How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women who have been victims of violence?

Roisin Murtagh

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ABSTRACT

Violence against women and women's oppression are reciprocally related – just as oppressive patriarchal contexts are conducive to violence, violence is also a tool for subjugating women. Women's empowerment is therefore often cited as a goal for psychological therapies provided to women who have been subjected to violence. However, literature surrounding empowerment within therapy holds various contradictions, gaps and problematic implications for women. Little is known about how UK practitioners navigate these issues. This research explored how practitioners conceptualise and approach empowerment within their therapeutic work with women subjected to violence. Semi-structured interviews were conducted with 12 psychological therapy practitioners representing a range of modalities, experienced in working with women subjected to violence. A reflexive thematic analysis, through a critical realist and feminist lens, was used to analyse participants' reports. Three overarching themes were constructed: *understanding empowerment, 'what I do with clients',* and *'a hand tied behind our back': practitioners face barriers to empowering therapeutic practice*. Participants predominantly aligned with an individualistic approach to empowerment centred around connection, coping, and reparation; and highlighted systemic barriers to ideal practice. Implications, limitations and suggested further research are discussed.

Keywords: empowerment, feminist psychology, gender-based violence, male violence, VAW, violence against women, women's empowerment

TABLE OF CONTENTS

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1. INTRODUCTION

As a researcher who adopts a critical lens, I believe research has the potential to evoke meaningful change towards greater social justice. As a woman and a feminist, I am particularly conscious of, and concerned with, matters relating to women's experiences of oppression, such as violence against women (VAW). This position has meant that I consider VAW a particularly abhorrent societal problem, one which majorly impedes women's daily lives. As such, this research began with the *a priori* assumption that VAW is a topic worthy of investigation, and the stance that I will attempt to uphold a commitment to social justice throughout the formulation, design and conduct of the present research. Throughout my clinical psychology training, I have spoken with professionals – psychologists, supervisors, peers, tutors – who work (directly or indirectly) in the provision of therapy for women subjected to violence, as well as listened to stories from clients who are victims/survivors of VAW. I also became aware of the vast body of literature on VAW outlining different approaches to therapeutic work, yet encountered little regarding how practitioners conceptualise their work and seek to support women. On these bases, I began to consider how practitioners engage with and think about the support they provide to women subjected to violence through psychological therapy, and thus this research topic was chosen. Honing the specific area and articulation of the research question occurred through processes of further reading and reflecting on themes presenting in the literature – much of which is presented and explored throughout this chapter.

This chapter therefore situates the present research within relevant previous literature. Firstly, I outline what is known about VAW; and explore how it is defined, the scope of the problem, and its relationship with patriarchal oppression. Next, I explore literature surrounding gender as related to VAW; and subsequently women's disempowerment, including the role of patriarchy, and the models and theories underlying psychological thinking around empowerment. Following this, I consider how such thinking is applied to psychological interventions for women subjected to violence. Finally, I present the results of a scoping review, providing insight into how

psychological therapies in the UK currently use the concept of empowerment, and where gaps and problems lie within this. This chapter culminates in the rationale and aims of the present research.

1.1. Violence Against Women

To provide insight into current understanding of VAW, this section explores how VAW is defined, including surrounding definitional issues; the scope of VAW, regarding its recorded impacts and prevalence; and finally, the relationship between VAW and patriarchy.

1.1.1. Defining Violence Against Women

Developing terminology which captures the range of violence women face has long been a debated issue, with psychology often at the epicentre in the use of contentious language. Historically, psychological research defined VAW in a way which captured solely violence within the home, with violence outside the home considered gender-neutral (Gordon, 2000). Conceptualising VAW in this way is problematic on a number of grounds. First, it fails to capture the nuanced violence women face outside the home, such as workplace harassment. Second, it accounts for the interchangeable use of *intimate partner violence* (IPV) or *family violence* within research pertaining to VAW. The gender neutrality of these euphemistic terms obscures the fact that violence in families is mostly perpetrated by men against women and children (Ellsberg & Heise, 2005). Additionally, women are subjected to violence in unique ways across their lifespan – from sex-selective abortions prenatally, female genital mutilation in childhood, through to repeated sexual violence (SV) throughout adolescence and adulthood (Watts & Zimmerman, 2002). Focusing only on violence perpetrated by partners disguises how violence embeds across women's lives (Tjaden, 2005). Avoiding gender-neutral language therefore facilitates VAW being accurately captured as a form of *gender-based* violence (Ellsberg & Heise, 2005).

The United Nations (UN; 1993) defines VAW as: ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty’ (p.2). The specificity provided by the examples in this definition circumvents the commonly encountered problem within VAW literature of vague, non-operationalised definitions of violent acts. This has previously obfuscated comparability between studies and leads to over-examination of sexual and physical violence (considered more easily defined and measurable) compared to psychological violence, which attracts less research attention (Ruiz-Pérez et al., 2007).

Some argue defining too broad a range of behaviours as VAW trivialises ‘serious’ abuse, conflating it with what is ‘debatably abusive’ (Fox, 1993, p.322). Ruiz-Pérez et al. (2007) contend that the breadth of the UN’s (1993) definition sacrifices its descriptive power. However, the risks of overly narrow definitions are far more concerning, as they can result in under-identification of violence and trivialise women’s experiences (DeKeseredy & Schwartz, 2011). The UN definition, by including examples like ‘psychological harm’ and ‘threats’, moves away from a narrow, criminal justice-based definition, towards a broader health- or human rights-based one (Tjaden, 2005).

Feminist scholars advocate for a broad definition (Renzetti, 2008) as narrow definitions result in underestimating the scope of the problem, and therefore reduce political prioritisation (and subsequent funding) of VAW initiatives (Snider, 2008). How VAW is defined therefore has political ramifications, as prevalence figures must be sufficiently large, while retaining descriptive power, for policymakers to act (DeKeseredy, 2000). The UN (1993) definition is used in the present research as it circumvents these dilemmas – it moves away from gender-neutral language and balances operationalised specificity with appropriate breadth.

1.1.2. The Scope of Violence Against Women

Extensive research evidences the detrimental impact of violence on women’s wellbeing (Logan et al., 2006). The World Health Organisation (WHO, 2022) claimed that VAW is the global leading cause of psychiatric disorders diagnosed in women,

particularly depression, anxiety, and – the most common outcome – post-traumatic stress disorder (PTSD). Violence also increases women's risks of developing physical health problems (Coker et al., 2000). Over a third of women globally have been identified as having been subjected to violence, with disproportionately higher figures for: young women, women from minoritized groups, transwomen, and women with disabilities (WHO, 2019). The Office for National Statistics recently illustrated continuing trends in high numbers of VAW police reports and declining conviction rates (ONS, 2022). Within a year, approximately a third of women in England and Wales reported experiencing sexual harassment; seven percent reported domestic violence (DV); three percent sexual assault; and five percent stalking (ONS, 2021).

However, prevalence figures vary across sources due to numerous methodological issues. As the breadth of behaviours considered VAW is not universally agreed, this results in inconsistencies in what is counted. Researcher attempts to gather prevalence data can also reflect unsettling, misogynistic assumptions. For example, women are not always believed, as some researchers argue victims' reports are tainted by 'memory bias' or inflated due to over-reporting of 'non-severe abuse' (Ruiz-Pérez et al., 2007, p.29). Additionally, a woman's willingness to report VAW will be mediated through what is culturally appropriate to disclose (Krantz & Garcia-Moreno, 2005); feelings of fear, guilt and shame contribute to a high rate of non-responses within VAW data collection (Gelles, 1990). There are also issues in relying on crime data to understand the scope of VAW. Firstly, women are only likely to report violence on criminal surveys if they have already labelled their experience as *criminal*; yet this is also a socio-culturally mediated process (Schwartz, 2000). For instance, rape myths (such as that rape always leaves physical injury) make it challenging for victims/survivors to identify they have been raped when their experience does not align with these inaccurate rape depictions (Taylor, 2020). This mediating process occurs prior to a woman deciding whether to report the violence, and indeed globally, most do not report it to any services (WHO, 2019).

Unsurprisingly therefore, surveys of VAW which are not contextualised as *crime* surveys result in considerably higher figures (DeKeseredy & Schwartz, 2011). Indeed, most UK women subjected to IPV told someone they knew personally, compared to less than a fifth who contacted the police (ONS, 2021). Additionally,

much of women's experiences cannot be conceptualised as criminal, such as threatening looks (Kernsmith, 2008); which, while not criminally violent, remind women of their powerlessness and vulnerability to violence (Coveney et al., 1984). Criminal data also delineate crimes, such as rape from DV. However, women are far more likely to experience multiple forms of violence than just one (DeKeseredy et al., 2006). Criminal data therefore only capture the minority of incidents of VAW. However, the UK relies upon criminal data to understand the scope of VAW and in making policy decisions (Home Office, 2021). A more useful starting place to understand the scope would be to instead conceptualise VAW as part of normative societal gender relations, rather than anomalous events, divisible into litigious categories (Shaw & Proctor, 2005). Additionally, constant cognisance of being a potential target for violence underlies everyday experiences of womanhood (Kelly, 1988). Reliance on criminal data therefore overlooks a unifying theme which is integral to understanding the scope of VAW: the violent manifestation of women's subjugation within normative societal gender relations.

1.1.3. Violence Against Women and Women's Subjugation

As popularity in researching VAW grew from the 1970s, so too did psychological efforts to understand and measure it (DeKeseredy & Schwartz, 2011). A vast body of literature exists aimed at theorising VAW risk factors and mediational models. Gordon (2000) provides a research overview of 'traits' found in men identified as VAW perpetrators; these risk factor models also often incorporate victim-blaming strategies by including women's supposed risk factors too, such as being 'antisocial' and 'assortative mating' with 'antisocial' men (Krueger et al., 1998, p.173). Gordon (2000) also states that women subjected to violence are more likely to be 'withholding' from violent partners, not 'supportive' or 'affectionate' (p.766). Research has also attempted to identify psychological profiles of violent men. Dutton (2006) argued that most men who perpetrate IPV have personality disorders, and the notion that VAW is actually a societal norm is 'misleading' and 'absurd' (p.11). This is despite evidence that most men who perpetrate IPV do not have a personality disorder diagnosis (Jasinski, 2001); nor that an estimated 90% of reported VAW cannot be tied to any psychiatric diagnoses (Brownridge, 2009).

Just as criminal data conceptualise VAW as infrequent, isolated acts, psychological research too provides a limited conceptualisation of VAW as an act perpetrated by unwell men against victim-prone women. This view likely remains popular as it is more comfortable to believe VAW is a function of mental illness than an entrenched socio-cultural quality (DeKeseredy & Schwartz, 2011). In this way, individualised psychological approaches to understanding VAW fail to challenge patriarchal structures. Challenging these structures is not only a difficult task, but an undesirable one for those who benefit from its status quo (DeKeseredy & Schwartz, 2011). Although not all men are violent, all benefit from the power conferred on them from patriarchy – a social system upheld by women's violent oppression (Coveney et al., 1984). VAW is an organic by-product of oppressive social systems and cultural attitudes – put another way, 'most men who assault women are not so much disturbed as they are disturbingly normal' (Katz, 2006, p.28). Therefore, as an act of gender-based violence, VAW is rooted in socio-cultural inequalities; namely, patriarchal beliefs around masculinity as superior to femininity (Krantz & Gracia-Morena, 2005).

1.2. Violence Against Women and the Construction of Gender

This section explores the notion of gender as a social construct, how masculinity and femininity are socially constructed, and how this construction creates the context for VAW.

1.2.1. Gender as a Social Construct

Although gender has been intimately tied to biological sex, there is no consistent basis for biological determinants for observed or perceived differences in behaviours between genders (Kennelly et al., 2001). Feminist research has shown that many differences between women and men asserted by traditional psychological sex-difference research are founded on weak empirical bases, cannot be replicated, or reflect the effects of cultural conditioning rather than biology (Kennelly et al., 2001). Gender is therefore best understood as a culturally-based set of normative values and behaviours assigned to each biological sex (Segal, 2004).

While I purport gender is helpfully understood as a social construct, I do not support dangerous trans-exclusionary rhetoric seen across feminist literature (see Elliot, 2010 for an overview). Rather, this understanding of gender should be used to further trans-inclusive theorising. It affords the following trans-inclusive ideas: that sex is not tied to gender; an allowance of space for gender identities outside of strict dichotomy (for example, gender fluid and nonbinary identities); and that a patriarchal construction of gender values men and cisgender identities, creating intersecting systems of oppression for those identifying as trans and/or a woman.

1.2.2. Social Construction of Masculinity and Femininity

Gender, through this lens, is something people *do* – by enacting what one believes is expected of their gender, individuals simultaneously participate in the process of gender construction (West & Zimmerman, 1987). This section outlines psychological approaches to understanding how gender is *done,* and exploring what people *signify* and *perform* (Segal, 2004) to be considered women and men.

1.2.2.1. Sex roles: Early social scientific exploration into gender centred around deconstructing 'sex roles' (Komarovsky, 1946, 1992) – contesting the presumption that women and men are better suited to particular roles due to biological traits, and arguing rather that enactment of differing roles reflect culturally-bound expectations. Worell and Remer (1992) offer some examples of the roles taught to women, such as: acquiescence to men at home and work, displaying "happy" behaviour in social situations, and taking major responsibility for childcare. This approach to understanding gender construction argues that societal expectations create socially approved patterns of behaviour, socialising individuals into their respective sex roles throughout their lives (Lopata & Thorne, 1978).

1.2.2.2. Gender order: Feminist scholars elaborated this idea by exploring *why* some attributes are idealised as masculine and others feminine, arguing that reified traits are ascribed to manhood, and denigrated ones to womanhood (Schippers, 2007). Understanding gender therefore went beyond identifying and describing women and men's behaviour, to considering gendered power relations and the construction of masculinity and femininity in ways which legitimise and sustain patriarchal structures.

Hegemony refers to the collection of features which serve the interests, and legitimate the ascendency, of dominant social classes (Schippers, 2007). Pervasive societal discourses and practices channel individuals towards conforming to embodiment of hegemonic ideals (Hamilton et al., 2019). Hegemonic masculinity is therefore not simply a configuration of gender practices, but rather a social position, aiming to secure the dominant position of men over women – referred to as the 'gender order' (Connell, 1987). In this approach, no femininities are considered hegemonic, as all versions of femininity are constructed in the context of women's subjugation. Instead, there is *emphasised femininity* – femininity defined around compliance to men's interests and desires; for example, the drive for women to be well-groomed, friendly, and polite (Connell, 2000). Within this approach, women are said to enact gender using learnt behaviours which uphold their own subjugation (Connell, 2000).

1.2.2.3. Hegemonic femininity and intersectionality: Collins (1990, 2004) moved from the notion of a gender order towards a more complex *matrix of domination*. Collins argues there is indeed a hegemonic femininity, although it is not equivalently powerful – while hegemonic masculinity is a superordinate dominating structure, hegemonic femininity is restricted to power relations amongst women. The danger in simplifying gendered oppression to a one-dimensional gender order is that other dimensions of inequality go unrecognised. This obscures the additional harm inflicted on women who do not embody hegemonic ideals (Hamilton et al., 2019). For example, the harsher judgement of men who rape white compared to black women means that white women, in their performance of hegemony, are afforded relative protection from violence (Crenshaw, 1991). By conceptualising gendered power relations in isolation, the harm caused by intersectional tools of oppression such as whiteness remain concealed.

1.2.3. Violence Against Women Within the Context of the Social Construction of Gender

Conflating gender with biological sex has historically meant VAW was problematically considered a natural, unchangeable consequence of biology – sex hormones driving a male tendency towards domination and aggression (Gebhard, 1969), and a female tendency towards submission (Ellis, 1913). This section

considers how each approach to conceptualising gender as a socially-constructed arrangement rather than a biological one adds ethical and explanatory value to understanding VAW.

Deconstructing sex roles related to VAW involves identifying how women are socialised into victims of violence and men into aggressors (Worell & Remer, 1992). For example, that women are socialised to behave politely and passively; and men to behave aggressively and powerfully (UN Women, 2019; Weis & Borges, 1977). In this way, cultural processes of sex role socialisation create configurations of gendered behaviour whereby oppressive behaviour is socially approved of in men, and oppressed behaviour in women, allowing the conditions for VAW to emerge from the enactment of respective roles.

A gender order lens looks beyond socialised behaviours to explore VAW as a manifestation of gendered power relations (Connell, 1987). Behaviours associated with hegemonic masculinity, such as displays of aggression and violence, are not incidental, but rather purposefully guarantee and legitimate dominance over women. Through this approach, VAW is understood as not just a *repercussion* of men's dominance, but also a strategy for *gaining* and *maintaining* it (Schippers, 2007).

While the matrix of domination would similarly point to gendered power imbalances as key to understanding VAW, it would also aim to capture nuances and inequalities within experiences of violence (Collins, 1990, 2004). For example, the undeniable role of racism in understanding why SV against white women is considered more of a violation and more worth preventing than that of black women (Pietsch, 2010). Collins' (1990, 2004) ideas around hegemonic femininity within a matrix of domination provide a useful strategy for understanding how the manner in which gender has been constructed contributes to VAW, in a way which illuminates, rather than conceals, intersectional oppression.

1.3. Women's Disempowerment

The argument thus far is that patriarchy maintains gendered oppression through the nature of how womanhood and manhood are constructed. This section outlines other disempowering social conditions created by patriarchy which result in VAW, followed by an exploration into what is meant by *empowerment,* and how it is conceptualised within the field of psychology.

1.3.1. Patriarchy and its Relationship to Women's Disempowerment and Violence Against Women

Prevailing beliefs and discourses around gender and relationships reflect patriarchal values. For example, a UK study found that around half of boys aged 13 and 14 years found hitting acceptable in a relationship (Gadd et al., 2013). Prevalence of this worrying opinion at this early age demonstrates the pervasiveness of violent patriarchal beliefs. For adult women, dominant discourse centres around violence prevention, positioning VAW as an inevitability and implying women must do everything possible to reduce their individual risk, such as learning self-defence strategies or not walking alone (Frazier, 2020). Along with experiences of violence therefore comes the implication that the victim too played a role – she failed to be sufficiently strong, unsexy, or sensible (Frazier, 2020). Patriarchal values are therefore observable across societal beliefs and discourses, as VAW is normalised, presumed inevitable, and considered at least partially the responsibility of women.

Patriarchal forces are centred within feminist models of VAW. Feminist movements were responsible for the emergence of scholarship around VAW in the 1970s and for breaking the silence on the topic (Liddle, 1989; Wilson, 1981). Additionally, the UK government has taken a loosely feminist stance by stating that 'over-arching social norms' have created a society too tolerant of VAW (Home Office, 2021, p.34). Regardless of one's theoretical or socio-political orientation, feminist theories are therefore crucial to understanding the knowledge-base surrounding VAW. Feminist models of VAW argue that interplaying patriarchal structures increase both the potential for violent behaviour from men, and powerlessness in women who are provided little recourse or protection (Worell & Remer, 2003). Indeed, widespread evidence indicates that victims/survivors of VAW feel their calls for help are not responded to, or they are treated with suspicion, by police officers; and that insufficient resources are allocated towards apprehending perpetrators (Moane,

2003; ONS, 2021). Patriarchy is therefore not just responsible for the gendered power relations conducive to VAW, but also reflected in the societal-wide failure to condemn it.

Violence – and the fear of it – are tools for controlling others' behaviours, thoughts and feelings (Pence & Paymar, 1993). For example, fear of walking home at night restricts women's freedom of travel, with far-reaching deleterious consequences for factors like career, social life, and exercise. Patriarchal structures are therefore sustained regardless of whether men perpetrate violence, due to simply the constant threat that they might (Collins, 2004). Thus, the relationship between VAW and women's disempowerment is best conceptualised as bi-directional: just as women's subjugation within patriarchy creates an environment which condones VAW, violence too maintains patriarchal structures.

1.3.2. History, Theories and Models of Empowerment

To enable a meaningful consideration of women's disempowerment, this section explores what is meant by *empowerment*. Empowerment literature originates in Human Rights discourse and is reflected in some psychological approaches, such as Community Psychology. Within Human Rights, empowerment refers to gaining access to resources; for example, removing barriers to permit survivors of human rights violations fair access to a legal system to seek justice and reparations (N. Patel, 2019). Within psychology, there is no singular, agreed upon definition. In the absence of one, researchers often utilise unrelated, diffuse ideas in the name of empowerment, in turn perpetuating and exacerbating imprecision of its definition (Cattaneo & Chapman, 2010). To offer an insightful consideration of empowerment, it is unfeasible and unhelpful to consider the innumerable conceptualisations of empowerment which exist. Instead, this section will chronologically outline the development of major models and theories from which variegated definitions arise.

1.3.2.1. Empowerment as social justice: Early conceptualisations of empowerment were rooted in radical social theories of the 1960s to 1980s from the global South (Khader, 2018), such as those of Paolo Freire and early women's empowerment theorists, the Development Alternatives with Women for a New Era (1985). Empowerment was understood as a process of increasing *collective agency* through

gaining awareness of power operations within one's social context, and challenging oppression through social action (McWhirter, 1991, 1998). These ideas are traceable to Freire's *conscientização* (1970) – often translated to *conscientisation* to mean *consciousness-raising* – 'learning to perceive social, political, and economic contradictions' (p.19) for the purpose of resisting and challenging them.

In this view, disempowerment referred to how socio-political ideologies and mechanisms of control used by dominant groups manifest in the lives of oppressed persons (Martín Baró, 1994). In the context of patriarchal ideologies, men's use of violence would be considered a control mechanism (Khader, 2018) which disempowers women in their daily lives; such as forcing women to restrict their activities to mitigate a constant sense of danger (Moane, 2003). Early conceptualisations of empowerment therefore captured an aspirational process for marginalised populations to collectively move towards social justice.

1.3.2.2. Empowerment as agency and choice: As its popularity increased in psychological literature and public attention, central ideas around empowerment began to shift. *Agency* became central – specifically, *individual* agency, signifying a shift from what was originally seen as a collective endeavour. Individual agency is considered internal qualities of critical thinking skills, decision-making, and ability to identify and achieve goals (Kabeer, 1999). Kabeer (1998, 1999, 2002, 2008) was a driving force for this shift, by suggesting empowerment means an ability to *choose.* For Kabeer, women are disempowered because of a lack of choice; for example, wealth inequality robs some women of the choice to leave violent men on whom they are financially dependent.

Prevalent empowerment definitions across academic literature and public policy draw on ideas of agency and choice. For example, recent literature defines women's empowerment as the 'ability to make and act on choices' (Richardson, 2018, p.541), and 'choice, agency, and autonomy' (Gram et al., 2019, p.1367). The World Bank (2012) similarly claims gender inequality is driven by women's 'lack of agency' – 'the ability to make effective choices and transform those choices into desired outcomes' (p.3).

Khader (2018) argues this approach is burdensome for women, as being an agent of choice while living within oppressive contexts means choosing from limited and unacceptable options. For example, ‘choosing’ to join the workforce does not alleviate women from household responsibilities – supposedly empowered women, therefore, ‘just get more work’ (Khader, 2018, p.142). As one’s ability to achieve goals is delimited by the reality of their power within societal structures, focusing on agency may position empowerment as an exercise in ‘psychologizing the structural’ (Khader, 2011, p.56),

1.3.2.3. Empowerment Theory: Zimmerman’s Empowerment Theory (1990, 1995, 2000) distinguishes three levels of empowerment: an individual psychological level, capturing intrapersonal variables such as agency; an organisational level, of resource mobilisation and participatory opportunities; and a community level, of socio-political structures and capacity for social change. Empowerment is therefore contextually-bound: an individual’s psychological empowerment cannot be considered in isolation from ecological influences (Zimmerman, 1990). This is a landmark theory within empowerment literature. It provided measurable groups of variables amenable to research (Cattaneo & Chapman, 2010) and drove many popular empowerment measures, such as the Socio-Political Control Scale (Zimmerman & Zahniser, 1991) and the practice of capturing participation in organisational and community activities as a measure of empowerment (Zimmerman, 2000).

This model extends beyond a lack of agency or choice to consider women’s disempowerment across systemic levels. Women may be disempowered at an organisational level, for example, by experiencing unequal division of household labour, or workplace harassment. At a community level, disempowerment might involve gender under-representation in policy-making positions, such as MPs in the UK (Uberoi & Mansfield, 2023). This theory adds explanatory value to agency and choice conceptualisations of empowerment by attending to disempowering factors in a woman’s social context.

However, research using this model predominantly centres around exploring psychological level empowerment, while organisational and community levels often go ignored. Zimmerman (2000) defends that Empowerment Theory should not

alleviate ‘institutional responsibility to take care of people and communities through structural interventions’ (p.57), and blames how researchers have utilised the model for contributing toward a tendency of individualising people’s problems within psychology.

1.3.2.4. The Empowerment Process Model: Cattaneo and Chapman (2010) developed their Empowerment Process Model to create a conceptualisation of empowerment particularly applicable to supporting women subjected to IPV. They drew upon Freire’s (1970) notion of praxis, arguing empowerment occurs through a bi-directional process of action and reflection. They define empowerment as an iterative process of setting and moving towards goals designed to increase one’s power, reflecting on the impact of these actions, and drawing on one’s ‘evolving self-efficacy, knowledge, and competence’ (p.647) to continually set and achieve goals. Disempowerment is said to be caused by unequal societal power distribution, leading to intrapsychic properties in disempowered persons – limited self-efficacy, knowledge and competence. Therefore, through a process of increasing these three factors, women supposedly gain power. Similarly to Zimmerman’s Empowerment Theory, individual, intrapsychic factors are understood as relevant to empowerment, but are not siloed off from the systemic inequalities from which they arise.

1.3.3. Conceptualising Empowerment

Early conceptualisations of empowerment aimed to challenge oppressive socio-political ideologies and structures. A Human Rights based approach would explicitly focus on the systems which prevent women’s empowerment, such as the impenetrable legal systems blocking victims/survivors of violence from reparation and granting ongoing impunity for perpetrators. There has therefore been a drastic evolution in how empowerment has come to be conceptualised, with the term *agency* often now substituted for *empowerment* in modern literature (Khader, 2018). Some argue this move has led to a watering down of empowerment as a concept; from a social movement to a synonym for a host of intrapsychic qualities, empowerment has shifted to a point of unrecognizability, depoliticised from its radical roots (Batliwala 2007, 2008; Sardenberg, 2008).

As outlined, the theories and models discussed in Section 1.3.2. were chosen to provide an overview of the historical development of empowerment as a concept. Even the most recent of those outlined originate from older literature, suggesting much of the key developments and predominant theorising surrounding empowerment occurred between roughly ten and sixty years ago. Understanding the history of its conceptual development illuminates patterns in what is currently observable in contemporary empowerment literature. As discussed (see Section 1.3.2.2.), recent literature shows a preference for *choice* or *agency* conceptualisations of empowerment (e.g., Gram et al., 2019; Richardson, 2018; The World Bank, 2012). Recently, researchers have utilised empowerment in aid of diverse ends across the field. For example, recent psychological theorising on increasing employee work performance points to empowerment as a personal resource akin to competence and self-determination (Juyumaya, 2022). Another, which recently examined empowering families of individuals with developmental disabilities, drew upon The Empowerment Process Model (Cattaneo & Chapman, 2010) to consider empowering interventions at varying levels, such as fostering individuals' skills within the context of participation in, and opportunities at, a community level (Szlamka et al., 2022). Researchers therefore continue to rely upon ideas of empowerment as a combination of internal qualities such as self-efficacy and agency, and participation in organisational and community activities.

These ideas around empowerment are currently proliferating beyond strictly psychological interventions, into the realm of general healthcare. For example, in a recent systematic review, Halvorsen et al. (2020) explored how empowerment has come to be conceptualised in the context of nursing and healthcare, formulating empowerment as both a set of internal attributes (such as autonomy, self-efficacy, and self-determination) and a state (a positive self-concept, a sense of mastery or control, and active participation in one's own healthcare). Hickmann et al. (2022) similarly point to an empowered patient in a general healthcare setting being one who actively partners with their healthcare provider in managing their own health. Conceptualisations of empowerment as a set of attributes centred around agency and skill (traceable to the work of Kabeer, 1999), active participation in organisations (originating from Zimmerman, 1990, 1995, 2000), and formulations based on Cattaneo and Chapman's (2010) Empowerment Process Model, therefore retain

popularity in contemporary literature. While empowerment continues to be a mainstay in psychological literature and beyond, predominant formulations appear to have shifted little since the individualising influence of authors such as Kabeer (1998, 1999, 2002, 2008), to whom the distancing of the concept from its socio-political and Human Rights roots is attributed (Khader, 2018).

Variegated definitions with a lack of consensus has led to pluralism in empowerment theories, hampering attempts at useful operationalisation of the concept. This calls into question how and whether empowerment can validly be measured. Richardson (2018) outlines three additional problems. Firstly, there is poor theory integration and a reliance on researchers' personal understanding of the concept in their choice of definitions and outcomes. Secondly, measurements can be imprecise and biased. For example, international development research often use indicators of women's empowerment which relate to their decision-making agency around household consumption and children's health, delimiting insight into women's power to pre-existing gender roles (Grabe, 2012). Lastly, researchers' reliance on variable definitions originating from variable contexts, sometimes unrelated to that of the population being studied, overlooks the context-bound nature of empowerment. This scattergun approach also makes it impossible to compare results across studies (Pratley, 2016). These methodological concerns impede meaningful research into the causes of people's disempowerment (Malhotra & Schuler, 2005) as well as the influence of empowerment-oriented interventions (Alsop & Heinsohn, 2005).

Despite pluralistic conceptualisations, what can be gleaned from this review is that empowerment can usefully be understood as: a process of praxis; a collective effort which acknowledges very real structural barriers of oppression; and has a central aim of increasing one's power within structures, over solely augmenting individual ability. Exploring individual agency in the context of empowerment is not in itself necessarily harmful. Yet an overemphasis on individual variables might stymie investigation of women's empowerment by: overlooking contextual factors in what choices a woman is afforded, what outcomes her agency may realistically influence, and how patriarchal power relations create barriers to meaningful change (Grabe, 2012). Women's disempowerment is therefore best understood as originating from

patriarchal forces which manifest in failures to prevent or condemn VAW, and use VAW as an oppressive tool.

1.4. Empowerment in the Support for Women Victims/Survivors of Violence

Women's empowerment frequently features in strategies from public bodies and international development organisations as an intervention for both VAW and associated psychological or psychiatric difficulties. The WHO (2022) stated that women's empowerment prevents VAW, and recommend it should play a key factor in service provision, as gender inequality and VAW increase women's risk of psychiatric diagnoses. The WHO (2013) had previously recommended women's empowerment should be central to psychological interventions provided to women subjected to IPV or SV. The National Health Service (NHS, 2010) also stated their intention to empower patients presenting with physical and psychological sequalae related to VAW. The term *empower* features as a key expectation from the UK Government for violence against women and girls (VAWG) related services (Home Office, 2022).

Despite identification of women's empowerment within these statements, rarely is empowerment defined or operationalised, and when it is, the focus remains on what women should do. Some argue proliferation of the term *empowerment* within social intervention rhetoric has culminated in ambiguity, as public bodies have appropriated a once progressive social movement in aid of a catchy buzzword, tenuously connected to empowerment research (Grabe, 2012).

1.4.1. Women's Perspectives on Empowerment and Therapy after Violence

Previous research has aimed to capture women's voices on what therapy following violence should involve. A survey of victims/survivors of SV captured the want for mental health services to help women feel heard, believed and not blamed, and for practitioners to offer a calm, supportive space which does not pressurise them to engage with the criminal justice system should they choose not to (The Survivors Trust, 2014). The survey also reports that the women valued being offered

personalised care, with an appreciation that each woman will need to be supported by mental health services in unique ways. They also reportedly valued psychological practitioners offering psycho-education and normalisation for possible trauma responses, rather than feel as though professionals pathologise their experiences. A more recent study with victims/survivors of SV similarly reported that the most helpful things about the psychological therapies they have received are practitioners helping them to feel safe and supported, and providing normalising psycho-education on trauma responses (May et al., 2022). Additionally, women interviewed by Heywood et al. (2019) who were each victims/survivors of domestic violence or abuse, spoke about the importance of professionals, including psychologists, being educated on identifying and understanding the signs and impacts of domestic abuse in order to increase their safety in a practical sense. Sorrentino et al. (2021) interviewed women who had been subjected to IPV, who pointed to similar aspects in therapy which were highly valued – personalised care which is responsive to the specifics of women's lives, and providing and creating safety – but also highlighted their desire for the complexity of their lives and self-determination of their own goals to be respected.

Part of providing this sort of therapy to women – according to Sorrentino et al. (2021) – is that practitioners aim to *empower* women throughout the therapy. However, what empowerment means to women as a therapeutic goal will invariably differ. It is important to note that women have often pointed to empowerment as an important part of recovering from experiences of violence, and that it can come from many avenues outside of psychological therapy. For example, women have spoken about how social activism has helped move them from experiences of shame to freedom and empowerment (Strauss Swanson & Szymanski, 2020), and for some women, simply entering the workforce and achieving career goals can be experienced as empowering after violence (Kumar & Casey, 2020). When it comes to empowerment in psychological therapy, women report it is a key part to good therapeutic care, and once again point to the importance of personalised, or survivor-centred, approaches to becoming meaningfully empowered through therapy (Cattaneo et al., 2021). This is similar to the argument from Jupp et al. (2010), who state that when it comes to defining and understanding what it means for a woman to be empowered, this is best left to the individual woman who is being supported to decide. Empowerment is

understood as something which will be unique to every woman and as such, therapeutic goals are only truly empowering when they are shaped by women's (and in some cases, their community's) values and priorities, and practitioners are best placed taking a supporting role (Kasturirigan, 2008). Similar to women's reflections on what makes for good therapy, they seem to identify personalised and person-centred therapy to be what makes it empowering. Different psychological approaches vary in how they apply empowerment when working with victims/survivors of VAW as it is a concept which is operationalised in variegated ways.

1.4.2. Empowerment not Tailored to Women

Individual-level interventions derived from Empowerment Theory (see Section 1.3.2.3.) aim to enhance skills in mastery and control over one's environment (Zimmerman, 1990). Conceptualising empowerment as skill development fails to consider how structural oppression may maintain a woman's disempowerment, regardless of attempts to change her interactions with the environment. For example, the social conditions created by intersecting patriarchy and whiteness leave UK women – particularly those from racialised groups – in precarious financial positions, often falling into poverty (National Education Union, 2019). In this scenario, interventions aimed at increasing a woman's control over her environment are inevitably limited, as without financial stability, control over important factors, like where and with whom one lives, are severely restricted.

Within the Empowerment Process Model (see Section 1.3.2.4.), clients are supported to develop a *personally meaningful* goal, one based on what empowerment means *to them* from their contextually-bound experiences of power (Cattaneo & Chapman, 2010). This fails to consider that women may only have oppressive, unacceptable options from which to identify a goal within their social context, potentially deepening their oppression in the name of empowerment (Khader, 2018). Women also have limited role models for empowerment, given patriarchal construction of womanhood is inherently disempowering (see Section 1.2.2.). It may be unrealistic therefore to expect women subjected to violence to set an empowering goal in the absence of both opportunities for empowerment, and experiences of empowered women.

Therefore, some psychological approaches which centre empowerment do so in a broad manner, ignoring the nuances of patriarchy and other elements of women's social context. Outside of empowerment approaches, therapeutic modalities commonly used with women subjected to violence also overlook relevant sociocultural context in a way which furthers their disempowerment. Early systemic theories, still incorporated in practice today, conceptualised families as enclosed systems with ostensibly arbitrary distributions of power. This inadvertently normalised patriarchal values in family functioning by failing to expose sexist power distribution (Goldner, 1985; Taggart, 1985). Divorcing family behaviour from its social context also divorces violence from the context of gendered oppression – as though violence is 'tossed indiscriminately from one segment of the system to another' (Holmes, 1981, p.599). For example, Weitzman and Dreen (1982) conceptualised VAW as a genderless, transactional pattern where victims play their role by acting immature, clinging, or depressed – offensively misattributing potential *impacts* of violence (albeit, pejoratively framed) to an aspect of the victim's supposedly provocative character. The roots of systemic theories absolve violent men of responsibility by normalising VAW as a relational problem in which responsibility is therefore partially shared with women (Hatty, 1986).

1.4.3. Empowerment as Blame

Many interventions for empowering women centre around setting and achieving goals, such as the Empowerment Process Model (see Section 1.3.2.4.). Focusing on what women can *do* to increase their power assumes they can and should be doing something more. This not only overlooks the role of disempowering context, but also implicitly blames women for their own disempowerment – as though they are disempowered because they are simply not doing enough or doing the right things (Khader, 2018).

Women being blamed for their own difficulties is not novel within psychology. Theories of women's personality and mental health are built upon a deficit model which conceptualise them as a deficient *other* compared to men – not as sensible, assertive, or independent (Hare-Mustin & Marecek, 1990; Tavris, 1993). This is largely a by-product of early psychologists being almost solely wealthy white men, with anyone outside of this group seen as different and deficient (Sherwood &

Nataupsky, 1968). These theories are the bedrock of misogynistic, harmful therapeutic practice which continue to disempower women subjected to violence.

Looking to the history of psychoanalysis, women's identity development was included as a later adjunct within Freud's psychoanalytic theory, driving androcentrism in the approach (Ribeiro, 2005). Androcentrism historically manifested in misogyny in the early years of psychoanalysis; for example, the proposition that women's superegos are predestined to be underdeveloped comparative to men's; resulting in lower moral development, passivity, and masochism (Freud, 1925/1974). Many of the psychological sequalae resulting from VAW (see Section 1.1.2.) were previously attributed to women's weak superego, locating the blame for distress responses to violence within the experience of being a woman (Hare-Mustin & Marecek, 1990). The psychoanalytic notion of the unconscious also historically lent itself to VAW victim-blaming; for example, Ellis' (1913) argument that unconscious instincts manipulate women's bodies in a way which allows for rape to occur. Psychoanalytic focus on fantasies, dreams and associations has also been said to have removed the root of distress away from oppressive conditions, and onto adjusting well to a (patriarchally-defined) society (Hutchinson & McDaniel, 1986).

Brandt and Rudden (2020) argue that while psychodynamic theorising has moved on in recent years, a reliance in therapeutic practice on blaming, misogynistic assumptions as a way of understanding a woman's response to violence continues in the contemporary practice of many psychodynamically oriented practitioners. They argue that in spaces such as clinical supervision, many practitioners continue to formulate what roles women supposedly played in being exposed to violence such as suggesting the victim/survivor is simply overly submissive in their character. Some contemporary psychodynamic theorising arguably continues to perpetuate harmful, victim-blaming assumptions in its explorations of VAW. For example, Dorahy (2017) argues that women prolong experiences of violent abuse (albeit not necessarily intentionally) by using shame as a defence mechanism, as shame means that women punish themselves rather than leaving their violent abusers. While women, or the traits attributed to them, may not be explicitly identified as causing VAW, implicit victim-blaming leads to the same assertion – that women attract, and maintain the violence against themselves – and are responsible for the

distress and the violence they endure. Worrell & Remer (2003) go as far as saying that a predominantly intrapsychic focus locates problems inwards, creating a therapeutic context whereby a woman can only be supported once she is initially blamed for her distress.

This critique extends to cognitive and behavioural theories. Early, foundational CBT literature, such as Beck's (1964) cognitive model of mental illness, similarly held women responsible by conceptualising distress as a result of faulty thinking (Worell & Remer, 1992). Behavioural approaches historically focused on how women could act differently to avoid encouraging violence. This could involve assertiveness training, teaching women to be neither passive (thus permitting the violence), nor aggressive (thus provoking the violence) (Ribeiro, 2005). Literature from recent years indicate that such approaches endure in CBT practice. For example, Cotti et al. (2020) outline that when working with women subjected to violence, the CBT model prioritises neutrality over '"calling out"' (p.392) men, by targeting the behaviours – of both victim and perpetrator – which supposedly 'codetermine' and cause 'mutual triggering' (p.386) of violence. They suggest this could include improving self-esteem and communication skills, stress management, or overcoming relational co-dependency for either party. Current practice of cognitive techniques such as thought challenging, Yakushko (2021) argues, mirrors Eurocentric touting of individual happiness, inner positivity, and self-control as empirical, scientific solutions to women's distress. She equates supporting women to control their inner experience to offering little more than 'rosy attitudes' (p.200) in response to real struggles. Interventions centred around controlling thoughts (thoughts which are decontextualised from patriarchal oppression by being considered simply *negative*) land women with the responsibility to remain happy regardless of disempowering contexts (Yakushko, 2021). Within these approaches, arguably, women are blamed for both the violence they are subjected to – having been insufficiently skilled to prevent it – and the distress arising from violence – having failed to successfully control their thinking to offset it.

1.4.4. Individualisation and Medicalisation

Through interpreting women's psychological difficulties as problems with them as individuals, these approaches also *individualise* the problem. Conceptualising

distress as an individual problem or pathology mirrors a medical, psychiatric view. Attempts to explain and contain deviancy from patriarchal standards of acceptable behaviour for women are traceable from notions of 'witchcraft', to 'hysteria', through to the determination of what is considered 'sane' using psychiatric diagnosis (Shaw & Proctor, 2005; Ussher, 2010). Diagnoses and evidence-based treatments proliferated as a reaction against the domination of psychoanalysis in psychiatry since the 1970s, and with it came the spread of medicalised understandings of distress (Gardner, 2003). In the UK, eight in ten women who sought support after SV were diagnosed with a psychiatric disorder (Oppenheim, 2022), and receiving a psychiatric diagnosis is a common outcome for women subjected to violence globally (WHO, 2022). This is reflected in the National Institute for Health and Care Excellence (NICE, 2014) recommendations for 'evidence-based' interventions (including 'medication') for the 'mental health conditions' arising from DV.

Individualising and medicalising approaches disempower women by denying causal links between inequality and distress in favour of pathologising survivors (Shaw & Proctor, 2005). For example, some argue women's unhappiness living under patriarchal oppression has been recast as *depression* (Ussher, 2010). Pathologising distress not only ignores the disempowered reality of women's lives, it also contributes to disempowerment. Firstly, viewing distress as evidence of internal deficits furthers stigmatisation (Worell & Remer, 1992). For example, women diagnosed with PTSD and prescribed psychotropic drugs after being raped described feeling blamed and silenced (Sturza & Campbell, 2005). Pathologisation might also preclude the possibility of empowerment, as understanding suffering as sickness means that unifying contributing factors between individuals – such as oppressive social contexts – are overlooked, averting interventions from changing systemic oppression to changing the individual (Almeida et al., 2007). In the UK, it is common for women subjected to violence to only be provided psychological support on the condition they first accept psychiatric diagnoses and drugs (Oppenheim, 2022). Women are therefore pressured to comply with oppressive narratives which problematise distress, and interventions which prioritise adjusting to, over challenging, oppressive life circumstances.

1.4.5. Approaches Focusing on Power

In contrast, approaches to empowerment which focus explicitly on power attend to the dynamics of those who oppress rather than those who suffer oppression (Almeida et al., 2007), seeking to empower women by challenging the patriarchal ideologies and structures underpinning gendered inequality (Batliwala, 1994). Feminist psychology is a branch of psychology which acknowledges women's oppression, prioritises representation of women's concerns, and uses knowledge to challenge inequality (Wilkinson, 1991). A feminist approach to therapy does not refer to a single modality; rather, it involves practitioners evaluating existing approaches against feminist beliefs and applying them in a way which reflects feminist values (Worell & Remer, 1992). Feminist therapy empowers women by: formulating difficulties as socio-political rather than intrapsychic, fostering egalitarian therapeutic relationships which do not reproduce societal power imbalances, and valuing women's perspectives (Worell & Remer, 2003). Similarly, a Liberation Psychology (Martín Baró, 1994) approach to working with survivors of VAW involves illuminating sources of oppression through consciousness-raising (see Section 1.3.2.1.), and exploring and evoking individual and group virtues to foster connections and solidarity (Afuape, 2011).

Feminist and Liberation Psychology approaches majorly overlap – both emphasise social change and consciousness-raising; prioritise voices of oppressed persons; and explore connections between political contexts and personal experience (Moane, 2010, 2014). As a result, they are often subsumed under the umbrella 'social justice approaches'. Amalgamating feminist approaches with others under this vague catch-all term undermines the specificity of what feminist approaches seek to achieve, blurring its edges to the point of being ineffectual. As well as being watered down through their conflation, feminist and Liberation Psychology approaches have also fallen out of fashion. Approaches with such deeply critical, political roots, are fundamentally incongruent with Eurocentric preferred psychological practices of individualising and depoliticising people's problems (Fine & Gordon, 1991).

1.4.6. Emerging Trends: Trauma-Informed Approaches

Conversely, currently increasing in popularity across the UK is the Trauma-Informed Approach (TIA, Harris & Fallot, 2001). TIA involves shifting from formulating client difficulties under the pretext of *what is wrong with you* to *what happened to you*,

highlighting that what are considered psychiatric symptoms often reflect coping strategies developed in response to horrendous life events (Harris & Fallot, 2001). The rationale for widespread implementation of TIA is clear, as extensive evidence suggests people who have experienced traumatic events are more likely to use mental health services and are at increased risk of suicide and self-harm (Kessler et al., 2010; Khalifeh et al., 2015; Mauritz et al., 2013). In their recent commissioning guidance, the UK Government requested that VAWG services adopt TIA (Home Office, 2022). TIA appears in national and local UK policies; however, it does not appear in formal legislation, with no formal funding commitment. Therefore, despite its popularity, the implementation of TIA in the UK remains 'disjointed' and 'piecemeal' (Emsley et al., 2022, p.2).

Empowerment features as a principle in both Fallot and Harris's core five TIA principles (2002), and core ten principles from Elliott et al. (2005). According to Fallot and Harris (2002), empowerment involves emphasising the strengths of coping strategies a client developed in the past to build hope for how they might cope in the future. For Elliott et al. (2005), empowerment is a principle which sits alongside choice and control. They argue clients should be supported to not only control their own lives, but also have choice in how services are run. This is reflected in the UK Government's commissioning guidance, which advised that part of adopting TIA involves designing VAWG services 'by and for' women (Home Office, 2022). Within TIA services for women subjected to violence, the empowerment aspect 'is essential to recovery from the overwhelming fear and helplessness that is the legacy of victimization' (Elliott et al., 2005, p.465). Through its inclusion in the currently booming TIA, empowerment is beginning to hold a key place within support provided for women subjected to violence, albeit to inconsistent degrees of implementation.

1.5. Current Psychological Approaches to Empowering Women Victims/Survivors of Violence

A scoping review was conducted in September 2022 to identify relevant literature. The purpose was to gain insight into how empowerment features within the psychological support provided to victims/survivors of VAW in the UK. Subject index

and key word searches were conducted on ‘PsycInfo (APA)’ and ‘Academic Search Complete (EBSCO)’ databases. Citation and author searches were conducted using Scopus and Google Scholar, and finally, a hand search was conducted on the ‘Violence Against Women’ journal. See Appendix A for details regarding the search strategy, including search items, and inclusion and exclusion criteria.

Thirty-two items were found, which were read and organised into the key themes outlined below. See Appendix B for a flowchart outlining the process of literature selection, and Appendix C for the exhaustive list of identified literature.

1.5.1. Trauma-Focused Approaches

Eleven papers found pertained to trauma-focused approaches to empowering victims/survivors of VAW. Five of these related to the Trauma Recovery and Empowerment Model (Harris, 1998) – a manualised intervention for women who develop psychological difficulties following physical or sexual abuse. It has three components: empowerment, trauma education, and skill-building; which are achieved through peer support and cognitive-behavioural therapy (CBT) techniques for PTSD. While the model does not provide an empowerment definition, it states it is achieved when clients ‘develop the strengths and skills necessary for more directly addressing trauma and its impact’ (Fallot & Harris, 2002, p.482). Empowerment is therefore conflated with trauma education and skill-building, with these latter two considered the processes through which empowerment is achieved.

Three papers pertained to TIA. Sullivan et al. (2017) implemented TIA in DV shelters, helping women develop skills to be in control of their lives and know how to keep safe. They conceptualised empowerment as a woman’s ‘sense of their own ability to put safety strategies into practice’ (p.568). Pebole et al. (2021) outlined trauma-informed exercise for victims of SV, where coaches were trained in TIA principles like running women-only classes and permitting only consensual touch. Although the authors stated that empowerment was a goal of this intervention, no explanation was provided as to how these practices would empower women. They stated that empowerment led to the women making unspecified ‘positive behavioural changes’ (p.4). Hadjiioannou (2021) outlined TIA to psychotherapy for victims of SV, said to empower women by respecting their own methods for processing trauma,

such as demonstrating respectful curiosity and supporting clients to set personally meaningful goals. The author defines empowerment broadly as freedom of movement between physical and psychological spaces.

Two papers referred to a broader trauma recovery approach. Dutton (1992) argued empowering women subjected to IPV involves supporting them to heal from trauma symptoms. Lloyd et al. (2017) outlined a programme to teach victims of VAW skills in assertiveness, managing distress, relaxation, relationship-building with children, and help-seeking. Empowerment was conceptualised as enhanced self-esteem and ability to care for children.

Finally, VanDeusen and Carr (2003) detailed a trauma-focused group for SV victims/survivors, integrating CBT, feminist, relational, and psychodynamic ideas. Through exploring traumatic experiences and reconnecting with others, empowerment was purportedly achieved as women experienced a ‘greater sense of control over herself and her environment’ (p.212).

Within trauma-focused approaches, empowerment appears to commonly be conflated with skill development in the name of trauma symptom reduction or management. In this way, empowerment is tied to the notion of control – an empowered woman is one who is perceived as in control of her life, environment, and distress.

1.5.2. Cognitive and Behavioural Approaches

Six papers outlined CBT approaches to empowering victims/survivors of VAW. Four of these pertained to the Helping to Overcome PTSD with Empowerment model – a manualised CBT intervention for women with supposed PTSD symptoms, residing in shelters after experiencing violence (Johnson & Zlotnick, 2006). CBT techniques for PTSD symptom reduction and management are referred to as an ‘empowerment toolbox’. Practitioners are said to empower by prioritising client choice throughout treatment, and teaching skills to live independently (Johnson & Zlotnick, 2009).

Santos et al. (2017) outlined a CBT approach to working with women subjected to IPV, including techniques like problem-solving and assertiveness training. Although

empowerment was identified as a key goal, it was not defined, but rather likened to self-esteem. Kubany et al. (2004) outlined a cognitive therapy with a 'self-advocacy and empowerment' module which includes teaching skills around assertiveness, identifying violent men, and decision-making in a way which satisfies personal needs. No definition for empowerment is provided, but it seems apparently conflated with getting one's needs met while avoiding harm.

These approaches aim to empower women by supporting them to achieve goals, teaching skills, and facilitating choice. Empowerment within these approaches therefore involves individual women changing their behaviour.

1.5.3. Creative Approaches

Four papers pertained to creative approaches; two of which related to music therapy. Despite describing music as the 'vehicle of empowerment' (Hernandez-Ruiz, 2020, p.3), neither paper defined empowerment, and instead likened it to a feeling. Some ideas were however shared as to how music therapy is empowering: MacIntosh (2003) cited group cohesion and communication, and Hernandez-Ruiz (2020) cited controlling anxiety and being 'at peace' (p.5) with oneself as the mechanisms of empowerment.

One paper outlined Wilderness Therapy – deriving healing from interactions with nature, guided by reflection with a therapist (Powch, 1995). This is purportedly empowering as coping with wilderness improves women's confidence in their ability to be self-reliant. Empowerment is conceptualised as 'connectedness with the powers of the earth' (Powch, 1995, p.12).

Finally, Guthrie (1995) outlined that through karate, women are healed 'from the wounds inflicted by patriarchal oppression' (p.110) by learning attitudes and skills which empower physically, mentally, and spiritually. Physical empowerment is defined as feeling able to defend oneself; and mental and spiritual empowerment as overcoming fearfulness and developing 'awareness of the importance of persistence and spirit in achieving goals' (p.112).

Within these creative approaches, empowerment is either defined vaguely or not at all. There is a reliance on empowerment being understood as a *feeling*; there seems an implicit spiritual element to the healing which arises from it.

1.5.4. General Therapeutic and Transtheoretical Approaches

Three papers did not ascribe to any particular modality. Prochaska and DiClemente's (1982) transtheoretical Stages of Change model featured as an empowering approach – one paper specifying problem-solving and another, Motivational Interviewing (Rollnick & Miller, 1995) as the mechanisms through which practitioners empower women to move through the stages. The empowering change was either ending relationships with violent men (Burman, 2007) or anything which would 'improve their safety' (Craven et al., 2022, p.335). Burman (2007) also framed empowerment as a feeling derived from leaving a violent relationship, likened to self-confidence.

Roberts and Burman (2007) described how combining general therapeutic strategies – such as active listening and safety planning – can empower women. Empowerment was framed as 'facing fears', 'taking control' (p.71), and challenging 'self-defeating thoughts and beliefs that restrain rational decisions' (p.80).

Control and decision-making are key to empowerment conceptualisations within these strategies, as these supposedly enable women to ensure her safety. Conversely therefore, making decisions which professionals deem undesirable or unsafe are framed as the hallmarks of a disempowered woman. This positions professionals as more knowledgeable on how one can best keep safe, and their role is to pass this knowledge to clients, empowering them to make better decisions.

1.5.5. Feminist Approaches

Three papers outlined feminist approaches to varying therapeutic practices. Hattendorf and Tollerud (1997) advocate a feminist approach to psychotherapy which empowers victims of VAW by validating their feelings and promoting assertive action – ideally, ending relationships with violent men. Richmond et al. (2013) detail integrating feminist principles with a TIA to empower a victim of SV. This involved:

building an egalitarian therapeutic relationship; considering how issues of social justice related to her identity and experience of SV; and engaging in social activism through protests. The client was said to be empowered as she was more aware of her own power and connected to issues of social justice. Finally, Crowder (2013) detailed an integrative mindfulness and feminist intervention, where empowerment and self-compassion were identified as the primary focus. Empowerment was not defined but was likened to a *feeling*, demonstrating little consistency in how empowerment is conceptualised and addressed across these feminist approaches.

1.5.6. Meditation

Three papers pertained to meditation practices: two of which centred around Mindfulness-Based Stress Reduction – a mindfulness programme including body scanning and present moment focus (Bermudez et al., 2013; Dutton et al., 2013). In both, empowerment was likened to assertive communication, confidence, self-efficacy, and ending relationships with violent partners.

Finally, Kane (2006) outlined concentrative meditation – teaching participants to remain aware of their breathing. This was said to empower women by reducing distress, thereby placing women in control of their recovery. Empowerment was likened to ‘self-acceptance’ and ‘connection with the self’ (Kane, 2006, p.511).

These approaches frame empowerment as the result of learning and practising a skill – supporting women to feel confident and in control of both distress and relationships with violent men.

1.5.7. Consciousness-Raising Approach

McGirr and Sullivan (2017) trained DV shelter staff in consciousness-raising exercises, such as discussing with residents how common DV is, reasons why this may be, and how it commonly effects people’s lives. Empowerment was defined as: making and trusting one’s own decisions, achieving goals, problem-solving, and believing one has the freedom and ability to make life changes. The authors suggest consciousness-raising empowers women by helping them ‘develop successful strategies for navigating [harmful societal] forces’ (p.159).

Curiously, this study amalgamates two potentially opposing conceptualisations of empowerment – a Liberation Psychology approach conceptualising empowerment as a collective endeavour (see Section 1.4.5.), while measuring empowerment using outcomes reflective of an individual agency conceptualisation (see Section 1.3.2.2.). While it condones a wider lens in understanding VAW, the avenue for empowering change remains with the individual woman and her skill acquisition.

1.5.8. Solution-Focused Therapy

Within a Solution-Focused Therapy approach, Lee (2007) conceptualised empowerment as a 'positive sense of self' (p.105), achieved through becoming aware of one's needs and goals. Practitioners are said to empower by supporting women's self-determination in what they want to change about their life, advocating for violence-free relationships, and supporting them to develop their own solutions to self-identified problems. The practitioner's role is to encourage women to 'do more of what works' (p.107) – with a caveat that this involves building violence-free relationships (no guidance is provided on how this can be achieved). Empowerment is conceptualised as control, safety, and a positive self-concept; with the acknowledgement that women already have the skills to achieve this – practitioners do not teach, but merely bring skills to the fore.

1.6. Summary and Research Aims

Empowerment features across various psychological therapeutic approaches used in the UK for supporting women subjected to violence. However, the concept of empowerment across these approaches is eclectic, often vague, and lacking explicit definition.

The absence of a clear, unified understanding and articulation of empowerment potentially limits its usefulness in therapeutic work with victims/survivors of VAW, and potentially also its therapeutic impact. Its definitional diffuseness permits claims that an approach empowers clients without requiring demonstration of any particular outcome. Additionally, the assumption that researchers are not required to provide

clear or delineated definitions presumes generalisability – that empowerment means something similar across populations. This may lead to the construction of women's empowerment through a default white, Eurocentric lens, which can also ignore intersectionality. This exemplifies a common critique of Eurocentric feminism – a presumption of generalisability which disregards variations of identities within womanhood, such as the contributions of race and sexuality.

The therapeutic approaches primarily focus on an individual's skill acquisition and trauma symptom reduction, overlooking the patriarchal context of VAW. Individualised approaches such as these undermine the pervasiveness of the problem, and situate individuals as the agents of change, obfuscating opportunities for collective action. Empowerment approaches aimed at skills acquisition are also predicated on the assumption that disempowered women are simply insufficiently skilled, reflecting harmful, victim-blaming rhetoric around VAW. This also places the onus on individual women to change themselves, supported by professionals patronisingly positioned as more skilled, whose role is to educate. The patriarchal roots of clinical psychology and psychotherapy are evident in these misogynistic conceptualisations of women's supposed contribution to their own violent oppression. Additionally, few frameworks exist for both maintaining womanhood and being powerful, as patriarchal society does not recognise these concepts as co-existing (Shields, 1975). Given the inherently disempowering nature of patriarchy, it is therefore difficult to imagine what aspirations clients might have as to what an empowered woman can be, or indeed what viable opportunities exist which women can draw upon in constructing empowerment-oriented goals.

Literature suggests therefore that the field of clinical psychology has taken a political stance. Firstly, by attempting to refuse one and operate apolitically, ignoring the relevance of patriarchy to women's disempowerment. Secondly, through preferential selection and practice of approaches which contain at best, incoherent, and at worst, harmful conceptualisations of women's empowerment. In addition, there is a substantial and varied body of psychological literature which outlines a range of therapeutic approaches for working with victims/survivors of VAW, many of which are reportedly employed in the name of empowerment. However, empowerment is

rarely, if at all, operationalised (nor features further beyond being simply named) within the techniques and methods of these therapeutic approaches.

In this way, existing psychological literature fails to adequately address a number of things. Firstly, should practitioners view VAW as a component within women's structural, socio-political disempowerment, it is unclear how they strive towards empowerment within therapy while operating within the context of theoretical and organisational apoliticism. Next, it is unclear how practitioners navigate the incoherent and potentially harmful conceptualisations of women's empowerment available to them in the literature to provide truly empowering care. Additionally, it is further unclear how practitioners make sense of, define, and therefore aim towards empowerment given the absence of operationalisation within the therapeutic models outlined in the literature. While plentiful literature exists exploring victims/survivors of VAW experiences of, and perspectives on, empowerment in therapy (see Section 1.4.1.), little is known about how *practitioners* navigate these various literature gaps, problems, and contradictions to provide the therapy said to empower these women. Put another way, it is unclear within the UK context how practitioners digest this literature to provide therapeutic support to this population in the empowering manner expected of them by various bodies and organisations (see Section 1.4.). The present research deliberately therefore focuses on practitioners in investigating this topic in order to shed light on this particular gap in the current VAW literature surrounding women's empowerment within therapy.

This research therefore addresses the question: how do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women who have been victims of violence?

2. METHODOLOGY

This chapter outlines how the present research was conducted, by describing the epistemological stance taken; the research design; the process of engaging with reflexivity; methods regarding participant criteria, recruitment, materials used, procedure, and ethical considerations; and finally, how data were analysed.

2.1. Epistemology

Research methodology, epistemology, and ontology are nested concepts, and as such, researchers should strive to achieve concordance across each level (Braun & Clarke, 2022). Epistemology refers to the nature of knowledge and what is considered meaningful ways of generating knowledge, and ontology refers to the nature of reality (Braun & Clarke, 2013). This research is positioned within critical realism with a feminist lens.

Critical realism (Bhaskar, 1978, 2010) combines ontological realism (the notion that an objective reality exists) with epistemological relativism. Relativism refers to the belief that knowledge is contextually and socially produced, and methods of data collection cannot provide direct insight into reality, but rather, into observable experiences (Seidel, 2014). Adopting a critical realist stance means the research is positioned between realism and relativism – retaining a concept of truth and reality, while recognising that human practices (like culture, language and politics) mediate perceptions of this reality. Thus, any understanding achievable through research will simply reflect perspectival and contextual truths (Braun & Clarke, 2022).

In constructing, reporting and reflecting on analyses from this research, I therefore draw upon notions of both participants' 'realities' (such as the constraints existing within their worlds) and the social production of their situated realities which is observable through their accounts. This is not merely a theoretical positioning – it is

also an ethical one. I do not view VAW and oppression as concepts which are *up for debate*; they are a material reality of people's lives. Adopting a critical realist stance permits me to acknowledge the influence of social and contextual positioning on the language participants use to construct their accounts, without losing focus on the very real manifestations of women's subjugation.

I also draw on critical feminist research principles; Lafrance and Wigginton (2019) outlined these core principles. Firstly*, positioning oneself as the constructer of a research question* (RQ) rather than hiding 'behind the veil of scientific neutrality' (p.539). As explored in Section 4.1., I acknowledge this RQ stems from my viewpoints that women's empowerment is a topic worthy of research, driven by my social positioning as a woman and value alignment with feminism. Secondly, *considering the role of language*. I attend to language through my critical realist stance, and consider patriarchal discourse around VAW and empowerment throughout this research. The third and fourth principles – *reflexivity*, and *representation and intersectionality* – are considered throughout (see Sections 2.3., 2.4.5.3., and 2.4.5.4.). Lastly, *mobilising research for social change*. In the present research, I highlight relevant implications on practice and policy (see Section 4.4.) and attempt throughout to avoid unnecessary jargon to increase the utility of the research for stakeholders across different fields.

2.2. Design

A qualitative approach was chosen for two reasons. Firstly, the RQ pertains to exploring how a particular group conceptualise a particular concept – addressing this requires a level of detailed investigation not achievable through the prepared measures or closed questions used in quantitative research. Secondly, qualitative approaches are advised within empowerment research. Given the lack of consensus on what the construct means, quantitative methods might delimit the field's attempts to understand empowerment; for example, reliance on closed questions means a researcher must predetermine what definition of empowerment participants are provided in quantitative research (Zimmerman, 1990). A qualitative framework provided me the space to explore participants' idiosyncratic understandings of

empowerment – in line with both the crux of the RQ and a critical realistic epistemology.

Thematic Analysis (TA) is a qualitative research method whereby a researcher *codes* a dataset (interprets the meaning of sections of data) and creates *themes* based on patterns they construct from the codes (Braun & Clarke, 2006). Reflexive TA (RTA) is an approach to TA which involves critical interrogation of researchers' actions; researcher subjectivity is therefore not a problem, but an asset to be engaged with (Braun & Clarke, 2022). I chose RTA as its engagement with subjectivity over valuing (attempts at) objectivity makes it well suited to both critical realism and research conducted by a single researcher (Braun & Clarke, 2022). It also lends itself to producing actionable recommendations for various contexts, such as policy development (Braun & Clarke, 2022), which I aim to provide. Additionally, the theoretical flexibility of RTA affords the adoption of a *critical framework* – analysis which interrogates patterns of meaning around a topic, as opposed to an *experiential framework*, which predominantly focuses on individuals' experiences.

RTA felt more relevant for the aims of my analysis than other qualitative approaches; for example, Interpretative Phenomenological Analysis. While this approach may also have enabled me to generate nuanced insights into participants' statements, its focus on experiences might have diverted attention from exploring patterns in participants' understandings and perspectives. Alternatively, I could have adopted a critical framework through Critical Discourse Analysis; however, the sole focus on language within this approach would not adequately address the breadth of the RQ.

I chose to collect data via interviews as exploring understanding and meaning-making are the 'root' purposes of using interviews in research (Seidman, 1991, p.3). I interviewed participants individually as opposed to, for example, using focus groups, to capture variegated opinions and perspectives in how practitioners make sense of empowerment, rather than capturing group meaning-making. Given the variety of services victims/survivors of VAW present in, it also made sense to interview participants individually as practitioners grouped into a focus group might have such vastly different training, ways of working, and workplace contexts, there may be little common ground for a meaningful discussion.

A semi-structured interview style was chosen to enable data collection relevant to a predefined RQ, while allowing unforeseen areas of pertinence (to either participants or myself) to be explored. A semi-structured style also helps keep researchers visible as participants in knowledge production, rather than obscured behind a pre-set interview (Brinkmann, 2020). This aligns with the ethos and goals within RTA and critical realism.

Via a questionnaire, participants were also asked to provide information regarding: gender identity, job role, main therapeutic modality, number of years post-qualification, and the type of service in which they work. This was to gather contextual data through which to interpret interviews. Additional information regarding demographics was not asked; in line with the epistemological stance, demographic data is not necessarily required (there is no expectation my participant group is a statistically representative sample). Rather, factors like age and race are only relevant insofar as their contributions to participants' perspectives, in which case, this is capturable in interviews should participants feel it relevant to address.

2.3. Reflexivity

Reflexivity is a tool for researchers to recognise and interrogate their assumptions. It is essential within qualitative research (Berger, 2015), particularly so for RTA (Braun & Clarke, 2022) which foregrounds researchers' critical interrogation of their role in the production of what they deem as knowledge. Reflexivity is also key in feminist research (Lafrance & Wigginton, 2019). Feminist researchers are particularly driven to dismantle notions of scientific objectivity as it has historically privileged and upheld patriarchal values in knowledge production (England, 1994). By explicitly stating their values and assumptions, researchers can avoid implying impartiality, reducing the risk of passivity and perpetuation of harm from existing patriarchal research structures (Lafrance & Wigginton, 2019).

As advised (Ortlipp, 2008), I used peer discussions, supervision, and a reflexive research journal to facilitate reflexivity around my values, beliefs, and assumptions. For example, six months into the project, my Director of Studies (DoS) and I

discussed whether the research title sufficiently captured the specificity of the topic. I brought this to supervision having noticed while reviewing literature that I was searching for research specifically around women subjected to violence, not necessarily all women – as stated in the original title. I felt surprised by this seemingly obvious oversight, as I had always intended to research VAW. I reflected that perhaps this oversight indicated an assumption I hold – assuming all women who receive therapy have been subjected to violence at some point. It was essential to not only correct for this error by changing the research title (see Appendix D), but to also remain cognisant that I hold this assumption and consider how it might influence the research. In interviewing participants, I reminded myself to make it clear I am enquiring around victims/survivors of VAW and not all women, and I have remained cognisant while writing this research that not all readers will feel VAW is as pervasive as I may.

Intersectionality refers to the idea that numerous systems of power intersect to create compounding attributes of privilege and oppression in how an individual is socially and contextually situated (Crenshaw, 1989). In line with feminist principles, intersectionality was useful in guiding both reflexivity and considering representation – researchers have a duty to consider how their work represents less privileged others (Richards et al., 2014). The area of relative disadvantage of being a woman felt easily at the forefront of my mind when interrogating assumptions, interpreting data, and critiquing evidence – facilitated by my feminist alignment. However, other areas may have been less obvious to me. I considered the role of my intersecting areas of privilege – such as being white, cisgender, straight and identifying as able-bodied – to direct my critical examinations of how I conducted this research (see Section 4.1.).

2.4. Method

2.4.1. Participants

This research aims to contribute towards the field of clinical psychology regarding the support provided to women subjected to violence. I therefore sought individuals

who were current practitioners of psychological therapy and felt sufficiently experienced working with women subjected to violence to reflect on this work. There were no exclusion criteria regarding therapeutic modality. I aimed to capture a naturalistic insight into therapy within the UK, so invited practitioners from across traditions and approaches.

I sought experienced practitioners, defined as: at least five years post-qualification, and/or those who supervise or train others in their modality. Although this criterion increased the risk of capturing an unrepresentative view of the workforce, this decision was made for two reasons. Firstly, newly qualified practitioners are likely to still be discovering preferred ways of working, so their viewpoints on this topic may change considering their perspectives and practices are likely in flux. Secondly, to increase the extensiveness of my insight by interviewing more powerful practitioners – for example, interviewing a supervisor provides insight into not just their practice, but how supervisees may too be encouraged to practice.

2.4.2. Recruitment

Recruitment emails (see Appendix E), with an attached advertisement poster (see Appendix F), were sent to individuals in my social and professional network. I utilised a snowballing technique by requesting they share my advertisement, if they felt comfortable to do so, with their teams and other suitable practitioners. I also emailed various UK organisations who specialise in psychological support for victims/survivors of VAW to introduce myself and the project, and outline eligibility criteria. I requested those interested and eligible to email me, and I confirmed respondents' eligibility via email correspondence, prior to arranging the interview and sending relevant documentation (see Section 2.4.4.).

Twelve participants were recruited. Guest et al. (2006) suggest that data saturation in qualitative research can be achieved by approximately 12 participants. However, data saturation is not necessarily a crucial aspiration for RTA, as the centring of the researcher's role in knowledge production contradicts the notion that codes and themes exist organically within data; ergo opposing that saturation of a researcher's analytic ideas can be reached by any predetermined number of datasets (Braun & Clarke, 2021). Whilst data saturation was not being pursued, I sought to recruit as

many participants as would be meaningful for theme generation within the time limitations of a doctoral thesis. Braun and Clarke (2013) propose that 12 datasets balances being sufficiently large for meaningful theme generation, while sufficiently focused to avoid superficial interpretations. Braun and Clarke's position provides a convenient guide to consider whether my participant numbers are generally accepted for analysis of this kind; however, this did not drive the decision to cease recruitment at 12 participants. Recruitment began in June 2022, and given the deadline for submission of the thesis in May 2023, it was decided, in discussion with my DoS, that to allow time for sufficient depth of analysis, recruitment should be completed by the end of December 2022. By January 2023, I had recruited and interviewed 12 suitable participants and was advised by my DoS to stop, in keeping with our pre-agreed deadline for what we considered would allow sufficient time to conduct thorough analyses in order to complete and submit the thesis by May 2023.

2.4.3. Materials

Interviews were mostly conducted using Microsoft Teams, and were audio and video recorded using the programme's functionality. One interview took place over the telephone, recorded using an encrypted Dictaphone, due to technical problems with Microsoft Teams. Interviews took place remotely due to the UK government's COVID-19 infection control guidance at the time of the research being designed. Data were stored on a secure OneDrive, provided by the University of East London (UEL). My university email address was used for participant correspondence. Transcripts were written, and later coded using the 'comments' function, using Microsoft Word. During the process of analysis, Microsoft Excel was used to keep track of developing themes and codes. Microsoft Word was also used to create the study advertisement, consent form (Appendix G), participant information sheet (Appendix H), debrief sheet (Appendix I), questionnaire (Appendix J), and interview schedule.

The interview schedule was created in two phases. An initial draft (Appendix K) was created through discussions with my DoS, which I piloted by interviewing a CBT therapist I recruited through a personal connection. After reflection with my DoS on the responses the draft schedule elicited and the challenges I encountered, edits were made – mostly around items which led to repetitive responses and adding in

clarifying statements for some of the terms used. This consequential second and final version of the schedule (Appendix L) was used for all 12 participants.

2.4.4. Procedure

Participants were emailed the participant information sheet, consent form, and questionnaire. I requested they read these and complete and return the consent form and questionnaire, inviting them to contact me if they wished to discuss further. Once we found a one-hour timeslot, where participants anticipated they could speak comfortably without disturbance, I sent a Microsoft Teams meeting link.

At the start of each interview, I checked participants felt comfortable for me to start recording, and that they had read the documents, and invited any questions. I welcomed them to pause or terminate the interview at any stage, and I aimed to be clear about why things were happening and what to expect next. There is an inherent risk of distress or unethical practice within a researcher–participant power differential; for example, participants feeling obliged to continue for fear of upsetting the researcher if they terminate the interview (T. Patel, 2020). Although these procedures cannot be said to eliminate this risk, my intention was to feasibly reduce it.

In line with a semi-structured style, each main (numbered) item in the interview schedule was asked to each participant, with variable follow-up questions. As advised for good practice in research interviews, I limited my responses to seeking clarification or elaboration, refraining from additional responses such as empathic statements, which may influence participants' responses thus compromising data integrity (Seidman, 1991). To hone these skills, I presented my DoS with a transcription of the pilot interview, who then provided feedback on my interviewing style and areas for improvement.

Interviews lasted between 41 and 73 minutes – the mean average being 51 minutes. At the end of each interview, I asked participants if they would like to receive a copy of the written research, and informed them I would email a debrief sheet, which was immediately sent. In this email, I also welcomed participants to get in touch with queries or concerns, and thanked them again for participating. I aimed to ensure

participants did not feel left alone to manage any distress arising from participation, in line with ethical guidelines (British Psychology Society [BPS], 2021).

I do not plan on seeking participant validation when I return the research to them. Within its critical realist epistemology, this research seeks neither 'truth' nor a summary of participant perspectives; I am instead creating an informed interpretation. As such, whether or not participants' own interpretations align with mine bears little weight in research not concerned with accurate summaries nor agreed upon truths.

2.4.5. Ethical Considerations

The UEL School of Psychology Research Ethics Committee granted ethical approval (see Appendix M). I used regular supervision throughout to enhance the research quality and reflect on my conduct – a requisite for ethical research (T. Patel, 2020) and *scientific integrity*, one of the core principles of the BPS Code of Human Research Ethics (2021).

2.4.5.1. Data processing: Data were processed lawfully in accordance with Article 89(2) research exemptions of General Data Protection Regulation 2018. Only I had access to participants' personal information, as I solely created anonymised transcripts and subsequently deleted recordings within three weeks post-interview (participants were informed they could only withdraw data until this point). Only my DoS and examiners can access these anonymised transcripts. Data, currently securely stored on my OneDrive, will be stored on my DoS's OneDrive following research completion for three years before erasure. This carefulness around confidentiality adheres to the ethical principle of *respect for autonomy, privacy and dignity* (BPS, 2021).

2.4.5.2. Valid consent: Participants were provided information sheets outlining the participation process; including their right to withdraw, and plans for data processing and dissemination; and I reconfirmed consent at the start of each interview. There is a risk of coercive pressure to participate when recruiting through direct requests to individuals as I had (T. Patel, 2020). By inviting contact without a time pressure so individuals had time to think about their response, and making it clear there is no

expectation to participate nor ramifications if they decline, I attempted to mitigate this risk and uphold the principle *minimising potential harm* (BPS, 2021).

2.4.5.3. Potential for distress: As the interview schedule and questionnaire enquired around professional practice rather than personal questions, I considered it unlikely to cause distress. However, distress may have been caused if participants felt pressured to provide information in the context of the researcher–participant power differential (T. Patel, 2020). This may have been offset by my trainee status, which put me in a less powerful position than the experienced practitioners I was interviewing. I also attempted to alleviate potential distress using clinical skills like active listening and curiosity (T. Patel, 2020). By conducting interviews remotely, participants had flexibility in deciding where and when they felt most comfortable to participate. Finally, in information and debrief sheets, I provided contact details for agencies participants could contact if distressed.

2.4.5.4. Dissemination and representational ethics: I will attempt to disseminate this research in a way which hopefully reaches key stakeholders (see Section 4.4.) – research dissemination is considered ethical practice (T. Patel, 2020), and aligns with the principle *maximising benefit* (BPS, 2021). The final BPS principle – *social responsibility* – refers to reducing the risk of research causing harm. I have upheld this duty to participants by attempting to remain true to what they said in my analyses and not undertaking belittling data interpretations. I also aim to uphold this duty to wider society by discussing implications of the present research which I believe will facilitate more socially-just psychological practice (see Section 4.4.).

2.5. Analysis

RTA requires information regarding the *context* and *content* of data. I captured what I considered relevant *contextual* information to the interviews using a reflexive journal (see Section 2.3.). I transcribed interviews verbatim (containing only verbal communication) as this allowed me to capture the *content* of participants' speech, thus satisfying RTA requirements. Verbatim transcripts are also appropriately detailed for predominantly semantic level (explicit, surface level) analysis (Braun &

Clarke, 2006). A semantic focus was chosen as I adopted a critical framework, which views language as an active component in meaning creation, aligning with a feminist epistemological lens. In other words, a critical approach involves looking *at* language to understand how reality and meaning are created, rather than looking *through* language to a reality it provides access to (Braun & Clarke, 2022). Widdicombe and Wooffitt (1995) also argue a semantic analysis aligns with critical realism as this too assumes meaning is reflected in semantic content, as it is through language that interpretations of reality are constructed, thereby reducing the utility of a more latent analysis.

I analysed data using the six phases of RTA: familiarisation; coding; generating initial themes; developing and reviewing themes; refining, defining and naming themes; and writing (Braun & Clarke, 2022). Familiarisation with the data begins during transcription, after which, I read through the transcripts twice to facilitate data immersion. I critically engaged with the data by documenting reflections in my research journal, to enable some distance from it. It is through these dual processes of immersion and distance that a thorough and reflexive analysis can occur (Braun & Clarke, 2022).

The second phase, coding, involves summarising portions of data into what meaning I have interpreted and what is notable about that meaning in relation to the RQ. I approached this research without particular analytic predictions, and worked from a naïve rather than theory-driven basis for gathering and analysing data. It was therefore logical to code inductively, and I aimed for codes to be data-driven as much as possible. I went through the transcripts to code items twice, as is the recommended minimum (Braun & Clarke, 2022) in a different order the second time, to facilitate fresh perspectives on the data. See Appendix N for an excerpt of a coded transcript, and Appendix O for an excerpt from the initial list of 388 codes.

I generated initial themes by exploring the shared ideas underlying these codes, aiming to provisionally tell a story about the RQ inductively from the data. This was facilitated by provisional thematic mapping to consider relationships between these shared ideas, while keeping the RQ in mind to explore patterns which illuminate understanding of the topic. I did this by printing the codes onto slips of paper which I could move and arrange into themes (see Appendix P). As advised (Braun & Clarke,

2022), I moved onto the next phase once I had mapped out provisional themes which I considered distinctive from each other and meaningfully contributed insight to the RQ.

To develop and review these themes, I discussed them in supervision and re-engaged with the data. This was done by re-reading codes and transcripts to ensure I had not strayed from the data or inadvertently misrepresented it by constructing themes based only on decontextualised codes. I then transferred these themes onto provisional thematic maps (see Appendix Q).

Themes were refined by checking for internal theme clarity and homogeneity, questioning whether each had a *unique* contribution to the analysis, and bearing in mind the critical framework by ensuring each focused on the interrogation of meaning. Theme refining and defining became a bi-directional process. As advised (Braun & Clarke, 2022), if I was unable to capture the essence of what defines the central organising concept of each theme, or demarcate their boundaries, I reviewed and refined the theme until this was possible. This was done both independently and in supervision – refining amendments are captured as annotations on the maps in Appendix Q. From this phase, I produced the final themes (see Appendix R).

In writing the analyses, I have edited quotations by replacing comments which I felt were unnecessary asides that may detract from the narrative flow, by using '[…]'. I have decided to use active, first-person voice, to ensure I remain visible in the process and 'own' my perspectives and views rather than implying they are facts. This writing style reflects an RTA and a feminist approach to research.

3. ANALYSES

This chapter presents the seven themes and 18 subthemes I created, arranged into three overarching themes: *understanding empowerment, 'what I do with clients',* and *'a hand tied behind our back': practitioners face barriers to empowering therapeutic practice.* Participant information is presented in Table 1 and a structural outline of the themes in Table 2.

Table 1

Participant Information

	Total
N	12
Gender	
Men	1
Women	11
Main therapeutic modality	
CBT	3
Systemic	2
Gestalt	1
Psychodynamic	1
Integrative counselling	1
Integrative: systemic, attachment	1
Integrative: Narrative, third-wave CBT	1
Integrative: Schema Therapy, CBT	1
Integrative: Person-centred, transcultural, Narrative	1
Years of experience post-qualification	
0-5	4

6-10	6
30+	2
Type of service currently working in	
NHS sexual violence service	5
Independent practice	2
Local authority	2
NHS psychiatric inpatient	1
NHS physical health	1
NHS clinical research	1
Professional role	
Clinical Psychologist/Specialist Clinical Psychologist	4
Psychotherapist/Senior/Specialist Psychotherapist	3
Clinical Psychologist and Professor	1
Systemic Family Therapist	1
CBT Therapist	1
Counsellor	1
Clinical Lead	1

Table 2

Outline of the Themes Created

Overarching Theme	Theme	Subtheme
A. Understanding empowerment	1. Understanding violence against women	1. Some women attract violence 2. Violence robs from a woman
	2. Coping is power	1. Putting up with it 2. ‘Back into the vastness of their own

		life': A person's story beyond violence 3. Taking back what was stolen 4. Won't get fooled again
	3. 'I just think it's more complicated than that'	1. You can't always get what you want 2. 'Like trying to stay afloat and kicking frantically': Practitioners also struggle
B. 'What I do with clients'	1. Therapist as human	1. 'We're all turkeys in the same turkey soup' 2. Human connection versus duty to modality
	2. What is done in the process of therapy	1. 'Letting them know that they're not alone' 2. Social action, but confined to within services 3. Building a reparative therapeutic relationship 4. 'It wasn't your fault': Challenging self-blame
C. 'A hand tied behind our back': Practitioners face barriers to empowering therapeutic practice	1. Problems with the field of psychology	1. 'We pathologise victims' 2. Feeling, but not being, empowered is all psychology can achieve
	2. Socio-political barriers	1. Under-resourced and disempowered services 2. Society needs to change first

3.1. Overarching Theme A: Understanding Empowerment

The first overarching theme pertains to how participants conceptualised empowerment. Theme one captures how participants understood VAW, offering insight into their understanding of the relevance of empowerment within therapy for this client group. In theme two, participants described what they understand empowerment to mean. Finally, theme three illustrates how participants described concerns around the relevance and utility of empowerment within therapy.

3.1.1. Theme One: Understanding Violence Against Women

This theme describes how participants understood VAW: from causes to impacts.

3.1.1.1. Subtheme one: Some women attract violence: Participants stated that how a woman has learnt to relate to people may make her vulnerable to violence.

> *We [participant and client] were thinking about […] how interpersonal cycles may be presenting for this person, and like how these patterns might actually blind her to warning signs or red flags about potential violent perpetrators* (Participant A)

> *There can often be a pattern that women experience multiple abusive relationships. And again, that's not any kind of blame on them or anything like that, but that can be a known way of relating* (Participant B)

Participants described their attempts to reduce VAW by exploring how their clients relate to people, including violent perpetrators.

> *If you are able to be thoughtful about your dilemmas, if you're able to be thoughtful about the other person and what's going on between you, you're likely to make better decisions* (Participant C)

> *[I use] narrative ideas around storytelling. So if you're the lead character in this drama, you know, what role did you play? What role did your husband*

> *play? […] Supporting someone to kind of see it from a helicopter view* (Participant D)

Participants shared that they did not want to blame victims, and did not conceptualise vulnerability as intrinsic problems within clients. However, they conceptualised how victims/survivors of VAW learnt to interpersonally relate as a cause of ostensive susceptibility.

3.1.1.2. Subtheme two: Violence robs from a woman: Participants described that violence takes things away from women.

> *People who've experienced violence […] their power, their choice, their autonomy, you know, has been taken away* (Participant E)

> *Something I think of, particularly with people affected by violence, is how people's choices are often taken away* (Participant F)

Participant B shared that violence robs a woman of control both over her body during violence, and over subsequent responses.

> *There's a massive component to violence and sexual violence, that somebody has taken control of your physical body* (Participant B)

> *When someone is having PTSD or like trauma reactions, they're out of their control as well. So that's another kind of, well, a side effect of the violence is they then start to have these physical or emotional symptoms, but they're out of their control* (Participant B)

Participants described VAW as an action which takes away women's choice, autonomy, and control, both immediately and longer term.

3.1.2. Theme Two: Coping is Power

In this theme, participants considered women who cope well after violence as more empowered.

3.1.2.1. Subtheme one: Putting up with it: Participants likened empowerment to an ability to tolerate and regulate distress following violence.

> *She was still suffering, but she was able to contain that and to feel good about herself. That was empowerment* (Participant G)

Some described the benefits of emotion-regulation being enhanced capacity for reflection and decision-making.

> *In terms of interpersonal effectiveness, emotion-regulation, helping her just find a way to reground and be able to enter that kind of wise mind […] where she could reflect on what happened* (Participant A)

> *When you're reactive and upset […] you're not in the position to see that you've got choices and hopefully, you know, make good choices […] you're more likely to be able to make better choices if you can stay calm and reflective* (Participant C)

Empowerment was synonymised with not 'giving up' (Participant I), survival, and perhaps even deriving strength from violence.

> *The fact that not only have they kind of survived the assault, but they're still managing to keep going and to keep themselves alive. I think [empowerment is] recognising the things that a client is moving forward with* (Participant B)

> *I've seen people come through this and while it does change who you are and like it will shape you, it doesn't have to be sort of like the end, but that can drive you to do incredible things […] 'this is what I wanna do now, like I want to move past from this, maybe use this to drive me rather than to sort of hold me back'* (Participant I)

Women were considered empowered if they also used this resilience to do more activities.

> *She's able to do so much more and manage so much more, which, you know, I think is empowering in itself to go 'wow, look how much I'm actually able to go back to work, I'm able to, you know, go on a holiday'* (Participant H)

> *Going out and sort of getting voluntary jobs and sort of doing these things that they didn't think they could do* (Participant I)

For some participants, an indicator of a woman's ability to do more is increasing independence from her practitioner.

> *When clients also stop asking for advocacy letters and support letters and they're doing it themselves towards the end of therapy. They're like, 'I've had a word with my new job and I said I need this time off therapy'. Whereas at the beginning it might be something that you provide an appointment letter for. So being able to have those conversations by themselves* (Participant J)

> *The really old school CBT knowing would be sort of helping clients become their own therapist, which, in my head, is empowering* (Participant F)

An empowered woman is therefore seen as one who can tolerate violence without becoming overwhelmed with distress, and thereby avoids resultant thoughtlessness, poor decision-making, or reduction in activity.

3.1.2.2. Subtheme two: 'Back into the vastness of their own life': A person's story beyond violence: Participants described that focusing on hope, resilience and how clients resisted violence, empowers women.

> *There was a before, and there's the now when we're having the therapy, but then there's the hope for the future. And I think hope and joy in therapy is a really big part of empowerment* (Participant B)

> *Sometimes I do a drawing, I say look, you told me about what he did, and it's like a huge big column, and I only know that little bit about you and what you did and what you responded. But I'm really interested to know more, because that is in fact possibly more important than what he did* (Participant G)

> *Create a fuller narrative that takes into account their suffering and their resistance, and their coping, and their resilience* (Participant G)

This is said to be empowering as it helps women develop a sense of identity which is not based around being a passive recipient of violence.

> *We're not saying that this isn't important, this is massively important, but that has become sort of the story of your life. And this is one space [therapy] […] where we can sort of focus on the rest of your life, focus on the rest of you, on what's important for you. So we are not saying it didn't happen, we're not saying it's not really influential in your life, but we're saying that there is more to you* (Participant I)

> *Supporting women to understand, you know, I suppose, supporting them to understand that they have an identity. They're more than just their experience* (Participant D)

> *If they're ready to sort of think about their identity a little bit, which includes their roots and their daily habits, their strengths and their skills […] it's such a powerful tool to bring them back into the vastness of their own life. That this [violence] has happened in this present time, but there's also this huge space they've occupied up until now* (Participant I)

Participants described an empowered woman as one who occludes their experience of violence with acknowledgement of their strengths and abilities when constructing a sense of identity.

3.1.2.3. Subtheme three: Taking back what was stolen: Participants described empowerment as an act through which women reclaim something taken from them, such as choice and control over their actions.

> *Empowerment is when somebody starts to gain control back. Over whether it's relational, whether it's sexual, whether it's personal or spiritual, that it's a way of slowly finding a way back* (Participant J)

> *Find[ing] a new sense of control. Thinking OK, well, what actually is our choice at the moment? What options do we have? Like, what do you want your life to look like now?* (Participant I)

> *You have the power, you have choices now, you can be the person you want* (Participant I)

> *I might explore with them, what does it mean to have free will? What does it mean to be free, to them? What does it mean to be a mother? What does it mean to be, you know, if it was their name, what does it mean to be [says own name]? […] what does it mean to be you now? What do you want to be doing?* (Participant D)

By reclaiming choice and control, clients can supposedly then also reclaim hobbies and personal goals.

> *Sometimes [empowerment is] really small things in personal life. I don't know, doing driving license, passing the test, making choices, going towards self and finding the sense of self again* (Participant K)

> *Empowering is really almost like a personal thing. It can be small things, finding own feet again. So drawing on the power, on the strength which people feel. And it can be going back to gym, very personal, starting back this hobby* (Participant K)

> *Whether that be a dance class or whether that be whatever they previously used to enjoy, that those things are starting to come back into their lives* (Participant B)

> *Empowerment I think I see it when it slowly comes, and 'I did this for me'. Or 'I remember doing this and I haven't done this in a while'. Or 'I applied for a promotion'. Or 'I got into a relationship and I didn't push them away'. Or 'I had sex and it was great'* (Participant J)

Participants also identified reclaiming a positive self-concept as an indication of empowerment. They described that women internalise violence, leading to negative feelings about themselves.

> *I think [violence] festers internally and it becomes something of self-hate and self-criticism* (Participant J)

> *Women arrive and they have this social notion, 'it's my fault, there's something wrong with me, I didn't do anything to stop it therefore it is my fault. And because there is something wrong with me, maybe that is what I deserve'* (Participant G)

Empowerment was likened to regaining self-worth and feeling good about oneself.

> *I would say empowerment is more about acknowledgement. You know, it's about value, it's about valuing yourself* (Participant D)

> *I think that's a really big part of feeling empowered, is that actually, 'I'm important'* (Participant B)

Participants described that this enhanced self-concept reduces a woman's vulnerability to future violence, as women might have the confidence to construct assertive boundaries when they no longer feel deserving of violence.

> *Empower someone to access more positive self-schemas and also to, in that case, how to feel better about themselves? How to feel more entitled to certain boundaries and certain responses from others? And how to name and call out responses that feed any kind of negative self-schema, so to call out any abuses or attacks* (Participant A)

> *Asking for your needs to be met, feeling more confident, asserting oneself in a relationship* (Participant E)

By redeveloping a positive self-concept after violence, women are said to be empowered to develop the interpersonal skills to prevent violence. Participants tied the act of reclaiming to what was initially seen as stolen through violence.

> *What I keep at the core is really trying to support someone to reclaim their sense of power, their control, or I guess that feeling of safety or self-worth that can be taken away following sexual violence or any kind of violence* (Participant E)

> *The opposite has happened within these relationships […] feeling like they have no power, no control, are to blame for their existence, for who they are, for how they've been treated […] empowerment would mean giving them some of that power back in terms of who they are as a person, knowing who they are* (Participant H)

Just as VAW was constructed as having taken something from a woman, empowerment was described as taking something *back*; a woman's act of reparation for what was stolen.

3.1.2.4. Subtheme four: Won't get fooled again: Empowered women were seen as those able to 'have a voice' (Participant H) and self-advocate for their needs.

> *They feel able to and confident to, you know, say whatever they might need in that moment* (Participant E)

> *To be able to speak up in certain situations or to be able to think, so not just necessarily to voice things, but to be able to think about their own needs as well* (Participant B)

Women who self-advocated by saying no and establishing boundaries with others were seen as particularly empowered.

> *With this particular client, she started putting boundaries in with her dad, and also boundaries in with the men that she was seeing. So she was able to advocate her needs and her pleasure* (Participant J)

> *Looking at saying no and what that means […] moving towards a place of, it's OK to say no, it's OK to have a voice, it's OK to put myself first* (Participant H)

Creation of relationship boundaries was seen as a way for women to prevent violence.

> *Being able to advocate that you deserve to […] not be treated in a way* (Participant J)

> *[Considering with a client] what consent looks like, what boundaries look like, what's OK, what's not OK. And empowering both men and women to feel like it's OK to put those boundaries in place and that they need to be respected* (Participant E)

An empowered woman therefore was described as one who is able to prevent future violence by identifying and asserting her needs to others.

3.1.3. Theme Three: 'I Just Think it's More Complicated Than That'

Entitled using a quotation from Participant L, this theme captures caveats to the usefulness and relevance of empowerment within therapy that participants described.

3.1.3.1. Subtheme one: You can't always get what you want: Participant L, in contrast to other participants, did not value empowerment interventions for women in therapy.

> *What [women] really need is for men to not be violent anymore […] empowerment groups do fuck all to help women. Stop men being violent, that's the answer* (Participant L)

Participant L described women's empowerment within therapy as intrapsychic, ruling out other possible approaches.

> *I think, you know, 'I'm gonna work with the woman in an empowering way', oh, are you gonna help her with the racism and the poverty and the shitty housing she's living in? And the lack of choices she's got in regards to education, or employment, or the lack of good childcare or, you know? Because for me,*

> *that's what empowerment means. It's more context-driven as opposed to an intrapsychic individual personal deficit* (Participant L)

While other participants described empowerment as something they indeed aim towards in therapy, many agreed it may not always be realistic within the context of women's realities. They described treading carefully when considering how realistic empowerment is for women in therapy.

> *It has to be realistic, I think. And what I mean by that is it has to fit with the person's circumstances and their potential and what's not gonna make a situation worse for them* (Participant C)

> *Discrepancy between what we should be able to do as women and what we are able to do as women is very different. So it's about holding in mind that balance* (Participant E)

> *There's something about choice and freedom that has space, but not everywhere […] it's an interesting one, I think I'm still figuring that part out* (Participant J)

Participants described that empowerment is only realistic when it involves change within the confines of a woman's existing social context.

3.1.3.2. Subtheme two: 'Like trying to stay afloat and kicking frantically': Practitioners also struggle: Participants described empowerment as something challenging for practitioners to achieve. For some, empowerment felt like a big endeavour.

> *I find this idea of empowering clients quite daunting* (Participant A)

Participant A shared his experience of trying to empower women in therapy was so daunting, it felt like 'trying to stay afloat and kicking frantically so to speak, to swim and not sink'. This was partly due to confusion around what the term meant – a sentiment shared by other participants.

> *You kind of hear this word empowerment and you feel like you know what it means, but then you could ask some questions around it and you think*

> *actually, do I know what that means, and what would that look like?* (Participant A)

> *I don't particularly like the word [empowerment]. I don't know that people have a shared idea about what that means* (Participant L)

> *I think empowerment in itself, it's too big a word and it doesn't mean anything, but it means something* (Participant D)

Participants described the subjectivity and grandiosity of empowerment as a barrier to confidently engaging with the concept in therapy.

3.2. Overarching Theme B: 'What I Do With Clients'

Entitled using a quotation from Participant H, this overarching theme captures what participants described they do to empower clients through therapy: bringing in their own humanity, and particular empowering therapeutic processes.

3.2.1. Theme One: Therapist as Human

Participants described how being in touch with their sense of humanity was important when empowering women.

3.2.1.1. Subtheme one: 'We're all turkeys in the same turkey soup': This subtheme, entitled using a quotation from Participant C, captures participants' descriptions of women's empowerment being facilitated by an acknowledgement of their shared humanity. Part of this is connecting and empathising with suffering as a fellow human and for some participants, a fellow woman.

> *[I draw upon] my humanity. Kindness goes a long way when you're talking with people who are hurt* (Participant L)

> *As a feminist, I particularly want to do this work, but also my consideration of myself as a caring person who wants to work with people affected by harm* (Participant F)

> *I think there is something very empowering in itself of working as two women together* (Participant B)

Participants described supporting and empowering clients by simply being alongside them through their suffering.

> *I think sometimes [therapy] is just going through the dark together* (Participant J)

> *That [empowerment intervention] didn't come from any particular theory. That came from just sitting as a human being with another human being who'd gone through an awful set of circumstances* (Participant A)

Women's empowerment was described as something some participants personally connected with and strived towards as an important part of their humanity.

> *[Empowerment] touches just the core of not only who I am as a person, as a therapist, I think being able to give someone that, or work towards that* (Participant H)

> *I think there is a kind of personal, spiritual element* (Participant G)

For some, this was driven by 'lots, lots and lots' of personal experiences of VAW (Participant C), motivating participants to empower women subjected to violence.

> *I come from a family of many strong women who've had many difficult experiences, quite a few of which involved violence. And I think probably that's really what drew me to this work* (Participant I)

> *I feel there is a spiritual connection from [relative who suffered violence] to me, and I just bring that dimension of support in me, and I feel that there is their love and support. I just feel I'm very approved by them in the work that I'm doing and that I'm just working towards repairing something and empowering women* (Participant G)

Connecting, empathising, and being alongside clients was described by participants as core to their personal sense of what it means to be a woman, human and practitioner.

3.2.1.2. Subtheme two: Human connection versus duty to modality: Some participants described a sense of duty to their modality, despite concerns about its utility in women's empowerment.

> *There's a real loyalty that is assumed because I'm trained in CBT […] But I think it fails different people in a way that we don't talk about or kind of acknowledge and think, OK, how can we help someone who's been through this kind of life event in a way that isn't looking at […] reducing certain symptoms? But about like empowerment and quality of life* (Participant H)

CBT in particular was described by participants as an approach which stymies human connectedness by being harsh, dismissive and blaming.

> *[CBT] feels really like harsh, sharp, kind of dismissive. And yeah you know, getting them to go away and do a worksheet* (Participant H)

> *I do worry about that idea of having thoughts that are unhelpful. So even though I understand it, I think sometimes the terminology, in that sense that we're doing something wrong, bothers me* (Participant I)

Participant A wondered whether the disconnect between modality adherence and human connection was an intentional act of professionals to avoid the 'anger' that comes with working with 'any type of oppression'.

> *It's easy sometimes with these difficult, complex topics [VAW] as a professional to hide behind the theory, the practice, the kind of, the models, and to forget about the kind of human element of it* (Participant A)

For practice to be empowering, participants deviated from 'formal' ways of working as they stated it was more important to be human than adhere strictly to modalities.

> *I've done it the formal way with the formulations, and I've kind of stepped a bit back from that and having it more of a conversation […] I want them to know that I'm looking at them, I'm seeing them, I'm hearing them, I'm, you know, we're kind of in that together, rather than me kind of turning off and doing the paper [CBT formulation]* (Participant H)

> *My sessions look different to say a normal kind of formal one-to-one […] expressing care, meeting her where she's at* (Participant I)

Participants described balancing what they felt was a duty to their modality, with human connectedness and empathy; reflecting that empowering practice involves more of the latter.

3.2.2. Theme Two: What is Done in the Process of Therapy

In this theme, participants described specific therapeutic processes for empowering women subjected to violence.

3.2.2.1. Subtheme one: 'Letting them know that they're not alone': Participants stated it was empowering for victims/survivors of VAW to come together as they could relate to one another in a way practitioners cannot within individual therapy.

> *Empowerment is there [in groups] from being with others, and with other survivors and peers. This is a very humankind need, to have someone who relates […] what is there is really support and empowerment in a scale which one-to-one sessions cannot afford* (Participant K)

> *There's being in [individual] therapy, and there's being heard and there's feeling empathy. But that's very, very different to feeling like somebody actually understands me [in a group]* (Participant B)

This is said to be particularly empowering as it encourages women to feel they are not alone in experiencing violence.

> *[Groups] are wonderful ways of clients to feel empowered […] because clients feel that they're not alone with something* (Participant B)

> *There's a real recognition that it's really hard to be a woman because these things are put on us […] recognize that actually everybody is going through this, like this is not something that is unique to you. So I think there's a real sense of solidarity […] something about having all these women in the room together with that shared experience that feels really powerful* (Participant I)

Participants described group interventions as empowering as they provide women opportunities for feeling understood and recognising violence as an experience tied to womanhood, not an individualised issue.

3.2.2.2. Subtheme two: Social action, but confined to within services: Participants stated the importance of involving clients in how services are run; indeed, Participant K described social action as being 'born through service users' involvement'.

> *Linking clients into our service user engagement work […] often it's thinking about OK, well, what kind of, what's important to you? Is it about changing services, is it about how can we make our services more user-led? And that can be anything from, you know, collaborating on documents to being on interview panels […] it's really embodying choice, you know, collaboration, making sure someone's voice is heard* (Participant E)

> *For clients to give back if they want to, I think that's quite empowering* (Participant J)

Participants conceptualised service user involvement (SUI) as 'getting active politically' (Participant I) which empowered clients by modelling how they could also evoke change outside of services.

> *It's so important that we help them to take control in the areas that they can […] We need to teach people that they can do that, and that they're gonna be listened to, so they can do that in their lives outside as well* (Participant I)

> *Being really collaborative from start to finish, even in the smallest of ways can be, I guess, can model giving back that sense of choice and power to somebody* (Participant E)

Participants considered social action an important part of empowering women, but within the confines of SUI – evoking change within services but not necessarily outside of them.

3.2.2.3. Subtheme three: Building a reparative therapeutic relationship: Some participants stated that therapy empowers women by providing opportunities for their stories to be heard.

> *For them [clients] to be able to find their own sort of voice and their own way, and to be able to tell their story and express their emotions in a way that feels right for them, so that they, in a way, can then at least take control back of their story* (Participant B)

> *The empowering thing for her was to have her story heard and believed* (Participant L)

The practitioner's role is to create space and trust for clients to tell these stories.

> *Giving people the space to talk through what's happened and just be really sensitive, empathetic to their, to their stories, really, I found probably the most powerful* (Participant H)

> *People know that if they can become ready, if they trust you enough to tell you, that you will be able to listen* (Participant C)

Practitioners described that acknowledging and hearing women's stories is an empowering experience as it contrasts violence which disempowers by 'silencing women' (Participant B).

> *Here's the empowerment – I repeat what he did to her. Because that's another thing, we disempower when we don't acknowledge the violence* (Participant G)

Practitioners also described offering contrasting and reparative experiences to violence by being gentle and sensitive to clients' needs.

> *When you can be alongside someone and […] hear and listen and be with the difficult feelings, which can be hard, I think it can feel empowering that someone's not alone. That actually 'there is someone there that can witness my pain and that is able to be there and be in it with me'* (Participant E)

> *[It's] really important to be person-centred. Like in a sense, not challenging. Because people are challenged a lot already […] so how important it is to be gentle* (Participant K)

Participants described equally sharing power within the therapeutic relationship to contrast with clients' experiences of powerlessness in the context of violence, thus offering another reparative experience.

> *You need to understand the therapeutic, the importance of the therapeutic relationship when you're working with violence, and not enacting power over people in a way that they're already experiencing* (Participant L)

> *[I want] clients to be able to question things. And when we think about empowering or control, you know, I might often say things like 'I might have got this wrong', as a way of inviting them to question me* (Participant B)

Some stated that equally sharing power is facilitated by building a collaborative relationship – a particular strength of CBT.

> *CBT does look at, you know, treating the person as an equal […] it does advocate for kind of empowering someone to take responsibility and not let it all fall kind of on the therapist as well, and taking responsibility for actions and change within their life* (Participant H)

Having conceptualised violence as something which robs choice from women, participants stated it was contrasting and empowering to find a 'way of bringing choice in' (Participant J) to therapeutic work.

> *Something I think of, particularly with people affected by violence, is how people's choices are often taken away from them. So something that I try to*

> *do clinically to help empower anyone, but also people who've experienced violence, is to offer a choice* (Participant F)

> *Even little things like moving, if you wanna move closer to someone in the room just like asking permission, 'is it OK if I move a bit closer to you, or is it too much kind of being this close?'. And just seeking permission and choice at every step, to give an opposite message* (Participant E)

Providing opportunities for client choice involved prioritising client decisions over practitioners' concerning what to work on in therapy.

> *Within the services I work for, what the person wants is at the crux of it and consent is key to the work that we do […] it's giving that person the onus and the choice which, for me, is empowerment* (Participant F)

> *I'm going to take my cues from them. And you know, if I want something for them they have not decided or are not clear, I'm taking over. I'm disempowering them. I'm not understanding what they want. And I'm actually wiping out their awareness of themselves or their situations, and somehow disregarding their whole experience and their whole judgment, and prioritizing my own judgment, saying 'I know what's best for you lady, you need to leave that partner'. That's completely disempowering* (Participant G)

Participants therefore described using the therapeutic relationship to offer an opposing 'new experience' (Participant I) to VAW, 'counteracting' disempowerment by 'do[ing] the opposite' (Participant G) of what violent perpetrators do – listening, being sensitive, equally sharing power, and prioritising choice.

3.2.2.4. Subtheme four: 'It wasn't your fault': Challenging self-blame: Entitled using a quotation from Participant B, in this subtheme participants described the importance of helping clients feel the violence was not their fault. They stated women often blame themselves after violence.

> *[Clients feel they] are to blame for their existence, for who they are, for how they've been treated* (Participant H)

> *Clients are put in a place where there's shame, there's guilt, there's self-blame* (Participant J)

> *A lot of my experience of women who are affected by violence has been sort of that internalised blame, which shouldn't be sitting with the person whose experienced that violence, it should be sitting with the person whose perpetrated it* (Participant F)

Participants stated that in therapy they acknowledge wider societal factors related to clients' experiences of violence.

> *I would definitely always acknowledge the field we live in as well. And mention feminism and mention the world and acknowledge the world like, why [NAMES VAW SERVICE] exists. Because the situation needs the service like that, because the situation is as bad as it is* (Participant K)

> *I'm an old fashioned feminist, so I will talk to women about what's happened in the UK and that it wasn't that long ago, historically speaking, that it was legal for a husband to beat his wife* (Participant C)

They stated they do this to empower women by reducing clients' self-blame that the violence was their fault.

> *Talk about how men may find that they are in a position of power […] to come to a humble place of, you know what? We are victimized. It doesn't say anything about us, it says something about the world out there* (Participant G)

> *Anyone could be victimized at any time. It's not saying something about the victim. It's not saying anything bad about the victim* (Participant G)

> *It can be helpful for people to hear that it's not about them as an individual, it's not their personal failings* (Participant A)

Participants also described challenging self-blame by validating clients' actions and reassuring them they did nothing wrong.

> *I think trying to validate the things that they did and explain […] 'you did the best that you could at that time'. And trying to, sort of, take away some of that shame or sort of like the blame* (Participant I)

> *Me as the therapist, you know, really letting the client know that I believe them and that it wasn't your fault* (Participant B)

> *As soon as a woman blames herself, I address it. I never let a blame go by* (Participant G)

A woman who did not blame herself for experiencing violence was ultimately seen as empowered.

> *A real sign of a client feeling empowered, alongside feelings of blame and shame, they might not disappear, but that those getting smaller and having that yeah, that rational thing of like, 'well I know that it's not my fault, but actually now I'm feeling like it really wasn't my fault'* (Participant B)

> *A sense of action rather than hopelessness, shame and blame or self-blame can be really empowering* (Participant F)

For many participants, the crux of women's empowerment was working towards placing blame in the right place – with oppressive contexts and perpetrators, rather than with victims.

3.3. Overarching Theme C: 'A Hand Tied Behind Our Back': Practitioners Face Barriers to Empowering Therapeutic Practice

Entitled using a quotation from Participant A, this final overarching theme captures two themes regarding perceived obstructions to women's empowerment within therapy: issues within psychology and wider socio-political factors.

3.3.1. Theme One: Problems With the Field of Psychology

In this theme, participants considered aspects of the field of psychology which act as barriers to empowering women subjected to violence.

3.3.1.1. Subtheme one: 'We pathologise victims': This subtheme is entitled using a quotation from Participant G, and highlights how participants spoke about therapeutic modalities predominantly aligning with a medical model of distress, as the 'emphasis is on counting and diagnosing' (Participant C).

> *There are, if you like, root causes to mental health distress that goes beyond a description of symptomatic behaviour* (Participant C)

> *I'm not sure how good clinical psychology as a profession has been at creating more nuanced, more complex narratives about mental health, and that interaction between the individual and the societal and everything in between, you know. I think we're far too complicit still with an illness model and a disease model of mental health* (Participant A)

Participants stated this disempowers women by pathologising rather than validating their experiences of violence.

> *The impact of living with violence is not a DSM category* (Participant C)

> *Medicalised language is disempowering* (Participant G)

> *The medical model I think is deeply detrimental […] people are not sick, they suffer. Suffering emotionally is not a sickness, it's a response to life* (Participant G)

As such, participants stated that the field must distance from the medical model to further empower women, but described disillusionment about this being likely.

> *Until we kind of figure out how to communicate more complex understandings of mental health and the many interactions and levels that functions on for individuals, until we get better at doing that in the public domain, we kind of have a hand tied behind our back* (Participant A)

> *NHS England is going to have to burn the DSM […] I think I'm more likely to learn that there's life on another planet in my lifetime than see them burn the DSM* (Participant C)

Pathologising and medicalising women's distress in response to violence is said to also subtly blame women for violence by implying something was wrong with them.

> *When we look at therapy texts, we blame victims, society blames victims, we pathologize victims […] 'It's their past' or 'it's their attitude' or 'it's a lack in them' that somehow contributes to their victimization through that pathology* (Participant G)

In this way, some described psychological therapy as adding to women's disempowerment through processes of pathologisation and victim-blaming.

> *Psychology is violent to people in the way we use diagnosis and the way that we like section people* (Participant L)

> *When we use [medicalised] language like that, we are no different to the perpetrator and the abuser because we're holding them responsible* (Participant D)

Some participants felt that until psychology disentangles from the medical model, it risks oppressing women just as violent perpetrators do.

3.3.1.2. Subtheme two: Feeling, but not being, empowered is all psychology can achieve: Participants described how therapy, predominantly done in a one-to-one format, was incongruent with work focused on social change.

> *We have these, like, tools like therapy that we rely a lot on, but I think until we get better at engaging with these socio-political issues and learning how to do that as a profession, [social action is] limited in routine services* (Participant A)

> *There's space for [social action], but maybe it's not something that I see within the one-to-one work* (Participant J)

Some stated that one-to-one therapy relies on clients making ‘personal sacrifices’ to ‘feel either more empowered, more in control, more safe’ (Participant E).

> *This idea that change only should happen for the woman, it's oppressive* (Participant D)

> *[Women] shouldn't have to change. This is not our role to change* (Participant E)

Participants considered therapy as best suited to being reactive, rather than preventative, to women’s disempowerment – Participant C described the current approach to supporting victims/survivors of VAW as ‘an endless list of women coming in for CBT for depression’.

> *[Current approaches are] not particularly preventative. They are, they’re more responsive to distress, rather than preventing distress* (Participant F)

> *Services […] work with the consequences of [violence]. You know, not surprisingly, people remain depressed, people become more anxious* (Participant C)

Psychological approaches were said to be better suited to working at an individual level ‘to feel more empowered’, but not necessarily empower ‘at the structural or societal level’ (Participant A).

> *The distress was more contained and it felt like there was some kind of resolution there even if that was purely at the individual level and not necessarily empowering her beyond that* (Participant A)

> *I think [therapeutic models] often put the onus on the person, whether that's a man or a woman, whoever it is in the therapy, to do the work. […] Rather than tackling, you know, maybe some of the more systemic issues. I think that's a criticism of therapy as a whole* (Participant E)

Therapy was conceptualised as a tool to help women *feel* empowered, but not necessarily *be* empowered. Participants discussed how they reconciled with this and

described the importance of ‘know[ing] where the limits to what you can offer are’ (Participant A).

> *As a therapist, I think you have to make your own peace, or at least find value, in the small window of work that you might be doing* (Participant A)

> *You've got to be realistic and hold in mind that you are a tiny little, you know, speck in systems that’ve been designed […] you've got to be kind of mindful and be realistic about what's possible and what's not possible* (Participant D)

Participants described finding inadequacies within therapeutic approaches to empowerment which they accept as the limits they must find value working within.

3.3.2. Theme Two: Socio-Political Barriers

This final subtheme outlines barriers to women’s empowerment within therapy which participants identified within broader society.

3.3.2.1. Subtheme one: Under-resourced and disempowered services: Participants described that underfunding in VAW services obstructs practitioners from supporting clients in ways they would like; Participant C stated having any sort of support after violence is dependent on being ‘fortunate enough these days, with the cutbacks’.

> *Within the NHS, I think funding is obviously a huge barrier to being able to do half of the work that we would love to do* (Participant E)

> *Any individual model of therapy in a modern day kind of resource-strapped NHS setting, you know, which wants quick fixes and wants to kind of ignore complicated problems and would rather deliver protocol* (Participant A)

> *In the sector of violence against women and girls […] funders [are] expecting more for less* (Participant B)

Underfunding was said to create service pressures, like long waiting lists, which prevented participants from working in ways they consider empowering, such as working promptly and preventatively, and offering choice and collaboration.

> *Thinking about service pressure, and how systems are then designed to help the service such as waiting lists […] are less empowering. Whereas, the therapy itself in perhaps where there is a lot of service pressure, there might be less time to offer an informed choice and sort of work in a paced, collaborative way* (Participant F)

> *You need much more therapeutic services available for these women. They need to not be on adult waiting lists for PTSD trauma treatments that they're waiting eighteen months for, like, they need access to therapeutic support and recovery, quickly* (Participant L)

> *Our service, we tend to be quite, I don't mean to say like reactive, but we're there afterwards. We often don't have the resources to also be there as a preventative service* (Participant E)

Participants described struggling to work in empowering ways amidst these service pressures which create disempowering working contexts.

> *I think it's really hard for individual practitioners to move in that direction [empowerment] when the system around them in which they work doesn't respect, or offer, or have the capacity to do that* (Participant H)

> *It's just kind of this hamster wheel, next client, next client, what protocol. Which I find really difficult when we're working with someone. We're working with a person, we're not in a business* (Participant H)

Busy, rigid and risk averse service cultures were said to hamper attempts at service improvements, as practitioners described facing a lot of ‘red tape’ (Participant E).

> *Employers would not allow us to dedicate time to working with it [a project aimed at improving practice] and […] colleagues were too busy or not interested* (Participant C)

> *We might have an amazing idea and really want to implement it, and then by the time we let everybody know and the right people know, it can be a year or so later and then that person’s now gone, out of the service. So things get*

> *pushed back and delayed, which can be a barrier to change. We're also very risk averse, which isn't a bad thing, but it means […] projects may not get done* (Participant E)

Participants described feeling they did not have the power to change practice or improve services; some described feeling it was *us versus them* between practitioners and those who make service-related decisions.

> *I think [we should be] saying to funders 'you're expecting this, but actually that's not realistic and this is what is needed, we're the ones that are doing the work'* (Participant B)

> *We are doing our best in our team and as individual practitioners. With recruitment and with other staff like managers and leaders, there could be done much more* (Participant K)

Ultimately, disempowered services were said to disempower practitioners.

> *Just how tiring and how emotionally draining our work can be, so are we getting the support that we need? Like are we feeling empowered in our work? Do we feel that we can have a say in what we do? Do we feel that we're listened to? Like that our ideas are listened to higher up in the team and that? So I guess it's all sort of like echoed* (Participant I)

> *We have to work in systems that are unkind and not very human, so it's quite hard to, I think, for practitioners to always work in ways that are human and kind* (Participant L)

Participants therefore described that due to under-resourcing, service pressures create a culture conducive to disempowered practitioners, inhibiting empowering therapeutic practice with clients.

3.3.2.2. Subtheme two: Society needs to change first: Participants described that empowering women through therapy is delimited by wider socio-political factors, and expressed frustration at the lack of action at a societal level.

> *I'm hugely frustrated with the lack of system change around working with violence in this country. So I'm hugely disappointed and I'm hugely frustrated with the fact that we seem to be saying that women, particularly women from global majority families, it doesn't matter if they get killed every week* (Participant L)

> *I wish there would be maybe something around sort of, a more preventative supportive lens to reduce violence against women […] in the sense of starting with young people and educating them* (Participant F)

For example, participants stated that therapeutic attempts at empowerment are negated or hindered if women do not have appropriate access to resources.

> *[Women] need all of the social context to support that recovery [after violence]. Finances, housing, support with children, support with parenting. That's what they need* (Participant L)

> *[Practitioners have] a responsibility to know how you can get people the support when they need it that goes beyond just your sixty minute session* (Participant A)

Empowerment therefore was not considered a unanimously achievable goal, as women – to varying degrees – were 'entrapped' (Participant A) within oppressive contexts, unchallengeable through therapy. One contributing factor which participants considered was whiteness. Participant L described empowerment as a 'white feminist idea' that is not 'a universal offer to women'.

> *It's a bit of a whitewashing middle class idea, that's what I think. And it's a bit Duluth-y, it's all coming from that Duluth control wheel, men are bad, women just need empowering. It's an outdated feminist idea* (Participant L)

Some shared they felt empowerment, or at least the way it is used in therapy, is rooted in white Eurocentrism.

> *It's quite a Eurocentric idea, empowerment, and it's sort of based on I think quite white feminist ideas of women having choices […] different women from*

> *different cultures, different backgrounds and religions would have a different set of options* (Participant L)

> *We can become fixed as professionals about what empowerment should look like and we forget that some of these things are Eurocentric, and they're constructed not for everyone, but for a specific demographic* (Participant D)

These participants described that particular characteristics of a woman and her social context influence the likelihood of these Eurocentric ideas around empowerment being applicable.

> *Choices about being empowered are very different for a woman whose born here, educated here, has access to finances, has family* (Participant L)

> *You don't understand context, you don't understand oppression, you don't understand disadvantage, you don't understand social context of people's lives, if you think all people have an equal access to being empowered* (Participant L)

> *Empowerment could mean privilege to some people, and not everybody has privilege. […] Say if you're a woman with no recourse to public funds, what are you gonna do with your empowerment because the system is gonna disempower you? Because you're then not going to be able to access X, Y and Z because of your position. So then what happens to that empowerment?* (Participant D)

Participants stated that women's empowerment in therapy is thwarted by intersectional oppression, as they described empowerment as a concept which is not 'one-size-fits-all' (Participant D).

> *One of the things that's always overlooked is […] culture […] if you've grown up in a culture, and it could be like even you know social class, you know that's someone's culture as well, and where violence and abuse is normalized then for you, you're gonna act into some of those ideas* (Participant D)

> *It's important to kind of hold in mind intersectionality, you know, there's multiple layers of oppression for some and not for others* (Participant D)

> *So many elements of race, class, religion, like so much has to do with your experience as a woman or a man that you can't generalise to all women this and all men that, because of those complexities, that intersectionality* (Participant L)

Underlying these critiques was the view that only women with access to resources or existing social privilege – whiteness, wealth, and originating from the UK – can become empowered through therapy.

4. DISCUSSION

In this chapter, I revisit reflexivity before discussing my analyses in further detail and examining the strengths and limitations of the research, and then I explore the implications of this research, before offering concluding remarks.

4.1. Reflexivity

In the present research, I was mostly an *insider researcher*, in that similar to participants, I too am a psychological practitioner with experience of working with women subjected to violence. I was also partly an *outsider researcher* as being a trainee meant I was more junior and less experienced than the clinicians recruited. I felt my juniority drove emotional reactions to some interviews. Specifically, when I enquired as to whether participants felt empowerment should be relevant within this client group, some seemed incredulous, as though the answer should be obvious: some participants vehemently stating it should, with others stating it should not. Such reactions evoked anxiety, as I interpreted it as an indication that the participant deemed me an incompetent trainee for asking what they considered a foolish question. I felt – but resisted – a desire to shy away from asking this question. As data collection progressed, I felt increasingly confident in the importance of the question, as the certainty with which participants answered suggested they may assume all practitioners think similarly to them. This may reflect siloed, echo-chambered working contexts within the field of clinical psychology and the NHS. I learnt the importance of resisting desires to avoid anxiety-provoking interview questions when in a position of juniority as responses may be unexpectedly illuminating.

During analysis, I worried that offering critical interpretations may be experienced as scathing and offensive to practitioners. I discussed this with my DoS, who advised I temporarily suspend this concern as this may foreclose analytic thinking, and to

reengage with it during this discussion phase. As considered below (see Section 4.2.), my analyses locates disempowering psychological practice within oppressive systemic structures, not within individual practitioners. The participants I interviewed – and the many practitioners whom they represent – are dedicated, compassionate professionals. I interpreted participants' comments as indicators of the tools provided to them through psychological therapies, and as such, my critique applies to the structure of the field, not individuals. Digesting the research in this way is both more ethical (T. Patel, 2020) and utilisable, as it provides insight into practice on a UK-wide, rather than individual practitioner, scale.

As a woman, I feel I am more likely to interpret the world through a gendered lens: noticing how societal structures operate in ways which privilege cismen. I have previously articulated my reflection that perhaps this led to an influential assumption I had made when formulating this research (see Section 2.3.); that women on the whole who access therapy – as stated in the original title (see Appendix D) – will likely have been subjected to violence at some point. Feminist and human rights literature draws attention to the continuum and pervasiveness of VAW. For example, the UN Women (2019) point to how violent cultures against women are embedded in societally normalised ways in which people think, speak and act. Through my own personal and professional experience, I am aware of the range of acts of VAW against girls and women on a daily basis (see Section 1.1.2.) – this has shaped both my lived experience and professional development as a feminist practitioner. In response to identifying this assumption, I not only changed the research title for added specificity, but I also remained conscious that I held such as assumption throughout the rest of the research. For instance, when I constructed the interview schedule (see Appendix L), I explicitly made it clear in the wording of each question that my enquiries related to specifically victims/survivors of VAW. Prior to making this decision, I feel I may have assumed implicit understanding – assuming all would share my perspective on the prevalence of VAW, and ergo assuming participants and readers would understand to whom I was referring without adding this specificity. Perhaps a similar assumption influenced other aspects of my research in ways I did not manage to pre-empt through my decision-making process. As a woman interviewing (predominantly) other women, perhaps I failed to explore with these participants how our similar gender may influence our discussion on this topic.

For example, perhaps participants failed to elaborate on specific views they held should they have assumed that as a fellow woman, I would implicitly understand their perspectives; with my own corollary assumption that I too understood their viewpoints more fully than they had indeed expressed. Put another way, a reciprocal process between myself and other women participants may have occurred whereby viewpoints were not explored as fully as possible as we each assumed that as women, we would *just get it.* This potential assumption may have influenced the research if it meant that viewpoints from women participants were less fully explained or explored.

I am white, middle-class, and identify as able-bodied and cisgender. The privileges afforded by these various social identities may have meant that I was less adept at noticing data which pertained to operations of power that were not associated with gendered oppression. For example, as a white person, I may be less aware of issues related to racial oppression, failing to notice how structures privilege white people. In the subtheme *society needs to change first,* I described how participants seemed to suggest that women's empowerment is delimited by wider and intersectional socio-political factors such as whiteness (see Section 3.3.2.2.). My analysis which led to the creation of this subtheme was based upon quotations from participants which explicitly identified and named factors like whiteness. This meant that my analysis pertaining to intersectional and racial oppression relied upon participants explicitly stating such factors, rather than my own ability to pick up on allusions to it and offer a critique. This may have limited my exploration into areas of oppression outside that which is related to gendered inequalities. This is also true for other areas of my privilege; for example, perhaps I was less adept at noticing ableism or trans-exclusion in the data, and closed off these areas quicker than areas related to gendered oppression. In this way, areas of my identity and life experiences shaped the research by driving what I may have been more attentive to, and what I may have overlooked.

Within the assumptions of critical realism and of RTA, beliefs will inevitably play an influential role in the conduct of a researcher's work (Braun & Clarke, 2022). My feminist belief is no different – it has influenced how I enact and conceptualise my role as both a psychologist and a researcher. It is common for clinical psychologists

to hold orientations and preferences towards particular therapeutic models, which would undoubtedly shape their analyses of such models. As articulated (see Section 1.4.5.), a feminist approach is not a singular modality; it refers to a practice of evaluating existing approaches against feminist beliefs and values (Worell & Remer, 1992). Regarding my own positioning toward medical and therapeutic modalities, my overall approach is to avoid being partisan to any particular models. For me, having an overarching critical feminist framework means that my lens is centred on understanding how patriarchal oppression is being reproduced when I offer a critique of any particular model. For example, as is explored further (see Section 4.2.2.), in the subtheme *human connection versus duty to modality* (see Section 3.2.1.2.), I describe how participants identify CBT as potentially blaming and dismissive of their clients. My discussion of CBT is not intended to add to partisan discourse. Rather, I aim to reflect what was shared by participants in a way which provides a considered reflection on the concerns articulated around the use of CBT in how it may reproduce patriarchal harms. In this way, my positioning is not one which is opposed to any of the models discussed in this research, and indeed I integrate a variety of approaches in my own clinical work. Simply, through a feminist stance, my positioning regarding models is one in which I look to understand how power structures are embedded and reproduced. Thus, my foremost intention is not to critique models themselves, but to offer careful thought and reflection around how a model is used to work with women. This positioning is important to articulate for the reader to garner useful context in which to understand my work, and as such, was expressed in my opening positioning statement (see introduction to Section 1.).

Another factor influencing my position regarding therapeutic modalities and the medical model is how I have been trained as a practitioner. The training ethos of the UEL doctoral course is one in which trainees are taught to value a critical approach. Training influences have encapsulated a varied range, but consistently they have involved exploring and critiquing operations of power – whether that be discursive or material power. This has meant that my approach – both in clinical practice and research – is to prioritise examination of how power may be operating, and how we, as practitioners and researchers in the field, reproduce that power. This influenced my analyses by attuning my attention to critiques of power operations made by participants above perhaps other articulated viewpoints. For example, in exploring

participants' perspectives on, and attitudes towards, the medical model in the subtheme *'we pathologise victims'* (see Section 3.3.1.1.), I attended to perspectives related to deconstructing the medical model and participants' reflections on how it could be used as an oppressive force for women. Being trained in a critical approach familiarised me with this sort of critique. As such, I may have been more sensitive to identifying, and motivated to articulate, this viewpoint than perhaps less critical ones, as deconstruction of the taken-for-granted knowledge reflected in dominant societal discourse is a familiar area of my routine practice.

Many important women in my life are victims/survivors of violence, and many report dissatisfaction with the psychological support they were subsequently provided. This may have impacted what I took for granted in my approach to this research – operating from a presumption that there is something "wrong". Similarly, as an NHS worker and someone with left-wing political views, I have first-hand experience of underfunded services, and feel dissatisfied with the current government. This may have meant I operated from a presumption that fellow NHS practitioner participants may too feel dissatisfied with working conditions; perhaps enabling conversations which were more critical, and overlooked conversations which were more complimentary, of the current government and its policies related to the NHS.

4.2. Discussion of the Analyses

This research set out to address the question: how do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women who have been victims of violence? This section discusses how my analyses address this question.

4.2.1. Understanding Empowerment

To examine participants' understanding of the relevance of empowerment within therapy for this client group, I considered it important to initially examine how they conceptualised VAW. Participants described that how women learn to relate to others creates a vulnerability to violence, reminiscent of older psychological literature

positing women's supposed violence risk factors such as how they interact with, and with whom they select as, partners (Gordon, 2000). In this way, participants' formulative lenses were focused on individual women. This aligns with neoliberalist narratives around women's responsibility to prevent violence, whereby victims are problematised for not having successfully conditioned their behaviour and body in ways which supposedly prevent violence, such as being confident and strong (Frazier & Falmagne, 2014). By conceptualising VAW as an experience limited to particular women with particular qualities, violence is not examined as an entrenched socio-cultural feature, and patriarchal oppression remains unnamed and thus unchallenged (DeKeseredy & Schwartz, 2011).

Participants considered the impact of VAW being that a woman is robbed of something. In this way, victims are problematised as yet more impaired for having been victimised. Participants seemed to imply a self-fulfilling cycle of violence: problematic women attract violence, which robs them of the qualities to prevent violence, making them increasingly problematic and therefore vulnerable. Empowerment, seen as a woman taking back these violence-prevention qualities, is therefore conceptualised as a way for an individual to break this cycle. Having taken back what was stolen, participants described an empowered woman as one who can *do more* to satisfy personal goals and needs. Khader (2018) argues this conceptualisation of empowerment burdens and blames women, who are expected to act agentically within oppressive contexts, suggesting disempowerment and distress are consequences of women's inaction. Empowerment was therefore conceptualised as a set of behaviours aimed at breaking self-fulfilling cycles. In this way, practitioners seem to adopt a behavioural stance, validating behaviours seen as *coping* and thereby limiting the ways women can experience and express distress after violence without being considered problematic.

Participants also described an empowered woman as one who does not allow violence to define them by foregrounding their strengths and coping abilities. Whilst this stance can be seen as countering the predominant deficit focus in psychology and mental health services, perhaps this approach to working with VAW in therapy serves a protective purpose for practitioners. Empathising with clients' distress has been associated with emotional exhaustion and burnout in mental health

practitioners (Turgoose & Maddox, 2017). Diluting conversations in therapy following VAW with alternative stories of joy and strength may support practitioners to circumvent unabatedly confronting client realities of suffering. This may be particularly pertinent for those working in the NHS. NHS practitioners currently provide therapy in the context of debilitatingly long waiting lists, poor wages, and the lowest ever recorded public support (Ham, 2023; Morris et al., 2023). They must therefore find ways to sustain themselves in their work, which this approach may provide. The risk however in occluding stories of violence with stories of strength and coping is unintentionally closing down expressions of distress by selectively attending to what practitioners consider are indicators of strength and empowerment.

Empowerment was also described as an ability to tolerate violence – not allowing it to cause distress, overwhelm, or poor decision-making. The common conceptualisation of empowerment as individual agency is indicated here, due to the implication that an empowered woman is one who is *in control* of her reactions, enabling her to choose the most sensible course of action (Kabeer, 1999). Participants seemed to conflate an agentic understanding with currently popular TIA and trauma-based understandings of distress, creating a notion of empowerment as having control over *trauma* reactions in particular. Individuals are situated as the agents of empowering change aimed at the level of individual trauma reactions. Such individualisation obfuscates both the pervasiveness of VAW as a problem, and the importance of collective action (Kitzinger, 1993).

Regardless of how participants *felt towards* empowerment within therapy, they all seemed to agree on *what it is:* behaviour change toward what are considered ‘empowered’ behaviours, mostly surrounding a woman’s control over trauma reactions and asserting her needs. However, this is not to say participants lauded individualised conceptualisations of empowerment. Participants stated they must accept a disheartening reality when it comes to empowerment within therapy: that the individualised approaches they provide are delimited by social context, but are as good as it gets. Previous literature has similarly argued that women who acquire supposedly empowerment-related skills through therapy cannot remain empowered when sociocultural contexts remain unchanged (Rudman & Glick, 2008). Practitioners are therefore forced to either: facilitate behaviour change which, at

best, helps women feel better but not experience tangible changes to their circumstances; or accept defeat and do nothing if a woman's context is deemed too oppressive for any change to occur at all. It follows logically that participants felt empowerment could be a daunting concept and were somewhat reluctant to engage with it, as this conceptualisation can rarely result in anything other than disappointment. Practitioners seem aware of inadequacies in their approaches to women's empowerment and believe an alternative approach – aimed at challenging oppressive social context over individualising the problem – would be superior. When it comes to empowering women, practitioners seem to argue that they know what it *should* involve, but that such an approach is plainly unattainable within psychological therapy.

4.2.2. 'What I Do With Clients'

Participants shared that they were motivated to support and empower women subjected to violence due to a sense of moral duty. For some, it felt of additional importance because of shared experiences of womanhood and violence, illustrating the dedication and compassion of these professionals. While human connectedness was perceived as essential to empowerment, participants stated that therapeutic modalities sometimes get in the way – particularly CBT, which they felt misaligns with other personal values like gentleness and sensitivity. They also echoed previous feminist critiques of CBT, such as that it problematically relies upon notions of women's thoughts being irrational (Worell & Remer, 1992). Interestingly therefore, CBT – a frequently used modality in the UK – is an approach which some study participants reported they do not always feel comfortable using nor entirely believe is consistently helpful for clients. Participants stated that CBT and other individualised approaches have problematic implications for women and those facing intersectional oppression, suggesting these approaches are perceived as upholding particular values, such as those originating in patriarchy and whiteness. Despite practitioners experiencing discomfort at using therapeutic approaches which they feel violate their values and moral principles, they curiously described a sense of duty to also adhere to them.

For participants, an important part of empowerment was bringing women together, somewhat speciously resembling earlier conceptualisations of empowerment.

Harking back to Freire's conscientização (1970) – consciousness-raising – participants stated bringing women together is empowering as it encourages them to locate the cause of violence within patriarchal experiences of womanhood, rather than individual aspect of themselves. Since the early days of the women's movement, feminist analysis has been incorporated into psychological therapy, with a large part of it consisting of consciousness-raising exercises (Moane, 2014). However, unlike in feminist consciousness-raising approaches where gained knowledge is used to evoke social change, participants made no mention of seeking to evoke change beyond the individual. They argued that removing self-blame is the crux of empowerment; thus describing a supposedly collective intervention, but to achieve only individualistic outcomes. Evidence suggests this approach may not be that helpful: Conlin et al. (2021) found that only through evoking collective action do consciousness-raising exercises result in greater subjective well-being for women. While women's empowerment is conceptualised as behaviour change or changes to how one feels about oneself, services offer interventions which do not seek to change anything about the world women live in – unchallenging and thereby upholding patriarchy through inaction.

Participants did however identify SUI as a form of social action they support women to engage with. The concept of SUI as a form of empowerment fits with TIA principles, that clients are empowered by having choice and control in how services are run (Elliott et al., 2005), similarly aligning with commissioning guidance for TIA VAWG services to be designed 'by and for' women (Home Office, 2022). By advocating for SUI, but not necessarily feeling social action on the whole is achievable through therapy, practitioners delineate therapy services from the outside world. While both are identified as places of disempowerment and oppression, participants indicated they felt they might only influence disempowerment within, but not necessarily beyond, service delivery.

By listening, showing sensitivity, and equally sharing power in the therapeutic relationship, participants stated they empowered clients by offering an opposing and therefore reparative experience to violence. It is unclear however how this empowers clients, replicating the commonly encountered problem in empowerment literature where absent operationalisation impedes the meaningfulness and utility of

empowerment as a concept in therapy and research (see Sections 1.6. and 1.3.3.). In this case, participants may have been likening empowerment to a feeling, as there is no mention of how offering reparative experiences might create change beyond a woman's experience of their relationship with the practitioner. Providing sensitivity, care and equality might also offer something reparative for practitioners. As described, participants shared disillusionment with the ability of psychological therapies to create empowering change at a systemic level. Creating an opposing experience for clients within the therapeutic relationship exalts therapy as a sort of *antidote* to violence, perhaps allowing practitioners to feel distanced and absolved from the oppressive harms done to their clients. Similar to identifying SUI as core to empowerment in therapy, practitioners describe a sphere of influence which feels limited to the service they provide.

A core part of this reparative experience was offering clients *choice*, such as choice about what to work on and how therapy will progress. This aligns with Kabeer's (1998) focus on identifying one's own goals as a process of empowerment, as she argues goal-setting is inherently empowering as it respects individual women's choice. Khader (2018) argues this spurious incorporation of choice in goal-setting within oppressive, patriarchal contexts overlooks the fact that women may only have disempowering, unacceptable options from which to identify their goals. For example, women may set goals limited to finding ways to tolerate and live alongside their own violent oppression as this feels more appropriate and achievable than goals aimed at challenging patriarchal structures. In this way, prioritising choice in therapy risks solidifying women's oppression in the name of empowerment.

Participants described approaching women's empowerment through the following: challenging victim-blaming elements of standard therapeutic practice, understanding VAW in the context of patriarchal oppression, bringing women together, collaborating with clients, and bringing in one's connectedness to humanity and womanhood. These are all core elements of feminist therapy (Worell & Remer, 2003). However, participants also described constructing and administering these elements in ways which advocate for: behaviour change in individual women, presuming women can and should do more to prevent violence against them, and helping women cope with and sustain living in oppressive contexts. Prioritisation of changing individual

behaviour in the name of empowerment, over restructuring women's available options in life, prevents the social change necessary for meaningful empowerment (Kitzinger, 1993). In this way, patriarchy is upheld by therapeutic practice under the guise of empowering women. However, what this analysis also illustrates is that practitioners report knowing what sort of practice they would like to provide, and that feminist values drive their sense of what therapeutic work should involve. Yet they report feeling their ability to empower is limited to *within* therapy and service delivery. They also experience a pressure and sense of duty to adhere to approaches regardless of whether they align with personal values or what they believe will actually help their clients.

4.2.3. 'A Hand Tied Behind Our Back': Practitioners Face Barriers to Empowering Therapeutic Practice

Some participants also articulated a feminist stance towards the medical model, arguing that it pathologises women's legitimate responses to oppression. Diagnostic approaches have been accused of stripping women's distress from the context of gendered oppression (Jimenez, 1997), disempowering victims/survivors of VAW further by denying causal links between oppression and distress (Shaw & Proctor, 2005; see Section 1.4.4.). Feminist approaches conversely prioritise tackling structural oppression over examining ostensive individual factors contributing to distress (Moane, 2014). However, participants described psychology as subordinated by psychiatry, particularly in NHS settings; understandable, given the reliance on psychiatric interventions within clinical guidelines, for example, for DV (NICE, 2014). By articulating a desire for psychology to move away from medicalised conceptualisations of distress, participants once again concurred with feminist values, yet felt disillusioned that the field of psychology might align with this wish.

Participants stated that individual therapy is a *reactive* intervention to VAW which burdens clients to make personal changes, rather than *preventative* interventions which would focus on changing oppressive contexts. Supporting women to feel differently without living circumstances improving was likened by Caplan (1992) to a boxing match, where therapists play a role in oppressing women by giving them just enough support to get back in the ring and take more abuse. Practitioners stated they not only felt therapeutic approaches are limited by oppressive social contexts,

but that they actively strive to make their peace with – rather than challenge – these limits, through deliberate acceptance of what they feel can realistically be achieved through individualised, depoliticised work. This is far flung from the original conceptualisation of empowerment as an aspirational process of moving towards social justice for collectives of oppressed people (see Section 1.3.2.1.).

Participants identified that underfunding and subsequent service pressures drove them to work in ways they do not consider optimal for empowerment – such as working reactively, or not wholly observing client choice. When wanting to create empowering change through service development initiatives, participants described a disempowering culture which blocked any progress they wished to see. It is important to bear in mind how my own political opinions may have shaped this analysis (see Section 4.1.). Yet it seemed to me that participants described a parallel process of disempowerment: just as they were disempowered within their working contexts, they too could offer only disempowering practice to their clients. This calls into question how a disenfranchised NHS system might be anything but disempowering to the people it serves. The *us versus them* relationship to those with the power to make changes only compounds their experience of powerlessness; it is little wonder why practitioners may not consider the possibilities of systemic change when it comes to women's empowerment. Put another way, practitioners described not being provided with sufficient resources to work in ways they believe are helpful and align with their values, while any attempts to challenge this are quashed. As such, they are left powerless and must find ways to tolerate and work to an acceptable standard within unacceptable working conditions. It follows naturally that a similar message may unintentionally be passed to clients – rather than considering the possibility of systemic challenges to oppressive structures, practitioners instead support clients to *make do*, replicating the expectation that one should accept unacceptable conditions. Neoliberal ideologies compound organisational inertia and rigid hierarchies in the NHS, driving an ethos defined by managerialism and uncaring attitudes towards those situated lower down (Truman, 2015). The patriarchal top-down structure this manifests in ringfences the potential for feminist contributions to little more than championing for gender representation at leadership levels, while upholding the uncaring, at times withholding, atmosphere at the hierarchical ground level where the most vulnerable and oppressed reside (Lawson, 2019).

Feminist psychology does not just aim to challenge social inequalities associated with gender; it is also concerned with inequalities existing along diverse axes like race and class (Wilkinson, 1991). As such, a feminist approach to women's empowerment deliberately undermines constructed differences among women, listening to the knowledge and strengths of all women, not simply privileging white voices or those with other existing social power (Parpart & Marchand, 1995). Participants described feeling as though therapeutic attempts at empowering women are limited when women face additional social disadvantage, such as not being white, wealthy and from the UK. Rather than seeing intersectional oppression as more of a reason for engaging in empowerment interventions with women, participants seemed to instead view it as a reason why empowerment could not work. Therefore, seemingly what participants considered *blocks* to empowerment actually reflect *reasons* for why empowerment is necessary. This may reflect a number of things. Perhaps participants conflated empowerment *as a concept* with how empowerment *is conceptualised* within psychological therapies. This would result in participants critiquing *empowerment* when instead their concerns around its applicability to those facing intersectional oppression actually apply to *how empowerment is approached* within white, Eurocentric psychological models. Additionally, this may reflect once again practitioner disillusionment with the field: believing therapy is only effective for isolated issues, uncomplicated by oppressive or otherwise challenging contexts.

4.2.4. Summary

This research set out to explore how psychological practitioners approach and understand empowerment – an often-cited, but rarely well-defined, concept – in the context of psychological therapy for women subjected to violence. My analyses suggest practitioners view VAW as perhaps a self-fulfilling cycle: just as women with particular problematic qualities attract violence, violence too robs them of the qualities needed to prevent future vulnerability. Empowerment was therefore conceptualised as an individual disrupting this cycle by reclaiming violence-prevention qualities like assertiveness and self-worth. Empowering therapeutic processes were similarly considered those which opposed, and therefore repaired, experiences of violence, such as providing choice and care.

However, practitioners described dissatisfaction with these approaches, as they felt these individual-level changes can only go so far when enduring patriarchal factors continue to oppress women. They described a desire for their therapeutic work to align with core elements of feminist therapy, yet felt their sphere of influence is limited to creating empowering change within therapy spaces and service delivery only. Practitioners outlined sources of hindrances to empowering women on a broader scale, including the subordination of psychology under psychiatric models, under-resourced public services, compounded by the disempowering expectation that practitioners just *make do*.

It is important to remember that I approached this research from a position of there being *something wrong* (see Section 4.1.). Yet I believe I have illuminated not simply the depoliticisation and enduring patriarchal discourse within psychological therapy. Further to this, the research indicates that practitioners are aware of such problems, take issue with them for violating feminist ideologies or other important personal values, and yet feel disabled to provide anything else. Throughout this research, practitioners described knowing what they *should* do, what they *want* to do, and nevertheless felt too disempowered to do.

4.3. Critical Evaluation

In this section, I will evaluate the quality of the present research. What constitutes high quality within a qualitative research paradigm is highly contested (Lincoln, 1995). Fossey et al. (2002) advise their framework for evaluating qualitative research should therefore be applied heuristically within research reviews, rather than as a prescriptive set of criteria. I chose this framework to guide this evaluation as it is tailored to qualitative methods commonly used in mental health research, and differentiates between the expectations of interpretive versus critical research regarding what constitutes high quality. This enabled me to consider how best to evaluate specifically critical, qualitative research pertaining to clinical psychology – the applicability of the framework enhancing my ability to meaningfully interrogate the present research. In line with the framework, I have structured this section according to evaluating methodological rigour and interpretive rigour.

4.3.1. Methodological Rigour

Fossey et al. (2002) outlined five areas pertaining to methodological rigour, which are concerned with how the research was conducted, the first of which is *congruence.* Rather than considering knowledge as objective*,* I engaged with critical discourse around how current social practices – in this case, therapy – are shaped by socio-political structures, such as patriarchy. I do not suggest my analyses should be consumed as a discovery, but rather that they reflect one possible way of viewing the data. In critical research, the purpose of inquiry is not understanding for its own sake, but rather is used as a tool for moving society towards social justice (Guba & Lincoln, 1994). I believe I have analysed and interpreted the data to reflect where potential problematic practice may lie, and have been careful to offer critiques and implications (see Section 4.4.) which I believe would result in more socially just ways of working. In this way, I have attempted to remain congruent with a critical, feminist approach throughout this research; from identifying what I considered a worthwhile topic and framing the RQ, to epistemological stance, through to methodology.

As outlined (see Section 2.1.), representation is a core principle of critical feminist research (Lafrance & Wigginton, 2019). Arguably, congruence with critical feminism could have been enhanced within the present study by paying additional attention to representing the views of stakeholders within the research development process. Relevant stakeholders would include women who have been subjected to violence, as well as psychological therapy practitioners working with these women. Such stakeholders were minimally involved in the development and formulation of this research; involvement was limited to working with a CBT practitioner to pilot and gather feedback on the interview schedule during its development (see Section 2.4.3). Research congruence therefore could have been enhanced by sustained and increased stakeholder involvement throughout the research process.

Increased stakeholder involvement would have offered additional benefits beyond alignment with feminist research principles. The National Institute of Health Research advocates for Patient and Public Involvement (PPI) in UK research (Denegri, 2015). PPI pertains to actively involving (and where possible, partnering with) members of the public – including patients and carers – in research design,

conduct, and dissemination, for the purpose of increasing research relevance and utility for those to whom it most applies (Ashcroft et al., 2016).

In a systematic review, Brett et al. (2014) identified various benefits of PPI within health and social care research. These included: the development of research objectives and questions relevant to patient and public priorities; the development of materials which were deemed 'user-friendly'; appropriate and effective recruitment strategies; and enhanced research dissemination. I may therefore have introduced a variety of limitations into the present research by failing to prioritise PPI. Key stakeholders, such as women subjected to violence and their psychological therapy practitioners, may have considered aspects of this research – such as the interview schedule – to have limited appropriateness and relevance to them. For example, item 3 (see Appendix L), which explicitly names and explores patriarchy, may not resonate with victim/survivors of VAW who do not make sense of their experiences of violence in the context of patriarchy. Such individuals therefore may not have found this area of the interview a particularly pertinent one to have been unequivocally explored across participants. Additionally, minimal PPI may have limited the research scope – both in terms of participant recruitment and potential dissemination opportunities (Brett et al., 2014). Working closer with a variety of healthcare workers, beyond the one CBT practitioner recruited for the pilot, may have extended my recruitment and dissemination reach.

Staley (2015) notes that the level of involvement in PPI can vary widely. At higher levels, researchers may co-produce research, or perhaps be entirely 'user led', taking a supporting rather than directing role with the potential for ongoing partnerships. In the present research, this higher level of involvement may have been unfeasible within the confines of conducting a doctoral thesis. Attempting this may have risked causing harm should my limited time and resource have resulted in a disservice to collaborators who may sacrifice heavily much of their own time. Attempting high level involvement when researchers are under time constraints can lead to tokenism in PPI, where it becomes viewed as a tick-box exercise (Pandya-Wood et al., 2017). Indeed, tokenism is said to be one of the biggest risks to PPI in contemporary health research, commonly driven by researcher time constraints (Boylan et al., 2019).

However, at a lower level, PPI may simply involve consulting with stakeholders to gather feedback, which is then used to guide researcher decision making. By consulting with women who have been subjected to violence, I could have gathered viewpoints on areas of particular priority for them regarding receiving empowering psychological therapy when constructing the interview schedule. Consulting with psychological therapy practitioners could have extended recruitment by gathering perspectives on appropriate and potentially effective recruitment strategies. For example, it may have proved fruitful to gather feedback on the advertisement poster (see Appendix F) from experienced practitioners who represented my target participant pool. The present research could therefore have been strengthened by engaging with PPI at any level I considered feasible within the constraints of a doctoral thesis.

I believe there were also potential limitations regarding sampling. Sampling strategies should demonstrate *appropriateness*, in that they identify participants who might provide data to suitably inform the RQ (Fossey et al., 2002). Many of the participants in this research worked in a specialist SV service (see Table 1), and those who did not, tended to speak of their experiences working with victims/survivors of DV. This replicates the tendency found in previous VAW literature to investigate physical or sexual violence over other behaviours as these are considered more easily defined and therefore amenable to research (see Section 1.1.1.). The danger of replicating this issue goes beyond representing the full range of VAW in research; it risks playing into the problematic implication that physical or sexual violence are the only forms worth recognising. This may have further dangerous implications for whether the full range of VAW is captured in public and political consciousness and therefore has implications too for funding and awareness.

Fossey et al. (2002) also point to *adequacy* in sampling: gathering sufficient differential perspectives on a research topic to offer an illuminating, corroborated account. In the present study, only one participant identified as a man. I garnered some insight into his experiences working with this client group, as he shared uncertainty regarding the value of bringing his perspective into empowering therapeutic work with women.

> *As a male therapist, who am I, you know, am I even in a position to answer what female empowerment looks like?*

There was not scope within this research to richly explore the relevance and implications of this, and considering there was only one man, I could not explore such a viewpoint thematically.

While I deliberately captured the gender of participants in the sample, further demographic information was deliberately not sought at the outset. For example, I did not seek information pertaining to participant ethnicity, sexuality, or age. As outlined (see Section 2.2.), I made this decision in consultation with my DoS, and decided that in keeping with a critical realist stance, what are typically described as 'demographic characteristics' are not seen in essentialist terms, as characteristics or attributes devoid of the context in which they are seen to be significant. Rather, participants' backgrounds become relevant when and how they talk about their experiences and share their perspectives. As such, participants were free to articulate this in the semi-structured interviews and I encouraged participants during interviews to reflect on what influences they draw upon in their therapeutic work with women subjected to violence (see item 4 in Appendix L) and prompted them to consider personal influences outside of psychological models and theories. My DoS and I considered this likely sufficient to elicit participant reflections on how their perspectives are influenced by demographic areas of their social identities. However, it is possible participants did not feel comfortable to spontaneously share such information. For example, as I am white, participants from racialised groups may not have felt sufficiently comfortable raising discussions of race when being interviewed by someone belonging to a socially privileged group. Demographic aspects of one's identity such as race and ethnicity influence one's social positioning – important to capture within critical realist research, where knowledge is understood as socially-situated. Postulating how aspects of participants' demographic background may have influenced analyses would equate to conjecture; however, it is reasonable to assume that perspectives on empowerment may differ for individuals depending on their experience of marginalisation. Deciding not to gather further demographic data therefore may have unintentionally foreclosed a richer analysis into how additional elements of social identity (beyond gender) drove participants' perspectives on this

topic. As such, my conclusions – and what readers can draw from them – are limited by the demographic information I chose to collect (and that which I did not explicitly seek), potentially divorcing interview data from other relevant contextual information through which to more fully understand the origins of participants' perspectives and views.

Fossey et al. (2002) also layout the importance of *responsiveness to social context*, in that data collected is relevant to the social setting to which the research applies. Participants in the present study predominantly practiced using CBT (see Table 1). This is representative of UK therapeutic work given the proliferation of this approach in recent decades, seeing it become the most commonly provided therapy by the NHS (Nicholls, 2022). Analyses regarding therapeutic practice which draws upon practitioners' reports of using CBT is therefore responsive to the UK context. As outlined in Section 2.4.1., I also intended to increase the extensiveness of my insight into UK practice by interviewing experienced practitioners. This was on the assumption that such practitioners would have greater influence over therapy delivery and supervision of more junior practitioners including trainees. The corollary assumption was that more junior practitioners may be less wedded to a particular model and are still in the process of learning and developing preferred therapeutic modalities. From my own experiences of being a trainee and knowing other trainee and recently qualified practitioners, I am aware of the challenges in earlier years of practice in being able to critique and explore the limitations of a therapeutic approach while still learning and developing the skills to deliver it. More junior practitioners are likely to have less experience working with clients and as such, have had less opportunity to collect (and therefore comment on) their own practice-based evidence. The assumption therefore was that more junior practitioners may feel less able to critique and comment on the strengths and limitations of approaches (drawing on their own practice experience) – as was required for this research – until they obtain more experience of applying them and gathering client feedback in therapeutic work.

Seeking experienced practitioners was not intended as a way of seeking a homogenous group, nor indeed were those recruited particularly homogenous; their predominant commonality being that they were each in various positions of influence over service delivery. However, a potential limitation could have been that if the

practitioners interviewed were particularly wedded to their modalities, being encouraged in the interview to question or critique therapeutic practice may have created a discomfort or cognitive dissonance considering the higher investment that comes in justifying a model one has been using for some time and holds influence within. This may have led to a shutting down of more critical conversations regarding how empowerment is understood and approached within contemporary therapeutic practice. In this way, I may have limited the viewpoints I was able to explore to those of individuals who hold relatively more power within clinical psychology, potentially impeding representativeness of practitioner views.

The final area pertaining to methodological rigour is *transparency*: the extent to which descriptions regarding processes of data gathering and analysis are sufficiently detailed so as to be transparent to the reader. I have attempted to detail each step taken throughout the present research, evidencing the methodological conduct in Appendices E-M and the analytic phase in Appendices N-R.

4.3.2. Interpretive Rigour

Fossey et al. (2002) outlined five areas pertaining to interpretive rigour, which are concerned with the trustworthiness of data interpretations. The first of which – *authenticity* – I strived to satisfy by using verbatim quotations to capture participants' voices, and by drawing upon a range of views, including those I perceived as dissenting (for example, see Section 3.1.3.1.). I presented as many verbatim quotations as possible without sacrificing clarity and readability in order to illustrate how the analyses plausibly 'fit' the data, demonstrating the second criteria, *coherence.* I also attempted to incorporate a large spread of data in the write-up by evenly including different participants' quotations. This was unfortunately not wholly possible as some participants may have expressed similar points more succinctly, and therefore were more amenable to a clear and concise write-up.

Another component of *coherence* involves capturing perspectives of multiple researchers to consider and resolve corroborating and competing viewpoints. This may add value to research by reassuring readers of a process of thoroughness to interpretations and analyses. Beyond supervisory input from my DoS, the present study was conducted solely and not part of a research team. Fossey et al. (2002)

also point to the importance of *reciprocity:* redressing participant–researcher power imbalances by involving participants in the analytic process; for example, seeking their input on interpreting data. Although I will return the research to participants, they were minimally involved in the analytic process and I have decided to not seek participant validation. However, the notion of prioritising corroboration of different viewpoints misaligns with both a critical realistic epistemology and RTA. The present research sought neither 'truth' nor a corroboration of differential researcher or participant perspectives. As such, whether or not a variety of researchers' or participants' interpretations align with mine bears little weight within this research approach. Instead, I sought to create a situated interpretation. Indeed, a strength I consider of this research relates to *permeability*: the transparency of aspects of a researcher which influenced their research, a third criteria of interpretive rigour. Through articulating key learning from processes of reflexivity, I have attempted to expose my intentions, assumptions and values, and have spoken to my personal experiences of the research process (see Section 4.1.). However, to uphold reciprocity without violating the assumptions of my epistemology, I could have involved participants in other ways, such as inviting them to review and verify transcripts of their interviews. This might have led participants to feel a sense of ownership over their data, potentially alleviating undue power inequality between participant and researcher.

Fossey et al. (2002) point to *typicality* in evaluating research quality: the extent to which analyses are generalisable. Generalisability is not necessarily an integral aim of critical realism nor indeed critical research, as knowledge is not considered universal nor standalone, but rather socially and contextually positioned. I will however endeavour to outline implications from this research (see Section 4.4.) in a way which generalises, and is optimally useful, to other bodies of knowledge, populations and settings.

To offer a final reflection, arguably taking an *a priori* critical feminist standpoint has both created a potential limitation as well as strengthened the present research. A potential limitation that arises in the use of research that has *a priori* standpoints is that it may threaten the likelihood that analyses can be considered truly inductive, as this research aimed to be (see Section 2.5.). Entering into analyses with *a priori*

assumptions may challenge readers' confidence that I coded, analysed and interpreted data based purely on data content and context as it presented, without this being influenced by my own feminist ideas or critical research agenda. However, efforts were made through processes of reflexivity to reduce the risk of construing interpretations unduly from data, such as keeping a research journal and routinely reflecting with my DoS on what I may have been bringing to the interpretation beyond what was truly present in the data (see Section 2.3). I believe adopting an *a priori* critical feminist standpoint has also potentially strengthened the research by keeping at the centre of its formulation, conduct, interpretation, and discussion, consideration of how power operations effect the lives of women. I feel this has enabled critical and feminist congruence throughout the piece, and therefore congruence also with what I consider to be ethical and meaningful positioning for research.

4.4. Implications

My analyses suggest practitioners feel unable to empower women in the context of disempowered public services. The present research therefore has various implications for evoking empowering change in wider systemic contexts. There may be additional implications which practitioners draw from this research for their own individual work, and I welcome such reflective practice. However, this section does not articulate implications for individual practitioners as I feel this misaligns with feminist values; diverting attention from the systemic roots of issues related to practice unfairly absolves relevant structures from implementing necessary changes.

After firstly outlining the implications for future research, this section will therefore then consider the key implications of the present research regarding funding and commissioning, service delivery, and practitioner training.

4.4.1. Future Research

Researchers could remain cognisant of the limitations highlighted (see Section 4.3.) to enhance future investigations into women's empowerment within psychological

therapy. Firstly, researchers with sufficient time and resources might consider increasing participant involvement to redress power imbalances, such as inviting them to verify their interview transcript. Similarly, future research into this area could be enhanced through PPI as discussed in Section 4.3.1., considering its documented benefits to the relevance and utility of health research (Brett et al., 2014). Careful consideration is advisable for future researchers when determining the level at which they can meaningfully engage with PPI (Staley, 2015), considering the contributory role of time constraints on creating a culture of tokenism (Boylan et al., 2019). Future researchers could also purposively attempt to recruit practitioners from a higher variety of services beyond those supporting victims/survivors of sexual or physical violence. This would enhance the ability of the field to better understand and represent VAW in its myriad forms, as well as the subsequent support women are provided.

Future research could be used to expand and deepen the present research. My analyses suggest participants felt inclined to adhere to therapeutic approaches and models despite doubting their ethical value or perceived usefulness for this client group. Research could explore what drives practitioners to adhere to approaches when they do not believe them to be the right choice, and what factors may empower them to practice in ways which better align with personal values and ideologies. My analyses could also be deepened by expanding sampling. Researchers could attempt to explore the reported perspectives of practitioners who identify as men to consider how a different gender identity may influence approaches to, and perspectives on, women's empowerment in therapy. Through purposive sampling, researchers could also attempt to recruit practitioners of particular therapeutic modalities to compare approaches to empowerment between different modalities, offering insight into therapies in a more nuanced manner to the present study.

Considering TIA are becoming increasingly widespread across the UK (Emsley et al., 2022), the notion of empowerment – intrinsically tied to TIA – is also likely to proliferate in coming years. My analyses suggest that disenfranchised public services disempower practitioners, who are thereby unable to empower their clients. Future research is needed to consider how practitioners can work towards empowerment, as required of TIA, while working in the context of ongoing under-

resourcing. Research could consider how practitioners might navigate such barriers and what change or support might be implemented to enable practitioners to work in a truly trauma-informed manner.

4.4.2. Funding and Commissioning

Participants argued that reactive interventions can only go so far in empowering women, as therapies targeting what are considered clinical levels of distress, after the point at which women have already been subjected to violence, may be too little too late. They described empowering practice therefore aligning rationally with *prevention* of VAW, rather than within clinical – thus presumably *reactive* – services. Creation of preventative strategies could provide a more cogent arena for proposing and advancing women's empowerment. For example, policies could lobby agencies involved in public awareness safety campaigns, such as the police, to shift focus from women's actions to those of men. Distancing from neoliberalist ideas around women's responsibility to prevent their own victimisation is far from a novel idea. For example, Taylor (2020) called for prevention programmes to cease asking women to make their lives smaller, limit their behaviours, or change something about themselves. The present research adds to such suggestions by arguing that policy must also distance from the misuse of empowerment in prevention discourse; for example, the notion that an empowered woman is one who *keeps herself* safe. Individualising empowerment in this way replicates blaming, problematising and oppression of women, and thus prevention strategies must adopt a broader systemic lens when advocating women's empowerment.

This research also holds implications regarding the current provision of VAW services. My analyses suggest underfunding creates a trickledown effect of disempowerment: from services to practitioners, through to the support practitioners feel they can offer clients. Without meeting practitioners' basic needs – such as sufficient service resourcing and properly staffed teams – they feel less able to access what they believe is required to successfully implement empowering approaches. When requiring services to empower clients (such as the many services designed to enact TIA principles), commissioners must remain aware that funding and resourcing must match their expectations; empowering therapeutic practice can only be provided by empowered services and practitioners.

4.4.3. Service Delivery

The present research suggests that medicalised conceptualisations of women's distress are experienced as disempowering. VAW services can utilise service policy to challenge medicalisation within their teams. This can be done in various ways depending on the service context. For example, reducing the use of diagnostic categories in care planning and decision-making regarding what support to provide women after violence. Similarly, if offering trauma-informed services, service policy can reflect the importance of discussing VAW outside of individual traumas and incorporating broader systemic factors in things like team formulations. Service policy changes such as these can contribute to creating service cultures less reliant on problematising women's expressions of distress.

Practitioners described the importance of providing group interventions for this client group as they experienced women depersonalising their experiences of violence as key to their empowerment. In creating these groups however, services should avoid ending the work there. Consciousness-raising, the tradition from which these exercises arise, endeavours to support oppressed persons to perceive socio-political sources of oppression for the purpose of challenging them. Rather than utilising consciousness-raising to solely change individuals' appraisals after violence, services could create groups which harness this for action. This aligns with evidence surrounding how consciousness-raising exercises benefit women (Conlin et al., 2021). However, practitioners cannot make such a change alone. Service and wider Trust policies should avoid apoliticism, which starts with valuing social action outside of merely offering SUI programmes. Services, when rallied, have the potential to hold the power necessary to influence policies related to wider society. As such, policies which allow and even encourage engaging in social action could fortify empowerment interventions with clients.

Service policy can also be used to create empowering working environments for practitioners. Practitioners are silenced and disempowered when service-related decisions are made entirely by staff uninvolved in delivering therapy without their consultation or input. Policies which essentialise staff consultation across service hierarchies and encourage collaborative decision-making may empower practitioners and break oppressive cycles of uncaring, paternalistic treatment.

4.4.4. Training

Finally, the present research holds implications for how psychological therapy practitioners are trained. In examining how practitioners conceptualise and understand VAW, my analyses suggest there is an enduring reliance on older psychological ideas around a woman's ostensive risk factors for attracting her own victimisation. When training practitioners on VAW, providers must remain cognisant that victim-blaming rhetoric pervades predominant psychological literature. Providers must elucidate the instrumental role played by extensive gendered oppression in VAW and the compounding of this by intersectional social positioning. Similarly, when exploring women's responses to violence, training providers must avoid gatekeeping what they consider acceptable behaviours (such as those taken to indicate *coping* or *being in control*) from those considered unacceptable (such as extreme distress or supposedly disorderly trauma reactions). Training practitioners in this way can support the adoption of a less purely behavioural stance focused solely on validating and rewarding idealised responses; instead, creating space for however women respond and express their distress.

The present research suggests that practitioners cope with feeling unable to provide the empowering therapeutic practice they would like by accepting and making peace with a limited sphere of influence. Training providers play an essential role in shaping what influence psychological therapy practitioners have, and are in a position to challenge, rather than collude with, the increasing individualisation and depoliticisation within psychology as a field. This might involve engaging trainees in becoming critical of research, or challenging oppressive policies across service and other systemic levels. Participants described that accepting psychology's limited sphere of influence is particularly difficult as supporting and empowering women was described as a deeply personal, at times spiritual, component to their humanity. Training providers have the opportunity to challenge rigid application of therapeutic modalities by encouraging trainees to critique and evaluate therapeutic practice against what practitioners describe as key to authentic empowerment, like feminist ideologies and connectedness to clients through shared humanity.

4.5. Conclusion

Unsurprisingly, oppressive problematic features which endure across clinical psychology – patriarchal discourse, victim blaming, individualisation – continue to disempower women who have been subjected to violence. This research illuminates that practitioners are very much aware of this; it drives disillusionment, discomfort, and ultimately, reluctant acceptance of perceived limits placed upon their practice. In looking to individualised psychological therapies to empower women, arguably, policymakers and commissioners are currently looking in the wrong place. Public services and practitioners are pouring from an empty jug, and must first be empowered through adequate resourcing and feminist therapeutic tools in order to empower women in a nuanced and socially just way. Inadequate psychological approaches to women's distress, inadequate working contexts, and ultimately, inadequate support provided to victims/survivors of VAW, are not inevitabilities society must accept. Policymakers and training providers have both the means and the duty to thwart the current slide towards individualising and pathologising therapeutic practice. By focusing less on the actions of the disempowered and more on the possibilities for systemic change, interrogating victim-blaming assumptions, challenging unhelpful rigidity, and cultivating services which distance from medicalisation and paternalism, victims/survivors of VAW can be provided with truly empowering therapeutic support. Having been profoundly moved by the dedication of the practitioners in this research, I am left tentatively balancing hope with caution as the field reaches a critical point in harnessing opportunities for meaningful action.

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APPENDIX A: Details of Scoping Review Literature Search Strategy

Step 1: Subject index searching

Searched 'PsycInfo (APA)' and 'Academic Search Complete (EBSCO)' databases using controlled vocabulary from APA Thesaurus of Psychological Index Terms. Each of these terms was searched for alongside the controlled term *'empowerment'.*

- psychology of women + *empowerment*
- battered females …
- human females
- gender violence
- domestic violence
- intimate partner violence
- sexual violence
- exposure to violence
- dating violence
- feminist therapy
- feminist psychology

Although there are no controlled vocabulary for 'psychological therapy' or 'clinical psychology', results were searched by hand to find papers relevant to psychological therapeutic, and/or clinical psychological practice.

Step 2: Key word searching

Searched 'PsycInfo (APA)' and 'Academic Search Complete (EBSCO)' using two or three subject term/key words at a time. Key words were as follows.

- Violence against women/VAW/VAWG + empowerment
- Violence against women/VAW/VAWG + psychology/therapy
- Violence against women/VAW/VAWG + empowerment + psychology/therapy

- Empowering women / women's empowerment + psychology/therapy
- Sexual assault + empowerment
- Sexual assault + empowerment + psychology/therapy
- Gendered oppression + psychology/therapy
- Feminist + psychology/therapy

Step 3: Citation searching

Using Scopus and Google Scholar, searched for literature which cited a paper from each of the eight modalities represented in the search results so far.

Step 4: Author searching

Using Scopus and Google Scholar, searched for literature published by six authors which were chosen for two reasons. Firstly, as they frequently appeared in search results and in other literature which was found and included in the scoping review; for example, as citations from other authors. Secondly, as they again capture a range of the modalities found.

Step 5: Hand searching

Finally, individually searched the last ten issues of 'Violence Against Women' (SAGE) journal, as well as searching the journal for 'psychological therapy intervention' for any further potentially relevant papers. Only one item was found that was not duplicated via previous searching methods, which initiated a further hand search regarding the Trauma Recovery and Empowerment Model. This journal was selected as it appeared frequently through other search means, and appeared to be most closely related to research topic. I also searched for "psychological intervention therapy victims of violence against women" using Google Scholar, and hand searched the first one hundred pages of results to capture additional grey literature.

Method of Criteria Application	Criteria	Rationale
	Inclusion Criteria	
Applied through 'Gender' filter	'Female'	Research pertaining to violence against trans and cis women only.
Applied through 'Language' filter	'English'	I am an English speaker without access to translation, so would not have been able to use literature in other languages. As the research pertains to UK context, my hope is that this will mostly or wholly be captured by literature published in English.
Applied through 'Age' filter	'Very old' (85 years +); 'aged' (65 years +); 'middle age' (40-64 years); 'thirties' (30-39 years); 'young adulthood' (18-29 years); 'adulthood' (18 years and older)	Research pertaining to violence against adult women at any age.
Applied through 'Classification' filter	'Behaviour disorders & antisocial behaviour'; 'health & mental health treatment & prevention'; 'sex roles & women's issues'; 'psychotherapy & psychotherapeutic counselling'; 'psychological & physical disorders'; 'group & family therapy'; 'neuroses & anxiety disorders'; 'psychological disorders'; 'health & mental health services'; 'psychoanalytic therapy'; 'cognitive therapy'; 'promotion & maintenance of health & wellness'; 'eating disorders'; 'substance abuse & addiction'; 'physical & somatoform & psychogenic disorders'; 'art & music & movement therapy'; 'affective disorders'	Literature pertaining to psychiatric disorders (which victims of violence against women therefore might be categorised within and receive 'treatment' for), and therapeutic interventions as relevant to the practice of clinical psychology.
Applied through 'Subject Major Heading' filter	'Sexual abuse'; 'human females'; 'victimization'; 'rape'; 'feminism'; 'sex offenses'; 'posttraumatic stress disorder'; 'intimate partner violence'; 'survivors'; 'trauma'; 'violence'; 'physical abuse'; 'domestic violence'; 'psychotherapy'; 'major depression'; 'mental health'; 'emotional trauma'; 'group psychotherapy'; 'feminist therapy'; 'college students'; 'empowerment'; 'treatment'; 'crime victims';	Attempt to not exclude any literature pertaining to variety of: violent acts (e.g. 'rape', 'domestic violence'); women (e.g. 'mothers', 'blacks'); interventions for potential reactions to violence

	‘mothers’; ‘battered females’; ‘distress’; ‘family therapy’; ‘eating disorders’; ‘psychotherapeutic processes’; ‘emotional abuse’; ‘psychoanalysis’; ‘blame’; ‘blacks’; ‘sexual harassment’; ‘aggressive behaviour’; ‘intervention’; ‘social support’; ‘symptoms’; ‘feminist psychology’	(e.g. ‘distress’, ‘major depression’); and approaches to psychological therapeutic practice (e.g. ‘feminist psychology’, ‘psychoanalysis’).
Applied through ‘Subject’ filter	‘Human females’; ‘victimisation’; ‘survivors’; ‘college students’; ‘symptoms’; ‘early experience’; ‘trauma’; ‘major depression’; ‘posttraumatic stress disorder’; ‘violence’; ‘feminism’; ‘rape’; ‘sexual abuse’; ‘sex offenses’; ‘mental health’; ‘physical abuse’; ‘blacks’; ‘intervention’; ‘mothers’; ‘emotional trauma’; ‘treatment’; ‘anxiety’; ‘domestic violence’; ‘interpersonal relationships’; ‘self-esteem’; ‘couples’; ‘intimate partner violence’; ‘social support’; ‘at risk populations’; ‘consequence’; ‘crime victims’; ‘distress’; ‘empowerment’; ‘life experiences’; ‘whites’; ‘family’; ‘self-report’; ‘patient history’; ‘psychotherapy’; ‘emotional abuse’; ‘severity (disorders)’; ‘communities’; ‘history’; ‘models’; ‘self-blame’; ‘sociocultural factors’; ‘theories’; ‘well being’; ‘battered females’; ‘latinos/Latinas’; ‘self-concept’; ‘stress’; ‘experiences (events)’; ‘drug abuse’; ‘emotions’; ‘parents’; ‘family relations’; ‘attribution’; ‘blame’; ‘psychopathology’; ‘self-disclosure’; ‘comorbidity’; ‘psychotherapeutic processes’; ‘sexual coercion’; ‘depression (emotion)’; ‘dissociation’; ‘mental disorders’; ‘interpersonal control’; ‘sexual partners’; ‘clients’; ‘family members’; ‘feminist therapy’; ‘recovery (disorders)’	Attempt to not exclude any literature pertaining to variety of: violent acts (e.g. ‘sex offenses’, ‘intimate partner violence’); women (e.g. ‘college students’, ‘crime victims’); names for women who have been subjected to violence (e.g. ‘clients’, ‘survivors’); interventions for potential reactions to violence (e.g. ‘blame’, ‘drug use’); potential perpetrators (e.g. ‘family relations’, ‘sexual partners’) and approaches to psychological therapeutic practice (e.g. ‘feminist therapy’, ‘psychotherapeutic processes).
Exclusion Criteria		
Applied through ‘Age’ filter Screening (by hand) literature in search results list	‘Adolescence’; ‘childhood’; ‘school age’; ‘preschool’; ‘infancy’	Research pertaining to violence against women, rather than girls/children.

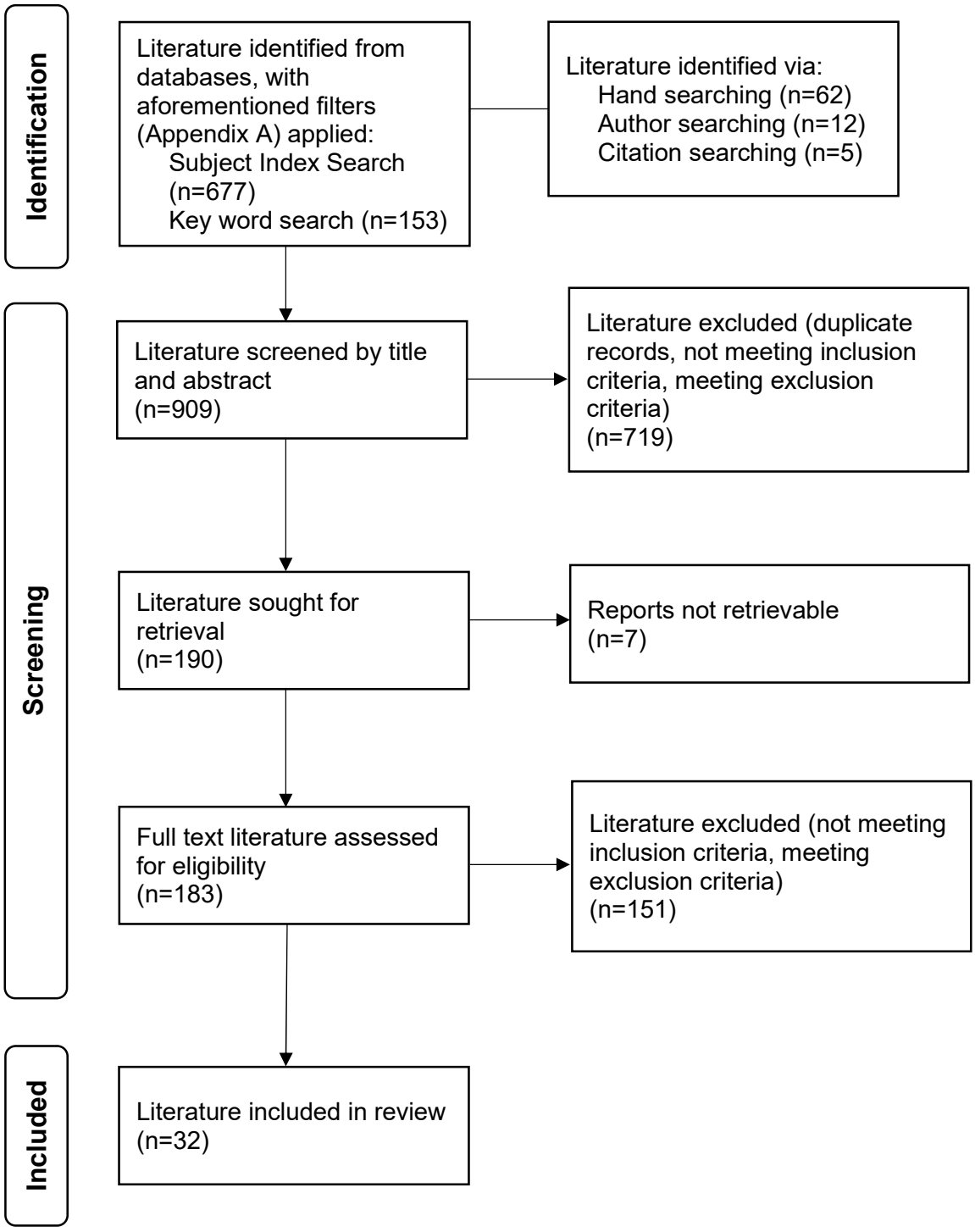
Screening (by hand) literature in search results list	Excluded literature that was not relevant to psychological therapeutic practice in the UK. If international research, must have relevance to UK practice; for example, excluded literature outlining programmes specific to a country which does not have an equivalency in the UK.	Research is pertaining to psychological therapeutic practice relevant to the UK context.
Applied through 'Classifications' filter Screening (by hand) literature in search results list	Excluded literature not relevant to women who had been subjected to violence; for example, research speaking to empowering women in general. Excluded literature which made fleeting reference to empowerment without stating it as a goal or facet of an intervention/therapeutic approach. Similarly, excluded literature pertaining to explorations of empowerment in general terms rather than in the context of it being used within a psychological intervention. Excluded literature related to do with reducing the risk of violence such as interventions for perpetrators of violence rather than dealing with its aftermath for victims. Excluded non-clinical psychology literature; for example, organizational psychology, psychiatric drug interventions, self-defence training where this was not in the context of integration with psychological therapy.	Research is pertaining to empowerment within psychological therapy for specifically victims of violence against women – relevant to the context of clinical psychological practice.
Screening (by hand) literature in search results list	Excluded literature pertaining to mediational factors associated with violence against women and/or empowerment; for example, explorations into whether clients who had a good social network were more 'empowered' than other victims of violence. Similarly, excluded literature pertaining to models or social processes of violence and symptomatology rather than interventions for victims.	Research is pertaining to specifically psychological interventions, rather than generic explorations of empowerment and violence.
Applied through 'Publication' filter	'Child abuse & neglect'; 'journal of child sexual abuse: research, treatment, & program innovations for victims, survivors & offenders'; 'sex roles: a journal of research'; 'child maltreatment'; 'military medicine'; 'monographs of the society for research in child development'; 'child abuse review'; 'international journal of offender therapy and comparative criminology'; 'military psychology'; 'military sexual trauma'; 'occupations'; 'personnel & guidance journal'; 'the vocational guidance magazine'; 'women & the military: systemic	These journals were excluded from results as they did not pertain to research regarding psychological therapy for women (adult age).

	feminist perspectives'; 'children & youth services review'; 'diseases of the nervous system'; 'journal of abnormal child psychology'; 'journal of adolescent health'; 'journal of adolescent health care'; 'journal of child & adolescent trauma'; 'journal of clinical child and adolescent psychology'; 'journal of clinical child psychology'	
Applied through 'Subject' filter	'Child abuse'; 'human sex differences'; 'test construction'; 'risk factors'; 'perpetrators'; 'coping behaviour'; 'epidemiology'; 'psychosexual behaviour'; 'sequelae'; 'childhood development'; 'prevention'; 'sex roles'; 'myths'; 'military veterans'; 'sexuality'; 'narratives'; 'experimentation'; 'test reliability'; 'test validity'; 'adult attitudes'; 'heterosexuality'; 'human males'; 'adolescent development'; 'attitudes'; 'sex role attitudes'; 'criminal offenders'; 'legal processes'	These subjects were excluded from the list as they did not pertain to research around adult women (for example 'child abuse'); psychological therapies (for example 'legal processes'); or psychological therapies for victims of violence against women (for example 'criminal offenders').
Applied through 'Subject Major Heading' filter	'Child abuse'; 'human sex differences'; 'early experience'; 'risk factors'; 'military veterans'; 'coping behaviour'; 'perpetrators'; 'sex role attitudes'; 'psychosexual behaviour'; 'sex roles'; 'military personnel'	These subjects were excluded from the list as they did not pertain to research around adult women (for example 'child abuse'); psychological therapies (for example 'risk factors'); or psychological therapies for victims of violence against women (for example 'perpetrators').
Applied through 'Classification' filter	'Social psychology'; 'criminal behaviour & juvenile delinquency'; 'educational psychology'; 'military psychology'; 'developmental psychology'; 'general psychology'; 'sexual behaviour & sexual orientation'; 'forensic psychology & legal issues'; 'health psychology & medicine'; 'industrial & organisational psychology'; 'criminal law & adjudication'; 'social processes & social issues'; 'professional personnel attitudes & characteristics'; 'community & social services';	These classifications were excluded from the list as they did not pertain to research around clinical psychology (for example 'educational psychology'); psychological therapies (for example 'social processes &

	‘personality psychology’; ‘clinical psychological testing’; ‘personality traits & processes’; ‘professional education & training’; ‘professional psychological & health personnel issues’; ‘childrearing & child care’; ‘psychosocial & personality development’; ‘criminal rehabilitation & penology’; ‘classroom dynamics & student adjustment & attitudes’; ‘police & legal personnel’; ‘curriculum & programs & teaching methods’; ‘social perception & cognition’; ‘personality scales & inventories’; ‘marriage & family’; ‘culture & ethnology’; ‘immunological disorders’; ‘physiological psychology & neuroscience’; ‘tests & testing’; ‘gerontology’.	adjudication’); or adult women victims of violence (for example ‘childrearing & childcare’).

APPENDIX B: Process of Scoping Review Literature Selection and Exclusion

Adapted from Page et al. (2021) Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flowchart



APPENDIX C: Details of Literature Included in Review

Modality	Approach	Literature
Trauma-focused approaches	Trauma Recovery and Empowerment Model	Harris, M. (1998). *Trauma Recovery and Empowerment: A clinician's guide for working with women in groups.* The Free Press. Fallot, R. D., & Harris, M. (2002). The Trauma Recovery and Empowerment Model (TREM): Conceptual and practical issues in a group intervention for women. *Community Mental Health Journal, 38*(6), 475–485. https://doi.org/10.1023/A:1020880101769 Fallot, R. D., McHugo, G. J., Harris, M., & Xie, H. (2011). The Trauma Recovery and Empowerment Model: A quasi-experimental effectiveness study. *Journal of Dual Diagnosis, 7*(1–2), 74–89. https://doi.org/10.1080/15504263.2011.566056 Karatzias, T., Ferguson, S., Gullone, A., & Cosgrove, K. (2016). Group psychotherapy for female adult survivors of interpersonal psychological trauma: A preliminary study in Scotland. *Journal of mental health, 25*(6), 51–519. https://doi.org/10.3109/09638237.2016.1139062 Masin-Moyer, M., Engstrom, M., & Solomon, P. (2020). A comparative effectiveness study of a shortened Trauma Recovery Empowerment Model and an attachment-informed adaptation. *Violence Against Women, 26*(5), 482–504. https://doi.org/10.1177/1077801219836730
	Trauma-Informed Approaches	Sullivan, C. M., Goodman, L. A., Virden, T., Strom, J., & Ramirez, R. (2017). Evaluation of the effects of receiving trauma-informed practices on domestic violence shelter residents. *American Journal of Orthopsychiatry*, *88*, 563–570. https://doi.org/10.1037/ort0000286 Pebole, M., Gobin, R. L., & Hall, K. S. (2021). Trauma-informed exercise for women survivors of sexual violence. *Translational Behavioral Medicine, 11*(2), 686–691. https://doi.org/10.1093/tbm/ibaa043

		Hadjiioannou, E. (2021). *Psychotherapy with survivors of sexual violence: Inside and outside the room*. Routledge/Taylor & Francis Group.
	Trauma recovery approach	Dutton, M. A. (1992). *Empowering and healing the battered woman: A model for assessment and intervention.* Springer. Lloyd, M., Ramon, S., Vakalopoulou, A., Videmšek, P., Meffan, C., Roszczynska-Michta, J., & Rollè, L. (2017). Women's experiences of domestic violence and mental health: Findings from a European empowerment project. *Psychology of Violence, 7*(3), 478–487. http://doi.org/10.1037/vio0000111
	Trauma-focused group	VanDeusen, K. M., & Carr, J. L. (2003). Recovery from sexual assault: An innovative two-stage group therapy model. *International Journal of Group Psychotherapy, 53*(2), 201–223. http://doi.org/10.1521/ijgp.53.2.201.42815
Cognitive and Behavioural approaches	Helping to Overcome PTSD with Empowerment (HOPE) model	Johnson, D. M., & Zlotnick, C. (2006). A cognitive-behavioral treatment for battered women with PTSD in shelters: Findings from a pilot study. *Journal of Traumatic Stress, 19*(4), 559–564. http://doi.org/10.1002/jts.20148 Johnson, D. M., & Zlotnick, C. (2009). HOPE for battered women with PTSD in domestic violence shelters. *Professional Psychology: Research and Practice, 40*(3), 234–241. https://doi.org/10.1037/a0012519 Johnson, D. M., Zlotnick, C., & Perez, S. (2011). Cognitive behavioral treatment of PTSD in residents of battered women's shelters: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 79*(4),542–551. https://doi.org/10.1037%2Fa0023822 Johnson, D. M., Zlotnick, C., Hoffman, L., Palmieri, P. A., Johnson, N. L., Holmes, S. C., & Ceroni, T. L. (2020). A randomized controlled trial comparing HOPE treatment and Present-Centred Therapy in women residing in shelter with PTSD from intimate partner violence. *Psychology of Women Quarterly, 44*(4), 539–553. http://doi.org/10.1177/0361684320953120
	Cognitive Behavioural Therapy	Santos, A., Matos, M., & Machado, A. (2017). Effectiveness of a group intervention program for female victims of intimate partner violence. *Small Group Research, 48*(1), 34–61. https://doi.org/10.1177/1046496416675226
	Cognitive Trauma Therapy	Kubany, E. S., Hill, E. E., Owens, J. A., Iannce-Spencer, C., McCaig, M. A., Tremayne, K. J., & Williams, P. L. (2004). Cognitive Trauma Therapy for battered women with PTSD (CTT-BW). *Journal of Consulting and Clinical Psychology, 72*(1), 3–18. https://doi.org/10.1037/0022-006X.72.1.3

Creative approaches	Music Therapy	MacIntosh, H. B. (2003). Sounds of healing: Music in group work with survivors of sexual abuse. *The Arts in Psychotherapy, 30*(1), 17–23. http://doi.org/10.1016/S0197-4556(02)00229-0 Hernandez-Ruiz, E. (2020). Empowering women survivors of domestic violence. *Music Therapy Perspectives, 38*(1), 3–6. http://doi.org/10.1093/mtp/miaa005
	Wilderness Therapy	Powch, I. G. (1995). Wilderness therapy: What makes it empowering for women? *Women & Therapy, 15*(3–4), 11–27. http://doi.org/10.1300/J015v15n03_03
	Martial Arts	Guthrie, S. R. (1995). Liberating the Amazon: Feminism and the martial arts. *Women & Therapy, 16*(2–3), 107–119. http://doi.org/10.1300/J015v16n02_12
General therapeutic and transtheoretical approaches	Stages of Change Model: Facilitated by Motivational Interviewing and Problem-Solving	Burman, S. (2007). Cognitive Problem-Solving Therapy and Stages of Change that facilitate and sustain battered women's leaving. In A. R. Roberts & B. W. White (Eds.), *Battered women and their families: Intervention strategies and treatment programs* (3rd ed., pp. 33–62). Springer. Craven, L. C., Carlson, R. G., & Waddington, A. F. (2022). Using the Stages of Change to counsel victims of intimate partner violence. *Family Journal, 30*(3), 334–340. https://doi.10.1177/10664807221090951
	Crisis intervention characterised by: Active listening, empathy; safety planning; relaxation; problem-solving; assertiveness training	Roberts, A. R., & Burman, S. (2007). National survey on empowerment strategies, crisis intervention, and Cognitive Problem-Solving Therapy with battered women. In A. R. Roberts & B. W. White (Eds.), *Battered women and their families: Intervention strategies and treatment programs* (3rd ed., pp. 63–88). Springer.
Feminist approaches	Feminist psychotherapy	Hattendorf, J., & Tollerud, T. R. (1997). Domestic violence: Counseling strategies that minimize the impact of secondary victimization. *Perspectives in Psychiatric Care, 33*(1), 14–23. https://doi.org/10.1111/j.1744-6163.1997.tb00528.x
	Feminist Trauma-Informed Approach	Richmond, K., Geiger, E., & Reed, C. (2013). The personal is political: A feminist and trauma-informed therapeutic approach to working with a survivor of sexual assault. *Clinical Case Studies, 12*(6), 443–456. http://doi.org/10.1177/1534650113500563
	Mindfulness-based feminist therapy	Crowder, R. (2013). *Healing the self: The role of self-compassion and empathy in a mindfulness based modality for women survivors of interpersonal violence* [Doctoral thesis, Carleton University]. Carleton University. https://curve.carleton.ca/system/files/etd/901b0d93-ed1f-4d39-aafe-

		9502059f877c/etd_pdf/ff2b351bde319a19c79fa4a58107b773/crowder-healingtheseltheroleofselfcompassionandempathy.pdf
Meditation	Mindfulness-Based Stress Reduction	Bermudez, D., Benjamin, M. T., Porter, S., Saunders, P. A., Myers, N. A. L., & Dutton, M. A. (2013). A qualitative analysis of beginning mindfulness experiences for women with post-traumatic stress disorder and a history of intimate partner violence. *Complementary Therapies in Clinical Practice, 19*(2), 104–108. https://doi.10.1016/j.ctcp.2013.02.004 Dutton, M. A., Bermudez, D., Matas, A., Majid, H., & Myers, N. L. (2013). Mindfulness-based stress reduction for low-income, predominantly African American women with PTSD and a history of intimate partner violence. *Cognitive and Behavioral Practice, 21*(1), 23–32. https://doi.10.1016/j.cbpra.2011.08.003
	Concentrative meditation	Kane, K. E. (2006). The phenomenology of meditation for female survivors of intimate partner violence. *Violence Against Women, 12*(5), 501–518. https://doi.org/10.1177/1077801206288177
Critical consciousness-raising approach		McGirr, S. A., & Sullivan, C. M. (2017). Critical consciousness raising as an element of empowering practice with survivors of domestic violence. *Journal of Social Service Research, 43*(2), 156–168. http://doi.org/10.1080/01488376.2016.1212777
Solution-Focused Therapy		Lee, M. Y. (2007). Discovering strengths and competencies in female domestic violence survivors: An application of Roberts' continuum of the duration and severity of woman battering. *Brief Treatment and Crisis Intervention, 7*(2), 102–114. https://doi.org/10.1093/brief-treatment/mhm002

APPENDIX D: Title Amendment to Ethics Application

Change project title - Miss Roisin Murtagh

Date	14 Nov 2022
Doctoral Researcher	Miss Roisin Murtagh
Student ID	2075220
Doctoral Research Project	How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women who have been victims of violence?
Project type	DProf
Project mode	Full Time
Project start	21 Sep 2020
School	Psychology

Change request form

Project title form

Please Note, if you have received Ethical Approval for your research you must also submit an Amendment to an approved Ethics Application. This can be done via the Ethics tab on your record and by starting a new application and choosing the 'Amendment to an application approved outside of ResearchUEL' option.

Failure to do this may result in a case of academic misconduct as your new research title will not have Ethical Approval.

Proposed new title:

How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women who have been victims of violence?

Reason(s) for proposed change:

To add more clarity and specificity that I am exploring therapy with women exposed to violence, not all women.

Researcher form

Did your research require Ethical Approval?

Yes

I confirm that I have completed an Amendment to an Approved Ethics Application form to change the title of my thesis

Having discussed the proposed change of title with my supervisory team, I am satisfied with the change proposed.

Yes

Supervisor form

Supervisor form

Did your student require Ethical Approval for their research?

Yes

I confirm that my student has completed an Amendment to an Approved Ethics Application form to change the title of their thesis

We recommend that the change in the registered title of the thesis progress as requested.

Yes

Notes

Research Degrees Leader form

Second approver form

Recommend this application for consideration at the School's Research Degrees Sub-Committee

Yes

Notes

Clinical psychology review group report

Committee report

Comments

Both reviewers recommended approval.

Recommendation

Approve

APPENDIX E: Recruitment Email

Dear [NAME OF SERVICE] Team,

I hope this email finds you well!

My name is Roisin Murtagh and I am contacting you in regards to my research into violence against women and women's empowerment, and I would love to hear perspectives from your organisation.

I am conducting this thesis research project as part of my Doctorate in Clinical Psychology at the University of East London (UEL). I am researching how experienced psychological practitioners work with women who have been victims/survivors of violence and exploring how women's empowerment factors into this work. I have attached my study advertisement for more information.

I was wondering whether any of the psychological practitioners in your team would be interested in/available to participate in this project? It takes just an hour, and it would be a privilege to hear from practitioners at [NAME OF SERVICE] as gaining any knowledge from their experience in this field of work would be invaluable.

I appreciate the team is likely very busy so I would be very grateful for any support you might be able to offer.

Thank you for your time, and I look forward to hearing from you.

Best wishes,

Roisin

APPENDIX F: Study Advertisement

CALL FOR RESEARCH PARTICIPANTS

Psychological practitioners: Are you interested in talking about how you work with women survivors of violence, and helping improve the support they receive?

Who am I?

My name is Roisin Murtagh, and I am currently studying for a Professional Doctorate in Clinical Psychology at the University of East London.

What am I researching?

How experienced practitioners of different psychological therapeutic modalities conceptualise and work with women's empowerment, and women who have been subjected to violence, through different models of therapy. This research aims to improve the support women victims/survivors of violence receive.

Who is eligible?

If you are: a currently practicing psychological therapy practitioner with experience of working with women victims/survivors of violence AND you

- are at least five years post-qualification OR
- train others in your modality

What is involved?

A confidential conversation discussing the topic above. The interview will last around one hour, it will be remote/online, using Microsoft Teams.

FOR MORE INFORMATION, EMAIL ME, ROISIN MURTAGH, AT U2075220@UEL.AC.UK

APPENDIX G: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women?

Contact person: Roisin Murtagh

Email: u2075220@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 14/02/2022 (version 1.0) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft functionality (for MS Teams interviews) or an encrypted Dictaphone (for telephone interviews).	
I understand that my personal information and data, including audio/video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	

I would like to receive a summary of the research findings once the study has been completed and consent for my provided contact details to be used for this to be sent to.	
I agree to take part in the above study.	

Participant's Name: (Typing your name will be counted as your authorised signature)

……

Researcher's Name:

Roisin Murtagh

Researcher's Signature:

……

Date:

……

APPENDIX H: Participant Information Sheet

Version: 1.0

Date: 14.02.2022

PARTICIPANT INFORMATION SHEET

How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women?

Contact person: Roisin Murtagh

Email: u2075220@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part, please read through the following information. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Roisin Murtagh. I am studying for a Professional Doctorate in Clinical Psychology in the School of Psychology at the University of East London (UEL). As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

Women's empowerment is often cited as the goal for psychological interventions and services designed to support women who have experienced violence. However, it is unclear how different therapeutic modalities are used to conceptualise and work with empowerment when working with women victims/survivors of violence. The proposed research involves interviewing practitioners of different psychological therapeutic modalities to explore how violence against women and women's

empowerment are conceptualised and worked with within different models of therapy used in the UK.

The United Nations (1993) defines violence against women as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty' (p.2).

It is the intention that this research will be useful for gaining an insight into what is being provided to women victims/survivors of violence, and making clinical recommendations for practitioners who aim to work towards empowering women in a way that is informed, beneficial and meaningful – note that the conversation is not limited to ciswomen.

Why have I been invited to take part?

To address the study aims, I am inviting experienced psychological therapeutic practitioners to take part in my research. If you are: a currently practicing psychological therapy practitioner with experience of working with women victims/survivors of violence AND you

- are at least five years post-qualification OR
- train others in your modality OR
- self-identify as committed to your modality

you are eligible to participate. It is entirely up to you whether you take part – participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to find a time for me to interview you (preferably via Microsoft Teams, but we can arrange a telephone appointment if necessary) about your views and experiences of working with women victims/survivors of violence within your main therapeutic modality. This interview is expected to last around 60 minutes. You will also be asked to complete a brief demographic questionnaire capturing some basic information about you, such as your gender and what sort of modality you work in. As the interviews are remote, you can be anywhere when you participate; however, to ensure the conversation feels comfortable for us both I do ask that you find a private space to talk where you will not worry about being interrupted. The interview will be recorded to allow for me to transcribe and analyse what was discussed; Microsoft Teams interviews will be audio and video recorded using the Microsoft functionality and telephone interviews will be audio recorded using an encrypted Dictaphone.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview, you can do so by informing me to terminate the interview or by simply hanging up the phone or exiting the software. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of your interview date (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

Violence perpetrated against women is something which affects the lives of many, if not all, people in some way. It may be that speaking about this in the interview may cause distress. If this is the case, remember you have a right to withdraw at any point. I also encourage questions and reflections about how you are feeling throughout the process at any stage. I will check in with you during the interview about how you are feeling. You could also reach out to the following agencies as sources of support if you feel this may benefit you:

- Women's Aid (grassroots charity providing support and advice for victims/survivors and anyone who wants to end violence against women) https://www.womensaid.org.uk/
- Freephone 24-Hour National Domestic Abuse Helpline: 0808 2000 247 or visit www.nationaldahelpline.org.uk (access live chat Mon-Fri 3-10pm)
- Speak to your GP for guidance around accessing therapeutic support

How will the information I provide be kept secure and confidential?

Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research. The transcripts will be anonymised by redaction of personally identifiable data within the content, and names will be replaced with: W (for woman including transwomen) or M (for man including transmen), an acronym for your key therapeutic modality, and a randomly assigned two-digit number obtained from an online random number generator. For example, a woman cognitive behavioural therapist might be anonymised to "WCBT25"; or a man systemic family therapist might be "MSFT32". Demographic information will be aggregated to protect against it being used as personally identifiable information.

I will securely store your contact details on my UEL email (as this is how we will be communicating), and only for as long as needed to arrange the interview before the email chain is deleted. To ensure only I have access to personal information, I will complete all transcriptions – after which, recordings will be deleted. All data will be stored on UEL's secure OneDrive which only I can access. However, anonymised data may be requested and seen by my research supervisor and examiners; if this is the case, the data will be shared through secure links via UEL OneDrive for Business. After the study is completed, all personal data will be erased and the anonymised demographic questionnaires and anonymised transcripts will be moved to my Director of Studies' OneDrive for three years before erasure.

Your data will no longer be kept confidential if anything you do or disclose suggests potential safety risks to yourself or anyone else, as I may break confidentiality to involve relevant authorities (e.g. NHS services) – if this is the case, this will be discussed with you.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the

GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online research Repository. Findings may also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal (and other) articles, conference presentations, and talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as personally identifying information will be either be removed (e.g. details you share which might identify your work place will be redacted) or replaced (e.g. your name will be replaced with an anonymous code).

You will be given the option to receive a summary of the research findings once the study has been completed (for which relevant contact details will need to be provided – this will also be kept confidential).

Anonymised research data will be securely stored by my research supervisor Prof Nimisha Patel for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me (email address at the top of this form).

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Prof Nimisha Patel. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: n.patel@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

APPENDIX I: Debrief Sheet

PARTICIPANT DEBRIEF SHEET

How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women?

Thank you for participating in my research study on how (and whether) different psychological therapeutic modalities are used to conceptualise and work with empowerment when working with women victims/survivors of violence. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online research Repository. Findings may also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal (and other) articles, conference presentations, and talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as personally identifying information will be either be removed (e.g. details you share which might identify your work place will be redacted) or replaced (e.g. your name will be replaced with an anonymous code).

If you would like to receive a summary of the research findings once the study has been completed, please inform the researcher (Roisin Murtagh) and provide relevant contact details – these details will be kept confidential and retained only as long as necessary for the summary to be sent to you.

Anonymised research data will be securely stored by my research supervisor Prof Nimisha Patel for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- Women's Aid (grassroots charity providing support and advice for victims/survivors and anyone who wants to end violence against women) https://www.womensaid.org.uk/
- Freephone 24-Hour National Domestic Abuse Helpline: 0808 2000 247 or visit www.nationaldahelpline.org.uk (access live chat Mon-Fri 3-10pm)
- Speak to your GP for guidance around accessing therapeutic support

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Roisin Murtagh

u2075220@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Prof Nimisha Patel. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: n.patel@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

APPENDIX J: Brief Questionnaire

A BIT ABOUT YOU: PARTICIPANT INFORMATION QUESTIONNAIRE

How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women?

Contact person: Roisin Murtagh

Email: u2075220@uel.ac.uk

Please complete this brief questionnaire, which captures some information about you which may be relevant and useful for data analysis. Do let me know if you wish to discuss any of these questions. Thank you.

How would you define your gender? (Please check relevant box)

a. Man including transmen ☐
b. Woman including transwomen ☐
c. Any other gender ☐
d. Prefer not to say ☐

What type of service do you work for? (E.g. NHS community mental health team, women's charity, IAPT etc.)

…….
What is your professional role/job title?

…….
What is your primary therapeutic modality/modality of expertise? (E.g. systemic family therapy, psychodynamic, integrative model [please specify] etc.)

…….
How many years of practice do you have post-qualification in this modality?

…….

APPENDIX K: Piloted First Draft of Semi-Structured Interview Schedule

Prior to commencement of interview, to check with participants their understanding of the information sheet and consent form, and welcome/address any questions.

1) What is your experience of working with women who have been victims of violence?
    a. What sort of work do you do with them, what does that work involve?
    b. Can you give me an example?
2) How is your way of working with women influenced by your therapeutic modality?
    a. What else has influenced your way of working with women?
    b. Why/how?
3) What is your understanding of empowerment in working with women who have been victims of violence?
4) You have described your therapeutic modality as... What does this model imply about women and men's position in society?
    a. Are there any patriarchal messages, about men, women and how they should behave, in your therapeutic modality? Examples?
5) Thinking about what you have said, how might empowerment be relevant to your work, should it be relevant and why/why not?
    a. How is the idea of empowerment relevant in the kind of therapy that you do? How does your model conceptualise and address empowerment?
    b. Is social action a part of this? If so, how?
    c. Why is it/is it not related? Can you give examples? Explain?
6) Given the conversation we have had, what do you think would be an appropriate way forward for working with women who have been subjected to violence?
    a. Implications for therapeutic work?
    b. Implications for services?
7) Is there anything you wish to add, including how this interview has been for you?

APPENDIX L: Semi-Structured Interview Schedule

Thank you for agreeing to meet today to be interviewed about your experience of working with women who have been victims of violence. The interview will take about an hour and I will be recording it so I can later transcribe and analyse the data. I have a few questions I would like to ask you and it would be really helpful if you could give as much detail in your answers as you can, and I may ask some follow up questions to your responses. Feel free to ask me questions as we go on including if any of my questions feel unclear, and let me know if you would like to pause or terminate the interview. Before we start, did you have an opportunity to read through the information sheet? Did you have any questions or anything you would like to raise with me before we start?

1. **What is your experience of working with women who have been victims of violence?**
    - What sort of work do you do with them, what does that work involve?
2. **How do you approach your work, in particular how do you understand and approach empowerment when working with women who have been victims of violence?**
3. **You have described your therapeutic modality as …. What does this model imply about women and men's position in society?**
    - (If 'patriarchy' has been brought up in their response) Are there any patriarchal messages, about men, women and how they behave, in your therapeutic modality? Examples?
    - (If 'patriarchy' has NOT been brought up in their response) Are there any specific messages, about men, women and how they behave, in your therapeutic modality? Examples?
4. **When you work with women who have been victims of violence, what do you draw upon in terms of models, theories, ideas, or any other influences?**
    - What else has influenced your way of working with women who have been victims of violence?

- Why/how?
- Can you give me an example?

5. **Thinking about what you have said, how might empowerment be relevant to your work, should it be relevant and why/why not?**
   - How is the idea of empowerment relevant in the kind of therapy that you do?
   - How does your model conceptualise and address empowerment? Is there anything that gets in the way of, or facilitates, your model in its conceptualising and addressing of empowerment?
   - (If participant has brought up the notion of collective action) Is social action a part of this? If so, how? (If unsure what is meant by 'social action', to offer explanation 'work that would involve people coming together to evoke collective action in protest against problems which are important to them'.)
   - (If participant discusses individually-focused work around empowerment) Would collective action ever factor in?
   - Why is it/is it not related?
   - Can you give examples? Explain? (If requiring clarification – can you give an example of a time where you have used your therapeutic model to conceptualise and address empowerment when working with clients/a client? How important and relevant did empowerment within that work feel?)
6. **Given the conversation we have had, what do you think would be an appropriate way forward for working with women who have been subjected to violence?**
   - Why?
   - What implications might this have for therapeutic work?
   - Any ideas about what services could do to better support women who have been subjected to violence?
   - You have suggested a way forward might be … how would [your therapeutic modality] achieve this? What are the potential problems with/barriers to this?
7. **Is there anything you would like to add, including how this interview has been for you?**

APPENDIX M: Ethical Approval

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	**Jeff Salter**
Supervisor:	**Nimisha Patel**
Student:	**Roisin Murtagh**
Course:	**Prof Doc in Clinical Psychology**
Title of proposed study:	**How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women?**

Checklist
(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐

All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.

APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED**

Minor amendments
Please clearly detail the amendments the student is required to make

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**Jeff Salter**

Date:	**01/03/2022**
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee	
RESEARCHER PLEASE NOTE For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place. For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.	

Confirmation of minor amendments (Student to complete)	
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	Please type your full name
Student number:	Please type your student number
Date:	Click or tap to enter a date
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

APPENDIX N: Excerpt from a Coded Transcript

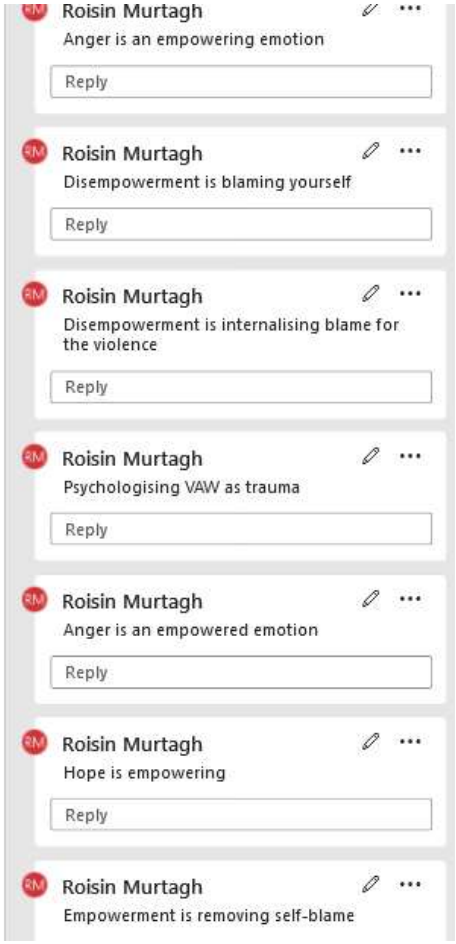
As part of phase two of the Reflexive Thematic Analysis, I used the 'comments' function on Microsoft word to 'code' my transcripts. Below is an excerpt of a coded transcript.

77 I: It does make sense, that's brilliant, thank you. So you've spoken a bit about some of the processes
78 that you'll use to make sure that therapy is an empowering experience. And I was wondering if there
79 are any particular outcomes that you might look for? So, for example, anything that might indicate
80 to you that a client's more or less empowered?

81 P: Sure. I guess changes I might hope to see in terms of what's happening outside of therapy is
82 people feeling like they can act, and can do things. Because often when people are affected by
83 trauma, it can be really, it can be disempowering and it can be life-limiting. And so I feel at the point
84 where I've worked with people in therapy it's felt like their life has shrunk, and they feel less able to
85 do things. Whether that's decisions relating to their work, education, the criminal justice process. So
86 sometimes it's, it feels quite frankly very good to see somebody taking action outside of therapy.
87 Whether that might be a complaint, whether that might be applying for a new job, whether it might
88 be choosing to date again, and for that to happen from a position of safety, and sort of, safeness. I
89 think that is something that is always very rewarding to see clinically. But I guess something I also
90 notice in terms of maybe more of the minutiae within therapy is what it's like for people to maybe
91 get in touch with anger clinically, as opposed to feelings of shame and self-blame about what
92 happened to them. And I think a lot of my experience of women who are affected by violence has
93 been sort of that internalised blame, which shouldn't be sitting with the person whose experienced
94 that violence, it should be sitting with the person whose perpetrated it. So often for me, that's a
95 reassuring thing to notice happening within clinical work, and might be kind of a thing that happens
96 within trauma therapy. So thinking what with the information that I know now, what, what's the
97 response that happens to, based on what's happened to you, and really sort of coming into contact
98 with those feelings of how that, what that's like. And I often think anger is very activating, and I will
99 tend to do a fair bit of work on psycho-education around anger and how it evolved as a response to
100 injustice and how the motivation to act is really adaptive. And I think that's good, a sense of action
101 rather than hopelessness, shame and blame or self-blame can be really empowering.

102 I: That's brilliant, thank you. So you've described your main therapeutic modalities are CBT, and sort
103 of third wave and trauma-focused as well. What do those models imply about women and men's
104 positions in society?

105 P: Oh, well I think what's interesting is when, with sort of a lot of CBT therapists, especially in terms
106 of how it seems to have trickled down, there's less formal acknowledgement about positions in
107 society. But, if we were model aware and we think back to maybe the sort of more, like when the
108 interacting subsystems theory, so the hot cross bun within CBT, was first acknowledged, it was sort
109 of labelled a bun because it was always bracketed. And that bracket is people's context, and people's



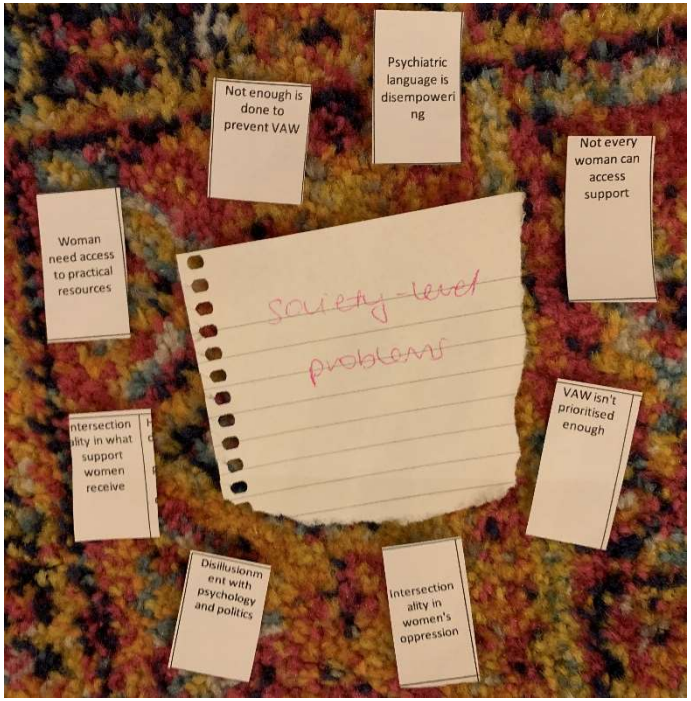
APPENDIX O: Excerpt from the List of Initial Codes

As part of phase two of the Reflexive Thematic Analysis, I kept a log of the initial codes I was developing. Below is an excerpt of this list, which I recorded using Microsoft Excel. There were 388 initial codes.

1	"Apolitical" NHS prevents social action
2	"Empowerment" won't function in real world
3	"Trauma processing" in VAW therapy
4	A positive self-concept leads to empowerment
5	A woman is blameless if she's not the ideal victim
6	Accepting inadequate support because services under-resourced
7	Acknowledging patriarchy
8	Addressing own vulnerabilities as a woman
9	Admiration of clients
10	Allowing the client power within the therapeutic relationship
11	Alternatives to medical model are not funded
12	An empowered woman is a 'different person'
13	An empowered woman is an activist
14	An empowered woman makes good choices
15	Anger is an empowered emotion
16	Anger is needed - practitioners are too polite
17	Aspects of the client made them vulnerable to violence
18	Awareness of gender similarity/difference with client/perpetrator
19	Balancing honesty with hopefulness
20	Being a different gender to client has pros and cons
21	Being a human, not a therapist
22	Being alongside - not leaving a client alone with pain
23	Being person-centred - giving choice and working on what's meaningful
24	Building awareness of relationships in therapy
25	By not honouring women's responses we compound self-blame
26	Can and should a practitioner empower a client?
27	Can't offer choice because service needs trump client needs

APPENDIX P: Provisional Thematic Mapping – Generation of Initial Themes

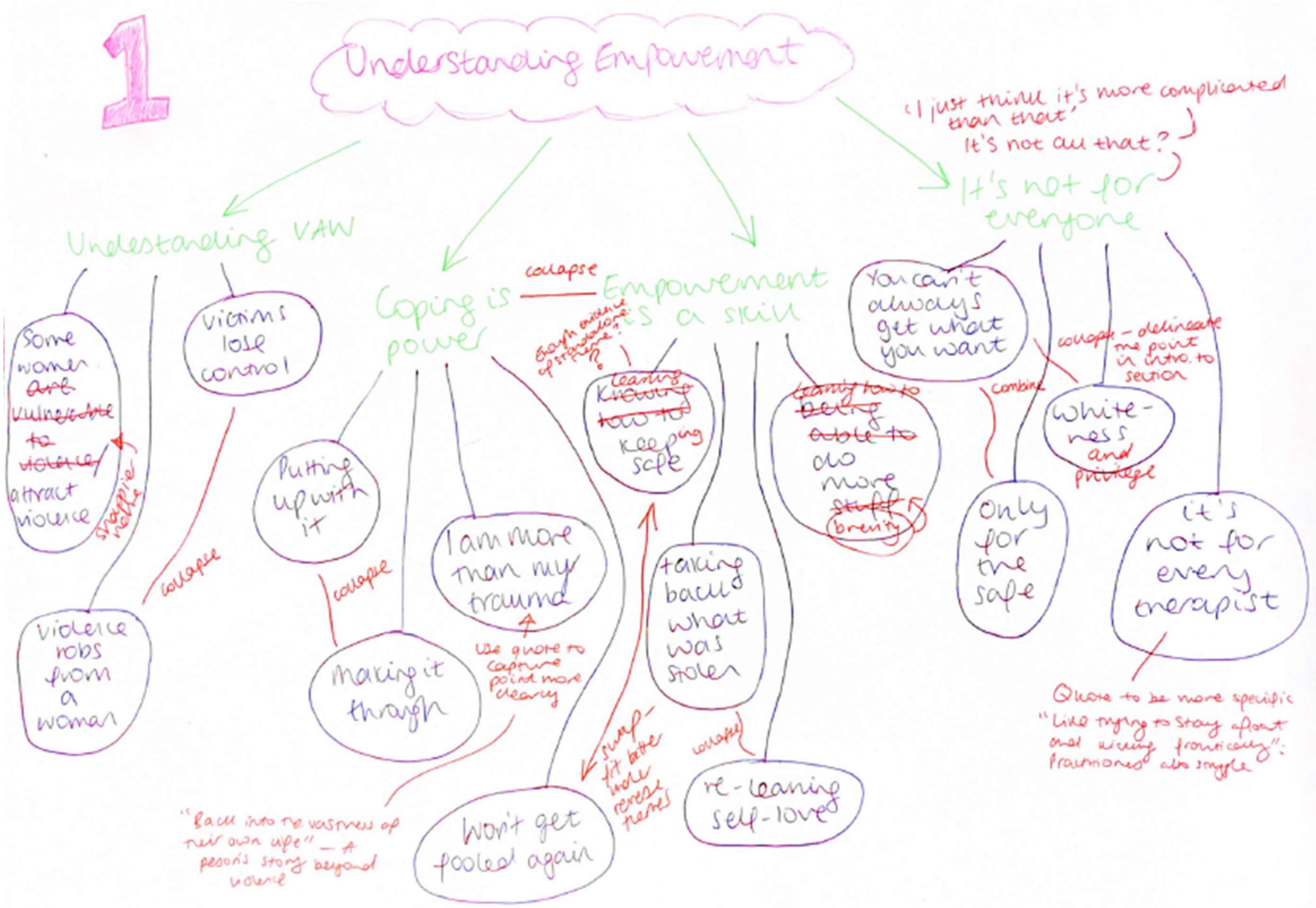
As part of phase three of the Reflexive Thematic Analysis, I grouped my codes into provisional clusters, which were later honed and developed into themes. I did this by printing off the list of codes onto slips of paper, and arranging the slips into groups. Below are two photographs demonstrating this process: the left, a photograph of all of the groups taken from afar; the right, a closer up photograph to capture more legibly which codes one of the groups contained. The number of these initial groups totalled 20.



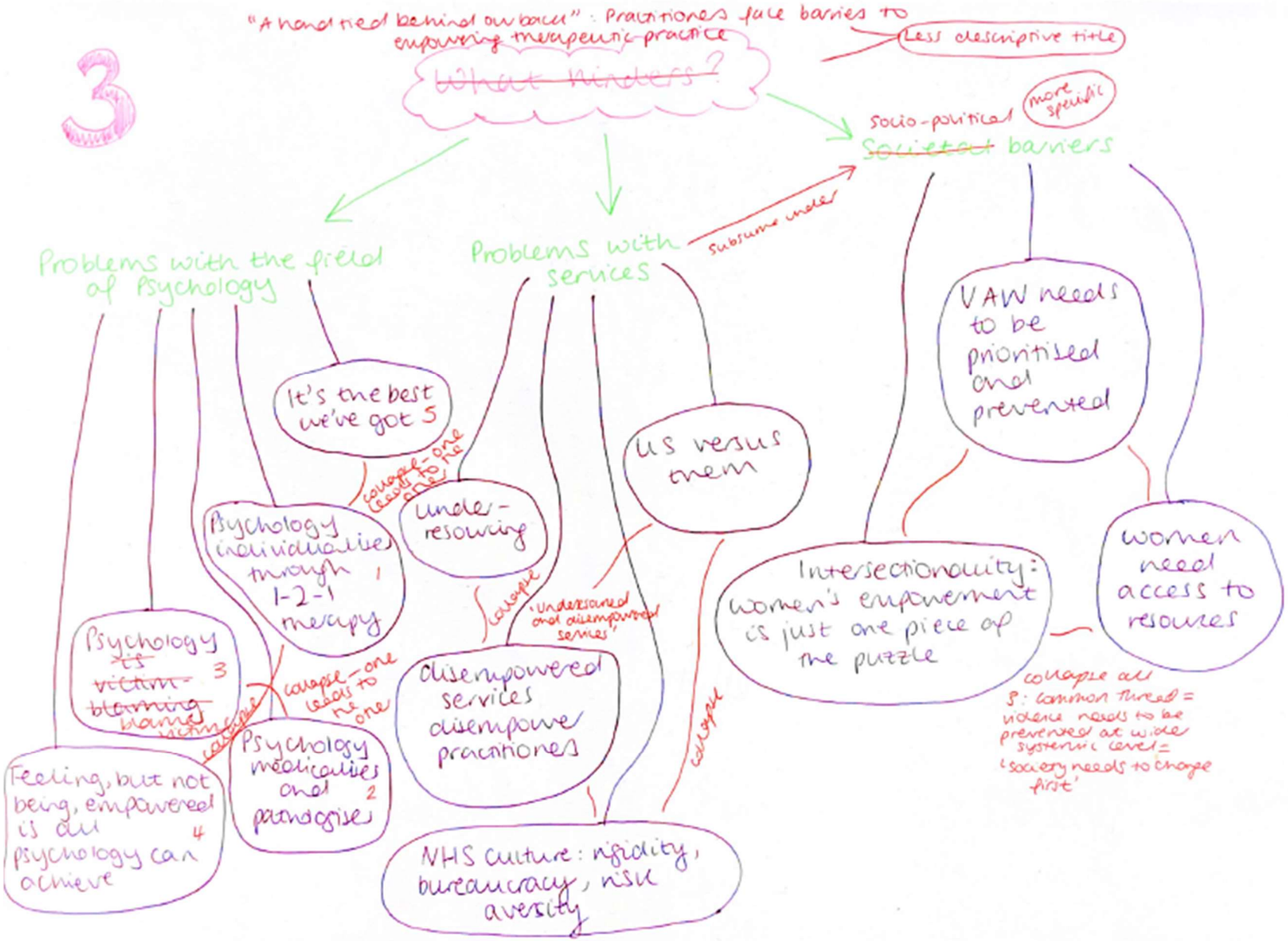
APPENDIX Q: Developing and Reviewing Themes

After discussing these initial groups in supervision, my supervisor and I considered some changes that could be made, and I revisited these groups to rework them into themes. I began this process by firstly readjusting the slips of paper, as seen in the photograph below. These themes contained 302 of the original 388 codes.

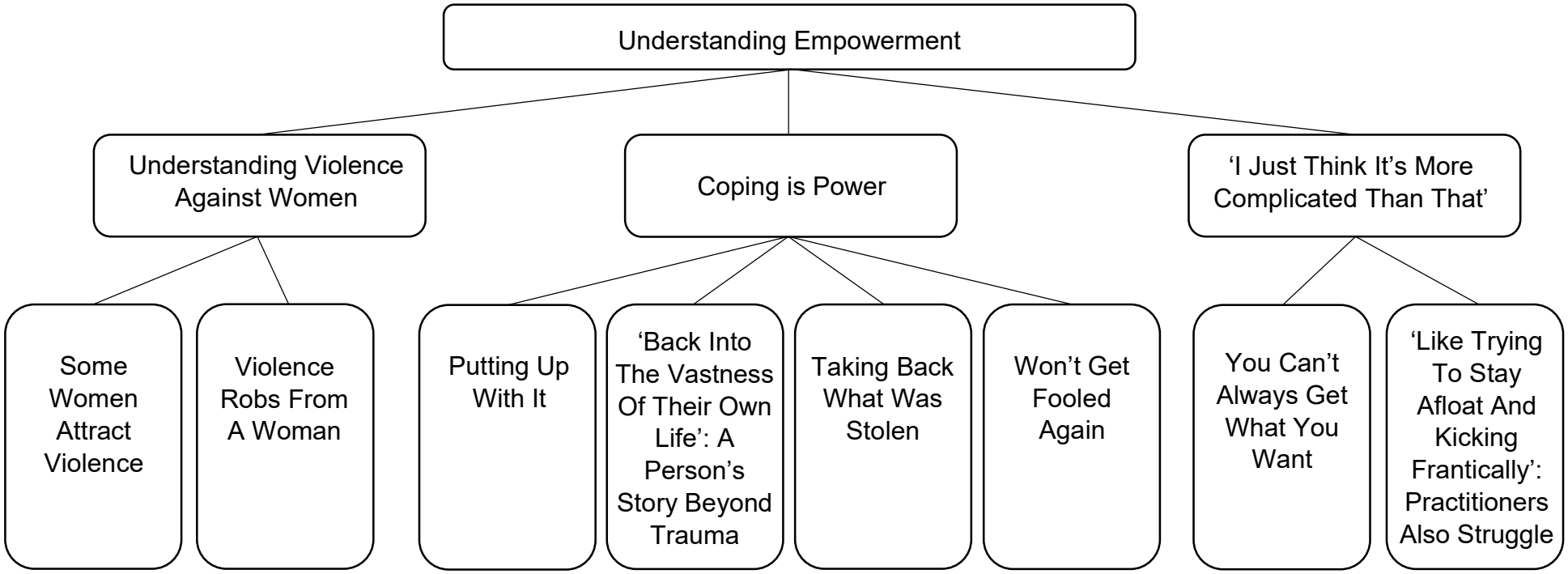
I then recorded these themes onto paper ‘mind maps’, which I again took back to supervision. My supervisor and I again considered more adjustments to these themes which might make them more compelling and clear – as can be seen in the red ink, I annotated these diagrams with the changes we discussed, finalising the themes presented in this report.

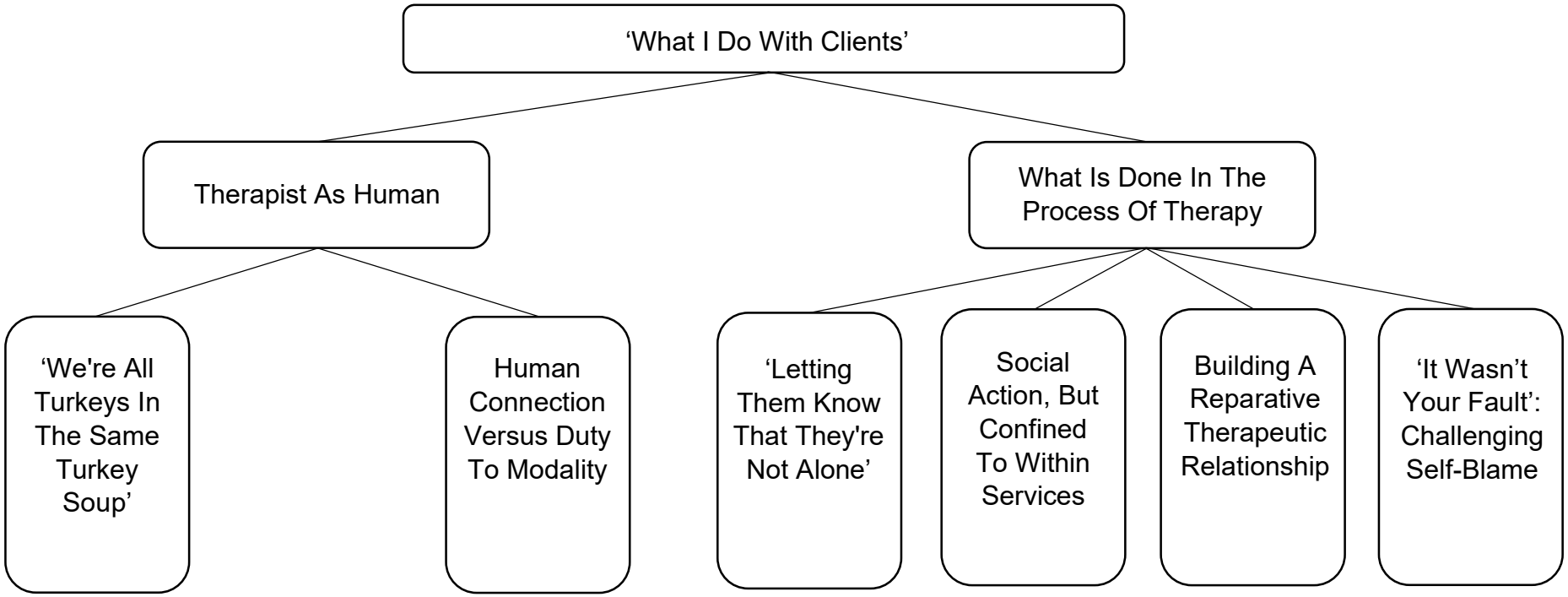

1
Understanding Empowerment
Understanding VAW
Coping is power
collapse
Empowerment is a skill
"I just think it's more complicated than that"
It's not all that?
It's not for everyone
Some women attract violence
snappier retort
Victims lose control
Violence robs from a woman
collapse
Putting up with it
collapse
Making it through
"Back into the vastness of their own life" — A person's story beyond violence
I am more than my trauma
Use quote to capture point more clearly
Learning/Knowing how to keeping safe
Won't get fooled again
jump-cut to the whole reverse theme
taking back what was stolen
re-learning self-love
collapse
You can't always get what you want
Only for the safe
combine
collapse - delineate the point in intro. to section
White-ness and privilege
It's not for every therapist
Quote to be more specific "Like trying to stay afloat and kicking frantically": Practitioner also struggle

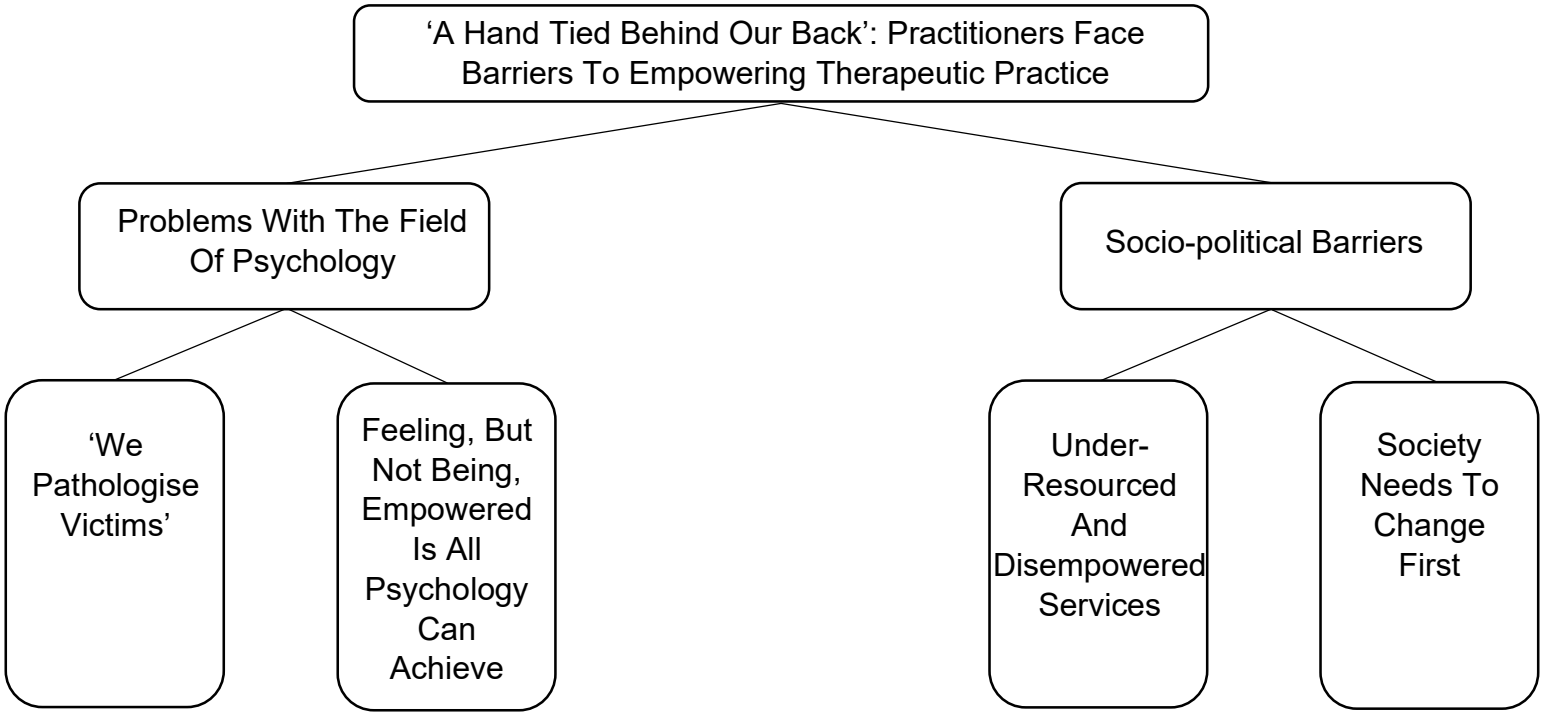

"What I do with clients"
direct quote - closer to data & less descriptive
What helps?
Therapist as human
Being a human, not a therapist
Defining help
What is help?
collapse
Active ingredients of empowerment within therapy
Providing the opposite experience to VAW
"I'm a woman" also too
use exact direct quote
collapse - insufficient delineating data
Human connection versus being a human doesn't fit with psychological practice
duty to modality
more concise
more specific
Client safety
Better understood as part of 'giving choice'
Add quote for more context - added clarity
"Put their experiences in context"
Locating VAW in the patriarchy
Subsume under
listening to women
being gentle and sensitive to client needs
use exact direct quote
"it wasn't your fault"!
giving as much choice as possible
I get it - I've been there
Quote to stay closer to the data
"we're all turkeys in the same turkey soup"
"Letting them know that they're not... You are not alone - victims helping victims
capture same idea using a ppt quote for increased accuracy
being client-led
"Following their lead"
use direct quote to stay close to data
collapse
Not enough distinction between the two in the data
building a reparative therapeutic relationship
disempowerment means having no choice
collapse
duty to modality
Social action - but confined to within healthcare services
brevity
part of giving as much choice to clients as possible
being disempowered means blaming yourself
delineate in intro to section


3
"A hand tied behind our back": Practitioners face barries to empowering therapeutic practice
What hinders?
Less descriptive title
Socio-political barriers
more specific
Problems with the field of Psychology
Problems with services
subsume under
It's the best we've got 5
collapse - one leads to the other
Psychology individualises through 1-2-1 therapy 1
Under-resourcing
collapse
'Underresourced and disempowered services'
US versus them
VAW needs to be prioritised and prevented
Intersectionality: women's empowerment is just one piece of the puzzle
Women need access to resources
collapse all 3: common thread = violence needs to be prevented at wide systemic level = 'society needs to change first'
Psychology is victim-blaming 3
collapse
collapse - one leads to the one
Psychology medicalises and pathologises 2
Disempowered services disempower practitioners
collapse
Feeling, but not being, empowered is all psychology can achieve 4
NHS culture: rigidity, bureaucracy, risk aversity

APPENDIX R: Thematic Maps




‘What I Do With Clients’
Therapist As Human
What Is Done In The Process Of Therapy
‘We're All Turkeys In The Same Turkey Soup’
Human Connection Versus Duty To Modality
‘Letting Them Know That They're Not Alone’
Social Action, But Confined To Within Services
Building A Reparative Therapeutic Relationship
‘It Wasn’t Your Fault’: Challenging Self-Blame


‘A Hand Tied Behind Our Back’: Practitioners Face Barriers To Empowering Therapeutic Practice
Problems With The Field Of Psychology
Socio-political Barriers
‘We Pathologise Victims’
Feeling, But Not Being, Empowered Is All Psychology Can Achieve
Under-Resourced And Disempowered Services
Society Needs To Change First

APPENDIX S: Application for Research Ethics Approval

University of East London

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2021)

FOR BSc RESEARCH;

MSc/MA RESEARCH;

PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)	
1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you

	will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details		
2.1	**Your name:**	**Roisin Murtagh**
2.2	**Your supervisor's name:**	**Prof Nimisha Patel**
2.3	**Name(s) of additional UEL supervisors:**	**Dr Matthew Boardman**
		3rd supervisor (if applicable)

2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**May 2023**
		Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	How do psychological therapy practitioners, in their therapeutic approach, understand and work towards the empowerment of women?
3.2	**Summary of study background and aims (using lay language):**	Violence against women can be seen as both a symptom and a cause of women's disempowerment and subjugation. As such, women's empowerment is often cited as the goal for psychological interventions and services designed to support women who have experienced violence. However, it is far from clear how (and whether) different psychological therapeutic modalities are used to conceptualise and work with empowerment when working with women victims/survivors of violence. The proposed research involves interviewing experienced practitioners of different psychological therapeutic modalities, and through Thematic Analysis, exploring how gender, violence and women's empowerment are conceptualised and worked with within models of therapy used in the UK. It is the intention that this information will be useful for gaining an insight into what is being provided to women victims/survivors of violence, and making clinical recommendations for practitioners who aim to work towards empowering women in a way that is informed, beneficial and meaningful.
3.3	**Research question(s):**	How do psychological therapy practitioners from different modalities, through their therapeutic approach, understand and work towards the empowerment of women who are victims/survivors of violence?
3.4	**Research design:**	A qualitative study using Thematic Analysis on data from interviews.
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	As I plan to analyse data using Thematic Analysis, I will aim for 12 participants as this is generally sufficient for data saturation (Guest et al., 2006) and allows for meaningful theme generation, yet not so large interpretations risk becoming superficial (Braun & Clarke,

		2013). Participants will be currently practicing psychological therapy practitioners with experience of working with women victims/survivors of violence. To ensure any conclusions drawn about specific modalities are fair and useful, I aim to interview practitioners who feel committed to their model and operate within it. Therefore, I plan to recruit experienced practitioners – at least five years post-qualification, and/or those who train others in their modality. Alternatively, failing to recruit sufficient numbers, I will invite any psychological therapy practitioner self-identifying as committed to their modality. I will screen possible participants by asking if they feel sufficiently experienced with this population to reflect on the work they have done. Participants will be practitioners from a range of approaches currently used in the UK; for instance, cognitive behavioural therapy (CBT), psychodynamic approaches, and systemic family therapy.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	I will recruit through advertising e-mails and social media posts from a convenience sample of my social and professional networks, from where 'snowballing' may extend my reach.
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	This project requires access to Teams and a secure OneDrive – both of which UEL provide. I will use my encrypted Dictaphone to record telephone interviews in the event of technological problems with Teams. There will be a demographic questionnaire which I will ask participants to complete. The interviews will be guided by a semi-structured interview schedule which is subject to amendment if this feels necessary and useful as interviews progress. The demographic questionnaire and interview schedule are both constructed by myself so there are no restrictions on the usage in this project.
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Advertisements will request for those interested to contact my University of East London (UEL) email address. From there, we can arrange a telephone call to screen according to the above criteria, and if suitable, provide information sheets, consent forms and schedule the interview. I will offer Microsoft Teams (or in the event of technological issues, telephone) interviews in line with government advice regarding COVID-19. Prior to interview commencement, I will ask participants to complete a demographic questionnaire. Interviews will last one hour maximum, recorded via Microsoft Teams (capturing video and audio); after which, participants will

		be debriefed and have an opportunity to ask questions. Debriefing will also provide me with an opportunity to provide participants with information about resources and support that they might find helpful. It will take the form of a conversation and a document providing additional information.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	Please state the value of vouchers	
3.11	**Data analysis:**	Interviews will be recorded and then transcribed at a semantic level and analysed using reflexive Thematic Analysis (Braun & Clarke, 2006, 2021). Ideally, enough participants will be recruited that themes can be considered within modalities (for instance, exploring themes that specifically develop from CBT practitioners' interviews). Alternatively, should there be too few participants sharing common modalities, themes will be considered across modalities with psychological therapies therefore explored more generally.	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐

	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	The transcripts will be anonymised by redaction of personally identifiable data within the content, and participants' names will be replaced with: W (for woman including transwomen) or M (for man including transmen), an acronym for their key therapeutic modality, and a randomly assigned two-digit number obtained from an online random number generator. For example, a woman cognitive behavioural therapist might be anonymised to "WCBT25"; or a man systemic family therapist might be "MSFT32". Demographic information will be aggregated to protect against it being used as personally identifiable information.
4.3	**How will you ensure participant details will be kept confidential?**	To ensure only I have access to personal information, I will complete all transcriptions of the interviews (onto a Microsoft Word document) – after which, interview recordings will be deleted. Personal data will be kept confidential unless myself and my Director of Studies (Prof. Nimisha Patel) feel concerned about anyone's safety.
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	All data (Microsoft Word anonymised transcripts and any potential copies I create to facilitate the Thematic Analysis; signed consent forms; demographic information; and for the first 3 weeks, the video & audio file recordings of telephone/Microsoft Teams interviews [approx..60 minutes x 12 participants] before erasure) will be stored on UEL's secure OneDrive, with transcripts and identifying information stored in separate locations. Demographic information will be aggregated to protect against it being used as personally identifiable information. As I will be using a Windows PC, Teams recordings will be automatically stored by default on the Microsoft Stream Library, so I will need to download a copy to upload to OneDrive for Business, and then delete any local copies from my downloads folder.
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	Anonymised transcripts (and any other potential temporary copies I may create in the process of Thematically Analysing the data) and aggregated demographic information will be shared with my Director of Studies which will be done by emailing the appropriate data to their UEL email address as relevant to the data analysis. Examiners will be required to formally request access to anonymised transcripts, and it will only be permitted if it is deemed necessary to facilitate the assessment of my work. Only aggregate demographic

		information will be available to them. The data will be shared using secure links via UEL OneDrive for Business.	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	Anonymised demographic questionnaires and anonymised transcripts will be retained for three years. The preservation of this data is of long-term value as it is possible that someone may question my findings during the process of publication and peer review, and having these retained provides necessary evidence that my findings are not based on false, erroneous or non-existent data.	
4.7	**What is the long-term retention plan for this data?**	After completion of the thesis and viva voce (September 2023), personal data will be erased; and anonymised transcripts and anonymised demographic questionnaires moved to my Director of Studies' OneDrive for three years before erasure.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	There is a risk of potential distress arising from discussing a sensitive topic. Ways this will be minimised: Information sheets and consent forms will outline relevant information around what participation will likely entail. Before the interview, I will check participants have understood the information sheet and returned a signed	

		consent form. I will remind them of the interview purpose, their right to withdraw, and address any questions. These steps ensure informed consent is gathered. I will treat consent as an ongoing process by checking how participants are feeling during the interview and whether they are comfortable to continue. I can seek advice from my Director of Studies regarding any concerns I have about participants post-interview. Participants may want to withdraw their data upon reflection after the interview. To ensure they can do this, they will be permitted to request to withdraw data three weeks post-interview (after which this will not be possible as identifying information will be removed during transcription). High levels of distress can be associated with increased risk of potentially dangerous behaviour towards oneself or others – it will be made clear to participants before interview commencement that their data will no longer be kept confidential if anything they do or disclose suggests potential safety risks to them or anyone else, in which case I may break confidentiality to involve relevant authorities (e.g. NHS services) under the guidance of my Director of Studies or second supervisor.
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	There is a risk of potential distress arising from discussing a sensitive topic. I feel prepared for having this sort of conversation from some of the strategies that develop from working as a trainee clinical psychologist. Such strategies include: • regularly 'checking in' with how I am feeling in response to difficult conversations • monitoring emotional experiences after and during such conversations • pausing and redirecting conversations which feel they may be straying into unhelpful or uncontained areas • actively engaging with my known self-care and self-soothing acts. I am also aware that I can reflect on difficult conversations with my Director of Studies, my second supervisor, or my personal tutor.	
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒	

5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	Interviews will take place remotely via either Microsoft Teams or over telephone.		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	**YES** ☐		
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor).			

	▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☒	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☒	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	001668652724	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian).		

	▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.

Section 7 – Other Permissions			
7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	**YES** ☐	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.		

Section 8 – Declarations		
8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Roisin Murtagh**
8.3	**Student's number:**	**U2075220**

8.4	**Date:**	**04/02/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		