

[redacted] is a Professor of Psychology
Department(s)/School(s) involved at City University London:
Psychology Department
If this is part of a degree please specify type of degree and year
Doctor of Psychology Research (Post Chartered Conversion)
Date of Submission of Application:
09.06.2014 Re-submission 08.09.2014

1. Information for Non-Experts

Lay Title (no more than 80 characters)

What is involved in the recovery from gender-based violence for adult women?

Lay Summary / Plain Language Statement (no more than 400 words)

NOTE: Ellsberg and Heise (2005) is frequently referenced in this document. This does not indicate reference to single authors only. The text is "Researching Violence Against Women", which is published by the World Health Organisation. It is a collaborative text from multiple authors, who will be referenced appropriately with any direct citation.

The term "gender-based violence" is increasingly being used internationally as it largely stems from women's subordinate status in society in relation to men. The United Nations (1993) defines this as harmful behaviours directed against women because of their sex, including "wife abuse, sexual assault, dowry-related murder, marital rape, selective malnourishment of female children, forced prostitution, female genital mutilation, and sexual abuse of female children," (Ellsberg and Heise WHO 2005).

This is a study which will look at significant life events and relationships in female survivors of gender-based violence to understand what has contributed to or hindered their recovery. Violence most commonly committed against females differs critically from that frequently committed against men, (Ellsberg and Heise WHO 2005), hence the sample will be women only, aged 18 and upwards.

This is a study which seeks to understand the essence of women's experiences in their recovery from gender-based violence. There will be an action-research component where learning opportunities will be identified out of meanings identified. These learning opportunities will then be provided to the participant by the researcher by means of the therapeutic relationship, the possible benefits reflected on, and the opportunities adapted accordingly, thus bringing together action and reflection, theory and practice.

Recovery will be determined from the perspective of the individual, but there will also be simple measures of ill health and quality of life to assess progress. The researcher will work collaboratively with the participants to see what they feel they need to promote their recovery. These learning needs will be identified during individual sessions, within the context of a solid therapeutic relationship. There will be a collaborative and sensitive identification of need and an attempt to find approaches to deal with problems or alleviate distress through the use of learning new skills and/or ways of understanding, or through the medium of a therapeutic relationship, or more likely a combination of both. A number of possible learning opportunities are listed in section 3.2 below. This list may not be comprehensive as the needs are not yet identified. Participants will be invited to join in a reflective process to identify what helps them move to their own understanding of recovery, and what is required to make further progress.

This will include reflection on any learning opportunities, the researcher behaviour and attributes including the therapeutic relationship, and any other possible effects which contributed towards the promotion of recovery.

The researcher is an experienced psychologist, with a lot of experience in working with gender-based violence, and has previously run skills programmes for survivors of abuse with good success. The researcher has a breadth of skills and knowledge to be able to safely manage any trauma symptoms. These are based on existing therapeutic modalities such as CBT (including trauma focussed CBT) and DBT: the researcher is an accredited therapist in both areas. It is acknowledged that Trauma Focussed CBT involves a focus on the trauma. As and when traumatic incidents arise or there is evidence that traumatic symptoms need addressing, the researcher will use existing knowledge and skills to address these needs, which at times may involve directly talking about the trauma. What the researcher will not do is probe for any personal interest, or for the sake of the study. Should participants become distressed and not wish to proceed, or not wish to talk to the researcher, they will be offered alternative supportive counselling.

The focus of the study is to promote autonomy and well-being of the women, to help them find ways to manage their distress and difficulties more effectively.

2. Applicant Details

This project involves:

(*tick as many as apply*)

☐	Staff Research	X	Doctoral Student

☐	Undergraduate	☐	M-level Project
☐	Externally funded	☐	External investigators
☐	Collaboration	☐	Other
Provide details of collaboration and/or other			

Address for correspondence (including email address and telephone number)

(Principal Investigator)

Katharine Craib

Student Number: 130048840

katharine.craib@yahoo.com

Other staff members involved

Title, Name & Staff Number	*Post*	*Dept & School*	*Phone*	*Email*
Carla Willig	Professor of Psychology	Psychology		[redacted]

All students involved in carrying out the investigation

Name & Student Number	*Course / Year*	*Dept & School*	*Email*

External co-investigators

Title & Name	*Post*	*Institution*	*Phone*	*Email*

Please describe the role(s) of all the investigators including all student(s)/external co-investigator(s) in the project, especially with regards to interaction with study participants.

There is a sole researcher, Katharine Craib. The research is completely overt in nature, with the researcher adopting the role of participant-observer, and a facilitator of learning during the action-research component. The role will entail the researcher being in a research and therapeutic relationship simultaneously, and there is no clear division between these roles. This will entail spending time with the selected participants in a Women's Refuge, initially an hour per participant per week, increasing if the participant finds it helpful.

The initial role of the researcher will involve the selection of participants in collaboration with the Manager of the Refuge, (see point 4.2 below).

During the time spent with the participant the researcher will have a number of roles including:

- Ensuring initial informed consent which will constitute a signed agreement, and on-going consent. Ensuring the participant understands the purpose and nature of the research study, their right to withdraw at any time, and how their safety, their confidentiality, and their well-being will be protected at all times.
- The researcher will have an on-going role to ensure the safety and well-being of the participant and of herself, and to take action if indicated.
- Establishing a good therapeutic relationship with the participant, identifying any barriers or therapy-interfering behaviours. These will not preclude participation in the study but will be observed.
- Administering the qualitative assessment measures (described in section 3.2 below), and analysing these. There will be an iterative process of data collection and analysis throughout the study.
- Continuing to engage with the participant for as long as she chooses with a cut off at the two-year point. The total time available will be made clear at the outset, and endings will be planned well in advance and sensitively managed.

- The researcher will be a facilitator of the learning process and the production of knowledge, not a director.
- Writing up the project and disseminating findings.

The researcher holds professional indemnity insurance, a certificate of which is available on request.

If external investigators are involved, please provide details of their indemnity cover.

Application Details

2.1 Is this application being submitted to another ethics committee, or has it been previously submitted to an ethics committee? *This includes an NHS local Research Ethics Committee or a City University London School Research Ethics Committee or any other institutional committee or collaborating partners or research site.* (See the guidelines for more information on research involving NHS staff/patients/ premises.)

YES ☐ NO X

If yes, please provide details for the Secretary for the relevant authority/committee, as well as copies of any correspondence setting out conditions of approval.

2.2 If any part of the investigation will be carried out under the auspices of an outside organisation, e.g. a teaching hospital, please give details and address of organisation.

The research will be carried out at a Women's Refuge.

Address deleted.

Whereas there is a specific location for the refuge, this is the address the organisation are happy to be released.

2.3 Other approvals required – has permission to conduct research in, at or through another institution or organisation been obtained? YES X NO

If yes, please provide details and include correspondence

There are currently no other governance issues relating to the Refuge, however, this is under review, and I will keep abreast of this through liaison with the manager at the Refuge, and will update the Committee as required.

Please see below the email confirmation received from the manager of the Women's Refuge, and copied with permission, also providing information on the selection of participants. For further information on selection, please see Section 4.2

X Text deleted to protect confidentiality
X
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2.4 Is any part of this research project being considered by another research ethics committee? YES ☐ NO X

If yes, please give details and justification for going to separate committees, and attach correspondence and outcome

2.5 Duration of Project

Start date: 2014 Estimated end date: 2017

Funding Details

2.6 Please provide details of the source of financial support (if any) for the proposed investigation.

Self-funding

2.6a Total amount of funding being sought:

2.6b Has funding been approved? **YES** ☐ **NO** ☐

If no, please provide details of when the outcome can be expected

2.6c Does the funding body have any requirements regarding retention, access and storage of the data? **YES** ☐ **NO** ☐

If yes, please provide details

International Research

2.7 Is any part of the research taking place outside of England/Wales? (if not go to section 3) **YES ☐ NO X**

If yes, please provide details of where

2.7a Have you identified and complied with all local requirements concerning ethical approval & research governance*? **YES ☐ NO ☐**

There are no other governance issues applicable to the Refuge at presence, but this is currently being reviewed, and the Researcher will update the Committee on any changes.

2.7b Please provide details of the local requirements, including contact information.

2.7c Please give contact details of a local person identified to field initial complaints local so the participants can complain without having to write to or telephone the UK

*Please note many countries require local ethical approval or registration of research projects, further some require specific research visas. If you do not abide by the local rules of the host country you will invalidate your ethical approval from City University London, and may run the risk of legal action within the host country.

3. Project Details

3.1 Provide the background, aim and explanation for the proposed research.

"Violence against women is the most pervasive yet under-recognized human rights violation in the world" (Ellsberg and Heise WHO 2005). Gender-based violence is

associated with serious health problems for women, thus there are significant resource implications for health providers. This is at a time when health providers in the UK are stretched beyond their resources.

This research is being proposed in light of current NHS conditions in respect to mental health diagnoses, and treatments subjected to Payment by Results, where there are fixed sessions allocated to clients. Whereas this may be beneficial in some circumstances there is a lack of specific clinical intervention which has been researched in respect to recovery from gender-based violence.

The aim of the study is to understand the essence of experiences in relation to recovery from gender-based violence, thus Phenomenology is the underpinning psychological tradition. From this understanding there will be a participatory action-research component where the researcher and the participant will seek to identify interventions and learning opportunities which are helpful to promote the recovery and empowerment of the individual.

It is recognised that knowledge gained from one sample group cannot automatically be applied to another group or individual without understanding the broader individual and cultural context, however this study will offer an opportunity to gain a deeper understanding of the phenomena involved in recovery, and an opportunity to transpose this understanding into learning opportunities which can be tested in within the context of the therapeutic relationship.

3.2 Provide a summary and brief explanation of the design, methodology and plan for analysis that you propose to use.

DESIGN

This is an in-depth phenomenological study which proposes to use Participatory Action Research as a design frame. The research is within a framework of learning and action, and takes the knowledge and experiences of the participants as a point of reference. It will use therapeutic and educational techniques to stimulate reflection and to create learning opportunities with a view to motivating individuals to act to address or alleviate their own problems and distress where they can, thus empowering the individual and contributing to social change.

METHODOLOGY

Data will be collected through the following methods:

- Participant-Observation – the researcher will actively participate in the sessions with the participants, and will make notes on observations of the participant, any unusual detail regarding the participant or context, verbatim comments recorded with permission only, and any incongruities.
- Semi-structured interviews to collect information about historical events, opinions, interpretations and meanings.
- Life history questionnaires which will act as an interview guide

- Time Line – using information obtained from the life history questionnaire, to explore trends over time and important events leading up to certain changes; personal experiences for example, when the abuse started and any actions the participant took or help received. This will be without judgement.

- Venn Diagram – to understand social distance in terms of organisations and institutions relevant to the participant, in addition to neighbours and other family members. There will be no identifying data recorded.

- Ranking – to help participants prioritize problems and possible solutions. This will be carried out at the start of the intervention and towards to end to identify any changes in beliefs over the course of time.

- Field Log to record Researcher's observations, reflections, feelings and interpretations. The Researcher will make personal reflections on the general environment of the Refuge, for example, a description of the physical surroundings, what can generally be seen, (e.g. the view from the window") and heard, (e.g. "the sound of voices in the background"), but will not make observations on anyone that has not given consent to participate in the research.

- Simple clinical measures on ill-health and well-being which will be administered at the start and towards the end of the intervention.

- An evaluation questionnaire will be created throughout the study listing learning opportunities identified, and any researcher / therapeutic relationship characteristics. This will be administered towards the end of the engagement, and the participant will be asked to comment on what was most helpful or not. This will link in with the Ranking described above.

- Notes will be written up within 24 hours.

From the Researcher's past clinical experience possible learning opportunities which may be helpful are listed below:

- Understanding concepts of trust, healthy versus unhealthy relationships, what is abuse, what are the effects of abuse, what is recovery (participants own definitions), what are healthy relationships, what is required to build these.
- Looking at behaviours which may interfere with recovery, for example, repeatedly getting drunk, the use of illicit drugs, self-harm. Understanding avoidance behaviours.
- Emotional regulation skills, including mindfulness, distraction, description techniques, controlled breathing techniques and muscle relaxation, self-soothing skills, the concept of emotional mind versus reasonable mind – many of these arise out of Dialectical Behaviour Therapy in which the researcher is an accredited therapist. Managing guilt, self-hatred, understanding issues of responsibility, moving forwards from these.
- Managing unhelpful thinking styles – identifying negative automatic thoughts and working with these and underlying beliefs, to develop more adaptive and helpful thinking styles. This will follow typical Cognitive Behaviour Therapy, the researcher is a fully accredited Cognitive and Behaviour Therapist.
- Specific skills to manage trauma symptoms, if required, for example, managing flashbacks, nightmares, dissociative symptoms, through the use of grounding techniques, positive imagery skills, trauma-focussed cognitive behaviour for

resistant problems causing distress (Researcher is BABCP accredited, and has extended training in managing PTSD symptoms). There will be the use of schema modes, for example, identifying inner child needs, and developing the concept of the participant as a "healthy adult" to care for these needs.

- Practical skills coaching in maintaining a healthy diet, exercise and its relation to stress, the use of behavioural approaches to introduce these into the participants lifestyle. Developing healthy sleeping routines.
- Specific skills to build healthy relationships, and what can get in the way of these. Developing interpersonal skills.
- Assertiveness skills
- Looking at perspectives of self, concepts of identify and agency, shaping these into concepts which are healthy and helpful to the participant.

The focus of the intervention is to be led by the participants, so that they can identify needs and learning opportunities which the Researcher may not be aware of. The Researcher will then seek to facilitate learning, with opportunities to reflect on what is useful, and what isn't, and how much time is spent on different things. The point is that it is not prescriptive, it is participant led and participant focussed.

A therapeutic relationship will be maintained throughout the whole process, and aspects of this which are helpful / not helpful will be reflected on and addressed on a continual basis.

ANALYSIS

The researcher will make use of the framework put forwards by Ulin et al (2002) for the purpose of data analysis. This includes four processes: data reading, coding, reducing and displaying, and all informing a constant process of phenomenological interpretation. There will be an iterative process between data collection and analysis throughout the study. To ensure rigor during analysis, the researcher will use member checking, where codes developed, conclusions and interpretations will be reflected back to the relevant participant to ensure truth value, applicability and consistency, as well as reducing researcher bias. The researcher will make use of triangulation where possible, if there are any other data sources such as personal diaries.

3.3 Please explain your plans for dissemination, including whether participants will be provided with any information on the findings or outcomes of the project.

The participants will be offered an executive summary. The research will be disseminated in academic journals and other academic and professional outlets which are open to anyone to access. It will be sent to relevant local women's groups and networks. It is hoped that there may be an opportunity to contribute towards specific NICE guidance in relation to gender-based violence at a later date.

3.4 What do you consider are the ethical issues associated with conducting this research and how do you propose to address them?

With this research there are issues of confidentiality, the need to ensure adequate and informed consent, possible problems of disclosure, as well as maintaining the safety of participants and the researcher. It is also highly likely that the process of the data collection will trigger a recall of traumatic events. There is a possibility of emotional dependency on the researcher. There is a risk to the researcher of bearing witness to distress.

This study will adhere to the Ethical and Safety Recommendations for Domestic Violence Research as laid out by the WHO (1999) as well as the basic ethical principles of bio-medical research of: respect for persons, non-maleficence, beneficence, and justice.

In particular the following points:

Confidentiality

Privacy will be protected, the sessions will always take place in a private room at the Refuge. There are two closable doors to the room to prevent outside listeners. All data will be anonymised. No records will be made of any personal details of the participant, except their first name, which will be altered for the purposes of writing up and any original record of their first name will be destroyed.

The need to balance autonomy with protection of vulnerable persons is acknowledged. The exceptions to confidentiality will be explained at the outset and include: planned harm to self, planned harm to another. If either event were identified, the manager of the Refuge would be advised, who would then complete a referral to relevant local authorities according to local protocol. The researcher would assist in this referral as required. The maintenance of safety is a higher priority than continuing in the study: if the action arising from the referral necessitated the participant to withdraw from the study she would be provided with alternative support as able, by means of referral.

Specific statements, verbatim comments, will only be re-produced with participant consent, and will not identify the identity of the speaker, including third parties. Participants will be specifically requested not to discuss anything outside of the sessions. Material will not be discussed with staff unless it meets requirements for a breach in confidentiality. All notes taken will be kept in a locked cupboard in a locked office. There will be no information stored on computer which reveals the identity of participants.

Adequate and Informed Consent

Women will be advised that their attendance in the study is entirely voluntary and they can leave at any point without penalty, where they would be offered additional support from in-house workers and ministers of faith who visit the Refuge, as required. A referral to another local support group / service would also be made by the researcher if required.

Women will be made aware of the purpose of the study, and the nature thereof. It will be made clear at the outset that this may involve conversations regarding sensitive personal information to do with violence and abuse. Women will be advised that they can end the interview or session at any time, and can choose not to answer any questions or prompts put to them by the researcher. These points will be re-emphasised throughout the study

Women will be asked to sign a written consent form, a copy of which will be provided to them at that same meeting. They will be asked when they would like to begin to participate in the study, and when is a good time to talk.

It is acknowledged that the Refuge is the (temporary) home of the participants, and in this way could be intrusive. Thus the sessions will only take place in the designated room, which is away from the residential area. There will be no observation of residents who are not involved in the study

Disclosure

There is a duty to report disclosure of possible child abuse to relevant authorities. This study is not directly working with children, however, it is possible that the participants have children. Any disclosure would be handled sensitively but the safety of the child would be paramount. The need to do this will be made clear at the outset. There will not be questions relating to abuse of the women's children. With the exception of this, everything will be done to promote the women's autonomous decision making. If the women disclose their own previous child abuse there will be no disclosure made to authorities so long as the woman continues to be free from risk. However, if the woman chooses to make a report to authorities she will be supported in doing this. Risk will be monitored on a session by session basis, and the researcher is qualified to do this.

Maintaining safety of researcher and participants

The women have already left their own homes to be protected by the anonymity and physical security of the Refuge, and are encouraged to maintain the privacy of their own whereabouts. If they choose to return to the place where the abuse has taken place this will mean that they are no longer able to participate in the study, however they will be offered alternative support local to them if required. This is to protect their safety, the safety of the researcher, as well as the difficulty of geographical location as many are from out of area.

The risk to the researcher is minimised due to the secure location within the Refuge. The researcher will not reveal her address or other movements

Recall of Traumatic Events

Participants will be able to talk about their own trauma if they choose to. The extent to which this is helpful will be reflected on, and needs and learning opportunities arising out of this will be identified. There will be no blame or judgement. These needs might be strategies to manage flashbacks, nightmares, strategies to change unhelpful thinking styles, and patterns of rumination. A more comprehensive list is provided in Section 3.2. The focus of this study is to promote recovery, seeking to maintain a therapeutic relationship and to offer learning opportunities to seek alleviate pain and discomfort.

Should the participants become distressed and not wish to talk to the researcher they will be offered alternative supportive counselling. Each participant is assigned a key worker in the Refuge who is there to provide practical and emotional support. There are other multi-faith support workers and ministers who regularly visit the Refuge and offer supportive counselling. If none of these options were considered suitable, then the participant would be offered a referral to an outside counselling agency. Participants are free to withdraw from the study at any point without any penalty. Options for the alternative counselling would be provided, as described above.

Emotional Dependency

There is a possible risk of participants developing a dependant relationship with the researcher because of their level of emotional need. The study seeks to promote autonomy of the participants in managing their own recovery. The researcher is aware of signs of individuals becoming overly dependent, for example, not engaging in thinking things through for themselves, always seeking the researcher's point of view, adopting a passive role. The researcher is skilled in managing these things through her use of reflection, and motivational skills, and maintaining an awareness that these women are breaking free from dependant relationship styles. The researcher will seek to facilitate individual personal growth through the use of the therapeutic relationship and empowering the participant with knowledge about recovery from trauma and abuse, and providing learning opportunities to manage difficult symptoms. The goal of becoming independent will be held at a fore.

The researcher will manage the professional relationship with the risks of dependency in mind, and will keep clear boundaries in respect to: time, for example containing each visit to previously agreed time; space: for example there is a designated room where meetings with the participants will take place, the researcher will not make observations of participants outside of that room; the use of self-disclosure: this would only be in instances where it is believed that it would therapeutically benefit the client; and maintaining an approachable, but professional relationship at all times.

Bearing witness to distress.

The Researcher is highly likely to be exposed to distressing material. This will be managed through the use of her Field Log and through supervision with her Research Supervisors. The Researcher is aware of the risks of vicarious traumatisation, and is aware of ways to self-care. Maintaining supervision will reduce the risks of losing objectivity.

3.5 How is the research intended to benefit the participants, third parties and/or local community?

It will benefit the participants for the following reasons:

1. They will have an opportunity to be heard, and to tell their story if they wish
2. They will be engaged in an empathic and supportive (professional) relationship with the researcher, the endings of which will be sensitively managed.
3. They will be empowered to identify their own definition of recovery, their own needs, and from this identify what they think will help to address these needs.
4. They will then receive the intervention, and have an opportunity to reflect back on any further changes which are required.

1. It is anticipated that this is a study where the findings can be widely disseminated into the community, into services including the NHS to develop the interventions specifically tailored to the recovery from gender-based violence.

3.6a Will invasive procedures (for example medical or surgical) be used?

YES ☐ NO X

3.6b If yes, what precautions will you take to minimise any potential harm?

3.7a Will intrusive procedures (for example psychological or social) be used?

YES ☐ NO X

3.7b If yes, what precautions will you take to minimise any potential harm?

3.8a In the course of the investigation might pain, discomfort (including psychological discomfort), inconvenience or danger be caused? YES X NO ☐

3.8b If yes, what precautions will you take to minimise any potential harm?

It is highly likely that the participants are already experiencing psychological discomfort and emotional pain prior to the commencement of the study. The study is designed to address / alleviate this suffering and pain as detailed above. It is acknowledged that women in the Refuge are free to talk to one another regardless of whether there is a study taking place or not. Participants on the study will be encouraged not to talk about traumatic experiences with each other because of the risks of re-traumatising, rather they will be encouraged to talk to each other in ways that provide support.

3.9 Please describe the nature, duration and frequency of the procedures?

The Researcher will meet with the participants once a week for the duration of an hour. This will continue for as long as the participant finds it useful, but for no more than 2 years. The expected average duration is 6 - 12 months, reflecting the average stay at the Refuge. During this time, data will be collected through the methods described in Section 3.2, as well as observation of the participant's reactions, feelings, levels of distress, ability to engage with new learning, and ability to engage in a therapeutic relationship. Each session will be managed by the Researcher to prevent emotional overload of the participant, ensuring that they have opportunities to learn how to

manage and contain emotion in a way that is helpful to them. If a participant requires additional time, she will be offered this.

4. Information on participants

4.1a How many participants will be involved?

8-10

4.1b What is the age group and gender of the participants?

Over 18 years of age, all female. The Refuge only accommodates females, (with the exception of children) and the research would only be carried out at this single Refuge. There is no assumption made that abuse and violence only affects females, but this study is only focussing on females due to the specific forms of violence that more commonly affect females. The Researcher acknowledges the limitations of the study in terms of transferability in respect to gender.

4.1c Explain how you will determine your sample size and the selection criteria you will be using. Specify inclusion and exclusion criteria. If exclusion of participants is made on the basis of age, gender, ethnicity, race, disability, sexuality, religion or any other factor, please explain and justify why.

As a qualitative study 8-10 is reasonable in light of the depth of material which is being sought. Sampling will be purposive. The manager of the Refuge would be actively involved in identifying suitable participants, through her existing knowledge. Suitability would be determined on the basis of the participant expressing an interest in seeking ways to promote her own recovery. This may be expressed to staff at the Refuge or to the Researcher arising from a general awareness in the Refuge that the study is taking place.

Exclusion criteria:

If the woman continues to be in an abusive relationship. This is a criteria for entrance to the Refuge, they have to have already left the abuser. It is also to protect the woman. Although there is the possibility of participants returning to the abuser this action means that they automatically leave the Refuge, although they can return if they subsequently leave the abuser again. If they returned to the abuser it would necessarily mean that they no longer continue on the study. Alternative options for counselling outside of the Refuge would be provided. However, the desire to return will be identified as a need, and skills be taught in terms of making decisions from a rational perspective,

and managing conflicting emotions. Participants will never be told what they should or should not do, but will be encouraged in the development of their own autonomy and agency.

If a participant is identified as actively suicidal / high risk of self-harming, they will be referred to local mental health services for appropriate intervention and management. Assessing this risk is the responsibility of the staff at the Refuge, but equally if this risk was identified by the Researcher, who is trained in risk assessment and management, and has extensive experience working with high-risk individuals, this would be considered grounds for breach of confidentiality, and appropriate referrals made.

Residents with significant dependency on drugs or alcohol will be excluded, "significant" being determined by the frequency of intoxication: individuals who are intoxicated on a daily basis would benefit from a referral to a Drugs and Alcohol team for help with managing their dependency, prior to be considered for the study. Individuals would need to be able to demonstrate that they could arrive for a session free of intoxication.

Having a severe and enduring mental illness will not exclude residents from the study, unless it is believed by the researcher that their condition would be better managed elsewhere, determined by the prevalence and severity of presenting symptoms. There is no exclusion on the basis of religion, ethnic grouping, disability, or sexuality.

If a woman was not suitable for the study she would be provided with an appropriate referral to an organisation which could better meet her identified needs. The Researcher would identify this at the initial point of contact, and would make the referral as required.

The Refuge only accepts females over 18 years of age, in addition to children. No-one under 18 years of age will be considered for the study. By her presence in the Refuge, the participant will have experienced gender-based violence.

4.2 How are the participants to be identified, approached and recruited, and by whom?

There will be a general awareness that the study is taking place in the Refuge, an awareness promoted by the staff at the Refuge, having been informed by the Researcher. Anyone expressing an interest will be offered the opportunity to talk further with the researcher. Residents will be provided with as much time as they need to consider whether they want to participate or not, they will be free to approach the researcher on the scheduled day that she will visit the Refuge to agree to participate or not. Each resident expressing an interest in the study will be provided with the information sheet and a sample consent form prior to recruitment to the study. When they have given their verbal consent they will be asked to sign the consent form. The study will then begin for that individual at a mutually agreed time.

4.3 Describe the procedure that will be used when seeking and obtaining consent, including when consent will be obtained. Include details of who will obtain the consent, how are you intending to arrange for a copy of the signed consent form for the participants, when will they receive it and how long the participants have between receiving information about the study and giving consent.

A copy of the consent form and information sheet are attached. Those that are interested will then be considered by the Researcher to assess for suitability. Suitability will be determined according to the information provided in 4.1c. The study will be fully explained, and informed consent will be obtained prior to any data collection. Participants will be asked if they would like time before signing the consent form and also when they would like to begin. They will be provided with a copy of their signed consent form at the time of signing. If a resident reaches the point of talking with the researcher about the study, and the researcher identifies at that point that she is not suitable, the resident will be offered alternative provision, in liaison with the manager, according to their assessed needs, for example a referral to the Drugs and Alcohol team. This will not preclude them being considered for the study at a later point.

It is acknowledged that there may be an over-demand for the study, due to its therapeutic component. The manager is aware of the weekly capacity of the researcher to engage with participants so a maximum of 4 ladies will be engaged with at any one point. The capacity of the researcher will be explained to other interested residents, and they will be held on a waiting list if required. Whilst on the waiting list they will be offered a referral to other local support agencies as required. The researcher is proposing to take 18 months to two years to work with the residents. This will also be made clear to participants in advance, particularly as time progresses, and participants are involved closer to the closing time for data collection. However, no engagement with the participant will be ended abruptly, rather the ending will be managed sensitively according to the participant' needs.

4.4 How will the participant's physical and mental suitability for participation be assessed? Are there any issues related to the ability of participants to give informed consent themselves or are you relying on gatekeepers on their behalf?

The mental capacity of the participants to give informed consent will be established at the initial meeting with the Researcher, who has received training on assessing mental capacity. If there was any question regarding the ability to give informed consent then the resident would not be considered for the study, and alternative support will be offered, for example engagement with the resident's key worker at the Refuge. Residents will not be excluded on the grounds of poor physical health. If health problems were a prominent issue, the resident would be encouraged to address these as best she was able prior to taking part in the study, and to seek medical advice from her GP. It is not anticipated that the study will cause any undue physical effects. The interventions, such as controlled breathing techniques, relaxation, mindfulness, are very likely to have a beneficial physical effect. The physical effects commonly associated with emotional trauma are increased arousal of the autonomic nervous system. The interventions listed above, plus other cognitive interventions, listed under 3.2 have the ability to reduce increased autonomic arousal, by altering unhelpful cognitions, and increasing the participant's ability to control their own body responses, for example, reducing an increased heart rate as a result of anxiety or stress. Increased perception of pain at a particular site as a result of abuse will be identified as an internal cue for a stress response, and this will be managed through reducing the negative impact of the specific event through working with underlying cognitions, reducing the traumatic memory through alternative positive imagery techniques, facilitating emotional and physical self-care by the use of the interventions listed in 3.2. Any physical wounds of illnesses will be dealt with by primary care services as appropriate.

The Researcher is also a qualified nurse and is competent to assess for and differentiate between physical effects which are associated with an emotional trauma response, and physical effects due to any ill health or injury which may require medical intervention, which would then be sought.

4.5 Are there any special pressures that might make it difficult to refuse to take part in the study? Are any of the potential participants in a dependent relationship with any of the investigators (for instance student, colleague or employee) particularly those involved in recruiting for or conducting the project?

The study is entirely voluntary, and this will be expressly stated. There are no dependent relationships between the researcher and any participants, or anyone at the Refuge. It is acknowledged that the participants may feel a pressure to stay involved due to the benefits of the therapeutic relationship. The depth of therapeutic relationship cannot be guaranteed to be provided elsewhere as it is a feature of this study, that the researcher is providing as much time and focus as the individual requires. It cannot be guaranteed that this can be provided elsewhere, thus this risk cannot be minimised, however, any participants wishing to leave the study will be provided with a referral to other support groups / agencies as required. Part of the focus of the study is to look at the ability of participants to make independent choices, and this will always be stressed. This includes their on-going consent to be involved in the study, which will be assessed by the Researcher on a session-by-session basis. Prior to any discussion surrounding violence or trauma the participant will always be given the option to decline to talk about it. The researcher will also manage the amount the participant talks about any trauma by observing signs of hyper-stimulation / over-arousal and will facilitate the use of skills to manage this, e.g. relaxation, guided imagery. They will be shown how to weigh up different options, for example, whether to stay in the study or to leave, and will be encouraged to make their choice according to what they consider most beneficial at the time. They will not be told what is deemed to be most beneficial by the researcher.

4.6 Will the participant's doctor be notified? **YES ☐ NO**

(If so, provide a sample letter to the subject's GP.)

Only at the participant's discretion.

4.7 What procedures are in place for the appropriate referral of a study participant who discloses an emotional, psychological, health, education or other issue during the course of the research or is identified by the researcher to have such a need?

The researcher understands that this study is highly likely to involve distressing thoughts and feelings, which may be triggered by asking when the abuse began / ended, but also about any significant events and relationships in the participant's life, or just by being in the study. Equally, distressing thoughts and feelings may be particularly dominant because the participant is struggling to find ways to manage them. The nature of the study seeks to find ways to alleviate emotional and

psychological need, and has come about due to the lack of specific interventions for this client group. Psychological and emotional distress will be readily engaged with by the researcher who will seek to maintain an empathic and congruent and non-judgemental position throughout. The researcher will offer learning opportunities as identified by the participant to facilitate the alleviation of distress. These possible learning opportunities are detailed in Section 3.2, and will be provided within the context of a therapeutic relationship. The researcher is trained and experienced in engaging sensitively with other survivors, able to take an objective position as well as engage with the subjectivity of others.

Should any of the participants become distressed, and not want to engage with the researcher they will be provided with an alternative contact / referral whereby they can obtain supportive counselling. There are other voluntary counselling services provided at the Refuge, by a trained counsellor, and various multi-faith ministers. It is unlikely that these services will equate to the provision within the study, as this is an identified gap in service provision. There are other local services provided in the area, such as the Freedom intervention, which all residents / participants have access to through the Refuge. Should an education or health need become apparent the Researcher will take this up with the residents' / participants' key worker at the Refuge for an appropriate referral.

4.8 What steps will be taken to safeguard the participants from over-research? (I.e. to ensure that the participants are not being used in multiple research project.)

It will be clarified that they are not currently engaged in any other research, or have any plans to join a research project in the near future.

4.9 Where will the research take place?

At a Women's Refuge DELETED The exact address is withheld at the preference of the Manager, however, she can be contacted through the following address: DELETED

4.10 What health and safety issues, if any, are there to consider?

There is a potential risk of violence to the researcher from the participants as a result of possible transference issues and projection, and difficulties in emotional regulation. A risk assessment will be carried out for each participant prior to the study starting. A risk assessment of the room will also be carried out to ensure adequate safety procedures. The researcher is competent to carry out such a risk assessment.

There is a security system within the refuge, and other staff are always present nearby. The Researcher is trained and skilled to assess for potential anger and/or violence and is trained at diffusing this.

There is also the potential for the researcher to experience vicarious traumatisation. The use of supervision, and the maintenance of a field log, not disclosing any details regarding the study or participants, just the researcher's own thoughts and feelings, will be used to manage this.

4.11 How have you addressed the health and safety concerns of the participants, researchers and any other people impacted by this study? (This includes research involving going into participants' homes.)

The Refuge is acting as a temporary home for the residents / participants. The Researcher will not enter the residential part of the Refuge, unless specifically invited to do so. The meetings with participants will be carried out downstairs in a private room near to the staff offices, to minimise intrusion into the participants' personal space. The safety and well-being of the researcher will be safe-guarded by the presence of other staff at the Refuge, and through the use of supervision. Any impact on the psychological and/or physical well-being of the participants has already been discussed in 4.7

4.12 It is a University requirement that an at least an initial assessment of risk is undertaken for all research and if necessary a more detailed risk assessment be carried out. Has a risk assessment been undertaken?* **YES X NO ☐**

4.13 Are you offering any incentives or rewards for participating? **YES X NO ☐**

If yes please give details

1. They will have an opportunity to be heard
2. They will be engaged in an empathic and supportive (professional) relationship with the researcher, the endings of which will be sensitively managed.
3. They will be empowered to identify their own needs, and from this identify what they think will help to address these needs.
4. They will be provided with learning opportunities, and have chance to reflect back on any further opportunities which are required.

*Note that it is the Committee's prerogative to ask to view risk assessments.

5. Vulnerable groups

5.1 Will persons from any of the following groups be participating in the study? (if not go to section 6)

Adults without capacity to consent	☐
Children under the age of 18	☐
Those with learning disabilities	☐
Prisoners	☐
Vulnerable adults	**X**
Young offenders (16-21 years)	☐
Those who would be considered to have a particular dependent relationship with the investigator (e.g. those in care homes, students, employees, colleagues)	☐

5.2 Will you be recruiting or have direct contact with any children under the age of 18?

YES ☐ NO X

There are children in the Refuge, however, none will be recruited for the study, and none will be either directly or indirectly observed, with the exception of noting any sounds heard, for example “I heard the sound of shouting…” The staff at the Refuge are primarily responsible for managing safeguarding issues at the Refuge, and have clear procedures in place for doing this.

5.2a If yes, please give details of the child protection procedures you propose to adopt should there be any evidence of or suspicion of harm (physical, emotional or sexual) to a young person. Include a referral protocol identifying what to do and who should be contacted.

Should the Researcher have any concerns regarding witnessing or hearing about anything which would require Safeguarding measures she would discuss these concerns with the Manager, who would follow the Safeguarding procedures laid out in the Refuge’s protocols. There is no requirement that the Researcher make a referral to the Safeguarding team, as this will be handled by the manager, however the Researcher would provide relevant information as able. Issues surrounding disclosure are discussed in Section 3.4

5.2b Please give details of how you propose to ensure the well-being of the young person, particularly with respect to ensuring that they do not feel pressured to take part

in the research and that they are free to withdraw from the study without any prejudice to themselves at any time.

5.3 Will you be recruiting or have direct contact with vulnerable adults? YES X NO ☐

5.3a If yes, please give details of the protection procedures you propose to adopt should there be any evidence of or suspicion of harm (physical, emotional or sexual) to a vulnerable adult. Include a referral protocol identifying what to do and who should be contacted.

There are already protection procedures in place due to the nature of the client group being in a Refuge as a result of gender-based violence. The Researcher is aware of these procedures, and will adhere to the policies and protocols of the Refuge for the maintenance of safety at the Refuge, for example, maintaining the anonymity of the address, however, she will not be required to make any referrals in respect to Safeguarding, as these will all be managed by the Manager. The women are placed out of area to their normal residency, and the Refuge is a place of safety from further harm from previous abusers. Should there be any additional disclosure involving current abuse, or the intention of the woman to return to an abusive relationship, or the intention to begin another abusive relationship, or planned harm to self or another or a minor, the manager of the Refuge, DELETED, will be notified. Should the woman be deemed by the researcher to not have mental capacity to make informed choice, e.g. regarding whether or not to return to an abusive relationship, or begin a new one, the researcher, who is trained to assess mental capacity, will make this assessment, and will then inform the manager of the refuge who will inform the local Safeguarding Team within the Community Mental Health Service. The rules of confidentiality, and the reasons for breach of this, for example: potential or actual harm to self or another, will be made explicit at the start of the intervention, and at the time if it is felt that the participant is about to make a disclosure. These are further detailed in section 3.4.

5.3b Please give details of how you propose to ensure the well-being of the vulnerable adult, particularly with respect to ensuring that they do not feel pressured to take part in the research and that they are free to withdraw from the study without any prejudice to themselves at any time. You should indicate how you intend to ascertain that person's views and wishes.

Time will be taken with potential participants to ensure that they fully understand what the study involves, their choice to partake in some or all of it, their freedom to withdraw at any time, without penalty or disadvantage. It is paramount that the woman is heard

in respect to her wishes and views, particularly at this early point when seeking engagement, as this is a key focus of the study.

5.3c Please give details of any City staff or students who will have contact with vulnerable adults and/or will have contact with young people (under the age of 18) and details of current (within the last 3 years) enhanced City University London CRB clearance.

Name	*Dept & School*	*Student/Staff Number*	*Date of CRB disclosure*	*Type of disclosure*
Katharine Craib	Psychology Doctoral Student	130048840	Last disclosure dated 19/03/2010.	Enhanced disclosure. No convictions, cautions, reprimands or warnings or other relevant information disclosed.

5.3d Please give details of any non-City staff or students who will have contact with vulnerable adults and/or will have contact with young people (under the age of 18) and details of current (within the last 3 years) enhanced CRB clearance.

Name	*Institution*	*Address of organisation that requested the disclosure*	*Date of CRB disclosure*	*Type of disclosure*

5.4 Will you be recruiting any participants who fall under the Mental Capacity Act 2005?
YES ☐ NO X

If so you MUST get approval from an NHS NRES approved committee (see separate guidelines for more information).

6. Data Collection

6.1a Please indicate which of the following you will be using to collect your data

Please tick all that apply

Questionnaire	**X**
Interviews	**X**
Participant observation	**X**
Focus groups	☐
Audio/digital-recording interviewees or events	☐
Video recording	☐
Physiological measurements	☐
Quantitative research (please provide details)	☐
Other:	**X**
Please give details	Time Line – using information obtained from the life history questionnaire, to explore trends over time and important events leading up to certain changes; personal experiences for example, when the abuse started and any actions the participant took or help received. Venn Diagram – to understand social distance in terms of organisations and institutions relevant to the participant, in addition to neighbours and other family members. There will be no identifying data recorded. Ranking – to help participants prioritize problems and possible solutions. This will be carried out at the start of the intervention and towards to end to identify any changes in beliefs over the course of time. Field Log to record researcher's observations, reflections, feelings and interpretations. The Researcher will make personal reflections on the general environment of the Refuge, for example, a description of the physical surroundings, what can generally be seen, (e.g. the view from the window") and heard, (e.g. "the sound of voices in the background"), but will

	not make observations of anyone that has not given consent to participate in the research. Simple clinical measures on ill-health and well-being which will be administered at the start and towards the end of the intervention. An evaluation questionnaire will be created throughout the study listing learning opportunities identified, and any researcher / therapeutic relationship characteristics. This will be administered towards the end of the engagement, and the participant will be asked to comment on what was most helpful or not. This will link in with the Ranking described above.

6.1b What steps, if any, will be taken to safeguard the confidentiality of the participants (including companies)?

The personal data that is taken is minimal, and only consists of the person's first name and age, their ethnic group and religion. This data is only collected as, with the exception of the name, it is possible that it will impact on the findings of the study. All personal data will be kept in a locked cabinet in a locked room at the researcher's office, which is on a secure site. Following the completion of the study all identifying data will be destroyed. The write-up will be completely anonymised, and there will be nothing which identifies or compromises the participants in any way.

6.1c If you are using interviews or focus groups, please provide a topic guide

The life history questionnaire which will be used for the semi-structured interviews is attached.

7. Confidentiality and Data Handling

7.1a Will the research involve:

• **complete anonymity of participants** (i.e. researchers will not meet, or know the identity of participants, as participants, as participants are a part of a random sample and are required to return responses with no form of personal identification)**?**	☐
• **anonymised sample or data** (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the	☐

identifiers. It is then impossible to identify the individual to whom the sample of information relates)**?**	
• **de-identified samples or data** (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location)?	☐
• **subjects being referred to by pseudonym in any publication arising from the research?**	**X**
• **any other method of protecting the privacy of participants?** (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only)	**X**
Please give details of 'any other method of protecting the privacy of participants' is used	
Direct quotes will only be used with specific permission.	

7.1b Which of the following methods of assuring confidentiality of data will be implemented?

Please tick all that apply

• data to be kept in a locked filing cabinet	**X**
• data and identifiers to be kept in separate, locked filing cabinets	☐
• access to computer files to be available by password only	**X**
• storage at City University London	☐
• stored at other site	**X**
If stored at another site, please give details	The data will be stored in a locked cabinet in a locked room at the researcher's office which is on a secure site.

7.1c Who will have access to the data?

Access by named researcher(s) only **YES X NO** ☐

Access by people other than named researcher(s) **YES** ☐ **NO X**

If people other than the named researcher(s), please explain by whom and for what purpose

7.2a Is the data intended for reuse or to be shared as part of longitudinal research?
YES ☐ NO X

7.2b Is the data intended for reuse or to be shared as part of a different/wider research project now, or in the future? YES NO X

7.2c Does the funding body (e.g. ESRC) require that the data be stored and made available for reuse/sharing? YES ☐ NO ☐

7.2d If you have responded yes to any of the questions above, explain how you are intending to obtain explicit consent for the reuse and/or sharing of the data.

7.3 Retention and Destruction of Data

Anonymised data will be kept for 10 years.

7.3a Does the funding body or your professional organisation/affiliation place obligations or recommendations on the retention and destruction of research data?
YES NO X

If yes, what are your affiliations/funding and what are the requirements? (If no, please refer to University guidelines on retention.)

7.3bHow long are you intending to keep the data?

The first names of the participants will be kept for the duration of the study only, there will be no other identifiable data. Anonymised data will be kept for 10 years.

7.3c How are you intending to destroy the data after this period?

All paper records will be shredded. There will be no identifiable data stored in any other format.

8. Curriculum Vitae

CV OF APPLICANTS (**Please duplicate this page for each applicant, including external persons and students involved.)**

NAME:	Katharine Craib
CURRENT POST (from)	Chartered Psychologist since 2007
Title of Post:	Chartered Psychologist
Department:	Independent
Is your post funded for the duration of this proposal?	

Funding source (if not City University London)	Self-funding

Please give a summary of your training/experience that is relevant to this research project

Curriculum Vitae

Katharine Craib

CPsychol, QCoP, MSc (couns), MSc (psych), BSc (hons), RGN, PGC

Professional Description:

Chartered Psychologist (BPS)

Registered Practitioner Psychologist (HCPC)

Fully accredited Cognitive and Behavioural Psychotherapist (BABCP)

Registered General Nurse (NMC)

Professional and Academic Qualifications

- Chartered Psychologist, Qualification in Counselling Psychology
- MSc Counselling Psychology
- MSc Psychology: Research Methods; Child Development and Learning; Crime, Offenders and Policing
- BSc (Hons) Psychology
- Graduate Certificate in Professional Studies including Applied Intensive Care (Distinction)
- Registered General Nurse
- Certificate in Adult Community Mental Health
- Further and Adult Education Teachers' Certificate

Additional Training

- Expert Witness Training through the BPS
- PTSD
- Trauma and Domestic Violence
- Dialectical Behaviour Therapy (DBT Therapist)
- Family Therapy

Areas of Expertise (Assessment and Intervention)

- PTSD including secondary PTSD. Good experience working with military personnel, abuse victims, survivors of domestic violence.
- Personal Injury and mental health
- Physical health problems (including chronic illness), and the impact on psychological functioning, specialised in working with critically ill patients, and the severely traumatised
- Psychological problems in the aftermath of alleged clinical negligence
- The impact of criminal injury on mental health / psychological functioning
- Assessment and Diagnoses according to DSM V criteria (e.g. depression, anxiety, PTSD, personality disorders, specific phobias, adjustment difficulties, attachment, all aspects of mental health)
- Family assessments, contact, access, risk assessment
- Parenting skills and capacity, evaluation of 'good enough' parenting, assessment of risk,
- Impact of parental mental health on children, including post-natal distress
- Attachment and the parenting needs of children
- Issues around placement planning, relations with foster / adoptive parents, attachment issues, contact with birth parents / siblings, residency disputes
- Child protection issues
- Impact of all types of abuse: (emotional, physical, sexual abuse, neglect) and domestic violence, including adults and children
- Impact of alcohol and substance abuse on individuals / family members
- Risk assessment of violence
- Self-harm and suicidal ideation
- Personality disorders

Relevant Experience

Katharine has over 24 years' experience in the NHS and the private sector. This includes 13 years as a nurse in general medicine, surgery, haematology and palliative care, with 7 years specialising in intensive care and trauma. She has an excellent knowledge base of health and medical issues, the impact of chronic illness and pain, physical trauma and the critically ill, and the impact on the individual and their family. During this time she re-trained as a psychologist.

She went on to work with adoption and foster agencies as well as social care agencies, first as a foster parent and then as a therapist, providing assessment and intervention for children and adolescents in the care system, including working therapeutically with adults and children with learning difficulties. Additionally she provided assessments of parenting skills and capacity, 'good enough' parenting, the risk of abuse, and attachment issues. This involved providing evidence in the family courts. She has post-graduate training in family therapy, couples work, as well as child development and developmental disorders.

She has a further 11 years' experience working with community and inpatient mental health clients, providing assessment and intervention for all aspects of mental health. This includes working with high-risk clients: risk of suicide, self-harm, and risk to others. She is a trained dialectical behavioural therapist. She has specialised in PTSD assessment and intervention, and has run recovery programs for survivors of abuse and domestic violence.

She now runs her own business as an independent Psychologist offering Expert Witness Services as well as Individual, Couples and Group Therapy. She works with a range of models as appropriate, including Cognitive Behavioural Therapy (CBT), Trauma Focussed CBT, Dialectical Behaviour Therapy (DBT), Schema Focussed Therapy, Solution Focussed Therapy, Motivational Interviewing, and the Person Centred Approach.

Her research interest areas include:

- Secondary PTSD in health care workers
- PTSD
- Agency of the client in therapy
- Recovery from abuse and domestic violence

8.1 Supervisor's statement on the student's skills and ability to carry out the proposed research, as well as the merits of the research topic (up to 500 words)

Katharine Craib possesses the skills and ability to carry out the proposed research. She has a wealth of experience of working therapeutically with vulnerable groups of clients and she has undergone rigorous training to equip her with the skills required to contain and process difficult feelings. Katharine's academic post-graduate training has equipped her with the necessary research skills.

The proposed project is an innovative and original piece of research which has direct implications for applied psychology practice.

Supervisor's Signature	[redacted]
Print Name	[redacted]

9. Participant Information Sheet and 10. Consent Form

Please use the templates provided below for the Participant Information Sheet and Consent Form. They should be used for all research projects and by both staff and students. Note that there are occasions when you will need to include additional information, or make slight changes to the standard text – more information can be found under the application guidelines.

11. Additional Information

12. Declarations by Investigator(s)

- I certify that to the best of my knowledge the information given above, together with any accompanying information, is complete and correct.

- I have read the University's guidelines on human research ethics, and accept the responsibility for the conduct of the procedures set out in the attached application.

- I have attempted to identify all risks related to the research that may arise in conducting the project.

- I understand that **no** research work involving human participants or data can commence until **full** ethical approval has been given

		Print Name Signature
Principal Investigator(s) (student and supervisor if student project)		KATHARINE CRAIB [redacted] [redacted] [redacted]
[redacted]		
[redacted]	[redacted]	

[redacted] **Information Sheet**

CITY UNIVERSITY LONDON

Title of study What is involved in the recovery from gender-based violence for adult women?

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish, including your key worker if you choose. Please ask me or your key worker if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
This study has come about because of the amount of abuse to women in our society. It aims to understand what things can help or hinder recovery from abuse. Where things are identified that hinder recovery, for example, nightmares, the researcher will offer learning opportunities to help you manage these. Things that are identified by you that help promote recovery will be encouraged, for example, participating in exercise, eating a healthy diet, learning skills to manage difficult feelings, learning skills to help you relax.

Why have I been invited?
You have been invited to join with the study because you have identified to your key worker or the manager DELETED that you are interested in finding possible ways to help you recover from your past experiences which brought you to the Refuge. The study is only being carried out at the Refuge, therefore your participation is only for the duration that you are resident there.

Do I have to take part?
No, you do not have to take part in the study, it is voluntary. You can choose to join in some activities and not others, and can leave the study at any time without worrying about being disadvantaged or penalized in any way. You will not be forced to talk about anything you do not want to. If you no longer wish to be involved in the study at any point, you will be offered alternative services that are available in the community.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?
- This part of the study is running over two years – You can be involved for as long as you choose to up to two years.
- The researcher is Katharine Craib, a Counselling Psychologist. You will meet weekly for about an hour initially, and more frequently if you identify that this would be helpful. During this time the Researcher will make notes on discussions and conversations, and will make observations on your levels of emotional distress, how you are feeling and behaving, your ability to engage with learning opportunities, and on anything identified as either hindering or promoting your recovery.
- The person carrying out this study (Katharine Craib) will have two roles, one as a researcher, and two as a therapist, helping you to find ways to help yourself. There is no clear line between these two roles, but her role of providing a helpful place for you where you can feel safe to explore some of your difficulties will always be the most important. By signing the consent form you will be agreeing to being in a therapeutic relationship with the psychologist, but also in a research relationship, where observations and discussions will be used for research purposes.

- When we meet we will talk about significant events and relationships in your life which have affected your ability to recover from gender-based violence. You will not be asked to go through traumatic experiences that you would rather not share, but if you want to share these then you can. The Researcher will ask questions about what is helpful and what is not helpful in terms of your recovery. She will ask you what recovery means to you. She will offer you learning opportunities, such as finding ways to manage difficult emotions, to help you move towards you definition of recovery. At the end of your time with the researcher she will ask you to complete a questionnaire listing the things covered, and to comment on what you did or did not find helpful, with an option to make additional comments on the study if you require.
- This study uses a method known as Participatory Action Research which largely means that it is discovering new information and testing this out in practice.
- This research will take place at the Refuge where you are staying, in a downstairs meeting room.

What do I have to do?
If you choose to be part of this study then please come and talk with me once week, or another frequency of your choosing. We will agree a time and dates. After the initial collection of information we will identify learning opportunities based on your expressed needs. This will be on an on-going basis throughout the study. You will be provided with support and coaching on the use of new skills and learning.

What are the possible disadvantages and risks of taking part?
It is highly likely that you will recall traumatic experiences from your past during this study, however, the aim of this study is to identify needs and create learning opportunities to reduce your distress. This would include the management of traumatic memories and symptoms if this was required. Should you feel distressed and were not happy to talk to the Researcher, you would be provided with an appropriate referral or contact for supportive counselling.

What are the possible benefits of taking part?
The possible benefits of this study include the development of a relationship where the researcher is committed to identifying with you your needs to facilitate your recovery from past events, and developing learning opportunities with you to help you find ways to manage your difficulties. The researcher is already a skilled and experienced psychologist in the area of trauma and abuse.

What will happen when the research study stops?
When the study stops, all of the information which identifies you will be destroyed. The study will not just suddenly stop, there will be a period of time when we will work towards the ending of our time together, when you identify that you feel more independent.

Will my taking part in the study be kept confidential?
- The staff at the Refuge will be aware that you are taking part in this study, and anyone else that you choose to tell. None of your personal information will be discussed.
- There will be no videos, no audio recording and no photographs.
- None of your personal information will be shared or disclosed.
- None of your personal information will be kept after the study has concluded.
- The conversations we have will be confidential. The information that is put into the write-up of the study will not identify you in anyway. If there is something specific that you have said, that is recorded word for word, the researcher will ask your permission before using it.

- The information written down during our time together will be kept in a locked cabinet in a locked room at the researcher's office. The office is located on a secure site. Information that is written up on the computer will not contain any personal data.
- The relationship with the researcher / therapist will be strictly confidential, however, there may be times when this confidentiality would be broken. These times would be if you planned to harm yourself or anyone else, or knew of any harm to another. This would include any plans to return to an abusive relationship. The researcher would have a duty to let the manager of the Refuge know about this, who would then have a duty to inform local services such as social and health services and possibly the Police. This would be to keep you and any others you have identified as safe as possible. You would be kept informed of the process as much as possible and would be offered support throughout.

What will happen to the results of the research study?

The study is likely to be published in academic journals / outlets where anyone can look at the results if they want to. It will also be sent to local women's groups. It is hoped that it will contribute to healthcare changes at a later date.

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time, without any disadvantage or penalty.

What if there is a problem?

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone [redacted]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: What are the experiential and phenomenological processes over time in the lives of survivors of abuse that impact on recovery?

You could also write to the Secretary at:

[redacted]
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB

[redacted]

Who has reviewed the study?
This study has been approved by City University London Senate Research Ethics Committee, and agreed to by the Manager of the Refuge.

Further information and contact details

Should you require additional information you can contact Katharine Craib.

X

You could also write to the Secretary at:

[redacted]
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB

[redacted]

Who has reviewed the study?
This study has been approved by City University, London, Senate and Psychology Research Ethics Committee

Further information and contact details

Supervisor: Professor [redacted] Department of Psychology, City University London, Northampton Square, London, EC1V OHB

Thank you for taking the time to read this information sheet.

10. Consent Form

CITY UNIVERSITY LONDON

Title of Study:

What is involved in the recovery from gender-based violence for adult women?

Please initial box

for each point

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this study is about recovery from abuse and violence that I may have experienced, and is likely to trigger a recall of traumatic experiences. I understand that I do not have to talk about anything that I do not want to, that I can end the session or my participation in the study at any point. I understand that the Researcher is focussing on finding ways to help me with my distress. I agree to: • being interviewed by the researcher • completing questionnaires asking me about my difficulties, and my wellbeing • participating in learning opportunities linked to difficulties I identify • participating in discussions about things which may help me I understand that I will be in a therapy-relationship but also that this information and observations about me made by the researcher, will be used for research purposes.	
2.	This information will be held and processed for the following purpose: I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that if I disclose information that involves harm to myself or to another then the Researcher has a duty to report	

	this to the Manager of the Refuge, and this will reveal my identity. I understand that the Manager of the Refuge will have a duty to report this information to social and health services, and/or Police services as required, and this will reveal my identity.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way. I understand that when I leave the Refuge I can no longer be part of the study. I understand that if I plan to go back to a known abusive relationship the researcher will have a duty to disclose this to the Manager of the Refuge.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purposes set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Participant	Signature	Date
Name of Participant	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Researcher's checklist for compliance with the Data Protection Act, 1998

This checklist is for use alongside the *Guidance notes on Research and the Data Protection Act 1998*. Please refer to the notes for a full explanation of the requirements.

You may choose to keep this form with your research project documentation so that you can prove that you have taken into account the requirements of the Data Protection Act.

	REQUIREMENT	✓	
A	***Meeting the conditions for the research exemptions:***		
1	The information is being used *exclusively* for research purposes.	X	Mandatory
2	You are not using the information to support measures or decisions relating to *any* identifiable living individual.	X	Mandatory
3	You are not using the data in a way that will cause, or is likely to cause, substantial damage or substantial distress to any data subject.	X	Mandatory
4	You will not make the result of your research, or any resulting statistics, available in a form that identifies the data subject.	X	Mandatory
B	***Meeting the conditions of the First Data Protection Principle:***		
1	You have fulfilled one of the conditions for using personal data, e.g. you have obtained consent from the data subject. Indicate which condition you have fulfilled here: Informed consent will be obtained from the data subject to participate in the study, understanding that there will be no identifiable data used in the study.	X	Mandatory
2	If you will be using sensitive personal data you have fulfilled one of the conditions for using sensitive personal data, e.g. you have obtained explicit consent from the data subject. Indicate which condition you have fulfilled here: There will be no use of sensitive personal data which in anyway identifies the participant.	X	Mandatory if using sensitive data
3	You have informed data subjects of: i.What you are doing with the data; i.Who will hold the data, usually City University London; i.Who will have access to or receive copies of the data.	X	Mandatory unless B4 applies

4	You are excused from fulfilling B3 only if all of the following conditions apply: i. The data has been obtained from a third party; i. Provision of the information would involve disproportionate effort; i. You record the reasons for believing that disproportionate effort applies, please also give brief details here: _____ _____ _____ _____ ____ N.B. Please see the guidelines above when assessing disproportionate effort.		Required only when claiming disproportionate effort
C	***Meeting the conditions of the Third Data Protection Principle:***		
1	You have designed the project to collect as much information as you need for your research but not more information than you need.	X	Mandatory
D	***Meeting the conditions of the Fourth Data Protection Principle:***		
1	You will take reasonable measures to ensure that the information you collect is accurate.	X	Mandatory
2	Where necessary you have put processes in place to keep the information up to date.	X	Mandatory
E	***Meeting the conditions of the Sixth Data Protection Principle:***		
1	You have made arrangements to comply with the rights of the data subject. In particular you have made arrangements to: i. Inform the data subject that you are going to use their personal data. i. Stop using an individual's data if it is likely to cause unwarranted substantial damage or substantial distress to the data subject or another. i. Ensure that no decision, which significantly affects a data subject, is based solely on the automatic processing of their data. v. Stop, rectify, erase or destroy the personal data of an individual, if necessary.	X	Mandatory

	Please give brief details of the measures you intend to take here: No personal data will be used. All identifiable data will be changed for the purpose of protecting confidentiality and maintaining anonymity.	

CITY UNIVERSITY LONDON

Ms K Craib
Department of Psychology
School of Arts & Social Sciences
City University London
London
EC1V 0HB

14 October 2014

Dear Ms Craib

Reference: SREC 13-14 CA 14 10 14
Project Title: What are the experiential and phenomenological processes over time in the lives of adult female survivors of gender-based violence that impact on recovery?
Start Date: 14 October 2014
End Date: 13 October 2017
Approval Date: 14 October 2014

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the City University Senate Research Ethics Committee following Chair's action to approve the proposal.

Please note that you are required to report any adverse events within 5 days. You are also required to notify the Committee of any amendments made to this study. If there are significant alterations to the protocol you may need to reapply.

Should you have any further queries relating to this matter then please do not hesitate to contact me. On behalf of Senate Research Ethics Committee I do hope that the project meets with success and many thanks for your patience.

Kind regards

[redacted]

Research Development Manager
Secretary to Senate Research Ethics Committee

[redacted]

PART D

PROFESSIONAL PRACTICE

‘Autoethnography reflecting on working within the sadomasochistic paradigm of narcissism in the offender population’

This content has been removed for data protection reasons