City Research Online

City, University of London Institutional Repository

Citation: Burelomova, A. (2017). Experience of therapy following interpersonal trauma: a counselling psychology perspective. (Unpublished Doctoral thesis, City University, London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: https://openaccess.city.ac.uk/id/eprint/20380/

Link to published version:

Copyright: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

Reuse: Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

City Research Online: http://openaccess.city.ac.uk/ publications@city.ac.uk

Experience of Therapy following Interpersonal Trauma: A Counselling Psychology Perspective

By Anastasia Burelomova

Submitted in fulfilment of the requirements for the degree of:
Professional Doctorate of Counselling Psychology

City University, London
Department of Psychology

April 2017

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	**6**
PART I	
PREFACE	**8**
Sections of the portfolio	
Evolution of the portfolio	
Themes weaving through the portfolio	
PART II	**13**
QUALITATIVE STUDY	
Experience of therapy in women exposed to Intimate Partner Violence (IPV) within a specialist Domestic Violence Service	
ABSTRACT	
1. Literature review	**15**
1.1. Introduction	
1.2. Conceptual framework and definition of violence	
1.3. Theories, frameworks and definitions of IPV	
1.3.1. Sociocultural theories of IPV	
1.3.2. Individual theories of IPV	
1.3.3. Typology of IPV by type of violence	
1.3.4. Integrative frameworks of IPV	
1.4. Impacts of IPV on women: empirical findings	
1.4.1. Physical health	
1.4.2. Mental health and psychological wellbeing	
1.4.3. Summary of IPV consequences	
1.5. Women's attitudes towards change and help-seeking within the context of IPV	
1.5. Support services and interventions for female victims of IPV	
1.5.1. Counselling and therapy interventions for female victims of IPV: empirical findings	
1.6. Lead into the current study	
2. Methodology	**66**
2.1. Introduction	
2.2. Epistemology, Methodology and Method	
2.2.1 Acceptance of qualitative methodology	

2.2.2. Critical realist position
2.2.3. Methods: Interpretative Phenomenological Analysis and Visual Methods
2.3. Research design
2.3.1. Interviews and Visual Methods
2.4. Ethical considerations
2.5. Data collection
2.5.1. Sampling
2.5.2. Procedure
2.5.3. Interview schedule
2.5.4. Transcription
2.6. Analytical procedures
2.6.1. IPA
2.6.2. Visual
2.7. Methodological and procedural reflexivity

3. Analysis **93**
3.1. Introduction
3.2. Findings from the IPA
3.2.1. Recovery as a process
3.2.2. Constituent theme 1: Abuse as disintegrating the Self
3.2.3. Constituent theme 2: Oblivion of abuse and awakening
3.2.4. Constituent theme 3: Therapy as a journey of empowerment
3.2.5. Constituent theme 4: Therapy as a continuous experience
3.3. Findings from the Visual methods
3.3.1. Recovery as a process
3.3.2. Therapy as a transforming experience
3.3.3. Therapy and feeling safe
3.3.4. Therapy as a process
3.4. Summary of findings

4. Discussion **171**
4.1. Introduction
4.2. Research aims and summary of findings
4.3. Discussion of the analysis within context
4.3.1. Individually tailored treatment
4.3.2. Consideration of IPV effects
4.3.3. Importance of IPV specialist knowledge
4.3.3. Therapy as a process of empowerment

4.3.4. Therapy as a continuous experience
4.3.4. Recovery as a process
4.4 Reflections on quality and avenues for future research
4.4.1. Reflections on the design
4.4.2. Reflections on the analysis
4.4.3. Reflections on the impact of the researcher
4.5. Reflections on practical implications and recommendations
4.6. Suggestions for future research
4.7. Conclusion
REFERENCES

PART III **233**
PUBLISHABLE ARTICLE
Experience of therapy in women exposed to Intimate Partner Violence within a specialist Domestic Violence Service: qualitative enquiry
REFERENCES

PART IV **274**
CLINICAL CASE STUDY
5.1. Introduction **274**
5.1.1. Summary of theoretical orientation
5.1.2. Referral and context of work
5.1.3. Initial assessment and presenting problem
5.1.4. Personal/Family history
5.1.5. Current circumstances
5.1.6. Formulation
5.2. The development of therapy **291**
5.2.1. Transference and projective identification
5.2.2. Rupture in a therapeutic process
5.2.3. The diagnosis of Foetal Alcohol Syndrome and toxicity
5.2.4. Paranoid-Schizoid Position, splitting and triadic relationship
5.3. The conclusion and review of therapy **303**
5.3.1. The therapeutic ending
5.3.2. Conclusion
REFERENCES

APPENDICES **309**
1. Recruitment advert

2. Information sheet
3. The CORE questionnaire
4. Consent form
5. Debrief information
6. Gratuity and travel expenses receipt
7. Interview schedule
8. Exemplar of the analysis (IPA)
9. Exemplar of the analysis (master themes and subthemes for Claire)
10. Appearance of themes for each participant
11. ‘Confused emotions at the Trust’ by Claire
12. ‘Breaking through’ by Nina
13. ‘Freedom’ by Ann
14. ‘Planted not buried’ by Kelly
15. ‘The story of my life so far’ by Jenny
16. ‘Safe place’ by Beth
17. ‘Finding your song’ by Sam
18. ‘Complex situation’ by Mary

Acknowledgements

I would like to express my heartfelt thanks to my supervisor, Prof. Marina Gulina, for her continued warm encouragement and advice, and for always finding time to help and support me.

I would also like to acknowledge the invaluable contribution made by my participants and thank them for their courage and generosity in sharing their experiences with me.

Many thanks go out to the Woman's Trust and Maya Gagni for helping me throughout the recruitment and data collection process. Your contributions are invaluable.

I would also like to express my gratitude to Jack Cummings for his devotion to the English language and for dedicating many hours of his time to proofread my thesis.

I would like to thank my colleagues and dear friends, as well as other trainees for their ideas, inspiration and for being there when the going got tough.

Thank you to my partner, Vasileios Tantsios, for his love, patience and encouragement throughout this whole journey.

To my brother, Aleksei Burelomov, and my sister, Elena Eyring, thank you for all your love and belief in me, and for making me laugh when it all felt unbearably serious.

Lastly, I would like to dedicate this portfolio to my parents, Dr. Sergey Polyakov and Dr. Irina Burelomova, and thank them for always putting me first, for their courage and selfless love, and for always being on the other side of the phone listening to every step of my journey.

Declaration

The author grants powers of discretion to the City University librarian to allow this thesis to be copied in whole or in part without further reference to her. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

PART I

Preface

This portfolio is concerned with aspects of the theory and practice of Counselling Psychology, with a focus on the issues of violence and trauma. This part will outline the sections in the portfolio, discuss the evolution of the portfolio, some threads weaving throughout the sections and author's reflections on professional issues recognised throughout her work towards completing this portfolio.

Sections of the portfolio

This portfolio consists of a qualitative study, a clinical case study, and a research paper that the author is aiming to publish in a scientific journal. This collection of work aims partly to illustrate the author's competency within Counselling Psychology research and practice.

The qualitative study aims to explore women's experiences of therapy for women exposed to Intimate Partner Violence (IPV), within a specialist a specialist Domestic Violence (DV) service.

The research paper presents the qualitative study outlined above in a form of a manuscript that fulfils the requirements for the submission to the Journal of Counselling Psychology. This journal has been chosen as it is particularly concerned with empirical studies on the evaluation and application of counselling interventions with diverse and underrepresented populations.

Finally, the clinical case study considers professional aspects of counselling psychology in practice as represented throughout author's work with a particular client. Some of the key aspects of this clinical piece resonate with the ones described throughout the qualitative study and the research paper.

When considered together these pieces of work represent the author's alliance to the scientist-practitioner model of Counselling Psychology. They signify the multidimensional and reciprocal relationship between theory and practice – something that the author experienced throughout her training as a Counselling Psychologist.

Evolution of the portfolio

The author's interest in the topics of IPV and interpersonal trauma began during her first year of training when she started working as a trainee counsellor at the Woman's Trust – a registered charity and mental health service, providing help and support for women affected by domestic violence. The author had limited knowledge of the complexity of IPV, which was coupled with the anxiety of being a first year trainee. In striving for the perfection of providing therapy for her clients, she started to study the subject and could never have foreseen just how much her interest would grow. To her surprise, the majority of the studies she came across predominantly considered the therapist's perspectives on the process of therapy, and what seemed to be missing were the experiences, views and preferences of clients themselves. She

felt it was important to give these women a voice, so that as health professionals, we could better understand our clients and provide the required help and support. As a trainee counselling psychologist she had an opportunity to contribute to both the practice and research in the field, and decided to embark on a research project investigating how women exposed to IPV experience therapy within a specialist DV service.

Following the completion of the literature review, the thesis and the write up of the qualitative study, the author was struck by the limited number of the research studies exploring women's experiences of therapy for victims of IPV violence. Publishing a research paper on the topic appeared to be a natural finale of the research process – one that would hopefully contribute to the existing knowledge in the field, and provide valuable insight for practitioners and researchers in the field of Counselling Psychology.

The researcher recruited her participants for the qualitative study from the specialist service, which applied a person-centred approach to counselling. However, being trained in an integrative way and having had a deep interest in psychoanalysis, she felt it was important to consider women's experiences of interpersonal trauma from a variety of different perspectives. She therefore decided to present the psychodynamic case study in this portfolio representing her clinical work with a woman who described being traumatised during her childhood when her mother abandoned the family. By being open to a variety of different approaches to therapy and research, the author was able to further appreciate her integrative training as a counselling psychologist

and she believes this portfolio represents her development as a practitioner and a researcher.

It is traditional to write academic pieces of work in the third person and this is how most of the portfolio sections are presented. However, it has was decided to write the clinical case study in the first person, highlighting the unique reflective nature of the interpersonal relationships between the author and the client.

Themes weaving throughout the portfolio

The process of therapy has been a central and evolving theme in this portfolio. The author has explored various components of the therapeutic process throughout all parts of the portfolio, including therapeutic relationships, exploration of past traumatic experiences, splitting and depersonalisation following trauma, the complexity and multifaceted nature of clients' needs, and endings in therapy to name a few. The portfolio highlights a variety of issues Counselling Psychologists might face when working with trauma survivors.

Participants in the qualitative study emphasised the necessity for holistic nature of treatment that would encompass a variety of their needs, including physical and psychological wellbeing, as well as legal help and advocacy. Like the participants, the client in the case study has been treated by a multidisciplinary team and needed support not only in the form of psychotherapy, but also social prescribing and physical health support. The research paper points out the complexity of context factors

related to traumatic experiences in clients and highlights the importance of a multimodal approach to treatment.

The process of overcoming the potential effects of trauma is another central theme in this portfolio. For instance, all participants discussed the detrimental effects of trauma on their sense of self. Additionally, distorted perceptions of the self, others and the world were thoroughly discussed throughout the case study. All participants described experiencing a variety of mental health difficulties, including depressive symptoms, anxiety symptoms, poor sleep, and panic attacks as a result of trauma. Some of them talked about social isolation and the difficulty establishing trust in their relationships. All these issues and many more are discussed in the case study in the context of author's clinical work with the client, and some are addressed throughout the research paper.

The development of this portfolio has been a challenging, fascinating and inspiring experience, which also reflects author's experience of undergoing training as a Counselling Psychologist. It has been incredibly helpful to reflect on this journey through the lens of a scientist-practitioner role, which has enabled the researcher to gain more clarity about her professional values and commitments.

PART II

QUALITATIVE STUDY

Experience of therapy in women exposed to Intimate Partner Violence within a specialist Domestic Violence Service

ABSTRACT

This study explores women's experiences of therapy for victims of Intimate Partner Violence (IPV) within a specialist Domestic Violence service. It aims to shed light on the lived experiences of the women and their perspectives on therapy.

The research took a form of a qualitative enquiry. Due to the sensitive nature of the topic, the multifaceted nature of IPV, the researcher's epistemological position, and the relative lack of qualitative research on the topic, it was deemed appropriate to remain rooted to the participants' experiences.

Eight women with the experience of exposure to IPV who have undergone therapy for victim-survivors of IPV within the specialist Domestic Violence service took part in this study. Individual semi-structured interviews were conducted to gain insight into participant's experiences of therapy within the service, and these interviews were analysed using Interpretative Phenomenological Analysis (IPA) and Visual Methods.

Derived from the IPA is the over-arching theme ‘recovery as a process’, with four inter-related constituent themes: ‘abuse as disintegrating the self’, ‘oblivion of abuse and awakening’, ‘therapy as a journey of empowerment’ and ‘therapy as a continuous experience’. Each constituent theme consists of a number of different sub-themes.

Derived from the analysis of the drawings are researchers interpretations of participants’ representation of their experiences of therapy as a part of their journey towards recovery. These findings are presented through four points of reference: ‘recovery as a process’, ‘therapy as a transforming experience’, ‘therapy as a safe place’, and ‘therapy as a process’.

The findings are considered in relation to the wider literature, including theoretical models and empirical studies. Links, consistencies, disparities and controversies are discussed. Potential implications for research and practice are addressed.

1. Literature review

1.1. Introduction

Intimate partner violence perpetrated by men against women is reported to be one of the most common forms of violence worldwide (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). The Global Status Report On Violence Prevention conducted by The World Health Organisation states that at some point of life one in three women have been a victim of physical or sexual violence by an intimate partner (Butchart, Mikton, Dahlberg, & Krug, 2015).

Intimate Partner Violence (IPV) can be defined as a threatened, attempted or completed act of physical, emotional or sexual aggression conducted by a current or a former intimate partner (Nathanson, Shorey, Tirone, & Rhatigan, 2012). Although it has been recognised that IPV can be perpetuated and suffered by both sexes and can occur in all population groups (McFeely, Whiting, Lombard, & McGowan, 2013; Robinson, 2006; Smith, 2012), its incidence is significantly more often reported in females than males (Thompson et al., 2006).

There is a growing body of research suggesting that a substantial proportion of women exposed to IPV often experience various mental health problems including depression, anxiety, phobias, post-traumatic stress disorder, substance abuse and suicidality (Bonomi et al., 2006; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Nixon, Resick, & Nishith, 2004; Stacey B. Plichta & Falik, 2001; Romito, Molzan Turan, & De Marchi, 2005).

It has been proposed that actions from health care professionals involved in counselling services for victims of IPV may be counter-therapeutic, and may pose a risk of re-traumatisation (Hattendorf & Tollerud, 1997). Therefore, some form of specialist approach might be required (Roddy, 2013). However, the psychological experience of women undergoing therapy for victims of IPV within specialist services is relatively unknown (Sanderson, 2008; Sullivan, 2012).

This chapter will consider the existing literature and ways of conceptualising the lived experiences of women who have been exposed to IPV and have undergone therapy for victim-survivors within a specialist Domestic Violence (DV) service. Firstly, it will draw on the conceptual framework of violence adapted in this study. It will then consider relevant theories of understanding IPV from a sociocultural, individual and integrative perspective. Empirical studies of possible impacts of IPV on women's health and wellbeing will be considered, and women's attitudes towards change and help-seeking within the context of IPV will be outlined. Available support-services and interventions for victim-survivors will be discussed, with the larger emphasis on counselling and therapy interventions and its empirical examinations. The chapter will end with a brief summary and introduction into a current study.

1.2. Conceptual framework and definition of violence

The existing literature proposes a number of ways do define the term violence (Åström, Bucht, Eisemann, Norberg, & Saveman, 2002; Barnett,

Miller-Perrin, & Perrin, 2005; O'Moore, 2006; Rhatigan, Moore, & Street, 2005; Smith-Pittman & McKoy, 1999; World Health Organisation, 1996a; Winstok, 2007). A comprehensive analysis of violence and its definitions would be outside the scope of this research as it focuses specifically on the IPV. However, it is important to briefly outline the conceptual framework and definition of violence adopted in this study to better understand the IPV phenomenon within the general concept of violence.

The present study adopts the following definition of violence proposed by the World Health Organisation:

'The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.' (World Health Organisation, 1996b, cited in Krug, Mercy, Dahlbers, & Zwi, 2002, p. 1084)

Following other researchers in the field, the terms violence and abuse are used interchangeably in the present research (Barnett et al., 2005; Capaldi, Knoble, Shortt, & Kim, 2012; Finkelhor, Turner, Ormrod, & Hamby, 2010; Hegarty, Hindmarsh, & Gilles, 2000; Henderson, 2002; Hoffman & Edwards, 2004; M. P. Johnson, 2006; Moyer, 2013). The terms batterer, offender, perpetrator and abuser are also used interchangeably (Follingstad & Rogers, 2014; Jin, Eagle, & Yoshioka, 2007; Moyer, 2013; Vanderende et al., 2016; Wareham, Boots, & Chavez, 2009).

The current study adopts the typology of violence proposed by Krug et al. (2002). The authors suggest that violence can be generally divided into three main categories according to characteristics of those committing the violent act: self-inflicted, interpersonal and collective (Figure 1).

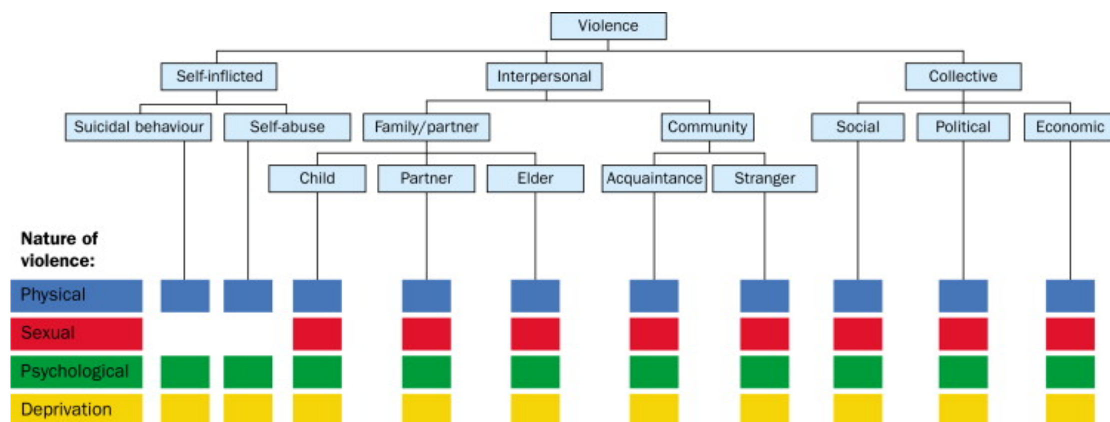


Figure 1. Types of Violence from Krug et al. (2002, p. 1084)

Each of the proposed categories of violence is divided into subcategories reflecting specific subtypes of violence and the nature of those violent acts (physical, sexual, psychological, and deprivation or neglect).

Self-directed violence as one of the three main categories of violence can be subdivided into suicidal behaviour and self-abuse. The former includes suicidal thoughts, attempted suicides and completed suicides. The latter – self-abuse – includes acts such as self-mutilation. *Interpersonal violence* as the second main category of violence can be also divided into two subcategories: family and intimate partner violence (violence mainly between members of the family as well as intimate partners), and community violence (violence between people who are unrelated, and may or may not know each other). The family

and IPV subgroups include forms of violence such as child abuse and elderly abuse. The community violence subgroup includes random acts of violence, rape and sexual assault by strangers, and violence at institutional settings such as workplaces, schools, prisons or nursing homes. *Collective violence* as the third main category of violence can be subdivided into three categories: social, political and economic violence. Unlike the first two main categories, collective violence can be referred to through possible motives for violence. For instance, crimes of hate committed by organised groups or terrorist cells could be identified as the type of collective violence committed to advance a particular social agenda. Examples of political violence could include war and related violent conflicts. Economic violence includes attacks by larger groups motivated by economic agenda. For instance, denying access to essential services, attacks carried out to disrupt economic activity or creating economic division and fragmentation.

Krug and his colleagues emphasise the complexity of the violence phenomenon, as well as the interconnected nature of different types of violence. They highlight the importance of examining the links between different types of violence, allowing for potential collaboration between groups of professionals working on preventing those (El-Bassel, Witte, Wada, Gilbert, & Wallace, 2001; Hindin, Kishor, & Ansara, 2008; Kruh, Frick, & Clements, 2005; LeBlanc & Kelloway, 2002; Swahn & Donovan, 2004; Vanderende et al., 2016).

The present study distinguishes the term ‘intimate partner violence’ from the term ‘domestic violence’. It stems from the notion that the term ‘domestic violence’ can be used broadly (Barocas, Emery, & Mills,

2016) including but not limited to intimate partner violence, as well as violence against or between other members of the family who might or might not live together (e.g. adult/child, elderly/adult, child/elderly, child/parent, or siblings).

For the purposes of the present research study it is particularly important to conceptualise IPV as a subcategory of interpersonal violence. IPV is broadly viewed as a type of interpersonal violence, occurring in a family/partner setting and directed towards an intimate partner, which will be discussed in detail throughout the following sections.

1.3. Theories, frameworks and definitions of IPV

Discussion of human violence in general and in specific contexts in particular raises questions about the meanings attributed to the term. Although its meaning might seem obvious, it appears that there is little consensus among researchers on how to define violence and its different 'forms' or 'types' (Barocas et al., 2016; Kilpatrick, 2004; Tjaden, 2004). Winstok (2007) suggests that disparities around definitions of violence could be a result of a vast problem involving ideologies, perspectives, theories and methodologies of studying violence, its perpetrators and victims. Therefore, in order to integrate knowledge about the phenomenon it is important to consider and critically evaluate prevalent approaches to IPV in the field.

1.3.1. Sociocultural theories of IPV

1.3.1.1. Feminist theory

Feminist theory, often referred to as the 'feminist model', aims to understand violent relationships through examining the sociocultural context in which these relationships occur. Supporters of this theory often view gender inequality and sexism within patriarchal societies as the main causes of IPV (Bell & Naugle, 2008). In short, they argue that IPV is primarily an issue of male violence against women caused by societal rules and patriarchal beliefs encouraging male dominance and female subordination (Abrar, Lovenduski, & Margetts, 2000; Bell & Naugle, 2008; Yllö, 1988). Proponents of the feminist theory suggest that men often use different tactics (including physical violence) to exert control and dominance over women and their families (Dobash & Dobash, 1978). They suggest that women's violent behaviour towards their male partner should be understood as self-defence, retaliation or pre-emption for male violence. Thus, such violence against women should be studied within the wider context of patriarchy and its intentions associated with violent event, whilst also applying non-patriarchal qualitative methods (McMahon & Pence, 1996).

The feminist theoretical tradition views violence towards women as a special case, different from other forms of violence and other forms of crime (Dobash & Dobash, 2004). Therefore, the treatment should be concerned with educating men and addressing their patriarchal beliefs, as well as their domineering behaviours towards women. The ultimate goal as per the feminist theoretical tradition is the overturning

patriarchal social structures to prevent, reduce and eliminate violence against women (Dutton, 2011).

Some of the studies supporting feminist theory indicate higher rates of assaults on the wife in husband-dominant families, husbands holding traditional ‘gender-role’ attitudes, or discrepancies between the acceptance of patriarchal values between a husband and a wife (Hunnicutt, 2009; Leonard & Senchak, 1996; Yllö, 1983).
Feminist research and some studies reporting significantly higher prevalence of IPV victimisation in women have been widely criticised for sample selection. For instance, recruiting women from shelters and refuges or emergency departments (Dutton, 2011), might result in findings that would be inappropriately extrapolated to the general population (Dixon & Graham-Kevan, 2011). In addition, qualitative and correlation studies are often referred to as the evidence of a connection between male patriarchal values and physical violence towards their female partners (Bell & Naugle, 2008). However, meta-analytic reviews do not provide support for such a connection (Sugarman & Frankel, 1996), nor do they identity patriarchy as being the most significant risk factor for IPV (O'leary, Smith Slep, & O'leary, 2007).

1.3.1.2. Power theory

Power theorists suggest that the origins of violence are rooted not only in culture, but also in family structures (Straus, 1977a). Gender inequality, social acceptance of violence and family conflict are assumed to interact and lead to the development and maintenance of IPV. It is

presumed that individuals employ violence to settle conflicts within the family and between intimate partners, whilst such way of addressing conflicts is learned in childhood by either witnessing or experiencing physical abuse (Straus, 1977b). Power theorists suggest that power imbalances between partners may increase tension within the family unit and consequently increase the risk of IPV (Sagrestano, Heavey, & Christensen, 1999).

There were a number of studies reporting higher IPV rates in families with higher rates of stress and conflict (Cascardi & Vivian, 1995; Leonard & Senchak, 1996; Mihalic & Elliott, 2005).

The power theory addresses a gender inclusive perspective and encourages research into examining both the male and female experience of IPV. Such a perspective incorporates a variety of theoretical standpoints, guiding research to understand why men and women of all sexualities perpetrate IPV.

1.3.1.3. Exploring the feminist and family violence perspective: Violence against women (VAW) vs. Intimate Partner Violence (IPV)

Conceptions of violence against women can be broadly categorised within two traditions which are only partially integrated (Gordon, 2000). The first evolved from advocacy movements for victims of sexual assaults and domestic violence. The other evolved from social and behavioural research on sexual assault and family violence (Winstok, 2007). The distinction between the terms domestic and family violence is not random. 'domestic' refers to structure, 'family' refers to relationships. Winstok (2007) suggests that the term 'domestic' violence

might imply a feminist perspective, whilst the term 'family' violence might be derived from social and family research, and is manifested in the works of researchers of family conflict.

Different theoretical standpoints would produce very different definitions of violence in intimate relationships. As mentioned earlier, Strauss (1979) – one of the prominent researchers following the familial violence approach – viewed violence as a non-legitimate tactic individuals employ to settle interpersonal conflicts in general and between intimate partners in particular. He and his colleagues defined violence as "… an act carried out with the intention of or perceived intention of causing physical pain or injury to another person' (Straus, Gelles, & Steinmentz, 1981, p.20). Their work was heavily criticised by feminist scholars who opposed the lack of attention to social context, symmetrical approach to gender, and to the scope of violence addressed (Johnson, 1995).

Following the feminist tradition, DeKeseredy (1997) proposed the subsequent definition of abuse towards women in intimate relationships: 'Woman abuse is the misuse of power by a husband, intimate partner (whether male or female), ex-husband, or ex-partner against a woman, resulting in a loss of dignity, control, and safety as well as a feeling of powerlessness and entrapment experienced by the woman who is the direct victim of on-going or repeated physical, psychological, economic, sexual, verbal, and/or spiritual abuse. Woman abuse also includes persistent threats or forcing women to witness violence against their children, other relatives, friends, pets, and/or cherished possessions by their husbands, partners, ex-husbands, or ex-partners' (DeKerseredy, 1997, p. 5). This definition is broader than the

one of Straus and colleagues, and encompasses various aspects of violence. It clearly defines the victim and the aggressor, and sees violence as a misuse of power. It defines the outcomes of violence, however lacks identifying criteria which makes it difficult to evaluate (Winstok, 2007).

In an attempt to integrate perceptions of both feminist and family researchers, Johnson (2001) focused on the discussion of whether only men are violent in intimate relationships, whilst women perpetrate violence 'in defence' (feminist perspective) or whether women also initiate violence (the standpoint of family conflict researchers). He proposed that the perspectives of both feminist and family researchers can be appropriate in explaining IPV (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995). This discussion produced a comprehensive typology whereby IPV can be classified into five qualitatively different types: Coercive Controlling Behaviour, Violent Resistance, Situational Couple Violence, Mutual Violent Control Violence, and Separation-Instigated Violence (Beck, Anderson, O'Hara, & Benjamin, 2013).

In one way the public health approach represents a compromise between the two perspectives. It defines IPV as *'behaviour within an intimate relationship that causes or has the potential to cause physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviours'* (Garcia-Moreno et al., 2015, p. 1686). This definition considers violence mostly within the framework of distinct categories: physical, psychological and sexual (Gordon, 2000; Löbmann, Greve, Wetzels, &

Bosold, 2003). However, it has to be noted that if physical aggression seems to be a relatively clear category, the other two, especially psychological aggression, are subject to disagreement between both different and within similar schools of thought (Winstok, 2007). This will be further explored in the chapter.

1.3.2. Individual theories of IPV

1.3.2.1. Social learning theory

Similarly to the power theory, social learning theorists suggest that ways of settling family conflicts are often learned through observing parental and peer relationships during childhood (Bandura, 1973; Mihalic & Elliott, 2005; Wareham et al., 2009). It is proposed that victims and perpetrators of IPV have either witnessed or experienced physical abuse during childhood, resulting in the development, acceptance or tolerance of violence within the family (Jin et al., 2007; Lewis & Fremouw, 2001; Vung & Krantz, 2009).

There is a number of studies reporting that witnessing or experiencing abuse during childhood might be associated with future IPV perpetration or victimisation in adulthood (Berzenski & Yates, 2010; Parks, Kim, Day, Garza, & Larkby, 2011; Shook, Gerrity, Jurich, & Segrist, 2000; Whitfield, Anda, Dube, & Felitti, 2003). It has been suggested that whether or not violence continues into adulthood depends on the context and consequences associated with violence in peer and dating relationships (Daigneault, Hébert, & McDuff, 2009; Riggs, Caulfield, & Street, 2000).

1.3.2.2. Background/situational model

Expanding on social learning theory, Riggs and O'Leary (1996) developed a 'model of courtship aggression' that explained a form of IPV. The model describes two general components – background and situational factors that contribute to the development and maintenance of courtship aggression. The background component refers to historical, societal, and individual characteristics determining future aggression. These factors might include history of childhood abuse, exposure to violence in childhood, personality characteristics, history of use of aggression, psychopathology, and social norms and attitudes towards aggression as a means of resolving conflict. The situational component refers to situational factors setting up the stage for violence to occur. These might include expectations of outcomes of violence, interpersonal conflict, intimacy levels, substance abuse or problem-solving skills. The interaction between these factors might affect conflict intensity and therefore determine whether or not the violence will occur (Riggs & O'Leary, 1996). It has been reported that factors such as witnessing violence, parental aggression, or positive attitudes towards the use of aggression were predictive of IPV occurrence, whilst substance abuse, partner's aggression and the degree of interpersonal conflict appeared to have had an impact on courtship aggression (Gwartney-Gibbs, Stockard, & Bohmer, 1987; Riggs & O'Leary, 1996; White & Koss, 1991; White, Merrill, & Koss, 2001).

1.3.2.3. Personality/typology theories

Researchers have attempted to identify psychopathology and personality traits and characteristics that might affect a person's susceptibility to perpetrate IPV. Holtzworth-Munroe and Stuart (1994) proposed the Developmental Model of Batterer Subtypes by reviewing 15 previous batterer typologies for common themes across classification metrics.

Three dimensions of severity, generality of violence, and psychopathology/personality disorder were suggested to classify three main types of male batterrer. These are categorised as 'family only', 'generally violent/antisocial' and 'dysphoric/borderline.' Later on an additional subtype defined as 'low-level antisocial batterer' was identified (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000). It was suggested that generic/prenatal factors, early childhood experiences and experiences with peers would affect development of variables more closely associated with IPV perpetration. These include attachment to others, impulsivity, social skills and attitudes towards women and violence (Holtzworth-Munroe & Stuart, 1994).

This theory has been successfully tested by various studies (Dixon & Browne, 2003; Holtzworth-Munroe, 2000; Langhinrichsen-Rohling, Huss, & Ramsey, 2000; Waltz, Babcock, Jacobson, & Gottman, 2000). Research exploring typologies of female perpetrators has found similarities to male offenders (Babcock, Miller, & Siard, 2003; Bender & Roberts, 2007; Dixon & Browne, 2003)

Other researchers have developed alternative batterer typologies. Although these typologies categorise subtypes or perpetrators through different lenses, most of them categorise betterers into two or three

different subtypes. Some of them focus on either behavioural, physiological or psychological characteristics, whilst offering a distinct perspective on the motives and patterns behind the subtypes of perpetrators (Gondolf, 1988; Gottman, Jacobson, Rushe, & Shortt, 1995; Hamberger & Hastings, 1986; Hamberger, Lohr, Bonge, & Tolin, 1996; Johnson, 1995). Such discrepancies make it difficult to synthesise these typologies or even make comparisons across them (Bender & Roberts, 2007). In an attempt to address these difficulties, Chiffriller, Hennessy, and Zappone (2006) examined clusters of offenders in a large study focused on behavioural and personality characteristics, distinguishing five subtypes incorporating previous typologies: pathological batterers, sexually violent batterers, generally violent batterers, psychologically violent batterers, and family-only batterers.

1.3.3. Typology of IPV by type of violence

Another framework for classifying IPV is by the form of violence or abuse (terms are used interchangeably in this study). The three main categories of physical, sexual and psychological violence are frequently used and reported in various studies (Devries et al., 2013; Ellsberg et al., 2008; García-Moreno, Zimmerman, et al., 2015). Some researchers have identified other categories such as financial or social abuse, yet, it is not clear whether those categories can be defined as separate dimensions of IPV (Ali, Dhingra, & McGarry, 2016).

1.3.3.1. Physical violence

Physical violence refers to the use of physical force to inflict pain, injury of physical suffering to a victim. Examples of physical violence might include beating, slapping, kicking, pushing, shoving, stabbing, dragging, scratching, choking, burning, threatening or using a gun, knife or any weapon (Garcia-Moreno, Heise, Jansen, Ellsberg, & Watts, 2005).

1.3.3.2. Sexual violence

Sexual violence is defined as 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, acts to traffic, or other coercive actions directed against a person's sexuality by any person, irrespective of relationship to the victim, in any setting, including but not limited to home and work' (Garcia-Moreno et al., 2015, p. 1686). In the context of IPV sexual violence refers to forcing a partner against their will to have sexual intercourse, do anything that the partner found degrading or humiliating, harming them during sex or forcing them to have sex without protection (World Health Organisation, 2013).

1.3.3.3. Psychological violence

Psychological violence refers to acting in an offensive, degrading or humiliating manner toward another, usually verbally, and may include threats, ridicule, withholding affection, and restrictions (e.g. social isolation, financial control (Maiuro, 2001). Some examples of psychological violence in IPV perpetrated by men against women can include verbal abuse, name calling, blackmailing, saying or doing something to make a person feel embarrassed, threats to beat a woman

or children, restricting access to friends and family, or restricting independence and access to information, education or health services (World Health Organisation, 2002, 2013).

1.3.4. Integrative frameworks of IPV

The brief reviews in the previous sections did not aim to exhaust the scope of reference to violence, but to demonstrate the complexity and disparity of the issues when one attempts to define IPV and the implications of that this defining has on theory and practice. Many researchers have argued the need for more comprehensive theories of IPV (Barocas et al., 2016; Sellers, Cochran, & Branch, 2005; Whitaker et al., 2006; Wilkinson & Hamerschlag, 2005). It is suggested that the theories should take into account perspective of both the victims and perpetrators whilst integrating standpoints from various academic disciplines such as psychology, sociology and criminal justice (Rhatigan et al., 2005). Furthermore, the authors argue that IPV theories should be more ideographic in nature, taking into consideration the significant heterogeneity of IPV (Bogat, Levendosky, & Eye, 2005) as well as addressing the context and proximal events associated with IPV (Bell & Naugle, 2008; Bogat et al., 2005; Wilkinson & Hamerschlag, 2005; Winstok, 2007).

Bell and Naugle (2008) developed a theoretical framework of IPV offering contextual analysis of IPV perpetration. This framework incorporates IPV empirical findings and theories, drawing heavily from Behaviour Analytic (Myers, 1995), Social Learning (Bandura, 1973) and

Background/Situation (Riggs & O'Leary, 1996) theories. The authors hypothesise that multiple contextual units are implicated in perpetration of IPV – namely target behaviour (e.g. physical, sexual or psychological aggression), antecedents of target behaviour, discriminative stimuli (e.g. presence/absence of others), motivating factors (e.g. substance abuse, emotional distress), behavioural repertoire (e.g. coping skills, anger management skills), verbal rules (e.g. beliefs about violence or women) and consequences (reinforcement and punishment). A number of potentially relevant proximal variables are identified for each unit. Authors argue that this contextual framework has the potential to offer significant improvements for conceptualising IPV as well as in IPV prevention and treatment problems (Bell & Naugle, 2008). However, it is yet to be empirically tested.

Winstok (2007) developed an Integrative Structural Model of Violence (ISMV) that might be helpful in understanding interpersonal violence in general in IPV, in particular through a set system of criteria and relationships between them. The author defines interpersonal violence as a 'non-legitimate forceful tactic intentionally employed by one party to cause physical and/or psychological harm to the other in the attempt to control a situation' (Winstok, 2007, p. 352).

ISMV consists of four levels of reference - violent behaviour (motive, action itself, consequences), the situation in which the violence occurs, the relationships between the parties, and the sociocultural context of the relationships. The ISMV provides framework for formulating the definition of IPV perpetrated by men against their female intimate partners as follows:

‘Violence is a non-legitimate, forceful (belligerent) tactic a man uses anytime anywhere against a woman with whom he has or had an intimate relationship. This tactic is part of the man's perception of a given situation and of his attempt to control it. The tactic is motivated by the man's need to prevent, balance, or gain something in his or other persons' interpersonal or social realities, as he perceives them. This tactic consists of at least one action of a physical, aural, or visual orientation employed by the man to (intentionally) harm the woman. Using this tactic can cause the woman at least one form of harm of a physical, social, or economic nature, including harming her self-esteem or self-, social, or pubic image in the short or long term’ (Winstok, 2007, p. 357).

The above definition gives content to the structural component of the model and includes reference to the meaning of violence, situational context, motive, action and consequence – what appears to be a detailed framework for conceptualising the complexity of IPV.

Overall, the theory and research on IPV demonstrates the phenomenon’s multifaceted and complex nature. Therefore, it is important that a broad range of factors is considered when assessing and addressing the problem. A narrow theoretical focus might exclude potentially important exploratory factors (Dixon & Graham-Kevan, 2011).

1.4. Impacts of IPV on women: empirical findings

Review of the literature suggests an association between poor physical and mental health, and an overall lack of wellbeing in women exposed to IPV, and has been established worldwide in numerous studies (Dillon, Hussain, Loxton, & Rahman, 2013; Ellsberg et al., 2008; García-Moreno, Zimmerman, et al., 2015). Qualitative studies often report women describing the devastating effects of IPV exposure on their self-esteem, self-confidence and self-identity leading to feelings of depression, anxiety, fear, anger and despair (Childress, 2013; Lammers, Ritchie, & Robertson, 2005; Murphy, Lemire, & Wisman, 2009; Oweis, Gharaibeh, Al-Natour, & Froelicher, 2009). This section will provide an overview of the quantitative and qualitative studies investigating the effects of IPV on women's health, with a particular focus on the consequences of IPV for women's mental health and psychological wellbeing.

1.4.1. Physical health

Research suggests that women who have been exposed to IPV generally report lower levels of physical functioning than non-abused women (Hurwitz, Gupta, Liu, Silverman, & Raj, 2006; Loxton, Schofield, Hussain, & Mishra, 2006; Tomasulo & McNamara, 2007). In addition, there are studies which show that physical functioning levels of abused women remain significantly affected after the abuse has been ceased (Alsaker, Moen, & Kristoffersen, 2008). Qualitative studies often highlight dangers of IPV for physical health, with women describing raised blood pressure, migraines and headaches, fatigue and low energy levels, digestive problems and being more susceptible to illness, whilst their 'ability to

cope' is being greatly reduced (Bhowon & Munbauhal, 2005; Hyder, Noor, & Tsui, 2007; Lowe, Humphreys, & Williams, 2007).

Exposure to IPV has been commonly reported to be associated with a range of chronic physical health conditions such a chronic pain (Nerøien & Schei, 2008; Vives-Cases, Ruiz-Cantero, Escribà-Agüir, & Miralles, 2011; Woods, Hall, Campbell, & Angott, 2008; Wuest et al., 2007), cardiovascular and/or circulatory problems (Loxton et al., 2006; Ruiz-Pérez, Plazaola-Castaño, & del Río-Lozano, 2007; Schneider, Burnette, Ilgen, & Timko, 2009), respiratory problems (Loxton et al., 2006; Schei, Guthrie, Dennerstein, & Alford, 2006), bone and muscle conditions (Woods et al., 2008), fatigue (Loxton et al., 2006), headaches or migraine (Kramer, Lorenzon, & Mueller, 2004), malnutrition and low weight (Gass, Stein, Williams, & Seedat, 2010).

There are also studies reporting that women suffer from various physical symptoms as a result of psychological abuse. For instance, Avdibegović and Sinanović (2006) described higher incidence of somatisation symptoms in women exposed to IPV. Similarly, in the study of Nerøien and Schei (2008), abused women reported psychosomatic complaints more often when compared to non-abused women.

There is a scope of studies reporting an association between women's exposure to IPV and gynaecological problems (Ellsberg et al., 2008; Gerber, Wittenberg, Ganz, Williams, & McCloskey, 2008; Nerøien & Schei, 2008; Woods et al., 2008). These problems include vaginal bleeding following sexual violence (Stephenson, Koenig, & Ahmed,

2006), and sexually transmitted diseases including HIV and AIDS (Dude, 2011; Josephs & Abel, 2009; Li et al., 2014; Vos et al., 2006).

Overall, results of the research, including cross-cultural studies suggest that the health issues associated with IPV represent IPV as a major health and human rights issue (Devries et al., 2013; Dillon et al., 2013; Garcia-Moreno et al., 2005; World Health Organisation, 2013).

1.4.1. Mental health and psychological wellbeing

The consequences to mental health as a result of exposure to IPV are far reaching (Matheson et al., 2015). A growing body of research points out the effects of IPV on women as individuals as well as the burden it places on social and health care providers (Miller, McCaw, Humphreys, & Mitchell, 2015; O'Doherty et al., 2014; World Health Organisation, 2013).

There is a growing recognition that exposure to IPV is associated with a range of adverse mental health outcomes. It undermines women's sense of self-worth, autonomy and independence (Kumar, Nizamie, & Srivastava, 2013). For instance, in the meta-analytic review investigating the impact of IPV on mental health, Golding (1999) reported that women exposed to IPV were 3 times more likely to suffer from depression and were more likely to be at risk of suicide, 5.5 times more likely to misuse drugs, and 6 times more likely to misuse alcohol. The research also shows that 31-84% of abused women meet the criteria for Post Traumatic Stress Disorder (Dutton, 2009; Jones, Hughes, & Unterstaller, 2001), they are more likely to display emotional distress

and suicidal ideation or attempt suicide (McLaughlin, O'Carroll, & O'Connor, 2012).

1.4.1.1. Depression

Depression appears to be one of the most commonly researched aspects of mental health in relation to IPV and numerous studies consistently reported a significant association between exposure to IPV and presence of depressive symptoms (Ansara & Hindin, 2011; Avdibegović & Sinanović, 2006; Carbone-López, Kruttschnitt, & Macmillan, 2006; Devries et al., 2013; Scheffer Lindgren & Renck, 2008). Whilst investigating the impact of IPV on women’s mental health Vos et al. (2006) reported high relative importance attributed to depression (34,7%) in its negative impact on mental health when compared to anxiety (27,3%), suicide (10,7%) or physical injuries (0,6%) as a result of IPV. In addition, Pico-Alfonso et al. (2006) found psychological IPV to be as detrimental as physical IPV in terms of depressive symptoms. Helfrich, Fujiura, and Rutkowski-Kmitta (2008) investigated mental health and functioning in women living in domestic violence shelters. The results suggested that the incidence of major depression in the last 12 months was 51,4% among women living in shelters compared to 2.4% in the general female population.

Research studies of IPV impacts often indicate that women frequently report exposure to various types of IPV and this can be associated with both the severity and probability of depressive symptoms (Houry, Kemball, Rhodes, & Kaslow, 2006; Pico-Alfonso et al., 2006). For

instance, Wong, Tiwari, Fong, Humphreys, and Bullock (2011) reported psychological abuse to be a predictor of higher levels of depressive symptoms, whilst the frequency of psychological abuse was also associated with the higher levels of IPV-related depression. Chen, Rovi, Vega, Jacobs, and Johnson (2009) found that women exposed to sexual IPV were more prone to developing depression than women who had experienced physical or psychological abuse when compared to non-abused women.

Zlotnick, Johnson, and Kohn (2006) investigated the long-term psychological effects of IPV. They reported that five years after the study, women exposed to IPV were still significantly more likely to experience a greater degree of depressive symptoms, low self-esteem and lower life-satisfaction levels than women without the history of IPV victimisation. The authors did not report any results suggesting that women who left the abusive relationships were better off in terms of psychological wellbeing than those who did not leave. Therefore, they concluded that women who have been exposed to IPV are at risk of a range of long-term mental health concerns regardless of whether they leave or remain in abusive relationships.

1.4.1.2. Anxiety

Anxiety as an outcome of IPV exposure in women is often reported along with depression and other common mental health problems associated with IPV (Ehrensaft, Moffitt, & Caspi, 2006; Helfrich et al., 2008; Savas & Agridag, 2011; Schneider et al., 2009). It is suggested that

a history of IPV victimisation in women is positively associated with increased rates of anxiety (Ayub et al., 2009; Ludermir, Schraiber, D'Oliveira, França-Junior, & Jansen, 2008; Wuest et al., 2007). Results of the study conducted by Vos et al. (2006) suggest that 27.3% of the total IPV burden of disease was attributed to anxiety, with only depression having a higher rate. In the study of Pico-Alfonso et al. (2006) the severity of the anxiety symptoms was associated with comorbid depressive symptoms, whilst anxiety was more severe in abused women experiencing symptoms of depression. In addition, severity and frequency of IPV has been linked to increased anxiety symptoms (Ansara & Hindin, 2011; Savas & Agridag, 2011).

1.4.1.3. Post Traumatic Stress Disorder (PTSD)

PTSD is another of the most commonly reported mental health problems related to IPV exposure in women. Research suggests that experience of IPV is positively associated with PTSD diagnosis as well as increased incidence of PTSD symptoms (Becker, Stuewig, & McCloskey, 2010; Forbes et al., 2012; Logan & Cole, 2007; Woods et al., 2008). For instance, Fedovskiy, Higgins, and Paranjape (2008) reported that women with a history of IPV had approximately 3 times the odds of meeting the criteria for PTSD than non-abused women. However, the prevalence rates of PTSD amongst IPV women survivors vary significantly across different studies.

Helfrich et al. (2008) reported that among women living in domestic violence shelters, 16.2% met criteria for PTSD. This is in contrast to 92.4% of women from crisis shelters reported by Woods et al. (2008).

O'campo et al. (2006) estimated that 30.9% of women with the history of IPV presented with PTSD symptoms compared to 13.7% in non-abused women, whilst in the exploratory study of Khadra, Wehbe, Lachance Fiola, Skaff, and Nehmé (2015) 97% of women exposed to physical IPV endorsed core PTSD symptomatology.

Similarly to depressive symptoms, PTSD-affected women who reported experiencing more severe and frequent IPV generally present with higher levels of PTSD symptoms (Chandra, Satyanarayana, & Carey, 2009; Houry et al., 2006), whilst experiencing more than one form of abuse leads to a greater degree of PTSD symptoms (Eshelman & Levendosky, 2012). Importantly, various studies report association between PTSD and depressive symptoms (Blasco-Ros, Sánchez-Lorente, & Martinez, 2010; Chandra et al., 2009; Pico-Alfonso et al., 2006). For instance, Fedovskiy et al. (2008) stated that women experiencing PTSD symptoms were ten times more likely to have comorbid depressive symptoms. The authors propose that this may be a result of PTSD and depression symptoms overlap.

1.4.1.4. Suicide and self-harm

Various studies investigating impacts of IPV on women’s health and wellbeing suggest that women experiencing IPV often attempt to commit suicide or present with suicidal ideation or thoughts (Ellsberg et al., 2008; Renner & Markward, 2009; Yoshihama, Horrocks, & Kamano, 2009). For instance, Ellsberg et al. (2008) reported that across ten countries women exposed to physical or sexual IPV, or indeed both,

were three times more likely to have thought about ending their life and almost four times more likely to have attempted suicide than non-abused women. Ishida, Stupp, Melian, Serbanescu, and Goodwin (2010) found that for abuse experienced in the last 12 months, physical and sexual IPV were more important risk factors for suicidal ideation than emotional IPV. In contrast however, Naved and Akhtar (2008) reported that among their sample of Bangladeshi women exposure to emotional and severe physical IPV were major determinants of suicidal ideation. The qualitative study of Wong et al. (2011) revealed that women exposed to IPV described self-harm as a way of airing emotional pain caused by abuse or as a last resort to escape from violence when they saw no other option and were no longer able to tolerate violence.

1.4.1.5. Self-perceived mental health and psychological wellbeing

Women exposed to IPV often experience lower levels of mental health and social functioning than non-abused women (Chen et al., 2009; Edwards, Black, Dhingra, McKnight-Eily, & Perry, 2009; Follingstad & Rogers, 2014; Fortin, Guay, Lavoie, Boisvert, & Beaudry, 2012; Loxton et al., 2006; Nur, 2012). For instance, Edwards et al. (2009) reported that levels of serious psychological distress in women exposed to both physical and sexual IPV during their lifetime was 15.4% comparing to 2.1% in non-abused women.

Qualitative studies suggest that women describe their experiences of IPV resulting in feelings of isolation and loneliness, sadness, despair and degradation (Childress, 2013). Lammers et al. (2005) described women exposed to IPV feeling hopeless, confused and in despair, whilst their

sense of self-identity felt diminished, they were feeling guilty and doubting their sense of self-sufficiency. Similarly, the study of Matheson et al. (2015) suggests that emotional abuse, controlling behaviour and constant threat of violence leaves women feeling disoriented and on constant alert, which attacks women's self-esteem and makes them more vulnerable to abuse. Authors describe the effects of the psychological abuse, intimidation, and verbal abuse as creating a deterioration of the sense of self, whilst having adverse mental health consequences – including erosion of self-identity, self-esteem and self efficacy, as well as overall psychological wellbeing (Matheson et al., 2015).

1.4.3. Summary of the IPV consequences

The research findings discussed in the preceding sections suggest that women who have been exposed to IPV are at an alarmingly increased risk of developing IPV related physical and mental health problems. Importantly, health issues related to IPV exposure, particularly implications for mental health and the psychological wellbeing of women have been found to last for many years – even long after the exposure to IPV has been ceased.

Research findings point out that persistent physical and psychological health problems associated with women's experience of IPV are partially intermediated by exposure to high levels of stress (Tomasulo & McNamara, 2007), subsequent reduced practice of healthy behaviours (Martino, Collins, & Ellickson, 2005), restricted access to health care

(García-Moreno, Hegarty, et al., 2015) or limited social and financial independence (Vyas & Watts, 2009). The overview of IPV's effects indicates that there is still a limited number of qualitative studies investigating consequences of IPV for women as well as women's experiences of other aspects of IPV victimisation. It can be suggested that more research is needed exploring women's views of the IPV phenomenon and its intricacy.

1.5. Women's attitudes towards change and help-seeking within the context of IPV

Research suggests that despite the ubiquity of IPV and its serious adverse effects on health and wellbeing, many women do not seek help from community, health or legal services or even family, friends and other informal sources of social support (Frías, 2013; Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Palermo, Bleck, & Peterman, 2014). The cross-cultural study of Klugman et al. (2014) showed that on average, only 4 in 10 women exposed to IPV sought any kind of support, whilst only 6% approached formal sources such as police, health care professionals or lawyers and social service organisations. Formal reporting of IPV has been also shown to vary across countries (Palermo et al., 2014), whilst women generally tend to seek help from formal sources when IPV becomes more severe and they fear for their life or safety of their children (Ergöçmen, Yüksel-Kaptanoğlu, & Jansen, 2013; Naved, Azim, Bhuiya, & Persson, 2006). In other words, it appears that

women often tend to seek help for IPV as a last resort rather than an informed response to a human rights abuse (McCleary-Sills et al., 2016).

Research into IPV has been working towards recognising the complexity of women's experiences, and adopting different models to highlight how women make decisions and create change. For instance, Alexander, Tracy, Radek, and Koverola (2009) analysed Stages of Change (SOC) in battered women in an attempt to identify factors associated with these. The findings suggest that earlier SOC were associated with ethnicity, economic and emotional dependence, preoccupied attachment, satisfaction with social support and women's use of aggression. Later SOC were associated with women's older age, higher levels of education and higher incomes. Burkitt and Larkin (2008) examined the process of change in IPV female victims and identify factors that might be related to SOC. They conducted a longitudinal cluster analysis over 3-4 months and identified 5 clusters reflective of SOC: reluctance – whereby women held onto beliefs that the perpetrator might change; uninvolved/ambivalent – whereby women were apathetic and ambivalent about their relationship; engagement – whereby women expressed willingness to make change, but required support; and action cluster – whereby women were able to execute change. The latter cluster had the biggest movement over time (6-42%), whilst progression through stages was related to both the use of community resources and ending the IPV relationship.

Barrett and Pierre (2011) examined the role of sociodemographic factors and IPV characteristics in Canadian women's decisions to seek help. The results suggest that the strongest predictor of help-seeking behaviour

was feeling that their life was in danger. Other predictors included frequency of violence, being physically injured, not having a high school diploma, and residing in a house where the language was not native.

The qualitative study of Chang et al. (2006) aimed to explore factors and circumstances that might be associated with women's motivation to change the IPV situation. Those decisions were described as being associated with women's desire to protect others from abuse or abuser; with the increase in severity or humiliation related to abuse; with increased awareness of options/access to support and resources; with fatigue or recognition that the abuser would never change, and partner betrayal/infidelity.

Petersen, Moracco, Goldstein, and Clark (2005) explored women's motivations and barriers to help-seeking or accessing IPV. In this study women described gaining knowledge, reaching an emotional or physical breaking point, and increased concerns for the safety of their children as the main motivators for seeking help. The main barriers for help-seeking were pressure not to talk about or address IPV, little knowledge of IPV or failure to recognise the events as IPV or lacking understanding that IPV was not acceptable, self-doubt and low self-esteem, fear of losses, fear of the perpetrator or consequences for the perpetrator. In another qualitative study, Nagae and Dancy (2010) reported that seeking help in Japan seemed extremely difficult for women due to cultural attitudes supporting male dominance and belief that the woman's disobedience was the cause of IPV. Women were discouraged to talk about IPV because of shame and embarrassment, lack of family support or for fear of more battering from perpetrator.

Generally, both qualitative and quantitative studies often report that, feelings of self-blame, guilt, shame, fear, low self-esteem and self-efficacy are associated with barriers for leaving abusive relationships or seeking help (Hardesty, Oswald, Khaw, & Fonseca, 2011; McLeod, Hays, & Chang, 2010; Overstreet & Quinn, 2013; Swanberg & Logan, 2005; Wilson, Silberberg, Brown, & Yaggy, 2007)

Reisenhofer and Taft (2013) conducted a comprehensive review of studies investigating women's experience of IPV-related change and adapted the Transtheoretical Model of Change (TTM) proposed by Prochaska (2013). The model defines five stages of change (SOC), as well as ten processes of change and constructs of decision balance and self-efficacy (Prochaska, 2013). The results of the review provide somewhat controversial outcomes. For instance, some studies found no correlation between demographics and SOC (Shorey, Tirone, Nathanson, Handsel, & Rhatigan, 2013). Other studies suggested that being older, having higher social or financial status were related to being at later SOC (Alexander et al., 2009), whilst higher levels of anger, anxiety, PTSD or perceiving relationships as abusive increased women's readiness to change (Bliss, Ogley-Oliver, Jackson, Harp, & Kaslow, 2008; Shurman & Rodriguez, 2006). Importantly, women often 'jumped' or 'lapsed' through the stages throughout their journeys to safety, which could demonstrate the non-linear nature of the process and uniqueness of the journey of each woman.

Liang et al. (2005) suggested another helpful framework for conceptualising the process of help-seeking among victims of IPV. Their

model tends to focus on individual internal cognitive processes, and include three stages: problem recognition and definition, deciding to seek help and the selection of help provider. The authors point out that although they present distinct stages of the process, this process is by no means linear. The stages are interrelated and mutually affect each other; they are also subject to individual, interpersonal and sociocultural influences. This model once again demonstrates the multifaceted nature of IPV, intricacy of its counterparts and the complex interplay of individual, interpersonal and sociocultural factors involved.

Overall, women's decision-making around the disclosure of IPV, help-seeking or deciding to leave the abusive relationship often appears to be exceptionally challenging. Women face challenges from the abuser and often from families, friends and even within support services. The importance of various factors, such as enhanced knowledge of clinicians, confidentiality issues, non-judgemental/empathic/caring attitudes of professionals have been well documented (Othman, Goddard, & Piterman, 2014; Overstreet & Quinn, 2013; Rose et al., 2011). However, the complex nature of IPV and its perception as hidden and often shameful, the components of relationships (both positive and negative), social isolation, women's lack of self-esteem and their decreased sense of self-efficacy can make disclosing, changing or leaving the abusive relationship extremely difficult (Childress, 2013). Furthermore, potential risks of retaliation and harm from the abuser, financial difficulties, loss of children, loss of social status or family and community support are all possible risks for women trying to end abusive relationships (Feder, Hutson, Ramsay, & Taket, 2006). It is therefore essential that clinicians

and other support providers acknowledge the complex nature of IPV, women's readiness and ability for change in the context of abusive relationships, as well as the challenges faced by women working to achieve safety from abuse.

1.5. Support services and Interventions for female victims of IPV

This section aims to discuss services and intervention programs available for women exposed to IPV with a larger emphasis on therapeutic interventions, research studies of their effectiveness and possible implications.

Review of the literature suggests that often health, human and legal services fail to adequately address the problems related to IPV either due to a lack of training or being unable to offer trauma-informed services necessary for this population group (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Feder et al., 2011; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007; Stacey Beth Plichta, 2007). As a result, many of the IPV survivors seek help from community-based agencies (Ingram, 2007; Macy, Nurius, Kernic, & Holt, 2005). Therefore, such services seem to fill in a critical need in many communities offering a variety of interventions of victim-survivors of IPV, such as a 24-hour crisis services, legal and medical advocacy, brief and extended counselling and therapy services, support groups and emergency shelters (Macy, Giattina, Parish, & Crosby, 2010; Macy, Johns, Rizo, Martin, & Giattina, 2011).

Research findings suggest that community-based services for victims of IPV can be effective in promoting survivor's safety, health and wellbeing (Bennett, Riger, Schewe, Howard, & Wasco, 2004; Campbell, 2006; Petersen, Moracco, Goldstein, & Clark, 2002). However, it appears that there is a little research on how those services should be delivered. Macy, Giattina, Sangster, Crosby, and Montijo (2009) described the current state of service delivery as a 'black box', suggesting that the inner workings of these services remain largely unknown. Their comprehensive review aimed to identify domestic and sexual assault services' best practices for violence in the US' community-based agencies. Referring to domestic violence services, and therefore, IPV, the authors described different subtypes and the best recommended policies of the available US services. The identified subtypes of services included crisis services and telephone hotlines, advocacy and legal advocacy, support groups, individual counselling and shelters for victim-survivors. Importantly, the authors point out that the efficacy of these service-delivery strategies are yet to be empirically evaluated. Thus, they recommended that researchers, community-based providers and violence survivors work collaboratively on investigating the effectiveness of community-based services for victims of domestic violence.

Notably, the literature on the topic of specialist services for victims of IPV within the UK appears to be relatively limited (Burman & Chantler, 2005; Burman, Smailes, & Chantler, 2004; Harne & Radford, 2008; Stanko, 2001). For instance, Williamson and Abrahams (2014) reviewed evaluations of three UK intervention programs for IPV victims named the Freedom Program, the Phoenix Program, and the Pattern Changing

Program. They suggested the need for much more rigorous evaluations. In addition, there is also some research suggesting that provision of specialist services for victim-survivors across the UK is inconsistent on many levels (Coy, Kelly, Foord, & Bowstead, 2011).
Although focusing on all the specifics of specialist service-delivered interventions and practice recommendations policies in detail would be outside of the scope of this research, it is important to point out the existence of such a gap in both practice and research.

1.5.1. Counselling and therapy interventions for female victims of IPV: empirical findings

The research on what constitutes a recommended approach to counselling and therapy interventions for victim survivors of IPV within a specialist service often provides a different and sometimes controversial scope of suggestions (Dienemann, Campbell, Landenburger, & Curry, 2002; Eckhardt et al., 2013; Hague, Mullender, & Aris, 2003; Murray & Welch, 2010; Wall & Quadara, 2014; Zeman, 2004). Given that current research is focusing on investigating women's experiences of therapy, it is important to consider a range of counselling and therapy interventions for victim survivors of IPV available in general.

Research studies on therapy interventions for IPV victims vary in methodological details, duration and intensity, contexts and intervention outcomes. The present section will focus on reviewing recent qualitative studies exploring women's experiences of therapy for victims of IPV, as well as quantitative studies investigating the effects of

counselling and therapy interventions for women's mental health and psychological wellbeing.

1.5.1.1. Quantitative research

For the purposes of this research, this section will mainly focus on the recent studies (randomised and quasi-experiments) examining extended (more than 3 sessions) one-to-one and group interventions, with the emphasis on how the intervention effects symptoms that commonly result from IPV victimization (e.g. depression, post traumatic stress disorder [PTSD]), factors that are assumed to affect risks for victimization (e.g. safety behaviours), and various important aspects of personal growth and change (e.g. self-esteem, social support, etc.).

Individual Interventions

The existing literature suggests that studies of the effects of individual Cognitive Behaviour Therapy (CBT) for victims of IPV have produced a number of controversial but promising findings.
Kubany and colleagues were examining the effects of Cognitive Trauma Therapy for Battered Women (CTT-BW) suffering from PTSD who have ended the abusive relationship (Kubany, Hill, & Owens, 2003; Kubany et al., 2004). CTT-BW is an individual therapy program which targets PTSD symptoms, and includes psychoeducation, stress management, exposure exercises, cognitive restructuring, and is focused on trauma-related guilt, self-advocacy and empowerment.

The results have shown significant improvement in PTSD and depressive symptoms as well as trauma-related guilt. Furthermore, the results remained persistent and were observed through 6 months of post-treatment follow-up. However, one of the limitations for CTT-BW was that its effects have not been replicated by an independent research team, and the maintenance of improvements in symptoms have not yet been studied beyond 6 months period.

In contrast, the study of Johnson and colleagues (Johnson, Zlotnick, & Perez, 2011) addressed the more immediate concerns and needs of women who were in the shelter at the time of the research. They examined the effectiveness of the “Helping to Overcome PTSD through Empowerment” (HOPE) program. Treatment was based on CBT principles and aimed to address the immediate risks of PTSD and its symptoms, as well as behaviours and cognitions that interfered with the participants’ goals and quality of life. Treatment was focused on coping strategies and personal empowerment. The results have shown that women who received at least 5 sessions of HOPE displayed lower levels of some PTSD symptoms and depression, as well as higher levels of social support. Furthermore the physical levels of IPV revictimisation 6 months after shelter were significantly lower in those who had undergone HOPE (42%) compared to those who had not (82%).

Another CBT study (Crespo & Arinero, 2010) examined the specific effects of exposure to traumatic memories versus training in communication skills for victims of IPV in the community. Participants in both conditions received various components of CBT treatment such as

cognitive restructuring, techniques to improve self-esteem, activity scheduling, diaphragmatic breathing exercises and psychoeducation about IPV to name a few. Both interventions were associated with a significant reduction in the symptoms of PTSD, depression, and anxiety whilst a significant increase in self-esteem was observed. Furthermore, the results were maintained at the follow-up. However, there were some isolated benefits of exposure – notably in reducing avoidance and the hyper arousal symptoms of PTSD, but not with regards to re-experiencing symptoms.

Cohen, Field, Campbell, and Hien (2013) investigated the effectiveness of two behaviour interventions for women exposed to IPV with comorbid PTSD and substance use disorder (SUD). Participants were randomly assigned to Seeking Safety (SS) therapy (Najavits, 2002) or to the Women's Health Education (WHE) psychoeducation group (Miller, Pegan, & Tross, 1988). SS therapy is a short-term manualised therapy that aims to reduce substance use and trauma symptoms by using cognitive-behavioural strategies. It includes cognitive restructuring, a basic education on substance use disorders and PTSD, action skills to prevent substance use and control PTSD symptoms, as well as help in overcoming relationship issues and developing effective communication skills. The WHE group is a psychoeducational intervention that mainly focuses on general topics relevant for women such as pregnancy, childbirth, nutrition, sexual behaviour and female autonomy among others. It does not provide any specific techniques or psychoeducation specifically about PTSD or substance abuse. In both groups the duration

of treatment was 6 weeks and consisted of two 90-minute sessions per week.

One of the aims of the study was to explore whether SS would be superior to a general psychoeducation group in reducing the risk of retraumatisation at follow-up. Results have shown that there was no effect for treatment condition. However, women from the SS group who were abstinent at the beginning of the treatment were significantly less likely to report IPV at the follow up. Furthermore, there was no main effect or interaction with treatment condition for PTSD symptom severity. Importantly, all participants were also enrolled in one of the community-based substance abuse treatment programs and received treatment-as-usual during the 6-week period, which may have affected the results. However, none of the programs provided trauma-focused treatment during the study.

Overall, although studies examining the effectiveness of various forms of CBT therapy for victims of IPV provide some promising results, they are somewhat controversial and more research is needed in order to be able to generalise findings.

The number of studies examining effects of individual therapy for victims of IPV other than CBT is very limited, however they do exist.

A randomised experiment by Chronister and McWhirter (2006) was designed to examine the effectiveness of the Advancing Career Counselling and Employment Support for Survivors (ACCESS) program versus ACCESS with Critical Consciousness (ACCESS-CC), versus wait-list control. ACCESS was based on social cognitive theory and aimed to

enhance self-efficacy and outcome expectations, increase support and promote career interests and goal pursuit. Critical Consciousness encouraged awareness of one's identity, through dialogue and group identification, power analysis and critical self-reflection. In both conditions women received 5 weekly two-hour sessions. The results revealed a significant multivariate effect at post-treatment as well as conditional differences in career-searching self-efficacy and critical consciousness, whilst intervention participants had significantly higher results than controls. However, there were no significant differences between the two interventions at the follow up. Furthermore, the data was provided only for those who completed treatment.

Another randomised experiment (Reed & Enright, 2006) was designed to examine the effects of Forgiveness Therapy (FT) based on the Enright's Forgiveness model (Enright & Fitzgibbons, 2000) versus alternative therapy (AT). FT was focused on defining forgiveness, psychological defences, self-blame, commitment to forgiving, grief and loss from abuse, and finding meaning in unjust suffering, among others. The duration of treatment varied by case, although the average duration was 8 months. The average number of sessions was not reported. AT as a control condition facilitated the discussion of current life concerns, anger about abuse and interpersonal skill-building. The results have shown that FT participants had a significantly greater increase in forgiveness towards the former abuser, finding meaning in suffering and mastery of the environment. They also had a significantly greater reduction in anxiety, depression and PTSD symptoms. However, except for anxiety and self-esteem, no changes suggesting the maintenance of

the results were found at the follow-up. Moreover, the sample in general consisted of highly educated participants who had no previously reported history of physical relationship assault victimization.

Zlotnick, Capezza, and Parker (2011) studied the effectiveness of Interpersonal Therapy (IPT) for pregnant women exposed to IPV. In this study IPT functioned as a highly structured intervention aimed to improve interpersonal relationships, enhance social support and facilitate a positive transition to motherhood. Therapy addressed healthy relationships versus abusive relationships, the consequences and cycle of abuse, its health and psychological risks, postnatal depression, symptoms of PTSD, interpersonal conflicts, support systems and goal settings. Women received therapy over a 4-week period of four 60-minute sessions during pregnancy and one 60-minute session within 2 weeks after delivery. On average women attended 3 of 5 scheduled therapy sessions. The control group received standard treatment as well as educational materials on IPV. Results in one measure revealed a significant decrease in PTSD symptoms for the group who underwent IPT. There was also a trend towards a decrease in depressive symptoms during pregnancy. However, no significant differences were found for depressive episodes, depressive symptoms or abuse exposure. Furthermore, the sample was highly selective, as only 54 women took part in the study out of an initial sample of 1633 women who met the IPV screening criterion.

Group Interventions

Studies examining the effects of group interventions for women exposed to IPV have also produced a number of notable outcomes. Kim and Kim (2001) examined the effectiveness of the weekly group intervention based on Seven-Stage Crisis Intervention Model (Knox & Roberts, 2001). They used a short-term, problem-oriented and goal-directed approach whereby each of the sessions aimed to address one of the following topics: trauma assessment, problem identification, understanding of the self, identification of coping strategies and batterer characteristics, improvement of coping strategies, action plans and promoting empowerment. Women received 8 weekly, 90-minutes sessions. The control group received no treatment, underwent pre and post-tests and accessed services as usual at the shelter. Results identified a significant decrease in anxiety in the treatment group, however there was no improvement in self-esteem between the pre and post-tests in both conditions. Importantly, a significant reduction in depression was found in the treatment group, although the degree of change did not vary significantly between conditions. Furthermore, it has to be noted that the sample attrition rate was high, and the participants in the experimental group began with significantly higher levels of anxiety, which might have affected the findings concerning anxiety reduction in the treatment group over time.

Constantino, Kim, and Crane (2005) designed another randomised experiment aiming to evaluate the effects of Social Support Interventions (SSI) on health outcomes in residents of a domestic violence shelter. The group therapy aimed to facilitate a sense of belonging, promote self-esteem and encourage resource access. The

duration of the treatment was 8 weeks with a 90-minute group session. The control group who received no treatment gathered in a room with the researcher 'for a free flowing chat session with no structure' (p. 582). Results of the study showed positive outcomes in the treatment group with regards to the utilisation of social support and health service. The treatment group also displayed a decrease in levels of psychological distress. It has to be noted however, that some of the authors raised concerns regarding the analytic method used to document the significant condition differences reported in the study (Eckhardt et al., 2013).

Effectiveness of group therapy for women exposed to IPV was also examined by Kasl ow et al. (2010) who evaluated Culturally Informed group intervention for African American women. Each therapeutic group contained 3-5 women and 2 facilitators. Treatment lasted for 10 weeks with a 90-minute group session. Therapy aimed to target resiliency, self-efficacy, problem solving and various other protective factors in order to enhance the ability to cope with stress, as well as facilitate feelings of hope. Women in the control group received treatment as usual including psychiatric and medical care in the hospital – which included 3 weekly suicide and IPV support groups. Results showed a significant improvement in depressive and trauma symptoms, suicide ideation and levels of global distress for women in the treatment group. Furthermore, there was more rapid reduction in depressive symptoms and general distress. Levels of depressive symptoms and suicidal ideation remained lower at the 12 months follow-up, although this was not the case for general distress.

In summary, the research literature indicates that quantitative and qualitative studies examining the effects of therapy interventions for victims of IPV provide encouraging outcomes. Although few in number, these studies suggest that there is a positive impact on various factors predictive of women's wellbeing. The majority of women who used supportive therapy at shelter homes reported feeling safer and more hopeful. Support groups helped victims feel a greater sense of belonging and increased their self-esteem, as well as reduced their levels of distress. Several counselling interventions have been associated with a significant change in outcomes, including the improvement of PTSD and depressive symptoms, the promotion of coping strategies and safety behaviours, as well as improvements in the quality of life. Although very limited, the research also indicates that group interventions help promote positive outcomes in terms of social support and improve women's self-perception. While there are still more questions than answers in this field, the empirical evidence described in this section suggests that interventions for victims of IPV makes significant changes across intrapersonal, interpersonal and social levels – promoting the well-being of survivors.

1.5.1.2. Qualitative research

As discussed in the preceding sections, IPV can be perceived as a complex phenomenon, which occurs in different forms and is often influenced by various factors including gender standards, interpersonal and social relationships. Various researchers have argued that the

experience of IPV cannot be studied in a purely quantitative manner outside of the context (Gavey, 2013; Hegarty, 2011; Kaur & Garg, 2010; Rose et al., 2011). They claim that, IPV mostly happens in private and cannot be observed, controlled, influenced or measured in laboratory settings. Understanding these experiences hugely depends on subjective meaning for women.

Qualitative researchers in the field of IPV seem to mainly focus on women's lived experiences of IPV (Glantz, Halperin, & Hunt, 1998; Kennedy, 2005; Lammers et al., 2005; Oweis et al., 2009), how health care providers make sense of IPV and IPV interventions (Husso et al., 2012; Wuerch, Zorn, Juschka, & Hampton, 2016), women's expectations from health care providers (Chang et al., 2005), women's experiences of decision making around the disclosure of IPV (Reisenhofer & Taft, 2013), barriers of disclosure (Othman et al., 2014) or decisions to leave the abuser (Edwards et al, 2012; Khaw & Hardesty, 2007). However, the review of the literature shows that recent qualitative studies exploring women's experiences of therapy for victims of IPV are extremely scarce, and some of them seem to be somewhat lacking methodological scrutiny.

Oswald, Fonseca, and Hardesty (2010) explored lesbian mothers' counselling experiences in the context of IPV through a secondary analysis of in-depth interview data. The authors analysed data from the 'Lesbian Mothering in the Context of IPV' project that aimed to explore the family dynamics of lesbian mothers affected by IPV (Hardesty, Oswald, Khaw, Fonseca, & Chung, 2008). All women recruited in this

study reported being in a current or former physically abusive same-sex intimate relationship. Thematic analysis was used for the data analysis. Some of the women who took part in this study described seeking therapy for IPV survivors after reaching a 'turning point' in their relationships, others accessed help for IPV survivors through seeking support related to other issues (e.g. concerns about children or trying to cope with a death of a relative). Women described being hesitant about seeking counselling due to a variety of reasons, such as feeling ashamed about their experience of abuse, the fear of being judged, the fear of losing custody over their children, the stigmas related to being in a same-sex relationship, and the fear of retaliation toward or from the abuser. The results presented in the study do not provide an in depth description of women's perceptions of counselling, however, the authors reported that half of the women perceived counselling as 'very helpful' when the dynamics of the relationship and women's experiences of IPV were addressed, whilst promoting self-empowerment.

Tetterton and Farnsworth (2011) conducted an exploratory investigation of two 'older women's' experiences of therapy. The data analysis 'consisted of thematic analysis of data from case studies, as well as research notes prepared during the study' (p. 2935). The aim of the study was to 'add to practitioner's knowledge about IPV and effective interventions' (p. 2935). All women who took part in the study were above 60 years old and 'presented concerns related to IPV' (p. 2932). The results of the study suggest that both women who took part in this study had a long-term experience of abuse, used 'unhealthy coping

strategies' such as substance abuse, and experienced being blamed by their adult children for them having to witness the abuse. However, 'ultimately, both began to regain control by identifying and resolving vulnerabilities that others had used against them for decades' (p. 2939). The authors pointed out the importance of establishing a good therapeutic relationship, being non-judgemental, illuminating individual contextual circumstances of the client, and promoting empowerment when working with victims of IPV.

Roddy (2013) explored women's perspectives of therapy for victim-survivors of IPV. She interviewed four women who had completed counselling for IPV survivors 3-18 months prior to the interview. The data was analysed using narrative methods analysis and grounded theory. The findings highlight the importance of establishing a good therapeutic relationship and forming an emotional connection with a therapist, 'through the provision of information and support in understanding their particular situation' (p. 58), and the acknowledgment of abusive experiences and normalisation of feelings related to the experiences of IPV. The author suggests that specialist knowledge of IPV its complexities might be beneficial whilst working with victim survivors of IPV.

Overall, although the research literature on counselling and therapeutic interventions for victims of IPV provides a range of encouraging findings, it is relatively sparse, especially when it comes to qualitative studies exploring women's perspectives of therapy and counselling for victim-survivors. More research is needed in order to help increase the efficacy

of currently available interventions, possibly develop new ones through understanding the specific needs of this population group, and provide scientific evidence for the importance of establishing specialist services for victims of IPV. It can be suggested that although enthusiastic and inventive, this research area is at the early stage of its development, with considerable distance left to achieve the goal of establishing effective programs to support victim-survivors of IPV.

1.6. Lead into the current study

So far the discussion of the IPV phenomenon indicates its extreme complexity in terms of the theoretical models and definitions of IPV available, its variety of outcomes and risk factors, its possible implications for women's health and wellbeing, and the barriers it raises with regards to help-seeking. It can be therefore assumed that the treatment of IPV victim survivors should be holistic, addressing the comorbid needs of women and emphasising the varied nature of IPV. Yet, review of the literature suggests that there are some gaps in both research and practice when it comes to investigating the IPV phenomenon in all its complexities, or indeed providing adequate help and support for victims of IPV. It is particularly evident across the qualitative studies exploring IPV the phenomenon, and research into specialist IPV/Domestic violence services, or their unequal distribution across the UK.

Although there is some degree of recognition that IPV should be studied within the context, and qualitative or mixed methods of research could

be more appropriate (Chang et al., 2010; Gavey, 2013; Testa, Livingston, & VanZile-Tamsen, 2011), it appears that there is a tendency for researchers in the field to focus on particular constructs (e.g. efficacy, symptom-reduction, or violence prevention), and rely on constructed quantitative measures.

Furthermore, as noted by a number of researchers, therapy for victim-survivors of IPV aims to address a variety of issues specific to this population group (Kubany et al., 2003; O'Doherty et al., 2014; Reed & Enright, 2006), and is therefore assumed to be different from other approaches, such as general counselling. Importantly, the existing qualitative research does not seem to focus on the views and perspectives of clients themselves when it comes to investigating therapy that aims to specifically target IPV related issues.

Finally, given the high prevalence of IPV victims amongst the female population and the fact that the majority of specialist service users are women (Anitha, 2010; Hines & Douglas, 2011; Peek-Asa et al., 2011), exploring their experiences of therapy appears to be of great importance. Addressing the experiences, specific needs and concerns of this population group can potentially facilitate positive therapeutic outcomes and provide grounds for the further provision of specialist services for IPV victims, as well as policy recommendations for service provides.

Therefore, it has been decided to conduct a qualitative study exploring women's experiences of therapy for victims of IPV within a specialist Domestic Violence service. The term 'Domestic' violence here does not refer to the theoretical orientation of the researcher, but rather

represents the terminology most commonly utilised by service providers and the general population.

2. METHODOLOGY

2.1. Introduction

This chapter aims to provide descriptions and explanations of how the researcher attempted to answer the research question: *how do women, exposed to IPV experience therapy at the specialist service for victims of DV?* It begins with outlining broad epistemological assumptions, and moves towards more detailed descriptions of research procedures, including the steps that were taken to ensure high quality of this research.

2.2. Epistemology, Methodology and Method

Epistemology can be defined as 'the study of the nature of knowledge and justification' (Schwandt, 2007; p. 88). It can provide justification for particular methodologies and guides methodological choices. Methodology can be defined as a theory of how research enquiry should proceed and 'involves analysis of the assumptions, principles, and procedures in a particular approach to enquiry' (Schwandt, 2007, p. 195). It shapes and is shaped by research questions, aims and objectives, and the design of the study (Carter & Little, 2007). Methods can be described as particular tools or techniques for gathering evidence in research. In short, methodology provides description, explanation and justification for the methods, and is different from methods themselves (Kaplan, 1973). Methods are determined by and make visible methodological and epistemic choices.

Carter and Little (2007) proposed that attending to all three fundamental facets of research – epistemology, methodology and method – whilst demonstrating internal consistency between them should provide the framework for conducting high quality qualitative research. In this section each of these research facets will be clarified and their interrelationships will be explored.

2.2.1 Acceptance of qualitative methodology

As discussed in the literature review section, there is a lot that is unknown about women's experiences of therapy for victims of IPV. It appears that exploring the subjective experiences of this population group might contribute to both the theory and practice of counselling psychology and provide a poly-dimensional and empowering insight into the area (Roddy, 2013).
Various researchers have stated that IPV cannot be studied in a purely quantitative manner outside the context (Gavey, 2013; Hegarty, 2011; Kaur & Garg, 2010; D. Rose et al., 2011). They argue that IPV normally happens in private and cannot be observed, manipulated or measured in laboratory settings. Understanding experiences of therapy in female IPV survivors hugely depends on the subjective meaning it carries for women, which makes it difficult to study in a purely quantitative manner. Qualitative researchers study people in their own territory, within naturally occurring settings. They are interested in the meanings attributed to events and experiences by participants, and respondents' own ways of making sense of those (Willig, 2013).

The following research is concerned with *how women exposed to IPV experience therapy at the specialist service for victims of DV*. Guided by the research question, a qualitative framework was adopted for this study in an attempt to understand women from their own points of reference, and to understand reality as they experience it (Strauss & Corbin, 1990).

As a trainee Counselling psychologist, the researcher is reflective of the importance of subjective individual experience, which aligns her naturally with qualitative research framework.

Willig (2013) emphasises that qualitative researchers can adopt a wide range of positions about the nature and status of knowledge their research aims to produce. She points out the importance of being aware of the research objectives and what kind of knowledge it aims to produce. The epistemological basis of this research will be discussed in the next section.

2.2.2. Critical realist position

The present study applies a critical realist epistemological position. It therefore, accepts that there is a reality out there which can be studied, however it also acknowledges that this reality is not always directly 'observable', it is instead generated by different mechanisms, often concept-dependent and needs-interpretative understanding (Fairclough, Jessop, & Sayer, 2004).

Critical realism differs from 'naïve' realism in its assumption that although research can tell us what is going on in the 'real' world, it is unable to do so in a direct, unmediated way (Willig, 2013). Although

critical realism is compatible with a number of very different substantive positions within itself (López & Potter, 2005), most critical realists argue that consistent regularities in this world are likely to arise only under very specific circumstances in 'closed systems'. However, 'open systems', such as the social world, are too complex and therefore the same causal powers can produce very different outcomes (Sayer, 2000). Therefore, given the extreme complexity and continuous change in the social world, one can assume that there might be a lack of regular relations between causes and effects. Consequently, the data obtained in psychology research would be context-dependent and need to be interpreted to further our understanding of underlying structures which generate the phenomenon under investigation (Mertens, 2014).

2.2.3. Methods: Interpretative Phenomenological Analysis and Visual Methods

2.2.3.1. Interpretative Phenomenological Analysis (IPA)

IPA is a qualitative approach that is concerned with the ways humans experience and gain knowledge of the world around them (Willig, 2001). It aims to gather detailed material capturing the quality and texture of participant's experience, whilst allowing both the researcher and participant to explore their own process in a reflexive manner (Pringle, Drummond, McLafferty, & Hendry, 2011). As this research was concerned with exploring women's experiences of therapy, IPA appeared to be an appropriate research method.

Furthermore, this research is interested in women's experiences of therapy within a particular mental health service. The therapeutic approach applied at this service values the client's accounts of their experience, without questioning the external validity of what the client is saying. This very much reflects an IPA approach that is concerned with the experiential world of participants rather than the 'real structures' that may constitute their experiences (Larkin & Thompson, 2003).

Another important consideration while choosing IPA was a match between researcher's epistemological position and the broadly critical realist stance adopted by IPA (Shinebourne, 2011). IPA aims to produce knowledge of how people perceive the 'objective' phenomenon under investigation (Larkin, Watts, & Clifton, 2006). However, these 'objective' conditions can be experienced in very different ways. Therefore, IPA is concerned not with the 'objective' nature of this world, but rather with people's subjective experiences of it (Biggerstaff & Thompson, 2008). Importantly, IPA recognises that such experiences are never directly accessible to the researcher, who rather aims to unravel the meanings of participants' accounts through the process of interpretative understanding (Smith, 2015), and thus can be assumed to produce 'critical realist knowledge'.

2.2.3.2. Visual Methods: drawings

The use of interviews as a linguistic method of data collection in a qualitative study relies on language as a main channel for the formation and communication of knowledge. However, one can argue that our

day-to-day experience is composed of diversity of dimensions. Those include visual and sensory, which are believed to be worthy of investigation, but are often difficult to express in words, as not all knowledge is reducible to language (Knowles & Cole, 2008).
Qualitative study concerned with a subjective experience can be criticised for using methods that constrain participants from conveying these experiences openly and in sufficient detail (Willig, 2001, 2013). It has been suggested that inclusion of non-linguistic methods into research may enable participants to express themselves more freely, and allow researchers to access and represent different levels of the experience whilst encouraging thoughts 'outside of the box', generating new ways of understanding (Mason, 2006).

Drawings as a visual method of research are often used with children (Eldén, 2013; Kortesluoma, Punamäki, & Nikkonen, 2008; Literat, 2013) or in cross-cultural studies (Banks & Zeitlyn, 2015; Smith, 2000), whereby there is an assumption that participants might find it difficult to express themselves through language. However, it has been argued that drawings can be successfully used as an adjunct to social research in general (Mitchell, Theron, Stuart, Smith, & Campbell, 2011).

Using drawings as visual methods offers benefits for the researcher and the research as they can broaden the experience, comprehension and representation of the research topic, allowing researchers to gain information that might have been difficult to access using other methods (Frith & Harcourt, 2007). However, drawings can be beneficial not only to researchers, but also potentially for participants.

Guillemin and Drew (2010) proposed that using drawings in research can foster a sense of participation and therefore be empowering, giving a voice to those who might otherwise not be heard. It approaches participants as knowers, valuing their accounts of reality. In addition, giving participants an opportunity to produce an image might help them portray what is sometimes difficult to express in words. It can be therefore assumed that using drawings as a method of research can be enabling for participants, whilst having a positive consciousness-raising (and perhaps even therapeutic) effect (Nowicka-Sauer, 2007).

Considering the sensitive topic of this research, it has been decided to use drawings as one of the research methods, as this can not only enrich the data by allowing participants to express the raw emotions and feelings experienced, but potentially give them more control over the process. Inviting participants to talk about their drawings can be helpful in allowing them to express what is difficult to communicate through language, therefore facilitating the making of meaning for participants and the researcher. Contemplating and producing the drawing can potentially give participants space to consider and reflect on their experiences of therapy in-depth. Following Guillemin and Drew (2010), it is however acknowledged that as with any research methodology or any experience in general, not all participants might find such a research experience entirely positive and transformative.

An important epistemological issue for researchers using drawings in their research is how to 'read' the visual material. Gillies et al. (2005)

proposed that there are at least four different ways of reading research drawings:

- as telling something about the nature of the phenomenon
- as telling something about the person who produced the drawing
- as telling something about the cultural resources/meanings available in relation to the topic
- as a stimulus to facilitate further discussion on the topic.

For the purposes of this research it has been chosen to read the drawings firstly, as a mean of eliciting further verbal exploration in the interview; and secondly, as telling something about the participants' experience via interpretative analysis. The pictures were therefore approached phenomenologically. It has been assumed that when placed within the context of the research as a whole, drawings can provide a rich source of meaning, and access parts of a participant's experiences that words could not (Boden & Eatough, 2014; Willig, 2013). It is acknowledged that drawings are no more 'real' than words, and are given meanings by research participants. They do not represent the participant's inner world in a direct unmediated manner and the researcher would need to interpret the image in an attempt to get to its meaning (Radley & Taylor, 2003).

In line with the proposed epistemological stance of the study, the epistemological assumptions about the use of drawings as visual methods in this research, as well as with the IPA method outlined in the previous section, an *interpretative approach* was taken to the data generated in this study. Therefore, the researcher was trying to make

sense of participants making sense of the actual reality, thus producing 'critical realist knowledge'.

2.3. Research design

Semi-structured individual interviews were used as one of the data collection methods for this research. According to Smith, Flowers, and Larkin (2009), interviews and diaries are the most standard methods of data collection, and enable researchers to obtain the detailed subjective accounts required for an IPA study. It was assumed that the interviews would not only help produce rich data to answer the research question, but their inter-subjective context might give an opportunity to explore any sensitive topics in a form of non-directive dialogue, enabling participants speak freely and openly, and to maximise their own understanding of what is being communicated (Willig, 2001, 2013).

Silver, Reavey and Fineberg (2010) suggest that when a researcher tries to enter the life world of the participant, visual methods can provide a good way of doing this. When the visual is used in an IPA study, it allows the researcher to find out more about how participants make sense of their experiences (Willig, 2013).

During the interview participants were asked to draw a picture of their experience of therapy and invited to talk about their drawing. It was hoped that asking participants to talk about their visual data would help to steer away from closed questions, allowing participants to talk about their experiences of the explored phenomenon more freely (Guillemin & Drew, 2010).

The drawings were also analysed independently from the verbal narrative through interpretative analysis. Following Guillemin (2004), drawings were seen as producing meaning and telling the researcher something about participants' experiences independently. The detailed description of the analytic technique used will be outlined in the following sections.

However, it is important to point out that participants were asked to draw a picture of their experience upon completion of the interview so that a sense of rapport would have been already established enabling participants to reflect on their experiences more freely. Secondly, asking participants to talk about their drawings was considered to be utmost important, including their descriptions of the nature of the drawing, the narrative behind what has been drawn, their choice of colour and spatial organisation of the drawing. It was assumed that talking about their drawings would not only facilitate reflections on the drawing itself, but would also foster further reflections on the relationship of what they have drawn to their particular therapeutic experience and significance of their statements made during the interviews. Finally, it appears that using drawings as an adjunct to the interviews enabled the research process to go more smoothly as a continuation of the narrative (Guillemin, 2004).

2.4. Ethical considerations

This research complied with the British Psychological Society ethical-guidelines, and abided by both the *Code of Ethics and Conduct (2009)* and *Code of Human Research Ethics (2014).*

Procedures were followed to ensure participants' rights for confidentiality, anonymity, fair treatment, valid consent and due process were consistent with those outlined.

Participants were explained of the nature of the research and were informed that they are free to withdraw from the study at any time. The data was anonymised and is untraceable back to participants by other parties. With participants' consent, excerpts from their transcripts, as well as their drawings were included in the presentation of research findings, however all identifying material was omitted.

Considerations were taken to ensure that the scientific and scholarly standards of the research itself are accountable and of sufficient high quality, thus complying with the principles of scientific value as well as social responsibility.

Due to the sensitive nature of the research topic, there might have been a potential risk in revisiting unpleasant memories. In order to ensure that appropriate help would have been provided if necessary, participants were given contact details of local counsellors prior to, and after the research.

Written consent was obtained, whereby participants were informed about the nature and aims of the research, the type of data and its method of collection, confidentiality and data protection, time commitment, and the right to withdraw from the study. It also included the contact details of the researcher, a way of accessing results, and the planned outcomes and potential benefits of the study. After the data collection all participants were debriefed.

Ethics application forms were submitted to and approved by the City University Ethics Committee and the Woman's Trust Research Ethics Committee.

Moreover, as it has been assumed that some of the potential participants might still be in abusive relationships, the recruitment emails were sent only to those women, whose personal file stated that it is "safe" to email them. This meant that participants would have agreed for the Woman's Trust to email them, and they have no concerns regarding the fact that someone might have access to their personal emails.

During the data collection, the researcher did her best to establish a warm therapeutic environment so that if any emotional issues arose they could be addressed in a professional manner. The researcher herself was a trainee counsellor at the Woman's Trust, and therefore was familiar with some of the issues presented during therapy for victims of domestic violence.
Additionally, the data collection was conducted at the Woman's Trust office, and therefore senior counsellors were present in the next room. They were aware of the sensitive topic of the research, and whilst fortunately not required, they would have been able to provide additional support for participants immediately if necessary.
All interviews were conducted at the Woman's Trust office within working hours. Therefore, there were no issues related to lone working. Data collection took place in a therapy room which is next to the main

office room, where at least 3 people are present at most times. No safety risks for participants or the researcher arose.

The researcher was also attending personal therapy and supervision in order to seek support and guidance, and avoid extensive psychological distress.

2.5. Data collection

2.5.1. Sampling

Only female participants who are over 18 years old, have been in relationships for the period of at least two months, and completed a course of therapy for victims of DV (18 weeks) were recruited for the present study.

After eight participants were interviewed, data collection was stopped since it had been decided that there was a rich wealth of data upon which to proceed with the analysis.

Participants were recruited from the Woman's Trust, the registered charity and mental health service, providing help and support for women affected by domestic violence. Primary risk assessment has been conducted for all potential participants within the service. Those women who presented with a high suicidality risk prior to, or post therapy at the Woman's Trust were not approached.

It appears that the results of this research will be available to other professionals, including the researcher's former colleagues at the Woman's Trust, who have been of enormous help and kindly supported her in recruiting participants from their service.

As some of these colleagues have worked with the participants in the clinical setting, for the purposes of confidentiality the researcher is unable to provide any details about her participants that might be recognisable, and potentially link their pseudonyms with their real identity.

The researcher refers to her participants by pseudonyms and calls them Nina, Claire, Beth, Jenny, Mary, Ann, Sam and Kelly. They are all over 18 years old, coming from different cultural and socio-economic backgrounds, and are currently separated from their ex-partners having all undergone therapy for victims of DV within the Woman's Trust.

Like Kelly said, they have all been 'married to a same man' in the sense that they have all experienced some form of abuse from an intimate partner. At the time of the interview they were all separated from the abuser, and undergone therapy for victim-survivors 6-12 months prior to the recruitment. However, each one of them has had a unique experience of therapy, and the researcher feels honoured that they bravely and openly shared with her their individual experiences of the therapeutic journey.

2.5.2. Procedure

Participants responded to the advert (Appendix 1) sent from the official email of the Woman's Trust (administrator). Only women who completed therapy 6-12 months prior were approached. Considering the sensitive nature of the research, it was hoped that this would increase participants' confidence in the study, and potentially decrease their anxiety about being contacted by an unknown person. They were

provided with a copy of the information sheet, and were asked to contact the researcher if they were interested or if they had any further questions.

Most of the participants contacted the researcher directly, either by telephone or email. Two of them responded to the official email from the Woman's Trust expressing their interest in the research, and asked the researcher to contact them over the telephone. Prior to the interview, the researcher had a telephone conversation with all participants. The researcher introduced herself, asked if it was a convenient time to speak (when contacted by researcher) and offered the opportunity to ask any further questions. Participants were then asked if they had read the information sheet and whether they had any questions.

All participants stated that they understood the information sheet (Appendix 2) and are interested in taking part in the study. At the first stage of the research, participants were asked to complete the CORE questionnaire (Appendix 3) over the phone. *The CORE outcome measure* is a client self-report questionnaire designed to measure their level of current psychological global distress (healthy to severe). The questionnaire was approached from a phenomenological perspective and served as an exploratory technique rather than an attempt to produce nomothetic knowledge. The ten questions from the questionnaire served to guide the conversation and were therefore asked in a form of free conversation in an attempt to gain insight into participants' current state of being. This allowed the establishment of an initial connection between the participants and the researches, and served to assess the then-current levels of a participant's distress,

minimising the risk of recruiting participants who could be potentially too vulnerable to take part in the interviews.

None of the participants who approached the researcher reported high levels of distress, and none were suicidal.

Participants were reminded that interviews will take place at the main office of the Woman's Trust, lasting approximately 60-90 minutes. They then collaboratively arranged with the researcher the most convenient time to meet for the interview.

The design of the study has changed during the process of the research. It has been agreed during the supervision to modify the title of the study from 'Childhood Maltreatment, Attachment Styles, Early Maladaptive Schemas and experience of therapy in women exposed to Intimate Partner Violence' to 'Experience of therapy in women exposed to Intimate Partner Violence within a specialist Domestic Violence Service', and proceed only with qualitative methodology. Participants were provided with the information sheet that was adjusted according to the new title, whilst including the old title as corresponding with the City University Ethics approval code.

2.5.3. Interview schedule

Eight semi-structured individual interviews to explore women's experience of therapy for victims of IPV were conducted (50-90 minutes). Those were conducted from a phenomenological perspective, offering insight into the participant's experience. The development of the interview schedule (Appendix 7) was an iterative and inductive process guided by the conceptual framework.

Participants arrived at the Woman's Trust office where they met the researcher for the first time face-to-face. They were invited to one of the therapy rooms where the interviews took place. Prior to starting each interview, participants were given a print out of the information sheet, which was emailed to them during the recruitment process. They were asked to go through it again and let the researcher know if they had any further questions. Participants were then asked to sign a consent form (Appendix 4) to show they understood the purpose of the study, what was required from them and their rights.
At the end of the interview participants were asked if they were willing to draw a picture of their counselling experience. Once again they were reminded that they are free to say 'no' if for any reason they were uncomfortable to proceed, however all participants were willing to go forward with the drawing. They were provided with a set of crayons, blank sheets of white paper and told that they could take as long as needed. They were then asked to tell the researcher about their drawing. The digital recorder was not switched off during the drawing process so that any comments or questions could be documented. Their descriptions were also audio recorded. Consent to include the participants' drawings in research findings was obtained. Participants were informed that the results of the study could potentially be published, however, no identifiable information would be included.

After the interview participants were debriefed (Appendix 5) and given 10GBP as a gratuity for their time and effort. Their travel expenses were also reimbursed (Appendix 6).

Confidentiality rules were strictly followed throughout the study. The recordings, questionnaires and drawings were kept in a locked cabinet. All names and identifying details were changed and made untraceable back to the participants. Any documents containing participants' real names were kept separately from the data, and all computer files related to the data were password-protected.

2.5.4. Transcription

The interviews were recorded on a digital device and then transcribed verbatim. Pauses longer than 2 seconds were indicated by (pause), laughter and other non-linguistic forms of expression were also identified by being placed in brackets, for instance (laughter). This has been done to create a text which is a close representation of its audible form. If any descriptive comments or associations came up during the transcription, they were noted for future analysis.

2.6. Analytical procedures

'One cannot do good qualitative research by
following a cookbook' (Smith, 2004; p. 40)

2.6.1. IPA

The term Interpretative Phenomenological Analysis is used to signal the dual facets of the approach (Smith, 1999) and the joint reflection from the produced analytic accounts (Smith, Flowers & Osborn, 1997). It is phenomenological in its focus on the individual's experience and interpretative in its recognition of researcher's centrality to the research

itself and its analysis (Smith, 2004). Therefore, the interpretations are bounded on one hand by the participant's abilities to express their thoughts and experiences, and on the other hand by the researcher's abilities to reflect and analyse (Pringle et al., 2011). This analysis requires close interaction between the researcher and the data, not only by comprehending the presented text, but also by concurrently making use of their own interpretations. According to Smith (2004), the quality of the analysis is determined by the "personal analytic work done at each stage of the procedure" (p. 40). It is also argued that it is not appropriate to provide a definitive methodology for IPA as it does not seek to claim objectivity through the use of standard procedure (Chamberlain, 2000). Therefore, the IPA analytic process is not linear, and for the purposes of this research it has been decided to use the six stages described by Smith et all (2009) as a guideline rather than a definitive procedure. Exemplars of the analytic process are presented in the appendix (Appendices 8-10).

1) *Reading and re-reading*

The first stage of the analysis aimed to familiarise the researcher with the text, this was done by the reading and re-reading of the material, which enabled researcher to note any comments, questions or summary statements arising in response to the text.

2) *Initial noting*

In line with suggestions of Smith et al. (2009), at this stage of the analysis a more comprehensive set of notes was produced. The aim was to get a more detailed understanding of the participants'

account. The notes included “descriptive comments” (participant’s subjective experiences), “linguistic comments” (use of language and its potential significance) and “conceptual comments” (focused on the context, abstract notions). All notes were written on the right hand margin of the transcript and colour-coded.

3) Developing emergent themes

This stage of the analysis required capturing the essential quality of what is represented by the text (Willig, 2013). Therefore, the researcher aimed to balance description and interpretation so that the emerging themes would be conceptual, whilst capturing the nature, quality and meaning of participant’s experiences. The emergent themes were noted on the left hand margin of the transcript.

4) Searching for connections across the emergent themes

The aim of this stage was to introduce structure into emergent themes. The themes were reviewed in an attempt to identify if any of the themes would form clusters of concepts that share meanings or references, and whether any of the themes would be characterised by hierarchical relationships with one another. In doing so, the researcher followed Smith, et. al (2009) by applying principles of abstraction, subsumption, polarisation, numeration and function. Clusters of themes were then given labels capturing their essence. Supporting themes were recorded under each cluster including brief quotations and references to the transcript.

5) *Moving to the next case*

Each transcript was reviewed before moving on to the next case. The stages described above were repeated for each transcript.

6) *Integration of cases*

At this stage of the analysis an inclusive list of master themes was produced. This was done in a cyclical manner, so that any emerging higher-order themes were checked against the transcripts.

2.6.2. Visual

Following Guillemin and Drew (2010), the drawings and interviews were seen as inextricably linked, requiring simultaneous analysis, whilst neither the data obtained from the interviews nor the drawings produced were perceived as the more 'valuable' data. Nevertheless, it is worth mentioning, that as the researcher is more familiar with dealing in written texts during her academic and research experience, she was more reliant on words to convey the research findings.

In this study, drawings were seen as a means of generating further discussion on the topic, but also as their own creative medium through which participants were able to generate and express their own meanings (Reavey & Johnson, 2008). In line with (Guillemin, 2004), it was assumed that although participants – as producers of the drawings – are the most relevant and appropriate persons to give meaning to their drawings; that does not mean that the researcher has no role to play. Instead, the researcher can provide an overall analysis to the

research – including the drawings – due to their ability to theorise, see patterns and maintain a relative distance from the participant-generated data. Although the researcher is reliant on participants' interpretations of their drawings, she might be more suitable to undertake an overall analysis, and interpret the visual data within the context of linguistic data and the research in general.

The analysis of the visual data consisted of two main parts:

1) The analysis of participant's verbal descriptions of their drawings. It was important to elicit a meaning that participant attribute to their drawings and their 'narrative' behind what has been drawn. At this stage the IPA was used to analyse the linguistic data. Interpretative approach has also enabled the researcher to further reflect on the nature and meanings attributed to the data as well as interpret the data obtained with the help of visual methods within the context of the data obtained from the interview and the research in general.
2) The analysis of the drawings as a creative medium through which participants were able to generate and express their own meanings. When analysing the drawings, the modification of critical visual methodology framework outlined in Rose (1996; 2016) was adopted. She suggested three main modalities to consider when analysing the images: production of the image, the image itself, and the site(s) where it is seen by audiences. She proposed a series of questions to guide the analysis of the images. Guillemin (2004) has helpfully suggested a modification of these questions when guiding the analysis of the drawings; it takes into account the participant, the researcher, and the drawing itself.

Baring this suggestion in mind, the researcher adopted an analytical procedure combing the descriptive and interpretative approach whereby the researcher was able to reflect on the drawing through the prism of the three main sights: the production of the drawing, the drawing itself, and the site where it is seen by various audiences (Rose, 2001). Below are the examples of questions advised by Guillemin (2004; p. 284) as guidance in the analysis of drawings. Although not entirely comprehensive, this set of questions was used when conducting the analysis of visual data in this study.

Examples of questions about the production of the image:

- What is the context in which the image was produced?
- When was it made?
- What events preceded the drawing, both in terms of the participant's condition and the relationship established between participant and researcher?
- Where was the image made?
- Who drew the image? Were the participants able to draw the image themself, or was assistance required?
- What was the response of the drawer to the request to produce the image?
- What is the relationship between the drawer and the subject of the image?

Examples of the questions about the image:

- What is being shown? What are the components of the image? How are they arranged?
- What relationships are established between the components of the image?
- What use is made of colour? What colours are used? What is the significance to the drawer of the colours used?
- What do the different components of the image signify? What is being represented?
- What knowledge is being deployed?
- Whose knowledge is excluded from this representation? And is this a contradictory image? (to other data collected, for example, in interviews)

Examples of the questions about the relationship between the drawing and the audience:

- Who was the original audience(s) for this image?
- Where is the viewer positioned in relation to the components of the image?
- Is more than one interpretation of the image possible? And how is it redisplayed?

It is important to mention, that the drawings were considered as both product and process, therefore considering the context of the production of the drawing was deemed to be necessary. The drawings were produced at a particular place and time, within the context of

research and the interview conducted by the researcher. Therefore, all the above worked to produce the understandings and meanings embedded in the drawings. Therefore, more attention was given to the contexts of the production of the drawings, participants' feelings, experiences and the meanings attributed to those, rather than solely to the content of what has been drawn. Having said that, the researcher still paid great attention to the drawings itself, including the colours, the size of the drawing, its arrangement on the page, its relationship to the other images produced, the shading and the force with which the drawings were produced.

Overall, a particular attention was given to the interpretation of the context in which the drawing was produced, the drawing itself, the boundaries between what was created and (re)presented, as well as the influence of the researcher and audience on the process (Reavey & Johnson, 2008). It is suggested that even though reflexivity as an analytic tool needs to be at the forefront of the entire research process, it is of particular importance when analysing the visual (Lynn & Lea, 2005). A large emphasis has been put on reflexivity throughout the whole study.

2.7. Methodological and procedural reflexivity

During the process of data collection and analysis the researcher was aware of the relationships that might have formed between her and the participants. One of the important points that had to be considered was the participants' perception of the researcher. The recruitment email sent to the participants included information about the research and described the researcher as a counsellor who had worked at the service.

This might have affected participants' ability to discuss their experiences openly and freely due to assumed potential bias. On the other hand, however, it might have also enabled participants to feel more safe with the researcher as an experienced professional who is sufficiently trained and capable of understanding their experiences.

To facilitate the interview and reassure participants further the researcher drew from her experience as a counselling psychologist practitioner, enabling her to work towards establishing a warm therapeutic environment during the interview – both to benefit the participant and enable the researcher to collect in-depth data. She paid the utmost attention to confidentiality and reassured participants that what was said in the room remained confidential and untraceable back to them. The researcher was aware that the interview was a product of the interaction between her and participants, and therefore the interview was presented in a particular form. This was a reminder of the researchers impact in both data collection and analysis, and enabled her to further reflect on the epistemological position of the research – whilst the experiences occurred in reality, the interviews were the product of making sense of these experiences within a particular context in time.

After the first interview the researcher met with her supervisor to discuss the researcher's concerns as well as the progression and potential challenges of the research. This enabled her to facilitate the discussion in a way that would help to illuminate each participant's unique experience in a way of a free discussion, rather than paying too much attention to the interview schedule. During the process of data collection and analysis the researcher has also regularly met with her colleagues (other counselling psychology trainees) to discuss any

concerns and anxieties, as well as the progression of their research. This seemed to promote a more in-depth understanding of the research process and enabled her to further reflect on the study.

3. ANALYSIS

3.1. Introduction

This chapter presents findings obtained through interpretative phenomenological analysis and visual methods.
Derived from the IPA is one over-arching theme with four inter-related constituent themes. The over-arching theme is 'Recovery as a process'; the constituent themes are listed below:

1. Abuse as disintegrating the Self
2. Oblivion of abuse and awakening
3. Therapy as a journey of empowerment
4. Therapy as a continuous experience

Each of the constituent themes has a number of subthemes. Although these constituent themes were expressed by all participants, that was not the case for all of the subthemes. A detailed description of these can be found in Appendix 10.

As discussed in the literature review, there are various factors associated with women's experiences of IPV, and therefore therapy for victim-survivors of IPV. These are often interconnected and affect one another, whilst it is difficult to consider the experience of therapy outside the individual context. It appears that the constituent themes are interconnected and even though it might seem that the last two themes are more related to the phenomenon under investigation, it was

assumed that women's experience of therapy can be better understood within the context of their journey towards recovery.

Derived from the analysis of the drawings are the researcher's interpretations of participants' representations of their experiences of therapy as a part of their journey towards recovery. It includes reflections on the process of the drawing, as well as participants' verbal descriptions of the drawings, followed by the researchers' interpretations of these descriptions and the drawings themselves. Findings from the interpretations of drawings will be presented through the following points of reference:

1. Recovery as a process
2. Therapy as a transforming experience
3. Therapy as a safe place
4. Therapy as a process

Overall, the presented findings aim to provide insight into participants' experiences of therapy for victim-survivors of Intimate Partner Violence within a specialist Domestic Violence service.

The researcher's interpretations of participants' interpretations of their lived experiences are presented in this chapter.

3.2. Findings from the IPA

3.2.1. Recovery as a process

'Recovery as a process' is an over-arching theme that appears to encapsulate the variety of the lived experiences of women who took part in this study. Although women often conveyed their stories in a chronological way, it is important to emphasise that this 'process of recovery' does not appear to be linear. It is instead a unique journey for each of the women and is being lived through in the present.

The purpose of this study was to investigate women's lived experiences of therapy for victim-survivors of IPV. Therefore, a larger emphasis will be given to two constituent themes: 'Therapy as a journey of empowerment' and 'Therapy as a continuous experience'. However, as the experience of therapy was a part of the women's 'journey' towards recovery, it cannot be understood outside the context. Although not asked explicitly about their experiences of abuse, all participants referred to and reflected on those during the interviews. These experiences appear to be unique and valuable for this study as they are closely related to, and in some ways represent the phenomenon under investigation. The findings will be presented as described by the women – in a sequential manner, starting from how participants experienced themselves, others and the world before, throughout and after therapy, followed by their lived experiences of 'now' as of the time of the interview.

3.2.2. Constituent theme 1: Abuse as disintegrating the Self

Although none of the participants were explicitly asked about their experience of abuse, all of them described it in one way or another. The theme 'Abuse as disintegrating the Self' emerged from these descriptions capturing the women's sense of how their experiences might have affected their sense of self. As most of them were talking about how they felt prior to starting therapy, one might assume that in some ways those feelings were brought into therapy.

3.2.2.1 Confusion and being overwhelmed

Participants discussed their feelings of being overwhelmed, often finding it difficult to make sense of what was going on in their life prior to starting therapy.

> *'I've come for you to help support me, to try to work through my mess, to work through my puzzle, to work through this big maze, to work through this wheel-spin.'*
> *Claire (5;31-34)*

Claire described coming to therapy for support, perhaps hoping that together with the therapist she could try to make sense of the complicated 'puzzle' and 'maze' of her thoughts, feelings and experiences. She called it a wheel-spin, which may imply having very little control over what was going on in her life, particularly if she felt like being 'trapped' in a 'maze' and was looking for a way out.

Sam called it being ‘bewildered’ and ‘lost’:

> *‘I was confused and bewildered. I didn't understand a lot of what was going on because I'd get these mixed messages all the time. Erm, and living with somebody who's so unpredictable is confusing.’*
> *Sam (7; 1-5)*

She talks about the perpetrator being unpredictable, giving her ‘mixed messages’ and how that left her having a great sense of confusion and feeling lost in her life, not knowing what to do. There is a profound sense of helplessness, trying to figure out what is going on and lack of control. Like Claire, she talks about looking for answers:

> *‘I was lost to what to do, and gradually I got some answers from people who helped’*
> *Sam (7; 5-7)*

Kelly described it as ‘turmoil’ and ‘anguish’:

> ‘*That top is like crazy-crazy on fire, nothing makes sense, turmoil, anguish, screaming. Horrible, horrible, horrible, horrible.’*
> *Kelly (17; 8-10)*

This description makes one wonder about the intensity of Kelly's experience. Once again, 'nothing makes sense', but this time the confusion takes the form or burning torment. It appears as if she was describing a sense of feeling trapped in a very nasty place, almost screaming for help when the pain was too difficult to tolerate.

3.2.2.2. Losing the sense of Self

Participants described how their experience of abuse affected their sense of self. They talked about how their core was changed and their journeys of trying to get back to their real selves.

> *'I was a totally different person, and you don't think you'll ever get back to being that person really.'*
> *Nina (9; 47-48)*

Nina conveyed losing her true self and becoming a totally different person. It appears that the change she conveys felt permanent and there was no way of going back to whom she was before the abuse. There is a deep sense of despair and loss, which appeared to have been addressed in therapy, as she then goes on to talk about how through therapy she 'learned skills and ways' of trying to get back to her real self:

> *'I just learnt a lot of skills and ways of thinking to help me to - get back to being me, because I'd just lost myself.'*
> *Nina (10; 1-2)*

Ann explained the sense of losing herself through having her life goals shattered, denigrated and laughed at for many years. She conveys a history of humiliation and belittlements resulting in a pervasive change in herself:

> *'I have this thing - because I was 20 years in that marriage, and all of me was change, and all my goals were stifled, sort of stamped away or laughed at…'*
> *Ann (4; 17-21)*

Claire talked about being persuaded into believing in something that did not appear to be in line with her own thinking:

> *'I didn't know myself. As I said I was brainwashed into Islam. A very militant Islam, where people don't like other colours. And I've kept myself above board. Sometimes I look and think 'no but you can't say that, because it has been put into your brain, it's not like that, that's what that person has told you'.*
> *Claire (8; 8-12)*

She describes being 'brainwashed', which gives one a sense of being deceived, forced into changing one's perspective on things without having an ability to question its validity at the time. She talks about being able to think about it in a more critical way now, though still appears to struggle with valuing what it is that *she* really thinks. The confusion seems to be still present in her everyday life, and her

statement might describe the process of trying to reverse the change in herself through validating her own thoughts versus what 'has been put into her brain'.

Jenny compared herself prior to starting therapy to how she might be perceived now:

> *'I'm sure you wouldn't know me, because I was something else. I wasn't like this at all.'*
> *Jenny (1; 45-46)*

One would wonder why she says 'something' else. There is a sense of some sort of depersonalisation, whilst 'how she is now' is different from 'what' she was back then and this difference might be difficult to comprehend.

3.2.2.3. Questioning Self-worth

Participants described a shattered sense of self-value. They used different terms and ways of unfolding it, but it appears that most of them experienced some kind of denigration resulting in them questioning their self-worth.

Mary described those continuous experiences as a 'really dark time':

‘And he'd put down every day, he'd say - you know - 'you're ugly'. Everything I'd do wasn't good enough or it was worthless. It was a really dark time…’
Mar (7; 2-4)

There is a sense of despair and worthless, when nothing she could do would change how she was treated. This is a time of darkness, with very little hope in it.

Claire describes how experiences of abuse intensely shattered her sense of self-worth and made her question herself to this very moment:

‘Things - psychological abuse in my brain would make me [..] I'd question myself - I still do question myself’
Claire (1; 32-36)

It seems that through ‘psychological abuse’ something was deeply ingrained into her mind, and she is still in the process of unravelling truth about herself and ‘working through her puzzle’.

Beth talked about wondering why she even ‘mattered to people’:

‘Because you know, why am I mattering to people, and that was a great support actually, you know, women saying “well you shouldn't have been treated this way, no matter what

you did no one has the right to treat you this way and you do matter"'
Beth (12; 8-12)

Perhaps Beth was questioning self-worth to an extent where she could not comprehend that someone would be compassionate and encouraging, or that people would be concerned and acknowledge that she was treated in a way no one should have been. This statement also makes one wonder whether it represents feelings of self-blame, as if she 'did something' to deserve being abused and therefore did not matter anymore.

3.2.2.4. Self-condemnation

Participants described a range of emotions related to their experiences. They talked about feelings of guilt and self-blame in different ways, and it appears that some of them were able to address those feelings in therapy. Beth describes it as promoting self-acceptance and shifting self-blame through realisation:

'She [therapist] could say "well he would have done this because he was trying to get you to do that" sort of thing - because with me I'm very sort of straightforward - say what you mean, mean what you say - but she was very good at reading between the lines and I think it sort of stopped me

punishing myself so much. Thinking: "why didn't I do this or why didn't I do that"…'
Beth (7; 38-45)

There is a sense of confusion and it seems that being a 'straightforward' person, Beth might have been struggling with understanding the perpetrator's motives and behaviours. Perhaps gaining more insight with the help of her therapist who could 'read between the lines' enabled Beth to recognise her choices of behaviour as the ones that would be natural and logical in the given circumstances. In turn, this might have helped her to validate these responses and therefore alleviate guilt around doing or not doing things differently.

Sam also described blaming herself for 'not doing' something:

> *'I remember quite early on talking to [therapist's name] and using terms like 'stupid' or why didn't I do this that and the other. And kind of realising that actually I'd done my best. You know, I tried to make it work…'*
> *Sam (5; 29-36)*

Talking about the initial stages of therapy she conveys feeling 'stupid' for not acting differently. It appears that she was somewhat feeling responsible for the failure of the relationship. However, it seems that gradually throughout therapy she comes to realise that it was out of her hands and there was nothing to blame herself for.

Kelly also depicts shifting the responsibility from herself onto the abuser through realisation:

> *'And that led me then to self-study that personality type and that's been helpful that I know I'm not the crazy one'*
> *Kelly (8; 34-36)*

She describes it as recognising that she is 'not the crazy one', but presumably the perpetrator as having a particular 'personality type'. Perhaps this is a representation of the internal work resulting in some kind of movement from feeling confused, when 'nothing made sense' to gaining more insight and therefore elevating feelings of self-blame.

3.2.2.5. Lack of control

The sense of a lack of control echoes throughout the transcripts. Participants mainly described it in a context of how they felt being in abusive relationships, but rarely talked about it explicitly.
Nina communicated it through not being able to predict what was going to happen, resulting in constant feelings of fear and being on edge:

> *'Obviously still being in that situation you never knew what was going to happen so it was always like being on edge. Walking on eggshells. It was just a horrible feeling of fear really. All the time'*
> *Nina (2; 42-45)*

She described it as ‘being on edge, walking on eggshells’ and one would wonder how limiting this might have been, and what her sense of control was over her own life, decision making and even self-expression.

Jenny also talked about her experience of being limited in her choices or decisions. She described how she was seeking help and refuge from an abusive husband in her parents’ house:

> *‘They said: “You know it's not allowed. You have to go back to your husband's house”’*
> *Jenny (6; 1-3)*

One could only wonder what this meant for her. Jenny’s narratives were often factual and she would rarely refer to how her experiences made her feel. Her statement implies having no other option than continuing to tolerate abuse. It evokes a sense of loneliness, isolation, profound sadness and powerlessness.

Claire described a sense of dreamlike reality, as if someone had simultaneously put her to sleep or almost hypnotised her, therefore making her more vulnerable and oblivious as to what was going on. There is again a deep sense of helplessness and complete lack of control:

> *‘Because it just felt like someone had clicked (she clicks her fingers) their fingers, and I had fallen asleep. And someone could take so much advantage’*

Claire (8; 48-49)

Ann also talked about being detached from reality:

> *'I see myself - I was in those bubbles that you blow. I saw myself in those. I was in a sort of bubble, and I didn't know I was in that bubble until I got my counselling…'*
> *Ann (6; 33-36)*

This gives one a feeling of being trapped, powerless and isolated. There is a sense of depersonalisation, very little control over one's life, as if she was locked up in a drifting bubble and had no power over its direction. She expressed having limited awareness of her way of being and later on talked about how she managed to get more insight through therapy.

Mary also used the term 'bubble' as a metaphor for describing her way of being. She also seems to have implied limited awareness of what was happening as a way of protecting herself from reality:

> *'I lived in a bubble. I was in denial about my ex's other partner and I had to put up with it. I had no – like my father didn't support me, I didn't have – I'd given up work. He put me in a really nasty place'*
> *Mary (6; 47-49; 7; 1)*

Mary described feeling unable to do anything other than 'to put up with it', and it appears this was partly due to financial dependence. There is a

sense of impotence and disempowerment, whereby she had to continue being in a 'nasty place', having little control over what she could choose.

3.2.3. Constituent theme 2: Oblivion of abuse and awakening

The women not only talked about having little control over their lives throughout the abusive relationships, they also described having little awareness of what was going on. The constituent theme 'Oblivion of abuse and awakening' encapsulates women's experiences of their journeys starting from 'not knowing', moving towards 'realising something is wrong' and 'looking for a way out'. The subthemes capture some components of participants' experiences of these journeys as well as their experiences of therapy as a part of the journey.

3.2.3.1. Becoming aware of abuse

It appears that one of the 'turning points' in the women's journey was realising that they were in abusive relationships.

> *'I was lost to what to do, and gradually I got some answers from people who helped. I think the key thing was saying "something's wrong"'*
> *Sam (7; 6-10)*

Sam described being lost and struggling to understand what was happening in her relationship or why the perpetrator was acting the way he did. She conveys that a ‘turning point’ for her was realising that something is not right, which appears to have enabled her to start looking for answers and mapping the course of her own actions.

Nina also described looking for some kind of answer in her attempts to restore failing relationship:

> *‘I went to see a counsellor after my relationship was breaking up, and at the time I didn't actually realise it was domestic abuse…’*
> *Nina (1; 11-14)*

She conveys not realising that she was in an abusive relationship and says it was the counsellor who advised her to see someone who specialises in domestic abuse. It appears that for Nina having a specialist approach to her difficulties was of great importance and it will be discussed further in the next sections.

Beth also described ‘not knowing’ why the perpetrator acted the way he did or what the reasons were for her own responses to his behaviours:

> *‘I had no idea why he was the way he was, or why I would - why I handled it the way I did […] So she [therapist] was able to shed light on it – put it into perspective which really-really helped to me, because I had no idea. Just no idea’*

Beth (7; 21-28)

Beth seems to convey the importance of becoming aware, understanding one's motives and perhaps the specifics of Intimate Partner Violence. Mary explicitly describes what such insight meant for her:

> *'She [support worker from DV agency] told me loads of things about my ex which makes me feel really powerful, like that time it was just like ok, I'm looking at him as a perpetrator'*
> *Mary: (5; 10-13)*

It appears that for Mary becoming aware of abuse and naming her ex-husband as a perpetrator became somewhat an empowering point in promoting insight and gaining control over the situation. She talked about being in denial earlier on and it seems that talking to a professional about her experiences enabled her to understand and bring the 'reality' of those to the surface.

Claire referred to other women and their experiences of IPV. She emphasised the importance of specialist support in promoting insight and becoming aware of abuse:

> *'Whether that's others going through things, other females going through things, but they're in denial of what's going on around them, I sometimes mention the Woman's Trust'*
> *Claire (7; 2-4)*

Like Claire, Kelly also reflected on the struggle with acknowledging the abuse:

> *'…it took a long time for me to say to myself, 'you're in an abusive relationship. This person is eroding you'. If somebody is eroding you then you are a victim to their erosion'*
> *Kelly (10; 1-4)*

It appears that for Kelly a turning point was accepting that she has been a victim of abuse, that her relationships have been destructive and damaging and actually naming them as 'abusive'. Perhaps, this realisation might have enabled her to move forward in her journey.

3.2.3.2. Lack of awareness about available support

Most of the participants described feeling lost and disempowered in their relationships. In such a situation being able to get appropriate help can become vital. Unfortunately, most of the participants reported a lack of awareness about availability of such support.
Jenny assumed that if she knew she could get help, she might have avoided having to face physical and mental health consequences:

> *'So I was thinking if I'd known all this before this one - even if I'd known there was a Woman's Trust somewhere, maybe I wouldn't have this high blood pressure. Maybe I wouldn't even be depressed'*
> *Jenny (7; 26-30)*

It appears that there is a sense of lost opportunities, that a lack of knowledge about available help resulted in permanent damage, and that had she had the appropriate support on time, such damage could have been avoided.

Claire also talks about the importance of awareness:

> *I do also think there needs to be a bit more awareness to the Woman's Trust, that they [women] can get counselling and everything like that.*
> *Claire (12; 7-9)*

Again she refers to other women and it makes one wonder what her own experience was like. Perhaps, having to face complications of 'not knowing' where to get help from has led her to emphasise the importance of knowing one's options, so unlike her, other women could obtain help with greater ease.

Mary also described not being aware of whether or how she could get help:

> *'I didn't know I could get help, but once I started the procedures [they] said "we can get you counselling, we can help you fight your case, we can get injunctions on him", because I was adamant that I didn't want to leave home,*

> *which can be dangerous and it turned out to be quite dangerous. But I took risk…'*
> *Mary (1; 13-20)*

It appears that knowing her options served as a push in decision making, promoting change and moving forward. Having support from professionals enabled her to 'take risk', and perhaps being aware of the available support affected her reluctance to leave the abuser and get out of the 'bubble' she described previously.

Sam also described how being informed about her options enabled her to feel more empowered and helped her to move forward:

> *'they [support line] realised that I was afraid to talk in my own house and I'm afraid to let him know and they booked me a GP appointment outside the house. I can't tell you how brilliant that was. That kicked off the whole thing, but it also had to happen because I think I was gonna stay put hoping for the best or something, and just not knowing what to do'*
> *Sam (2; 36-44)*

It appears that Sam's experience was largely affected by the involvement of professionals. She describes feeling fearful and isolated in her own house and therefore reluctant to take any actions in order not to make the situation worse. It sounds similar to Nina's statement about walking on eggshells and being frightened all the time. Perhaps, by reaching out for professional support, Sam got out of the 'bubble'

described by Mary and Ann. She became informed and therefore more powerful, enabling her to move forward in her journey.

3.2.3.3. Looking for a way out

Participants who took part in this study had left their abuser, and during the interview reflected on their experiences. Exploring these experiences seem important in the context of this study as it might help to shed light on women's journeys towards recovery and therefore the phenomenon under investigation.

Women described their experiences of leaving/deciding to leave abusive relationships in different ways. They expressed how they were feeling towards the end of the relationship, what happened after they had left or why they decided to leave. Kelly described having no other option and having to almost run for her life:

> *'I felt like I was dying inside and it was manifesting itself physically in illnesses, and that I had to do something about it. So my first step was to run away'*
> *Kelly (1; 34-36)*

Kelly had been in an abusive relationship for many years, and she described her emotional pain as being too unbearable, resulting in her body 'taking her off the planet'. She referred to the death metaphor many times during the interview, and one would wonder whether at

times she felt like that was the only way out or the only outcome of the abusive relationship. Claire described it as being taken down to the grave:

> *They slowly take you right down to the grave, and you're not even realising you're taking yourself down - they're taking you down to the grave.*
> *Claire (8; 42-44)*

Statements like ‘taking yourself down to the grave’ or ‘side of involuntary suicide’ (Kelly) send a very powerful message – as if by staying in abusive relationships these women felt they were killing themselves by allowing the abuse to go on and being unable to escape. It appears as if there are only two options – either staying in the relationships and therefore death, or a getaway.

For Nina leaving was also the only way out:

> *‘There is nothing anyone could say or anything, it was only when I left that situation that I started to feel better’*
> *Nina (2; 28-30)*

Ann described being at a different stage of her life now, whilst at some point it felt as if she was also on the edge:

‘But I never dreamt I could reach that stage because when you're in there you think that that's the end, you know, there's no way out’
Ann (21; 11-14)

Sam reflected on the importance of being informed, knowing that there are other women with similar experiences to her own, and that she could get help and there was in fact a way out:

Well knowing that what I was experiencing was not unusual and that there were ways out and there were other people who found their way out.
Sam (17; 24-27)

It appears that for some of the women who took part in this study, deciding to leave the abusive relationships felt like a life or death decision. Perhaps, for some of them this might have been a turning point in their journeys, and it makes one wonder how those decisions might have been affected if those women had received appropriate and timely professional support.

3.2.3.4. Abuse, mental health and legal issues

All participants described their experiences of having to go through some legal procedures in relation to their experiences of abuse or

separation. Most of those experiences appear to be traumatic in some ways, having an overall effect on the women' psychological wellbeing:

> *So it's like there's two abuses — there's the abuse in the relationship and now you're going to escalate it by saying "hahaha, it's all in my name, you chose to leave". And I felt like I'd been shot in my heart'.*
> *Kelly (2;50; 3; 1-3)*

Kelly described feeling like she has been 'shot in her heart', perhaps, implying the deep disappointment, helplessness and feelings of betrayal. She portrayed preparing herself 'for a fight ahead' of her and continued with saying:

> *'I felt as though with the Woman's Trust, I'd recruited an army in group counselling. That we are going to march together to march through and bring you through the other side'*
> *Kelly (3; 43-47)*

It appears that for Kelly being a part of a group of women with similar experiences to her own gave her a sense of belonging, a tremendous sense of empowerment – particularly when she felt that she was a part of an army. A notably large and powerful source to get her through any struggles she might face when standing up to the abuser.

Beth and Mary also pointed out the importance of having support when dealing with legal issues related to abuse:

> *'I couldn't just sort of forget about the whole thing because I had the worry of the court case coming up, so it's a long time between April and November. But I had a lot of on-going support through the counselling so that really-really helped'*
> *Beth (4; 27-30)*

> *'And in between I got a bit ill. I went through a breakdown. My kids were given to their Dad, but when I went back I was very distort, and again she [therapist] sort of tried to pull me together'*
> *Mary (1; 40-43)*

One could only imagine what it was like for these women – the prolonged experience of continuous abuse and disempowerment, and finally making a decision to break a chain of violence, but then having to deal with the consequences of their decision. These two participants luckily had support of their therapists, but one would wonder what happens to those women who have to deal with it on their own.

> *'I'd just had a court case - the final hearing for the contact - and it didn't go well at all. So it really got me down…'*
> *Nina (3; 41-43)*
> *'We're a problem, because many a time the police don't help you. They make it worse for you. Many a time…'*

Claire (7; 33-35)

'My case had to do with immigration issues again, and the Home Office was like threatening me with taking me back to [country of origin], and this [country of origin], that's where I'm gonna meet this man that beats me every day. So I said "no, I'd rather die here than go back to [country of origin]"'
Jenny (1; 29-34)

'we had a full year of the most pernicious, nasty law and litigation about it all […] I think he thought he was off to a good thing. To cut a long story short, I had to bring a non-molestation order, an occupation order […] it was a year of law and court because it cost a huge amount of money…'
Sam (1; 18-28)

Participants' descriptions of their experiences with legal services convey a very disturbing picture. Not only had these women been continuously abused by their partners in intimate relationships, it appears as if the abuse continued when they tried to get out of them. Furthermore, the abuse was often conducted through or even by a third party – the legal authorities. The adequacy of the legal response to IPV is outside the scope of this discussion, however, it seems that for each of the participants who took part in this study, those experiences were far from positive and caused a great deal of distress. This emphasises even more the importance of on-going practical and psychological support for

victims of IPV. It raises question and concerns regarding the provision of specialist services for victim-survivors of IPV.

3.2.3.5. Specialist knowledge as a catalyst of insight

Participants talked about importance of specialist knowledge in different ways. It appears that for many of them their therapist's knowledge about the specifics of IPV, and the motives or 'personality type' of perpetrator, as well as ability to clarify and explain victim's behaviours played a very important role in promoting insight. This empowered them, helped them feel more in control and alleviated self-blame to name a few benefits.

Claire described her experience of gaining insight into the motives of the perpetrator behaviour with the help of her therapist as an 'awakening':

> *'I kept saying: "I'll never forget this, I'm awake". I kept saying: "I'm awake, I'm awake, I'm awake".'*
> *Claire (8; 46-48)*

It appears that for Mary getting insight was related to a sense of empowerment:

> *'When you know what you're dealing with and you're informed - an informed being is very powerful rather just*

being sort of left to talk about yourself every day or every session'

Mary (5; 16-19)

Mary seems to imply a more active role of the therapist in promoting empowerment through guidance and enabling the client's insight, as opposed to a more passive role when Mary felt being 'left to talk about herself every session'.

Beth also described a positive experience of being informed:

> *'She [therapist] knew a lot about the character and personalities of men that behave as my ex-partner behaved to me, and she was able to sort of shed light on a lot of things that happened which was very-very helpful to me, because I had no idea why he was the way he was, or why I would – why I handled it the way I did'*
>
> *Beth (7; 17-21)*

It seems that for Beth it was an experience of being able to outline a particular 'type' of men who are violent in relationships, and realising that her ex-partner did fit into that 'category'. Perhaps, it enabled Beth to better understand her experience and promote self-awareness.

Kelly describes a somewhat similar perspective:

> *'I've lost my innocence, you know. The change in me […] is the realisation that there is this person, this personality type that consumes individuals, almost a different species and they will destroy you and we have to stay away from them'*
> *Kelly (10; 39-42)*

For her, like for Beth, it was an experience of 'realisation' which appears to have shifted the responsibility from the self and wondering whether it was her who caused the abuse. She also describes a particular 'type' of men who behave violently and the only way to keep safe is to avoid them.

Nina also talked about the shift of responsibility and lifting self-blame through psychoeducation and promoting insight in therapy:

> *'So because she [therapist] was able to talk through how this can happen, and she had so much knowledge about it that I kind of was educated. And so I could start to see like - that made me able to understand and realise that it wasn't anything to do with me'*
> *Nina (6; 39-42)*

For Sam, therapy and psychoeducation appears to have also been an experience of working through the normalization of feelings, including self-blame and shame:

'So there was lots about him that I felt I had been deceived by, and part of this counselling was recognising that I had every reason to believe that he was a decent guy, you know?' Sam (6; 21-25)

It appears that acquiring knowledge or explanations about the constituents of IPV, motives of the perpetrator's behaviours as well as women's own responses to it has been a positive therapeutic experience for participants who took part in this study. One can assume that this can be an indication that a specialist approach might be required when working with victims of IPV.

3.2.4. Constituent theme 3: Therapy as a journey of empowerment

The theme 'Therapy as a journey of empowerment' consists of four subthemes representing empowerment as a process in therapy. All those themes appear to be interrelated and affect one another. For instance, experiencing therapy as a safe place and establishing connection with one's therapist seems to have facilitated the participants' ability to communicate their thoughts and feelings more freely. Consequently, all of the above would promote empowerment and be a part of it. Participants described various components of empowerment as a process and for each of the women, moving towards feeling empowered appears to have been a unique experience.

3.2.4.1. Communication thoughts and feelings

All participants described the importance of having the opportunity to explore and process their thoughts and feelings in therapy. Some of them had no one to talk to about their experiences of abuse or chose not to, so having the ability to 'talk through it', 'let things out' or 'give it all' in therapy appears to have been a valuable experience for the participants who took part in this study:

> ***'…****everything was in my head. Everything was in my mind, no one to tell. Until I came to counselling'*
> *Jenny (6; 21-22)*

> *'I just thought it'd be good to go and talk to someone and let things out.'*
> *'It was such a relief to go there and be able to talk'*
> *Nina (1; 47-48; 5; 21-22)*

> *'I started to feel a little bit happier because I was talking through it'*
> *Claire (14; 6-7)*

> *'…just the whole being able to go somewhere and talk about whatever was troubling me once a week'*
> *Beth (9; 27-29)*

Mary described her first encounter with the therapist, and how she was instantly able to connect to her, which appeared to have enabled self-expression:

> *'I instantly warmed to her, she's really – you know like – she's very heart focused and a very open person. She's just like very – you know you could sit with her for hours and hours and talk to her. And I cried a lot in my first session - a lot - so that was all my stress being released…'*
> *Mary (14; 15-21)*

It seems that establishing this kind of connection helped Mary to open up and process her feelings more freely. She described her therapist as 'heart focused', perhaps perceiving her as genuine and congruent, which seems to have enabled Mary to feel more comfortable at her first session and communicate difficult emotions openly.

Participants discussed the difficulty in containing their emotions or being deprived from the opportunity to release and explore them. Ann talked about developing a particular way of coping with her emotional pain:

> *'I have this sort of mask that I've developed over the years, and I know how to compartmentalise things and still function, so I think that's always been my thing, but I was always afraid that it would manifest suddenly sometime. So I wanted to be able to talk to somebody, to you know, say how I feel or what's going on'*

Ann (2; 1-8)

It appears that for Ann, putting aside or perhaps even suppressing disturbing emotions rather than processing them has been a way of defending herself from the reality of dealing with difficult experiences. It seems that she was aware of her feelings, and found them too difficult to tolerate and contain whilst they were building up. Perhaps, this struggle is represented in her worry that they would 'manifest suddenly' and that she would be forced to face them all at once and on her own.

Kelly described the process of communicating her thoughts and feelings using a 'dustbin man' metaphor:

> *'But I felt that, it's like I'm filling up my bin with rubbish all week and then I know, that I'm going to the dustbin man, I'm going to the dump and I'm going to give it all and I'm going to try and leave it- psychologically leave it there'*
> *Kelly (6; 35-48)*

It appears that Kelly described a similar experience of having to contain distressing thoughts and feelings which were building up and too difficult to bear. She talks about feeling the need to 'give them' to someone who is perhaps more capable of dealing with it. One wonders whether this way of coping with her painful experiences represents that at the time, Kelly did not feel strong enough to fully process her emotional pain.

Sam was also reflecting on the importance of processing difficult thoughts and feelings:

> *'…of course it is important not to think about those things all the time. But I think having an hour when you can is hugely important, hugely important. I don't know what people do if they don't have that'*
> *Sam (12; 12-17)*

Sam pointed out the importance of being able to disengage from disturbing thoughts, but still have a space to process those in a contained environment, which she described as an invaluable experience.

Ability and willingness to communicate one's thoughts and feeling appears to being linked with experiencing therapy as a safe space. Participants' descriptions of these experiences are incorporated in the next theme.

Importantly, when discussing their experiences of abuse some of the participants described feeling disappointed, uncomfortable and unable to disclose their experiences when therapists were unable to contain their own emotions:

> *'If you're breaking down every minute, where is that going to put me? Because I've come to you for help. So you can't be that emotional a person, you've got to be uplifted and upright. You can cry after and you can think about it after,*

but in face-to-face with that person? You can't make tears drop. Because you're not here to make that person feel weaker than what they actually may feel already, because all they're going to be thinking about is 'oh gosh, my counsellor, she was crying', because that's exactly what I used to come home and say to a family member, 'oh gosh, the counsellor was crying'. It'd be like every time I looked up the counsellor's wiping their eyes, and I'm thinking 'oh gosh, what's happened to her in her life?' I've not come here for that, I've come for you to help support me!'

Claire (5; 22-32)

'I liked the counsellor. Erm, she felt like a sister. It felt comfortable. I was a bit uncomfortable once because she was crying when I spoke to her.

Interviewer: The counsellor was crying?

Yeah. But I have to tell myself, we are all human beings. Sometimes something might touch you. You know, she got very tearful and then I started thinking oh I don't want to say things that might make her upset'

Kelly (5; 11-21)

Although the importance of the therapist's resilience and ability to contain distressing emotions whilst working with vulnerable clients might seem obvious, it appears that some of the therapists might have

failed to address client's needs in an appropriate manner, perhaps taking the noting of being congruent too far. This seems to have adversely impacted their therapeutic work and might have affected their clients in a negative way.

3.2.4.2. Therapy as a safe place

Participants talked about their experience of feeling safe in the therapeutic environment in different ways: physical safety, atmosphere in the room, confidentiality and being able to talk freely or being in an environment that is positively different from their everyday life.

> *'I guess it was nice atmosphere in the room. I felt safe in there and very supported'*
> *Nina (4; 23-24)*

> *'I had a very nice place to go to once a week, it was a nice comfy room, it was all very safe'*
> *Beth (9; 25-26)*

> *'I knew it was a safe environment in which to try and heal yourself'*
> *Sam (4; 38-40)*

Kelly describes her experience of looking for a place to heal that would be 'emotionally hygienic', and she appears to have found that in therapy:

‘…even though I'd left, I was looking for an emotionally hygienic environment, like an operating theatre, you're going to operate, you need no germs. I needed no anger. I needed no negativity. I just needed to be in a space that I can heal’
Kelly (1; 39-43)

Kelly points out the importance of having no ‘anger’ and ‘negativity’ after leaving the abusive relationship. She stresses the importance of being in a safe and non-toxic environment, perhaps both physically and emotionally, so she could disengage and heal from her painful past experiences. One could perhaps reflect on therapy as a process where often difficult emotions are being brought up to the surface, and this is often far from being completely ‘positive’ and ‘emotionally hygienic. Perhaps Kelly might have been at the stage of her journey when she was looking to ‘psychologically leave’ her experiences somewhere, rather than having to face more distress whilst processing them.
Ann described being able to express herself freely and safely without having to worry about confidentiality issues:

‘Talk about anything I wanted to talk about - anything. I know that it would stay within those walls, and that's what helped I think’
Ann (5; 9-11)

Jenny also emphasised the importance of confidentiality in therapy and discussed its importance in establishing trust and therapeutic relationships:

> *'What you've discussed with them, you start hearing somewhere else. So I just said: "I am not going to trust anyone again, not until I meet this lady". And she was really-really helpful. And since I've finished with her I've not heard anything I discussed with her from anywhere'*
> *Jenny (3; 17-22)*

It appears that for Jenny feeling safe in therapy seems to be a part of the therapeutic relationship, and is closely related to the ability to connect with her therapist. This will be further discussed below, in the context of another subtheme: 'connecting with a therapist'.

3.2.4.3. Connecting with a therapist

Jenny talked about relationships with her therapist and emphasised the importance of establishing trust:

> *'Just once in a while, when you think something is really bothering you, you need to share it with someone, because I developed that relationship with her - my counsellor - and I've put that trust in her, because [in] this country, so many people let me down'*

Jenny (3; 11-14)

It appears that Jenny's life experiences led her to finding it extremely difficult to trust people. She described being abused by her husband, being unable to get help from her parents, and once free from the abuse, faced with immigration issues and 'threatened' to be sent back to her home country where the abuse would continue. She described an experience of being unable to rely even on the closest people around her, and therefore found it difficult to establish trust. It appears that for Jenny her therapist has been one of the very few people she felt able to trust and share her experiences with. Later on she described having huge separation difficulties after the therapy ended, and stressed the importance of having further contact with her therapist.

> *'…as long as you build up a rapport as an individual with your counsellor, you'll be good'*
> *Claire (12; 26-27)*

Claire described her experience of connecting with the therapist at a human level. Similarly, Mary talked about her therapist being 'heart focussed', so they seem to have also been able to connect 'at a different level':

> *'They don't have to think things. They sort of connect to you at a different level - if you're thinking things over you can never say things. But if you connect with your client you know, there's like a flow, so you sort of – and then instantly*

whatever you [therapist] say, either it will make sense to you – which it usually did…'
Mary (6; 22-28)

It appears that Mary was describing an experience whereby having this connection with the therapist would help not only to establish a rapport, but promote understanding. She then explains it further:

'…so that's what I'm trying to say, that I think if you're a thinker, you can refrain yourself from saying many important things, but if you sort of initiate from a heart level […] I know there's professional sort of guidelines, but for me, every time something was said, it made sense to me. Rather than just sitting there noting things and thinking "if I said this or if I said that", then that sort of – it becomes very flat rather than multidimensional'
Mary (6; 22-38)

Mary seems to reflect on the therapist's ability to remain congruent and open to a free dialogue. She describes it as a natural flow of conversation when both the client and the therapist are not restricted by sets of rules. They form a genuine connection that perhaps enables them to meet at a level of therapeutic depth. Mary described it as being multidimensional, perhaps referring to their relationship promoting a deeper level of connection, encouraging openness and free exploration.

3.2.4.4. Empowerment as a unique experience

This theme encapsulated participants' experiences of empowerment as a complex and unique phenomenon. They have all talked about feeling empowered, but described it in different and multifaceted ways. It appears that for each of the women who took part in the study, empowerment was a big part of their therapeutic experience and enabled them to move forward in their journey towards recovery.

Nina referred to the importance of feeling understood and restoring her self-confidence when describing feeling empowered:

> *'I could just talk, and she understood, and could make me feel better about things and empower me, because I had no self-esteem. Self-confidence had gone and she really tried to build that up. With encouragement you can gradually get back your self-esteem and not feel guilty. So that really helped'*
> *Nina (3; 26-32)*

She described feeling like her self-esteem was not present as a consequence of being in abusive relationships. There seems to have been a mixture of feelings related to her past experiences and she was left with a sense of self-doubt. She describes a positive therapeutic regard and 'encouragement' in therapy, which appears to have enabled Nina to move on and stop blaming herself for what happened.

Claire also referred to feeling understood, working through the chain of doubting self as well as not feeling judged:

> *Understanding. Taking time to listen. Not judging. I would say - what's the word I'm looking for - maybe leading questions so you can look into yourself more. And not looking to yourself in a bad way just look into what you keep questioning yourself about, and keep blaming yourself about, and also knowing that you're not the only person out there…*
> *Claire (3; 20-25)*

Claire talks about empowerment through promoting self-awareness and working towards a more balanced perception of the self. She seems to have described a more active role of the therapist in enabling and guiding this process, whilst remaining a non-judgemental and active listener. Claire referred to 'other women' who have had experiences of IPV throughout the interview. It appears that for her, as well as other participants, knowing that many other women have had similar experiences to her own might have been therapeutic, serving as a way of normalising her feelings and experiences, as well as enabling her to see that there are ways of overcoming abuse.

Ann seems to have described empowerment as a process of understanding herself rather than looking for some kind of solution in the present:

‘So it's really much about developmental stuff in the end, as apposed to moving forward, as apposed to like immediate remedies’
Ann (15; 41-46)

Other participants have also described the importance of being informed, and being able to understand themselves better whilst in a safe therapeutic environment.

‘I think the 'understanding', and the 'educational' learning helped a lot, and erm the 'compassion' really if I could say that…’
Beth (12; 3-6)

‘So because I was being informed, it was making me very strong. When you know what you're dealing with and you're informed - an informed being is very powerful…’
Mary (5; 14-19)

It appears that for Beth and Mary being able to achieve a more balanced and informed way of understanding and evaluating their experiences enabled empowerment. ‘Compassion’ (Beth) or ‘raw connection’ (Mary), perhaps as ways of describing therapeutic relationships seems to have played one of the key roles during the process of empowerment.

Jenny described empowerment as feeling encouraged. It appears that for her therapy has felt like a hugely transforming and positive experience of empowerment:

> *Relating to my own counselling - mine was brilliant, it was encouraging and it was helpful. And very-very encouraging. Because now tell me - I don't know where I cannot go, and I'm not scared of anything again, and I'm not scared of any decision I make about my life again. Never. And I'm never going to be scared of anything again.*
> *Jenny (12; 1-7)*

Jenny seems to have experienced an increased sense of independence, self-confidence and self-acceptance. She described feeling much more powerful and confident in taking important decisions in her life, and seems to feel more in control.

Sam also talked about empowerment in terms of promoting self-acceptance:

> *'Help me acknowledge the feelings that I had had, help me... identify the strengths that I had. Not anything- it all felt sort of empowering and that word's so overused but it's a good word. But it was, it was empowering and I would say it acted as a safety valve. And accept. Accept my feelings'*
> *Sam (15; 35-41)*

She described her experience of working towards acknowledging her past experiences, accepting her feelings related to those, and working towards recognising her strengths.

Kelly also reflected on the nature of empowerment and how emphasising her strengths felt particularly important:

> *'…you don't just want somebody saying "you can do it". That's just smoke. You want points of reference, you want them to prove to you that you can do it by showing you, you've done it'*
> *Kelly (13; 29-32)*

She later described how feeling empowered enabled her to go through the difficult times, and gave her strength throughout her journey to recovery. She compared feeling empowered to having fuel for this journey:

> *'Nothing happens without empowerment, so... you know empowerment, that's like your engine. It's like no, you can live another week. You can live another month. It's like petrol in a motor. How much petrol are you giving? Or how much petrol can I take, how much fuel from this interaction that can help me to cope with the next week or the next month'*
> *Kelly (16; 2-8)*

Interestingly, this saying seems to point out the time-limited nature of empowerment as experienced by Kelly. It appears that at the time of the 'fight', as she described it earlier, Kelly needed to have continuous support. This will be further explored in the next section and seems to stress the importance of long-term continuous support for women affected by IPV.

3.2.5. Constituent theme 4: Therapy as a continuous experience

This constituent theme encapsulates participants' experiences of therapy as an enduring experience. The subthemes represent participants' interpretations of their experiences as prolonged in time, presumably having affected their lives as experienced in the present.

3.2.5.1. Therapy as taking through

Participants described their experiences of therapy in the context of their 'journeys of moving forward'. It appears that for some of them therapy might have served as a means of support throughout this journey and enabled them to progress.

Nina described her experience of therapy as support throughout leaving the abuser:

> *'…it took me from when I was at my low, to when I'd left - yes - the whole journey. It was amazing, I wouldn't have got so far without counselling. It's such a big thing'*
> *Nina (4; 36-39)*

She seems to talk about therapy as supporting her throughout the progression of her journey and emphasises how vital this support has been. Similarly, Claire also talks about moving through stages or levels:

> *'Trying to move you on. From one level, to another level. That's the therapist's job. To move you on from one level, one stage of your life to the other stage'*
> *Claire (8; 27-29)*

It appears that for Claire the experience of therapy has been about the developmental context of moving forward in her journey. She describes it as moving through stages of her life and an active role of therapist in this progression.

> *'I thought it would be patronising, but it became a sounding board - someone to give me suggestions on moving forward or help me to make decisions on what I needed to do in moving forward, and somebody to be there while I did make the first steps of moving forward, and that was the first set. The second set was continuing me on that journey, on moving forward…'*
> *Ann (8; 6-11)*

Ann also described therapy as assisting her in moving forward. However, she seems to have assumed a more active role in it. She referred to therapy as a 'sounding board' rather than being 'patronising', perhaps pointing out a client-centred perspective and emphasising the reflective nature of therapeutic work. She described therapy as a process of supporting her throughout the whole journey - from making initial steps and decisions towards maintenance and support in keeping up with the course.

Some participants described therapy as a means of support that would help them go from one week to another:

> *'So you live from one week to the next. So I'm here today at counselling and I take away what I need to make me live one more week and then at the counselling I get to live one more week'*
> *Kelly (7; 23-26)*

Kelly's intense description seems to encapsulate her experience of therapy as a source of power enabling her to continue her 'fight'. This continuous support appears to have been vital, providing her 'petrol in a motor', as described earlier.

Jenny talked about therapy as a steady weekly support she could attain to and was looking forward to:

'Everything was in my mind, no one to tell. Until I came to counselling. It was every Tuesday - I was always looking forward to Tuesday. Go to the station, start writing it down. And I'd say 'God, I can't wait'…'
Jenny (6; 24-28)

She described a sense of isolation and loneliness, having to keep her thoughts and feelings to herself prior to starting therapy. It appears that therapy enabled Jenny to have a sense of belonging and continuous support, and a space to process her distress every week.

'it was a great -was a huge support to me it really was, and it was a comfort to know that however badly things were going, I had a counsellor to talk to once a week about how I was coping, so that was numerous help, it really-really was to me'
Beth (15; 38-42)

Beth also described the importance of having professional help she could turn to for support every week. She talked about the comfort of knowing that she would be able to process the challenges of her journey in a safe supportive environment that would be there for her every week if needed. Presumably, one of the very few steady things in her life at the time.

3.2.5.2. Importance of therapy duration

Most of the participants emphasised the importance of therapy duration. It appears that although appreciative of the relatively lengthy treatment duration when compared to some other services (up to 18 sessions), some of the participants expressed that they would benefit from further treatment:

> *‘Maybe [the sessions] for a longer period. I would like to continue having them’*
> *Ann (12; 13-14)*

> *‘So I sort of think now - if I have more counselling, [it] probably would be beneficial…’*
> *Beth (6; 14-16)*

> *‘The 18 weeks is generous and I know it's generous and I was very grateful to have the maximum, you know. But I don't expect to have- to keep going forever but it's nice...’*
> *Sam (14; 14-18)*

Sam seems to describe a struggle of trying to rationalise her feelings about the ending of the therapy. It appears that despite having ‘the maximum number of sessions’ and understanding that therapy cannot ‘go forever’, she still experienced it as a loss.

Jenny described struggling with the ending and at the time of the interview seemed deeply distraught with the fact that she 'was not allowed' to contact her therapist once the therapy stopped:

> *'Which is why they should let the contact - even if it's once or twice in a year - for her just to say 'how're you getting on? Are you ok? Everything alright with you?' They should let us maintain that. Instead of just cutting it…'*
> *Jenny (3; 22-27)*

Jenny talked about her journey of allowing herself to trust her therapist and establishing good therapeutic relationship. She described having very little social support and her therapist appears to have been the only person she could turn to for help. She seems to have struggled a lot with separation and ending, seeking to have further contact with her therapist.

Nina had experience of a short-term therapy at a different service. She described an experience of having a longer-term treatment as a positive one and reflected on the therapy duration:

> *'I think because it was over such a long period it really helped, because I had another counselling session just before hers that was just for 6 weeks, and it was good but it wasn't long enough. This was great for 18 weeks, because it took me from when I was at my low, to when I'd left - yes - the whole journey. It was amazing…'*

Nina (4; 31-38)

It appears that for Nina the beginning of therapy coincided with her decision and taking steps towards leaving the abuser. She described therapy as taking her through this lengthy journey and, as experienced by Nina, the 18 weeks felt sufficient enough.

Claire seems to have had a different experience. She appears to have experienced the ending of therapy as a big loss and reflected on the importance of further treatment:

> *'It just needs to go on longer. It don't - it's like a big loss, it's a loss because you just feel like you're sitting. You're stuck. Because you're still not getting that support, so for it to go on longer'*
> *Claire (11; 29-31)*

This statement gives one a feeling of a very abrupt ending, as if Claire was struck by surprise and totally unprepared. She described feeling stuck and unable to move on when deprived from the support. Perhaps, this could point out the importance of one's 'readiness' to face the termination of therapy and attain sufficient independence to move on being on their own. Possibly, Claire's experience might represent the importance of continuous on-going support for victims of IPV.

3.2.5.3. Importance of continuous support

Participants described their experiences of therapy ending in different ways. Some of them have reflected on whether or how they would have liked it to be different and what they believe could have been done after the therapy stopped.

Ann called this 'the after-life':

> *'More information on [life after counselling] - because these sessions have to come to an end. […] some people they may need more or whatever, so the after-life. After the counselling allocation'*
> *Ann (6; 16-21)*

Ann seems to describe the importance of having some sort of guidance after the therapy ends. She referred to 'some people' who, perhaps, might be at the stage of their journey when they would need further support. Similarly, to Ann, Nina has also pointed out the importance of continuous support once the therapy stops:

> *'Maybe if they had an information pack with numbers of different organisations that you could get help from, or some phone numbers or addresses with legal help, things like that. So when you finish the session you can find your own practical help'*
> *Nina (5; 31-36)*

Jenny described her experience of being referred for further support once the therapy stopped:

> *'Woman's Trust would not leave you to languish like that on your own. Woman's Trust will link you to somewhere else that will continue the work they started, and that is what [name] did'*
> *Jenny (7; 20-24)*

It appears that both Nina and Jenny reflected on the importance of having continuous support, but perhaps their experiences within the organisation were different. One could speculate whether Jenny and Nina both requested to be referred somewhere else after the end of therapy and had different experiences of this, or whether that was not the case and Nina was talking about having the information pack for future reference. Regardless, it seems evident that both Jenny and Nina emphasised the importance of some sort of maintenance once therapy ends.

Kelly described her experience of abuse as multimodal and reflected on the importance of having support that would incorporate different modalities of help:

> *'you have the man that is giving you the problem or has given you the problem. Then you have the practical things that you're trying to do to cope with the effects of being in an abusive relationship is erm, psychological in terms of how*

you're thinking. It's physical in terms of the way you are to make sure you're not physically in that space, and it's the practicalities of keeping it going, you know, how do you get help to disentangle yourself from this person. Erm, so I think that there needs to be more signposting'

Kelly (14; 31-33; 15; 1-7)

Kelly described having to deal with various effects of being in an abusive relationships and talked about different stages of the journey towards recovery. She emphasised the importance of having both psychological and practical support that would continue throughout the whole process of 'disintegrating oneself' from the abuser.

3.2.5.4. The enabled self and new ways of coping

Participants reflected on how they have been experiencing their journeys towards recovery and a place of therapy throughout this journey in enabling them to move on.

Nina described feeling more capable of coping with difficulties through rationalisation and a more balanced way of thinking:

'But that's the good thing about counselling. It's that it's helped me…Ok things might come up, problems might come up, but I can deal with them a lot better now and kind of try to see through – ok, things didn't go quite to plan, but try to

see the positives – and not dwell on things, or think about him or his reaction. So although I've had a few dips, I'm able to get over them'
Nina (3; 46-39)

Claire talked about managing her emotions and points of reference her therapist presumably might have suggested as a way of managing them:

'There is still certain things in me, the counsellor has instilled things into me, and as much as I might be emotional, I try to keep things there'
Claire (9; 5-8)

Kelly also described still 'having her moments', but it appears that rationalisation has helped her to become more capable of managing disturbing emotions:

'It's not so - I don't feel so despairing. I sort of have my moments, I don't sleep still hardly but I have learnt, I have some rationalisation tools, I prove to myself why this happened and that helps'
Kelly (11; 35-38)

Beth also talked about being able to better make sense of her experiences through therapy:

'Well, I think I felt - I think the counselling did help me put a lot into perspective, that's very helpful, and I think by the end of the sessions I had, I was feeling a lot more independent. Like I'd be ok without the weekly support, I could sort of manage without the weekly support. I think that's the best way of putting it'
Beth (6; 47-49; 6; 1-4)

She described the empowerment and promotion of independence in therapy, so by the end of the sessions she appeared to have been more capable of moving forward without relying on weekly support.

Jenny's experience of therapy seems to have promoted independence and self-confidence, and empowered her to continue moving on in her journey even when things do not go as planned:

'I used to be very-very fearful, but now nothing scares me, I'm not afraid of anything again, because I know even if it goes wrong I'll still pickup from somewhere again'
Jenny (12; 5-9)

Ann also described being determined to move on. She appears to be adamant that her past experiences have to be left behind as looking back might affect her ability to change and be in control of her future:

I'm moving forward and I'm not going to look back like Lot's wife in the Bible who looked back and turned to salt. I'm not going to do that.
Ann (6; 16-21)

Mary, almost as if she was continuing Ann's thought, reflected on the importance of being hopeful and looking ahead rather than giving up, so one could have a life chosen for themselves:

'…*as long as you have the intention and you have the hope it's like a siege to whatever you want to manifest'. It's very true, like it really is. I'm not giving up on life, you know, because I think life hasn't given up on me'*
Mary (10; 20-25)

Sam appears to have reflected on her experience as both challenging and transforming:

'I know there's this phrase 'whatever doesn't kill you makes you stronger', but it — there is something in that. I now love my own company up to a point, and I now love being at home, and I'm not chasing after a man. No way. No way'
Sam (8; 19-24)

She seems to describe being more attentive to herself and perhaps more appreciative of the simple things in life. She described changes in her behaviours and standpoints that she appears to perceive as positive.

3.2.5.5. Gratitude for the help

Regardless of the specifics of their journeys towards recovery and individual experiences of therapy, the majority of participants talked about feeling appreciative of the help they got:

> *Claire (7; 35-36)*
>
> *'…so they really helped me, this organisation. I don't know how to thank them really'*
> *Jenny (2; 34-35)*
>
> *'I'm only crying though because I'm so happy with the help I got. I'm so appreciative of it'*
> *Sam (2; 28-29)*
>
> *'I mean when I first needed them, God they were such a lifesaver, literally…'*
> *Mary (24; 37-48)*
>
> *'It's amazing how different it can make you feel. I think it's like invaluable for women…'*
> *Nina (8; 36-37)*

The above quotes appear to be reflective of how participants seem to feel about their encounter with the Woman's Trust as an organisation providing support for victims of IPV, their experiences of therapy within the service and presumably, overall feelings about being supported and encouraged throughout their journeys towards recovery. However, it is important to emphasise the importance of participants' own roles during this journey. Ann expressed in the following way:

> *'That is how I've survived and that's why I am so happy to just give back because yeah the system has helped me, but I've manipulated it in a way that with my own conviction, I've made sure that I've used the resources for my own advantage as opposed to you know…yeah, I could've easily stopped working and decided to go on benefits. No, I didn't want to do that because that wouldn't get me where I want to get because I want to do another degree, I want to do another Masters. I want to do lots of things'*
> *Ann (11; 42-29; 121-4)*

This statement not only represents Ann's experience of getting support from the service for victims of IPV, but notably, it also reflects on her own active role during the journey towards recovery, her determination to move on, how she refused to give up and continued to fight for her future. It is important to pay tribute to the fortitude and inner strength of the participants as well as other women who managed to find internal forces, seek help and move towards changing their lives.

3.3. Findings from the Visual methods

Towards the end of the interview participants were asked to draw a picture of their experience of therapy, they were also encouraged to talk about their drawings as well as asked to give a name to their drawing. This enabled a sense of rapport to be established before asking participants to draw; as a result, the drawing appeared to flow smoothly as a continuation of the narrative. The results derived from the visual methods will be presented in conjunction with participants' descriptions of the drawings. Both the drawings and the descriptions of the drawings comprise the data.

Prior to presenting the drawings, it is important to note that participants reacted in different ways to the request to draw a picture of their counselling experience (despite the information sheet). Sometimes it seemed to come as a surprise, and often participants needed a few minutes to consider their experiences and what they would like to draw. Some of the women expressed their concerns about their ability to draw; others appeared excited and later expressed taking great pleasure in drawing said picture. Some of them took a photograph of their drawing, and the majority stated that drawing a picture was a 'fun' experience and also helped them to 'put some things into perspective'.

Some of the pictures were drawn in the form of a pictogram, including statements describing the participants' experiences; others were more symbolic and acted as metaphors. One of the women drew a mosaic she created around the time the therapy began and described what it represented.

It is assumed that the drawings were records of participants' interpretations of how they experienced therapy at a particular place and time. The events, experiences, and interactions that precede the drawings all work as a means of producing the understandings embedded in the drawings (Guillemin, 2004).

Analysis of the drawings revealed diverse ways women experienced therapy. For the purposes of a more structured presentation the findings will be presented under the headings representing the 'themes' or points of reference that emerged from the interpretation.

It was important to consider any commonalities as well as any inconsistencies or contradictions with the data collected through IPA. Those will be outlined in the discussion.

Representations of participants' drawings will be embedded in the text in a smaller format. To review drawings in the larger format, please, refer to Appendices 11-18.

3.3.1. Recovery as a process

Despite being asked to draw a picture of their experience of therapy, instead, some of the participants seem to have drawn and described more generic representations of their journeys towards recovery. Perhaps, one could assume that some of the participants found it difficult to separate their experience of therapy from the overall experience of moving forward.

Claire described her picture as representing the story of her journey since she came to Woman’s Trust.

‘This is when I came to the Trust. There were sort of tears in my eyes. This is when I went for my one-to-one and I saw [name of the therapist]. I started to feel a little bit happier because I was talking through it. I felt I could still somewhere along the line win. But now there's a big teardrop because I'm not doing no counselling because I've still got it going on for me. So it's confused emotions at the Trust’

Claire (14; 4-10)

FIGURE 2. ‘Confused emotions at the Trust’ by Claire

Claire started to draw her picture from the centre of the flower, then moved on to the petals, followed by the stem of the flower and a red heart next to it. She then drew the 'raindrops/tears' representing the way she felt when she first came to the Woman's Trust at the beginning of her journey. Once she finished drawing the rain, she drew a big teardrop at the bottom of the page as a representation of her current emotional state, as she 'still has it going on for her'. Finally, she drew the grass. It took her over 20 minutes to complete the drawing, she ensured great detailing, neatly shaded large parts of the drawing and used carefully selected shades of colour.

Claire started describing her picture from the top, down to the bottom of the page. She missed out the heart in her first description and when asked about it, explained that through therapy she was able to start restoring her sense of self, re-establish the lost connection with her family and found she 'still had a heart' and 'could have some form of love still':

> *'I found some form of- I could still love somewhere along the line because of the Trust it's made me build that up because I didn't have a connection with my children anymore. My Grandson especially, my Grandchildren. I didn't have a bond with him because I didn't know how because someone told me that I didn't know how to love no more. So that [The Trust] made me feel like I could have some form of love still'*
> *Claire (14; 18-24)*

Claire named her drawing 'Confused emotions at the Trust', she explained that there is still a great sense of confusion and she often struggles to contain her emotions. The large teardrop represents a massive loss for Claire – as if it was all coming together, but then had been stopped abruptly leaving her to grieve the loss of therapy:

> *'I went to one-to-one and the sunflower represents that I started to bloom. My counsellor made me realise I still had a heart somewhere. But now because I have no more counselling with the Trust, I've got this big teardrop with these little tears dropping out. But I do know somewhere along the line the grass is green somewhere. So yeah, confused emotions at the Trust'*
> *Claire (15; 45-49; 16; 1-2)*

> *'The sun's come out as well. They [the Trust] have really shown me so much because that just came back to thought that, this picture I've done. I'm a creative person anyway'*
> *Claire (15; 16-18)*

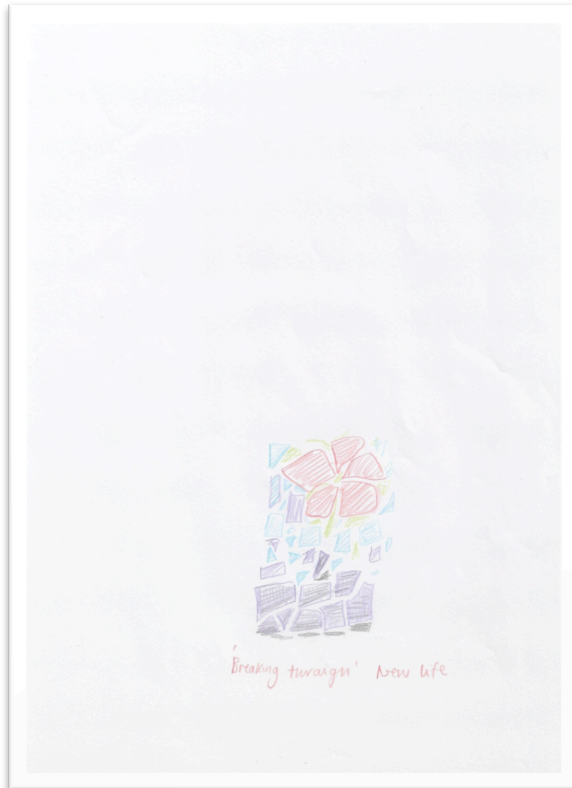
Claire described still being in a lot of pain, her emotions are confusing and seem to be difficult to tolerate. Nevertheless, she appears to be hopeful, so as the flower she drew. It makes one think of a new beginning, a rising sun at the start of a new day and therefore, a new stage of life for Claire. The colours are bright and warm. Yet, the stem of her flower is very thin and looks tiny when compared to the rest of the flower, whilst the centre of the flower is crammed with black dots.

These makes one think of Claire’s fragile state, and although hopeful, the flower is still a head full of difficult thoughts and feelings.

Claire drew the heart next to the stem of the flower that appears to be firmly rooted in the ground. Perhaps, as a reminder that the love she rediscovered in therapy was rooting her in her journey, providing her strength and support in moving forward. Yet, it is separated from the body, giving one a sense of dissociation and confusion.

The grass and the flower are facing in a different direction, perhaps, as a reminder that Claire is still feeling lost and finds it difficult to sync with the rest of the world so she could move on to where ‘the grass is greener’. It appears that Claire’s picture might be representative of her desire to progress in her journey towards recovery; yet, she is struggling to do so and seems to still require a lot of support.

Nina drew a picture of the mosaic she made after the therapy was commenced.



'It's based on a collage that I did - not a collage - a mosaic, I started mosaicking after - actually around the time I finished counselling, and this was my first mosaic, and it represented him at the bottom and like - my life. The blue bits were the support that I got, so counselling, friends, family. And then the green was new beginning, and then there's a flower that represents my new life, so I just did that. So yeah, it's a mosaic that I made'
Nina (7; 39-48)

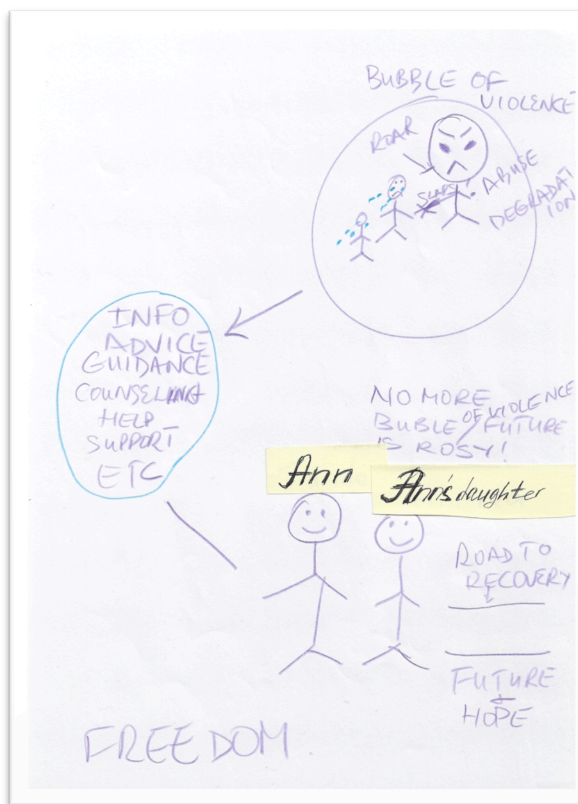
FIGURE 3. 'Breaking through' by Nina

Unlike Claire, Nina drew her picture within a few minutes. She barely had to think of what she was going to draw and once finished, could easily describe what it represented. She explained her choice of colours, whereby the dark ones would represent abuse and the perpetrator, whilst the light green, blue and red – the support, new beginning and blooming life.

She seems to have described a process of change, 'new life' and 'new beginning' as represented by the flower she drew. Yet, the flower has to break though large blocks representing her past life and experience of abuse, some of which seem to be present next to the flower and is a part of her new life.

She called her drawing ‘Breaking through’ and then later on wrote ‘New life’ next to the name of the drawing, as if she was portraying her journey towards recovery and her new life. The flower is at the top of the drawing and is perhaps representative of her now being able to blossom despite her past experiences.

Ann described her drawing as a ‘very high level pictogram showing her journey’. She explained that it is ‘high level’ because there are many details in-between.



‘Yeah. I've put - this [is] my bubble of violence, that's what I call it for now. That's him. I did stick people so I couldn't do their hands, but then[they're] roaring and evil and slapping and abuse. Let me add abuse to it. (she writes). And then moving on to - that's the counselling. This is info, advice, all the stuff I got. And then moving on to me and my daughter, even though I put smiley faces, we do have issues but I could practically put smiley faces as opposed to that, and then this is the road - beginning of the road to recovery. A future and hope, and that's me and her’

Ann (16; 46-49; 17; 1-8)

FIGURE 4. ‘Freedom’ by Ann

Ann started her drawing from the ‘bubble of violence’ at the top right hand corner of the picture. It looks like she and her daughter are crying and trapped. The abuser is much bigger in size, perhaps, representing the overbearing sense of helplessness.

She then drew an arrow and wrote down 'info, advice, guidance, counselling, help, support, etc.'. It looks as if it could also be a 'bubble', but perhaps, a 'bubble of protection', rather than violence. Afterwards she drew two people on the right side, representing herself and her daughter, next to the 'road to recovery' and 'future and hope'.

It appears that for Ann, therapy has been a part of her journey towards recovery and a new life. Perhaps, therapy and the help she got enabled her to break through the bubble of violence she described earlier on during the interview, so she could move forward in her journey.

There is no 'bubble of violence' or the abuser in the present, yet it appears that Ann is still carrying the pain with her. Almost the whole picture is drawn using the same colour and one would wonder whether this could be a representation of the pain that is still being carried through. She and her daughter are yet to move on through to the road to recovery. There is hope and the 'future is rosy' ahead of them, but they are yet to experience it.

Ann called her drawing 'Freedom' and later on said:

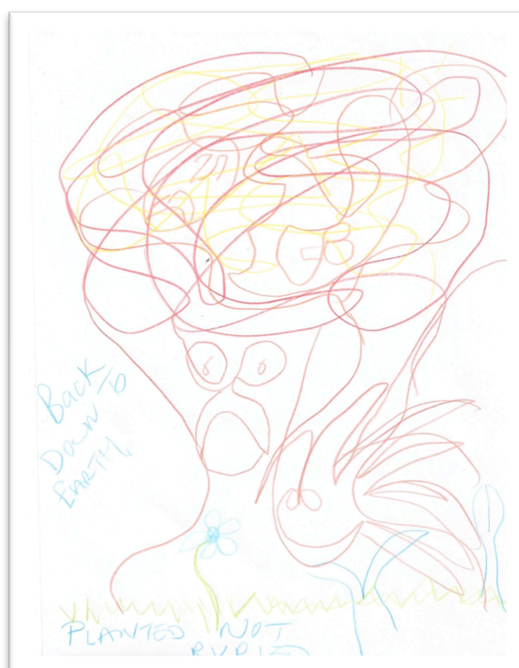
> *'I'd never dreamt that I'd ever be able to be so happy, and it's getting quite emotional now. But the meaning of the word "freedom". I don't think many people know what it means'*
> *Ann (17; 43-48)*

It appears that Ann described how her experience of being able to 'break through the bubble of violence' enabled her to become more appreciative of where she is now and understand a true meaning of freedom. Although her journey seems to have been incredibly hard, she appears hopeful and determined to move on.

3.3.2. Therapy as a transforming experience

Participants' drawings of their experiences of therapy often seemed to have represented a process - some kind of change, growth or progression.

Kelly described her experiences of therapy as enabling her to better make sense of her experiences and gain insight through rationalisation.



'That top is like crazy-crazy on fire, nothing makes sense, turmoil, anguish, screaming. Horrible, horrible, horrible, horrible. And then you go down the funnel rationalisation, opening up into realising that you feel like you were being buried alive. Like you've just been planted... growth... that's it, so from (interviewee lowers voice)... to tangible... growth... Erm, I mean potential'

Kelly (17; 8-14)

FIGURE 5. 'Planted not buried' by Kelly

Kelly started her drawing from the top and first drew what looks like a complicated and somewhat chaotic flow. She then moved down the page and drew what she called ‘a funnel of rationalisation’, followed by the grass and blooming flowers. One could assume that the progression of her drawing might have represented her therapeutic journey. As stated in her description, she began with a great sense of confusion and lack of control over the complexity of her experiences that were difficult to depict or understand. She seems then to have been able to make sense of what she was experiencing and started seeing the new beginning ahead of her.

It appears that there is very little sense of control at the beginning of this journey. As if Kelly was falling ‘down to Earth’, but was caught by the safety net of therapy, so she could slowly descend down to the ground and, instead of facing death, could start a new and blooming life. She called her drawing ‘Planted not buried’ and drew flowers and grass at the bottom to representing growth and potential.

Kelly used a variety of colours; yet, there is an impression that the picture is predominantly brown. The ‘anguish and turmoil’ of her past, painted in red and yellow, occupies a large space in the drawing, whilst the grass and the flowers look very fragile. One would wonder whether this could represent a fragile state of her new born sense of self or the stage of her journey where she is just starting to bloom.

Jenny drew a picture of herself before and after therapy.

'Yeah, that was before the counselling. I was like that, but now after the counselling I'm jubilant and laughing. I was crying before the counselling. I was sad. But after the counselling - I now begin my happy person'

Jenny (13; 4-8)

FIGURE 6. 'The story of my life so far' by Jenny

She started drawing her picture from left to right, as if she was portraying her past and progression to the present. The figure on the right represents how Jenny experienced herself before she started therapy. The figure is bold and tearful – Jenny believes she lost her hair as a result of stress and traumatic experiences. The body language appears to be defensive, as if she has been trying to protect herself from someone or something.

The second figure, which is a representation of how Jenny might be experiencing herself now, appears to look more active and Jenny called it 'beginning her happy person'.

The body language seems more open and the arms are stretched out in a more active position, yet, the face is not smiley. Instead, it is baring

teeth, perhaps, representing Jenny's readiness to fight the challenge. Earlier on during the interview she talked about feeling empowered in therapy, she described herself as becoming more confident and not as fearful any more. Perhaps, therapy might have enabled Jenny to be more in touch with her feelings and experiences, as well as enabled her to process them. She seems more able to look at the past trauma from a position of strength, rather than being powerless and defensive.

3.3.3. Therapy and feeling safe

'It was just so bright and warm and… outside are the black and the purple and all these shadows….'

Beth (16; 24-26)

FIGURE 7. 'Safe place' by Beth

Beth started drawing the picture from the middle – she drew the armchair, and paid great attention to the details, such as buttons on the backrest of the armchair or the stitching on the seat. She then contoured the square surrounding the armchair in yellow and afterwards moved on to the shadows outside.

It appears that Beth's picture might represent her experience of therapy as protective, safe and full of warmth. She used bright colours to draw a chair and cold blue, purple and black for the outside and the shadows.

One would wonder if the chair might not only represent the 'space' of therapy, but Beth's way of experiencing herself. Although there is light and comfort somewhere in sight, it is not clear whether she feels willing to integrate with the outside world that she sees as grim and dangerous.

3.3.4. Therapy as a process

It appears that a part of Sam's drawing also represents her experience of therapy as a safe place; yet, it is also a process.

FIGURE 8. 'Finding your song' by Sam

'Two birds in a tree. Suddenly realised that the wings are quite important because they both fly away from the tree but the tree is a safe surround and the other birds outside don't necessarily, you know, aren't necessarily part of it. And it's a good solid trunk to the tree and the tree's you know, a tree that's been there for a long time'
Sam (18; 33-40)

Sam started her drawing by outlining the trunk of the tree and then moved on to the upper branches. She then drew the two birds amongst the leaves and at last, drew the third bird outside.

She described a 'good solid trunk' of the tree, which appears to represent strength and safety – perhaps, that is how she might have been feeling in therapy. The two birds on the tree appear to represent Beth and her therapist, whilst the third bird – the outside world and people who are not part of the therapeutic process.

She described her drawing further:

> *'The wings I didn't think of until later […] But then I realised that the wings are really quite important that you have them. You don't always feel able to use them'*
> *Sam (19; 24-29)*
>
> *Interviewer: Do you think you felt able to do it?*
>
> *'God yeah, god yeah definitely. I mean I was still able, I was still able to use them and I could use them in a heavy way and had to use them in a heavy way but afterwards, because I was sorting everything out, I was able to fly because I enjoy it'*
> *Sam (19; 37-42)*

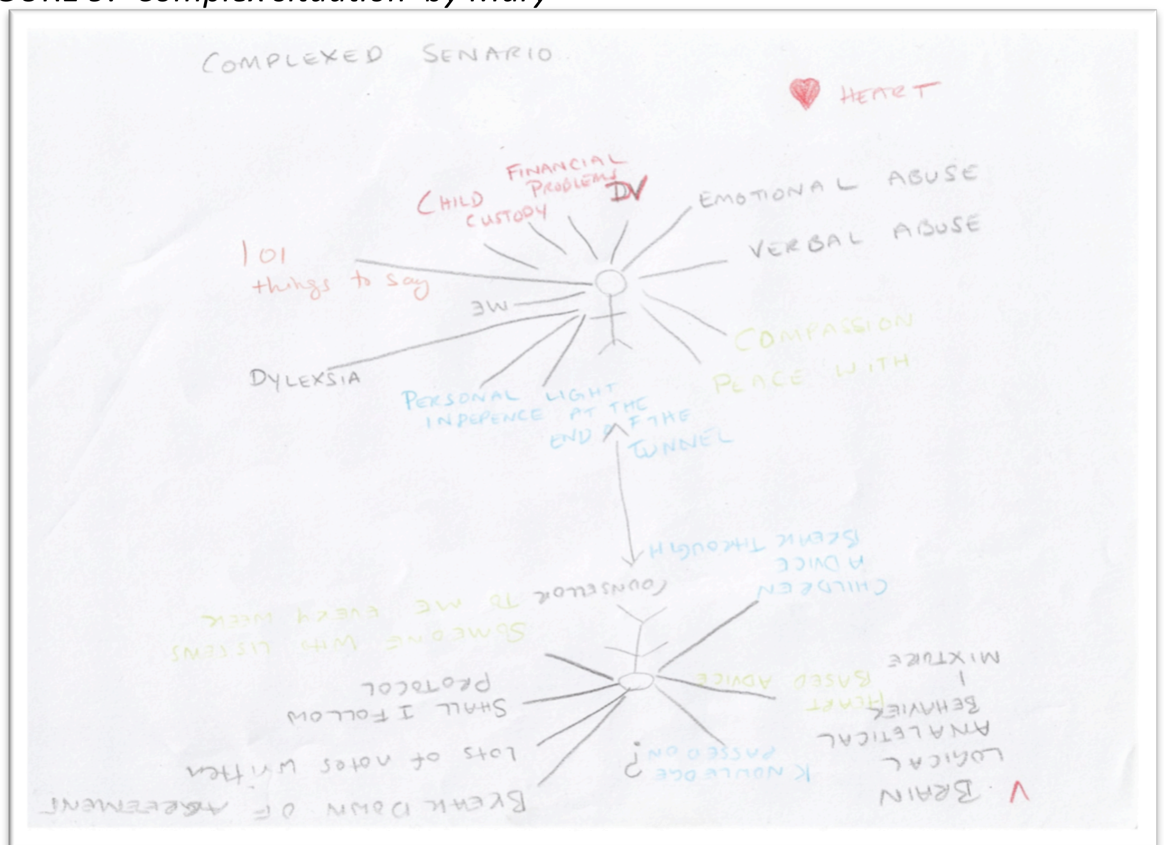
It appears that birds' wings might represent power, independence and strength. Beth drew those is different colours to the bodies of the birds, as if she was trying to stress their importance. Perhaps, whilst in therapy, Beth could choose, whether she wanted to use her wings. She could allow herself to be vulnerable and 'sit' on the solid safe tree

without having to fly and use her wings. Through therapy she appears to have been able to feel empowered and acknowledge her strengths.

She called her drawing 'finding your song', which is perhaps representative of rediscovering her strength and getting her life back.

Mary's drawing of her experience of therapy appears to be done in the form of a pictogram.

FIGURE 9. 'Complex situation' by Mary



'Erm, it's a mixture of all my experiences in counselling. This is me with millions of things going on. When I walk in every time I'm carrying all these things with me. Different times different layers come through, so I sort of explain myself - and then again, this is a mixture of - the black ones are where I felt a little bit let down, like I was told more about the

agreement, a lot of notes were written down. For me it was like the other person's 'shall I follow protocol' questions in her head. On the other hand, it was - other sessions - knowledge was passed on, heart based advice, children advice which is very-very profound. Someone who listens to me every week, again that was a good thing, and then I've just written all the things I carry with me'
Mary (21; 48-49; 22; 1-13)

Mary started her picture by drawing a figure in the middle to represent herself. She then wrote down what she described as 'millions of things going on'. Afterwards she turned the paper around and drew her therapist. Around the figure of the therapist she wrote down different components of therapy and descriptions of how Mary experienced it. Finally, she connected the two figures with the bidirectional arrow.

Mary used a variety of colours and described the black one as representative of the times when she felt disappointed. The blue and green appears to represent the positive moments in therapy such as compassion and peace, personal light and independence or knowledge being passed on.
Although it might look confusing, Mary's drawing seems to present a way of structuring her experiences. She separates the positive and negative using colour, antagonises 'heart' and 'brain' advice, preferring the former, she also seems clear as to what the positives and negatives are within her own inner world as well as her therapist's approach.

The bidirectional arrow appears to represent a connection between her and the therapist, whilst both figures look equal in size, which could presumably represent the way Mary experienced the therapeutic relationship.

She called her drawing ‘complex situation’ as a representation of her past experiences and the therapeutic process of trying to unravel those. It appears that the drawing could be a representation of the process of therapy and its components as experienced by Mary.

3.4. Summary of findings

This chapter presented an interpretative phenomenological analysis of the interview transcripts as well as an interpretative analysis of participants’ drawings.
Derived from the IPA is an overarching theme of ‘Recovery as a process’ that consists of four super ordinate themes: ‘Abuse as disintegrating the self’, ‘Oblivion of abuse and awakening’, ’Therapy as a journey of empowerment’ and ‘Therapy as a continuous experience’. These themes were echoed through participants’ drawings. Overall, the IPA and analysis of the participants’ drawings appear to produce results that are in conjunction with each other and are therefore consistent.

4. DISCUSSION

4.1. Introduction

This chapter aims to discuss the results of the study by first, reviewing the research findings in relation to the initial aims of the research. The results will be then discussed in relation to the context of wider literature. The quality of the study will be reviewed by considering the strength and limitations of the design and analysis methods, and the impact of the researcher on the study. Finally, further avenues of research, potential clinical implications and recommendations will be discussed and followed by conclusions.

4.2. Research aims and summary of findings

The present study aimed to explore women's experiences of therapy for victims of IPV within a specialist domestic violence service. The results highlight the complexity of the phenomenon and suggest that women's experience of therapy for victims of IPV might be better understood within the broader context of recovery as a process.

When describing their experiences of therapy women emphasised the significance of a therapeutic relationship, having an opportunity to explore and process difficult thoughts and feelings, as well as the importance of specialist knowledge, empowerment and promoting insight in therapy. They talked about the importance of specialist knowledge, therapist's resilience and acknowledging the complex nature of IPV, as well as the provision of continuous support and a multimodal

approach to treatment. Women described therapy as promoting empowerment and independence, increasing their self-esteem and self-confidence, improving coping strategies and helping them to gain better insight into their experiences of abuse. They talked about being more capable of managing distressing emotions associated with their past experiences and feeling more hopeful for their future.

However, it appears that regardless of the overall experience of therapy as being beneficial for their psychological wellbeing and allowing them to take certain steps to move forward, participants who took part in this study have not yet been able to fully overcome the experience of IPV and some of them described requiring further support. In addition, it appears that for some of the participants the experience of IPV might have instilled some degree of permanent damage, both physical and psychological leading to them questioning their ability to ever recover fully. This once again raises questions about the importance of continuous support for victims of IPV.

4.3. Discussion of the analysis within context

4.3.1. Individually tailored treatment

All women who took part in this study received therapy for victim survivors of IPV within a specialist domestic violence service. All of them described a variety of adverse consequences as a result of being exposed to IPV and explained how some of them were a focus of their therapy. The main therapeutic approach applied in the service is Person-Centred (Rogers, 2012), however, it appears that participants described

a variety of therapeutic techniques from other approaches being incorporated into therapy. Those included psychoeducation around IPV or physical symptoms of anxiety, interventions often applied in Cognitive Behavioural Therapy (e.g. breathing techniques and role-plays) or exploration of how childhood experiences might have an effect on client's life at present.

Adapting different approaches to therapy, or incorporating a variety of techniques into the main approach whilst working with victims of IPV, have been documented across various studies (Bogat, Garcia, & Levendosky, 2013; Cort et al., 2014; Kubany et al., 2004; Vaddiparti & Varma, 2009; Zlotnick, Capezza, & Parker, 2011). There seems to be no consensus as to which therapeutic approach might be the most appropriate for this population group, however, there is recognition that due to the multifaceted nature of IPV phenomenon, a 'one-size-fits-all' approach to treatment might be inadequate and disempowering for women (Kulkarni, Herman-Smith, & Ross, 2015).

Women who took part in this study described their unique experiences of IPV exposure, different experiences of separation from the abuser, a range of previously encountered and available support sources they had during therapy, and a mixture of IPV adverse consequences they reflected on and wanted to address at the time of therapy. For instance, besides overall symptoms of psychological distress and shattered sense of self, some of them needed extra legal support, others were seriously concerned with their physical health and how it was affecting their psychological wellbeing – one woman had concerns regarding her immigration status, another woman was worried about the effects of witnessing IPV on her daughter. This demonstrates that clients with a

history of exposure to IPV may present with a variety of concerns, goals and unique needs that can also vary enormously by the virtue of different contextual factors. Many scholars in the field of IPV advocate for a survivor-defined approach to treatment that takes into account the variation of client's situations, different goals they might pursue and thus diverse kinds of support they might need (Davies & Lyon, 2013; Kulkarni et al., 2015). It can be therefore assumed, that whilst providing therapy for victims of IPV it is important to consider a multifaceted nature of IPV phenomenon, a variety of contextual and underlying factors, and therefore tailor the treatment according to client's individual needs.

4.3.2. Considering IPV consequences

Although the effects of being exposed to IPV have not been a primary focus of this research, women discussed these in the context of their experiences of therapy. They described that the experiences of IPV have negatively affected their mental and psychological wellbeing, physical health and ability to cope with everyday life, which appears to be in conjunction with other research in the field (Childress, 2013; García-Moreno et al., 2015; Golding, 1999).

Participants described that as a result of abusive relationships they were feeling confused and overwhelmed, felt little control over their lives and were questioning their sense of self-worth and overall identity (Matheson et al., 2015). They talked about constant fear of the perpetrator, decreased self-esteem and self-efficacy, having their life goals shattered, whilst feeling ashamed and guilty and blaming

themselves for abuse or not being able to sustain their relationship (Bonomi, Anderson, Rivara, & Thompson, 2007; Mechanic, Weaver, & Resick, 2008; Overstreet & Quinn, 2013; Zlotnick, Johnson, & Kohn, 2006).

All participants described having to encounter legal services in relation to or as a direct consequence of being exposed to IPV. All of them described devastating consequences of having to go through legal procedures for their psychological wellbeing. Some experienced significant financial loses as a result of divorce procedures and found court decisions to be less than satisfactory. One of the women directly expressed that police involvement is not helpful 'many of the times'. Another woman had to face immigration services and believes that her case was not considered appropriately, resulting in detrimental effects for her mental health.

Research suggests that often legal response to IPV can be considered as inadequate whilst re-traumatising and exacerbating survivor's self-blame (Koss, 2000) with some authors questioning whether laws or legal reforms can be used to help victims of IPV (Lakeman, 2000). There are studies reporting significant rates of re-abuse during or after court prosecution, or violation of protective orders (Fleury-Steiner, Bybee, Sullivan, Belknap, & Melton, 2006; Holt, Kernic, Lumley, Wolf, & Rivara, 2002). However, there are also empirical findings suggesting that legal interventions have the potential to contribute to abuse cessation (Bell, 2007), whilst it is important to consider victims perspectives (Goodman & Epstein, 2008). Bell et al. (2011) conducted a mixed-method study investigating women's perceptions of Civil and Criminal Court helpfulness. The results suggest that a supportive, or at least not

antagonistic attitude of the court personnel enabled women to feel less alone and helpless, whilst diminishing the seriousness of the offence, behaving in an intimidating or 'not welcoming' way of approaching IPV issues resulted in victims feeling humiliated and aggravated self-blame. Given the number of women who come in contact with legal services as a result of exposure to IPV, it appears that the justice system interventions can have a tremendous impact on the wellbeing of IPV victims.

These findings highlight the multifaceted nature of IPV consequences as significantly affecting physical, psychological and legal domains of women's wellbeing. It is therefore essential that both health and legal professionals attain to the complexity of IPV phenomenon, its impacts and consequences and strive to find adequate ways of prevention to facilitate women's journeys towards recovery.

4.3.3. Importance of IPV Specialist Knowledge

Women who took part in this study described having limited knowledge about IPV in general, their legal rights or avenues of available support prior to starting therapy or prior to deciding to seek help. They described feeling confused, bewildered and lost as to what their options were should they decide to seek help, or even the motives of their own behaviours when encountering IPV.

4.3.3.1. Unperceived IPV

All participants talked about the importance of specialist knowledge of IPV throughout their journey towards recovery. They often described that prior to starting to seek help, they either were not aware that the abuse was occurring or were 'in denial' about what was happening. Research indicates that most of the women exposed to IPV pass through a stage when they do not perceive violence as such (Petersen, Moracco, Goldstein, & Clark, 2005). Psychodynamic theory suggests that minimisation of IPV can sometimes reflect the client's defence mechanisms (denial, dissociation), distorted guilt and self-blame, intentions to protect a perpetrator (Siegel & Forero, 2012), or could also be a part of woman's developmental history (Celani, 1999). Prolonged use of defences associated with IPV minimisation can negatively affect women's wellbeing, interfere with their everyday life and hinder recovery or the decision to leave the abuser (Luxenberg, Spinazzola, & Van der Kolk, 2001; Merritt-Gray & Wuest, 1995). It is therefore important that therapists and other professionals carefully attend to IPV disclosure so that the degree of abuse and its severity can be accessed, client's ego integrity evaluated and treatment tailored accordingly (Bogat et al., 2013). From the Person-Centred theory perspective traumatic experience might lead to the process of breakdown and disorganisation of the self-structure (Rogers & Koch, 1959). Experiences that are incongruent with the self-structure are perceived as threatening and not allowed to be symbolised in awareness. The denial to the awareness of the experience occurs in an attempt to keep the experience consistent with the self-structure (Joseph, 2004).

Empirical studies indicate that at the stage when IPV is unperceived women often report feeling depressed, experiencing anxiety and/or

other psychological and physical symptoms, but do not relate those to IPV. For instance, Sonego et al. (2013) conducted a cross-sectional population study of 2385 women in Spain. They interviewed women over the telephone and asked questions related to different types of IPV followed by the question of whether women felt abused by their current or ex-partner. The results revealed that out of the women who met the criteria for IPV victimisation, only 3.4% perceived their experiences as IPV versus 8.8% of those who did not, with unperceived IPV therefore being 2.6 times more frequent. In addition, when compared to a non-abused population group, women who did not perceive IPV as such, but were still exposed to it, displayed a higher prevalence of depressive and anxiety symptoms, use of antidepressants and anxiolytics, use of counselling support and psychotherapy, or visits to a psychiatrist. The presence of these symptoms appears to have also consequently affected the women's physical health (Sonego et al., 2013).

These findings indicate that even when unperceived as such, IPV is far from being harmless and can be associated with a variety of physical and psychological problems in women. In addition, failure to recognise the presence of IPV during its early stages might result in an escalation of violence severity, hinder women's help-seeking and have further negative impacts on women's health and wellbeing.

When considering the population sample, the data from the British Crime Survey (Coleman, Kaiza, Hoare, & Jansson, 2008) indicates that 65% of respondents who reported exposure to IPV in the last 12 months did not perceive it as 'domestic violence', however, women were more likely to view the abuse as domestic violence compared to men (39%

and 30% respectively). Importantly, 29% of victims described it as 'just something that happens' (36% males and 23% females repectively), 30% thought that 'it was wrong, but not a crime' and only 19% perceived it as 'a crime' (p. 70). In addition, half of the people who took part in the survey thought that too little is being done about the problem by the government and agencies and one-third said they did not know whether they are doing enough or not.

All these figures raise questions of whether professionals are implementing appropriate actions to ensure that the population perceives IPV for what it is and considers it to be a criminal act rather than an inherent part of everyday relationships. For instance, various researchers reported that psychoeducation could significantly increase knowledge of IPV and promote help-seeking (Anderson & Holgerson, 2013; Bridges, Karlsson, & Lindly, 2015; Guez & Gill-Lev, 2009). Others indicate that IPV needs to be addressed as a multifaceted phenomenon within psychological, sociocultural and legal domains to integrate prevention and intervention of IPV for victims across interdisciplinary lines (Hien & Ruglass, 2009).

4.3.3.2. Specialist Knowledge of IPV as promoting insight in therapy

All participants discussed the importance of specialist knowledge of IPV during the process of therapy. They reflected on being educated about the complexities of IPV, discussing personality types of perpetrators, and exploring their own reactions and feelings in relation to IPV exposure. All

of the above seem to have promoted an insight into their experiences of abuse and helped them to come to terms with trauma.

Participants referred to 'personality types' of abusers and experiences of gaining insight into how those might be related to perpetrating violence in intimate relationships. It appears that this exploration served as a way of gaining insight into the perpetrator's motives of behaviours with consequent realisation that abuse was not the victim's fault or was not caused by her actions, but rather a perpetrator was prone to committing violence due to having a particular type of personality (Cattaneo & Goodman, 2005; Kelly & Johnson, 2008; Ross & Babcock, 2009). In addition, women described that gaining better insight into their own feelings and behaviours allowed them to perceive those as a 'normal' reaction to a given situation (Dutton, 1992, Herman, 1998). This in turn, might have elevated distress and shifted self-blame for being abused or for the failed relationships (Dutton, 2000).

Most of the women described how being informed and educated during therapy enabled them to feel more powerful and in control of their life, helped to decrease overall levels of distress and increased coping skills, served as a way of normalising their feelings and behaviours, and empowered them to move on in their journey towards recovery (Anderson & Holgerson, 2013; Buschel & Madsen, 2006; Guez & Gill-Lev, 2009). Roe-Sepowitz, Bedard, Pate, and Hedberg (2014) found that being informed about abuse can significantly increase awareness and recognition of abuse, decrease trauma symptoms, promote coping strategies and increase emotional functioning. (Buschel & Madsen, 2006) suggested that using psychoeducation whilst working with IPV survivors can serve as a way of identifying the effects of trauma,

normalise feelings related to abuse and common responses to trauma, and consequently relieve guilt and shame, allowing victims to acknowledge their feelings and experiences.

Findings from the present study highlight the importance of the educational component of therapy whilst working with victims of IPV. Becoming informed about complexities of IPV phenomenon, including possible aims and motives of perpetrator’s behaviours, potential effects of IPV victimisation and trauma, as well as common emotional, behavioural and physiological responses in victims seems to promote an insight into the women’s experiences, help them acknowledge and process difficult emotions related to abuse, elevate guilt and self-blame, and endorse empowerment. Being able to recognise the occurrence of IPV and awareness of the available support sources, seems to serve as a means of facilitating change and help-seeking, enabling the sense of control over one’s life and promoting empowerment in women.

4.3.4. Therapy as a process of empowerment

Findings from the present study suggest that women perceived empowerment in therapy as a complex a unique experience. They described a variety of factors that appear to have contributed to the overall feeling of being empowered.

Most of the women talked about having an opportunity to explore and process difficult thoughts and feelings in a safe, non-judgemental environment of therapy, allowing them to focus on their individual

needs and attend to what they wanted in their lives. Shamai (2000) referred to it as the 'discovery and recognition of the right to be someone with legitimate feelings, thoughts, and desires' (p. 90). The author suggests that exposure to abuse often involves a space-invading experience of intrusion into the women's entire existence space. Therefore, therapy space can be experienced as the only place where a woman can be 'herself' so she could rediscover herself and attune to her own needs and desires (Shamai, 2000). In addition, the non-judgemental and attentive attitude of a therapist appears to have enabled women to accept their experiences and lifted feelings of guilt and self-blame by shifting the responsibility for the abuse from victim onto the perpetrator (Beck et al., 2011; Grauwiler, 2008). Generally, emotional support and the caring attitude of professionals working with IPV survivors has been widely discussed as an important intervention tool (Grauwiler, 2008; Othman, Goddard, & Piterman, 2014; Zweig & Burt, 2007). For some of the women, active guidance from the therapist and being informed felt more empowering than the assumed passive role of the therapist as primary a listener. As discussed earlier, rationalisation and normalisation of feelings and behaviours appear to have been perceived as empowering in most of the women.

The majority of the women emphasised the importance of establishing strong therapeutic relationships and allowing themselves to trust their therapist. They described that having a connection with one's therapist allowed them to be more attuned to guidance, led to feeling supported, encouraged and therefore more confident in making independent decisions about their lives. Generally, the importance of therapeutic

relationships has been seen as central to the process of therapy in many schools of therapy (Cooper, O'Hara, Schmid, & Bohart, 2013; Gilbert & Leahy, 2007; Hayes, 2004; Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000; Mearns, Thorne, & McLeod, 2013). It is suggested that strong therapeutic relationship can provide a holding space for working through affect deregulation and dissociation, distorted perceptions of the self, others and the world that are often seen as a result of trauma in women exposed to IPV (Spermon, Darlington, & Gibney, 2010).

Person-Centred approach to therapy (Rogers, 2012) proposes that being in a supportive environment of therapy characterised by the six core conditions, a client can have an opportunity to become intrinsically motivated to integrate self and experience in a way that self-concept is reconfigured within the context of the traumatic experience. This change is assumed to lead to personal growth and development beyond the level of functioning prior to the traumatic event. For instance, Payne, Liebling-Kalifani, and Joseph (2007) examined the efficacy of a client-centred group for survivors of interpersonal trauma with complex PTSD. The results suggest that when the group is perceived as emphatic, congruent and unconditionally accepting, there is some evidence of positive change in trauma symptoms. From theoretical perspective, Person-Centred therapy helps a client to accurately symbolise their traumatic experience in their awareness consequently leading to reintegration of the self and experience in a way that is consistent with actualising tendency and becoming a more fully functioning person (Joseph, 2004).

All participants talked about restoring their sense of self and identity, through therapy, trying to build up self-esteem and having their self-

confidence shattered as a result of abuse. Herman (1998) suggests that disempowerment and disconnection from others are the core experiences of psychological trauma. Recovering from trauma therefore can take place through empowerment and building new connections. Within relationships with others a survivor can recreate psychological capacities that might have been damaged as a result of abuse. Those could include the ability to trust others, autonomy, competence, identity and intimacy (Erikson, 1963). The author argues that restoring these capacities and gaining back control over one's life are the guiding principles of recovery, whilst a therapeutic relationship can serve as an invaluable space for allowing these competencies to grow.

However, working with trauma victims can also have an impact on the therapist. Dutton (2000) argues that it could lead to responses of countertransference including a sense of helplessness, over-identification, inundation or despair and consequently symptoms of PTSD, change in cognitive schemata or disruptions in relationships. Herman (1998) suggests that like the patient, the therapist might defend against overwhelming feelings by withdrawal, or impulsive, intrusive actions using rescue attempts, boundary violation or attempts to impose control on the client.

Two women stressed out the importance of therapist's resilience and ability to contain their own distressing emotions following the disclosure of IPV experience. One of the women explained that seeing her therapist crying in response to the client's story has left her feeling unable to further communicate her experience as she felt that the therapist was unable to tolerate her pain. The other woman described her past experience of therapy outside the specialist service. She talked about

her therapist crying on various occasions and defined it as being unprofessional, disempowering and traumatising. She was not able to continue working with this therapist. Various authors explored possible impacts of traumatic material in therapy, how it might influence therapeutic relationship and the self of the therapist (Caringi & Pearlman, 2009; Pakman, 2004; John P Wilson & Thomas, 2004). Figley (2002) discusses the impacts of traumatic stress, secondary stress and cumulative stress on professionals working with victims of trauma and calls this process ‘compassion fatigue’. He suggests that the compassionate quality of therapists’ responses will depend on their ability to protect or isolate themselves from the pain, their perception on achievement whilst providing help, and their ability to handle stress in therapy by utilising various means of support. Failure to address their own personal material such as own historical trauma or disruptions in a therapist’s personal or professional life, and impacts of secondary traumatisation when doing trauma work might result in negative impacts on both the clients and the therapists themselves (Hernández, Engstrom, & Gangsei, 2010).

Therapists and clients exist in a context of their relationships in which they influence and affect each other and construct meaning. Bogat et al. (2013) discusses splitting as one of the common defences in IPV survivors and suggests that a therapist can be often viewed as a powerful and idealised object who is supposed to defend a client against the bad objects. It is therefore important to discuss the pattern of splitting and meanings behind those during therapy, whilst acknowledging that the idealised caregiving object is neither real nor realistic (Clarkin, Yeomans, & Kernberg, 2007). Once some degree of

stability of self-identity and perception of objects is established, work can be directed towards the integration of negative emotions. Importantly, a role of container must be assumed by a therapist (Cartwright, 2014). Psychodynamic perspective suggests that once an IPV victim gives up her defence of splitting, she might be more likely to more realistically consider the good and the bad qualities of future partners (Bogat et al., 2013).

Results of this study suggest that for all participants empowerment has been a valuable part of the therapeutic process. Women however described different factors and components of therapy as promoting empowerment, suggesting a multifaceted nature of the process and the unique experiences or viewpoints of each of the women. This highlights multidimensional nature of women's experiences in regard to IPV itself, the process of therapy for victim survivors, and empowerment as a fundamental component of it (Barocas, Emery, & Mills, 2016; Kasturirangan, 2008; Macy, Johns, Rizo, Martin, & Giattina, 2011; Reisenhofer & Taft, 2013; Winstok, 2007).

4.3.5. Therapy as a continuous experience

Participants described therapy as an enduring experience. For instance, the majority of the women discussed therapy as a means of support that was gradually enabling them to move forward through active practical guidance, emotional support and empowerment. They emphasised the importance of the prolonged and consistent nature of this support, including therapy duration or enabling clients to seek further help once

the therapy was terminated. This highlights the importance of flexibility, long-term commitment and on-going nature of the support required for women exposed to IPV (Morgan & Coombes, 2013).

There appears to be no universally accepted recommendations regarding therapy duration for victims of IPV. Some studies however report that generally treatment duration can be associated with the degree of therapeutic benefit (Barkham et al., 2006; Hansen, Lambert, & Forman, 2002). When working with trauma, the length of therapy tends to depend on the individual needs of a client and type of the intervention (Briere & Scott, 2014; John Preston Wilson, 2014). Some of the participants expressed difficulties in adjustment and a sense of loss following therapy termination, and a desire to be more in control of its duration. Some studies suggest that when the treatment duration is collaboratively determined by the therapist and the client, treatment outcomes might be more superior than in time-limited interventions (Miller, 1996).

In addition, women expressed the need of being informed about other services that could provide support for victims of IPV both throughout the therapy and importantly, after its ending. Research suggests that support services for victims of IPV are perceived as most helpful when there is a collaboration with other services or when the agency itself is able to assist with several client's needs (Zweig & Burt, 2007). The use of safety planning and assisting women in getting help from additional recourses such as legal aid, housing options or child support have been identified as beneficial when working with IPV survivors (Campbell, 2006; Grauwiler, 2008; Tutty, Rothery, & Roberts, 2002; Zweig & Burt, 2007).

The majority of the women who took part in this study portrayed some degree of change over time both following leaving the abusive relationship and undergoing therapy for IPV survivors. The subjects of 'change', 'transformation', beginning of 'new life' or 'growth' and 'blooming' echoed throughout the transcripts and were represented through participants drawings. These findings appear to be in line with other research in the field (Chang et al., 2006; Cluss et al., 2006; Cobb, Tedeschi, Calhoun, & Cann, 2006; Humphreys, 2003; Senter & Caldwell, 2002).

4.3.6. Recovery as a process

Participants portrayed their experiences of therapy within a broader context of their journey towards recovery throughout interviews and in their drawings. This appears to conform to the wider literature describing IPV as a complex phenomenon that encapsulates a variety of multifaceted lived experiences whilst its counterparts are interrelated and affect each other (Burkitt & Larkin, 2008; Childress, 2013; Oweis, Gharaibeh, Al-Natour, & Froelicher, 2009; Winstok, 2007; Zlotnik, Capezza, Parker, 2011).

Although not asked explicitly about their experiences of abuse, all participants referred to and reflected on those during the interviews, whilst describing how they were experiencing the world in the beginning of their journeys and prior to starting therapy. Those experiences appear to have largely affected women's psychological wellbeing and sense of self, including self-esteem and self-worth, and resulting in feelings of

shame, guilt, self-blame, self-doubt and feeling loss of control over one's life (Kumar, Nizamie, & Srivastava, 2013; Lammers, Ritchie, & Robertson, 2005; Matheson et al., 2015; Pico-Alfonso et al., 2006).

Most of the women described their journey towards recovery as a process of moving towards realising that abuse was occurring, that some degree of change was required, and then starting to consider their options of how this change could be executed (Chang et al., 2010; Khaw & Hardesty, 2007). Experience of therapy appears to have been a part of this journey.

Most of the participants discussed having limited knowledge of available support resources and whether and how they could access those. They often emphasised the negative impacts of being initially unaware of the existing support options for IPV victims (Reisenhofer & Taft, 2013) which hindered women's help-seeking.
Women also stressed the importance of specialist knowledge among professionals working with IPV victims (Ramsay et al., 2012; Vaddiparti & Varma, 2009), whilst adapting a non-judgemental, empathic, caring and individually tailored approach (Feder, Hutson, Ramsay, & Taket, 2006). Participants described how working through the traumatic experiences of abuse in therapy enabled them to gradually gain insight into the perpetrator's motives of behaviour and their own responses to it. It seems, that the use of specialist knowledge around the complexities of IPV in therapy and consequent promotion of insight into women's experience of abuse has helped some of them to move towards coming to terms with trauma, feelings of guilt and self-blame, as well as the

promotion of empowerment and enablement of better ways of coping. Women reported that in turn, feeling encouraged and empowered in therapy has helped them to start restoring their identity, feel more independent and capable of moving on with their life (Burke, Denison, Gielen, McDonnell, & O'Campo, 2004).

Generally, being informed and educated about various components of IPV, its potential causes, effects and 'most common' responses among victims appears to have served as a therapy tool for rationalising women's experiences of abuse, seems to have consequently promoted empowerment, and helped women to move on in their journeys towards recovery (Crespo & Arinero, 2010).

It appears that women who took part in this study were at different stages of their unique and non-linear journeys. Some were still experiencing low mood or anxiety, flashbacks and unwanted memories of the abuse, have had financial difficulties as a result of separation from the abuser or were in the middle of a court case (Childress, 2013; Dillon, Hussain, Loxton, & Rahman, 2013; Evans, 2007; Ham-Rowbottom, Gordon, Jarvis, & Novaco, 2005). Although all participants reported significant improvements in their overall wellbeing following leaving the abuser and engaging in therapy for victim survivors of IPV (Constantino, Kim, & Crane, 2005; Edwards et al., 2012; Johnson, Zlotnick, & Perez, 2011; Kaslow et al., 2010; Roddy, 2013; Zlotnick et al., 2011), some of them were still experiencing the adverse effects of having been exposed to IPV. They emphasised the importance of continuous support, the holistic nature of the treatment, signposting and being aware of the

ways of accessing further help once the therapy was commenced (Bailey, 2010; Malpass et al., 2014; Roddy, 2015). This might highlight the question of what 'recovery' from IPV encompasses.

The majority of studies on IPV interventions measure the 'effectiveness' or 'success' of these interventions in terms of symptom reduction of depression, anxiety, trauma-related symptoms or decrease in overall levels of psychological distress (Constantino et al., 2005; Eckhardt et al., 2013; Kaslow et al., 2010; Kubany et al., 2004). However, very few studies investigated the effectiveness of IPV interventions at the follow-up (Cohen et al., 2013; Crespo & Arinero, 2010; Reed & Enright, 2006) or what it means for women to be 'healthy' or 'recovered' (Smith, 2003).

Some researchers suggest that the 'final' stage of recovery could be establishing a new, violence-free life (Patton, 2003), others stress out the importance of re-establishing safety (Herman, 1998) or the shattered sense of self (Kearney, 1999). Although not asked explicitly, it appears that none of the women who took part in this study described perceiving themselves as fully recovered and some degree of adverse IPV affects was still present in their lives at the time of the interview. Some of the participants overtly expressed their doubts that full recovery was ever possible at all. It has to be noted, that although all women had left the abusive relationships by the time of the interview, the interviews took place 6-12 months following completions of therapy. It can be therefore assumed that ether more time and professional support could be required to overcome the experience of abuse, or the degree of damage following IPV victimisation was too severe to achieve full recovery. For instance, Evans and Lindsay (2008) argue that experience of abuse is not something one can 'get over'; instead, it

causes fundamental alterations in the victims that cannot be erased. They suggest that the term 'incorporation' might be more appropriate than 'recovery' when describing the process by which IPV survivors subsume or integrate traumatic experiences within their sense of self. Wuest and Merritt-Gray (2016) identified it as 'taking on a new image' (p. 89) – a process of leaving behind an image of abused woman or survivor of violence and taking pride in the new person one has become. Results from the study of Evans and Lindsay (2008) indicate that exposure to IPV will impact women in a variety of ways for the remainder of the lives of most survivors. This once again indicates the importance of on-going continuous support for victims of IPV enabling them to incorporate their experiences into their sense of self and post-relationship journey.

4.4. Reflections on quality and avenues for future research

Assessing a quality of qualitative research is a contested issue and scholars have offered important insights about best practices for qualitative research (Mays & Pope, 2000; Morrow, 2005; Ritchie, Lewis, Nicholls, & Ormston, 2013; Tracy, 2010). sley (2017) suggests that the procedure for ensuring and demonstrating a good quality of qualitative research can be grouped into four key dimensions: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Yardley, 2000). These guidelines have been considered throughout the research and are briefly summarised and outlined in this section.

The review of the wide literature on the topics of violence and IPV in particular assisted in ensuring an initial sensitivity to context. This has not only enabled the researcher to be versed in the existing theoretical and conceptual frameworks in the area, but to critically evaluate and engage with the existing discourses whilst considering a variety of contextual effects. The researcher's experience of providing therapy for victims of IPV within a specialist domestic violence service has also facilitated an introduction into the clinical context of the study. The personal reflection enabled the researcher to remain aware of the social context of the relationship between her and participants. It became apparent that the IPV phenomenon itself is too complex and context dependent which has confirmed the appropriateness of the chosen qualitative methodology appreciating participant's experiences. The data was therefore free from any preconceived categories but rather the meaning generated by the participants was carefully considered. Ethical issues have been thoroughly considered, whilst the researcher's awareness of the complex disputes and different perspectives on the topic appear to have enabled her to develop a more profound and far-reaching analysis.

However, the researcher played close attention to remaining rooted in the data itself, the interview transcripts and participant's drawings, which were considered in relation to context of the relationship and the meaning they might entail in relation to the researcher.

Evidence of 'Commitment and rigour' is represented throughout the thesis, particularly in the Methodology and Literature review chapters. It includes in-depth engagement with the topic, both as a researcher and a

clinician, development of competence and skills in the IPA and visual methods as represented through an in-depth close analysis of interviews and participants drawings. The researcher attempted to address the complexity of the phenomena under investigation through careful consideration of the data at several of the analysis and both as an individual researcher and under the supervision. 'Triangulation' was employed throughout data collection and analysis. To gain a better insight into participants' experiences the data was collected through interviews and visual methods. To explore an alternative and outsiders perspective on the analysis researcher consulted with her supervisor and colleagues.

'Coherence' is represented as the fit between the research question, the epistemological perspective and methods adopted in the study. 'Transparency' is illustrated throughout the Methodology and Analysis chapters providing the detailed descriptions of data collection and processes with the excerpts from the data. The reflexivity, researcher's thought, feelings and assumptions are described in relation to the research to openly reflect on how those might have influenced the product of the research.

The potential impacts and importance of the findings for both research and practice are emphasised throughout the study and summarised in the Discussion chapter. It is hoped that findings have the potential to be appreciated by researchers and clinicians working in the field of Counselling psychology and particularly IPV, other professionals providing help and support for victims of IPV including policy makers. It

is also suggested that this research might have the potential to have an impact within a broader socio-cultural context in understanding IPV as a phenomenon through the lens of women's perspectives.

4.4.1. Reflections on the design

The present study aimed to explore women's experiences of therapy for victims of IPV within a specialist domestic violence service. The qualitative design of the study implied that it did not aim to generalise the findings to a larger population, but rather to consider women as experts who could provide valuable insights and guide understanding of the phenomenon under investigation.

One of the limitations of the study lies in the recruitment procedure. Firstly, only those women who completed therapy 6-12 months prior to the starting point of the recruitment were approached. Secondly, only those women who either separated from their partner or those who considered themselves as being safe from the abuser were invited to take part. Thirdly, only those women who did not describe high levels of distress or suicidal ideation were recruited. These considerations were taken to minimise the risks of secondary traumatisation and ensure participants physical and psychological safety. However, this might have affected the findings as these restrictions in recruitment could have possibly undermined the influence and interplay of various contextual factors. In addition, this approach might have missed the women who were less motivated to participate in the research. The findings suggest that all participants were generally satisfied with the therapy they had, considered it to be beneficial and expressed gratitude for the help they

got. It is possible that women who did not respond to the advert might have felt that their experience was not as positive.

Additionally, the study explored only perspectives of female victims of IPV as perpetrated by male partner. It might be beneficial to adopt a variety of perspectives on the topic including male survivors of IPV or those of women in other types of relationships – for instance, same-sex couples. It might be the case that participant's experiences would vary across different population groups. Furthermore, all participants were recruited from the same service, and their experiences could have been different had they undergone therapy at a different service for victim survivors. It is worth noting, that although making generalisations was not the aim of this study, it would be interesting to explore other avenues of the research on the topic.

The use of interviews as a method of data collection not only helped to produce rich data to answer the research question, but its inter-subjective context enabled the researcher to explore sensitive topics in a form of non-directive dialogue enabling participants to speak freely and openly, and seem to have facilitated participants' understanding of what was being communicated. Supplementing the research with visual methods of data collection allowed the researcher to find out more about how participants made sense of their experiences by generating further discussion on the topic and by enabling interpretative understanding of the additional medium through which participants generated and expressed meanings of their experiences.

Meeting participants in the safe environment of a therapy room seemed to have enabled them to be more open and express their thoughts and feeling more freely. However, collecting the data at the premises of

Woman's Trust might have also limited their desire to disclose some of the experiences more openly. Engaging with what was going on in the room facilitated a more in-depth understanding of participants' experiences, allowed a first-hand relational experience of participants and helped developing a better rapport which consequently promoted a more in-depth exploration during the interviews. Establishing a connection with the participants was drawn from the researcher's experience as a practitioner and can be considered as a strength of this study.

4.4.2. Reflections on the analysis

The detailed discussion of why adopting IPA and analysis of visual methods was considered to be the most appropriate in answering the research question and generating the type of knowledge the study aimed to produce. However, it is important to outline some key challenges and discussion regarding limitations of those methods.

Willig (2013) outlines three major limitations of IPA concerning the role of language, the suitability of accounts, and explanation versus description. These limitations will be discussed below in relation to the present study. Willig (2013) highlights the debate about the explanation and description in phenomenological research. She claims phenomenology aims to describe and document the lived experiences rather than explain them. It has to be noted that the present study intended to explore participants' experiences rather that explain their causal mechanisms or origins. Through exploring the breadth of

literature, philosophical and conceptual frameworks as well as a variety of contextual factors it attempted to move beyond description and consider practical implications.

Furthermore, she underlines the assumption that IPA relies upon the representational validity of the language. This suggests that the participants would have the sufficient capacity to describe their experiences through language, whilst the researchers would be adequately equipped to capture these experiences though language. It also has to be noted, that English is not the researcher's mother tongue and thus her capacity to apprehend the meanings entailed by the participants might have been somewhat limited. In addition, some authors argue that language constructs rather than describes reality making the experience itself inaccessible (Potter & Wetherell, 1987).

Furthermore, Willig (2013) points out that IPA relies on participants' ability to describe their experiences. Interestingly, throughout the interviews some of the participants seemed to require time to answer some of the questions. However, the researcher felt it was a representation of the in-depth reflection on their experience rather than trying to find the 'right' words to describe those.

In an attempt to partially overcome these limitations, drawings were used as an additional method of data collection. This has enabled the researcher to gain insight into participants' experiences through non-verbal methods of data collection and provide valuable insight into participants' experiences. However, despite the fact neither the data obtained from the interviews nor the drawings were seen as the more 'valuable' data, the researcher is still more familiar with dealing with

written texts during her academic and research experience. Therefore, she was more reliant on words to convey the research findings; they are however presented in a form of both the written texts and the drawings as a separate entity.

In addition, when analysing the visual data, careful considerations were given to the role of the researcher. In line with (Guillemin, 2004), it was assumed that although participants, as producers of the drawings, are the most relevant and appropriate persons to give meaning to their drawing, this does not mean that the researcher has no role to play. The researcher aimed to provide an overall analysis of the data from both verbal and non-verbal methods of data collection. It appears that her ability to theorise, see patterns and maintain a relative distance from the participant-generated data enabled her to produce valuable insights into participant's experience. Although the researcher was reliant on the participants' interpretations of their drawings, she was able to undertake an overall analysis and interpret the visual data within the context of the other data and the research in general. One of the challenges however was trying to consider the drawing separately from the interviews and although might have been only partially accomplished, analysing the visual seems to have enriched researcher's understanding of the phenomenon under investigation.

4.4.3. Reflections on the impact of the author on the research

It is important to recognise how the researcher's interactions with participants might have influenced the direction of the research. Some

of these reflections are illustrated in the methodology chapter and were considered throughout the research process. Others will be outlined below. Firstly, it appears that the researcher's position as an 'outsider' to participants' experiences might have had an effect on the research. She has never had an experience of undergoing therapy for victim survivors of IPV, nor has she has ever been exposed to IPV. Some authors argue that being an 'insider' to participants' experiences can enable insights, help to elicit meaning and subjective domains that might be overlooked by the outsiders (Hamdan, 2009). Others suggest that being an insider could be beneficial in enabling participants to feel understood, and therefore become more open. This in turn would help to produce more rich data (Dwyer & Buckle, 2009). The researcher believes that her position as an outsider has helped her stay relatively refrained from presumptions she might have had if she was an insider to the participants' experiences. In additions, it enabled her to remain genuinely curious and open throughout the data collection and analysis, and explore the phenomenon under investigation from the position of a researcher rather than the insider. Her position as a trainee counselling psychologist has helped her to consider the phenomenon under investigation from clinical and research perspectives, whilst her clinical training was beneficial in establishing warm therapeutic environment throughout the process of data collection and she believes enabled participants to open up and share their experiences with greater willingness.

Conversely, the researcher was aware that participants' knowledge that the researcher used to work within the service as a therapist in the past

might have negatively affected their ability to express their thoughts and feelings more freely. To minimise this throughout the data collection the researcher emphasised confidentiality and encouraged participants to express both positive and negative experiences of therapy if they had encountered them.

In addition, the researcher's experience of working as a therapist within the service has helped her to gain better insight into clinical aspects of working with victims of IPV. However, she was aware that this experience might have affected her ability to achieve greater clarity as she might have assumed that she understands what participants meant rather than trying to clarify it, or could have for instance remained solely rooted in the feminist conceptual frameworks of IPV adopted within the service. She therefore paid close attention to remain relatively free from potential biases that could have distorted the meanings participants attributed to their experiences. She also tried to consider a variety of philosophical and conceptual frameworks that enabled her to be more flexible, hold onto multiple viewpoints and consider the complexity of contextual factors during the interactive research process.

4.5. Reflections on practical implications and recommendations

Several practical implications can be drawn from the results of this study and review of the literature. The results suggest that when providing therapy for victims of IPV, it is important to consider a multifaceted nature of IPV phenomenon, a variety of contextual and underlying factors, and therefore tailor the treatment according to client's individual needs.

The findings also highlight multifaceted nature of IPV consequences as significantly affecting physical, psychological and legal domains of women's wellbeing. This points out the need for a multimodal approach to treatment and support for IPV survivors that would address their complex needs. It is essential that both health and legal professionals attain to the complexity of the IPV phenomenon, its impacts, consequences and adequate ways of prevention to facilitate women's journeys towards recovery.

Furthermore, the discussion about IPV is often unperceived and this lack of awareness among victims and the general population raises questions – in particular whether professionals are implementing appropriate actions to ensure that the population perceives IPV for what it is, and considers it to be a criminal act rather than an inherent part of everyday relationships. Relevant literature suggests that efforts to address issues of IPV and increase public awareness have been made in various community sectors, including faith-communities (Levitt & Ware, 2006), education (Foshee et al., 2005) or workplace (Widiss, 2007). Those initiatives show promise, however, results of the present study suggest that there might still be a need to increase awareness of IPV phenomenon and available avenues of support for victims amongst professionals and the general population.

Results of the present study also underline the importance of the educational component of therapy whilst working with victims of IPV. It is therefore essential that professionals providing therapy for IPV survivors undergo sufficient training so they are able to better address the complexity of IPV phenomenon, its contextual factors and the best ways to facilitate women on their journey towards recovery.

In addition, the results of the study highlight the importance of multimodal and on-going continuous support for victims of IPV, enabling women to incorporate their experiences of abuse into their sense of self and post-relationship journey.

Based on the findings of the study, it appears that services providing support for victims of IPV might benefit from the following recommendations:

1) Aiming to potentially assist with a variety of client's needs (including legal aid, housing options, child support and many more) either within the service itself or through collaboration with other services. It appears to be particularly important after the therapy has been ceased.
2) Psychoeducation, increased awareness of the IPV complexities and the available avenues for support among general population as well as service users might have the potential to partly prevent incidents of IPV, facilitate victims' recovery, and save lives.
3) It might be beneficial if the treatment duration is not predetermined by the service, but defined collaboratively by the therapist and the client, based on the individual client's needs. Treatment outcomes in long-term interventions might be more superior than in time-limited interventions.
4) It appears that multimodal and on-going continuous support for victims of IPV, including open-ended therapy, group interventions, regular follow-ups might enable women to

incorporate their experiences of abuse into their sense of self and post-relationship life.

5) It is suggested that due to the multifaceted nature of IPV phenomenon, a ‘one-size-fits-all’ approach to treatment might be inadequate and disempowering for women. It is therefore important that a variety of therapeutic approaches is adopted within the service for IPV survivors.

6) It is essential that service providers undergo sufficient professional training enabling them to attain to the complexity of IPV phenomenon, its impacts and consequences on victim’s physical and psychological wellbeing.

Based on the findings of the present study, it appears that therapists working with victims of IPV might consider the following suggestions:

1) The journey towards recovery of each client with the experience of IPV victimisation should be considered as a unique and non-linear process.

2) The traumatic experiences appear to often have detrimental effects on women’s psychological wellbeing and sense of self, including woman’s self-esteem and self-worth, and resulting in feelings of shame, guilt, self-blame, self-doubt and feeling loss of control over one’s life.

3) Therapeutic interventions should be defined on the individual basis. However, it appears that a flexible, integrative approach to treatment adopting interventions from different

approaches and therapeutic modalities might be the most beneficial.

4) Therapists working with IPV survivors should acquire appropriate training, reflect on the necessities of their on-going personal and professional development as well as risks and impacts of secondary traumatisation on both the clients and the therapists themselves.

5) Enabling client's insight into the nature of the IPV phenomenon, its complexities as well as perpetrator's motives of behaviour and victims' responses to it appears to facilitate positive therapeutic outcomes.

6) It appears that for IPV survivors restoring these capacities to trust others, autonomy, competence, identity and gaining back control over one's life might be the guiding principles of recovery from IPV victimisation, whilst a therapeutic relationship can serve as an invaluable space for allowing these competencies to grow.

4.6. Suggestions for future research

Theory and research into IPV demonstrates the multifaceted and complex nature of the phenomenon. Therefore, it is important that a broad range of factors are considered when assessing and addressing the problem. However, literature review suggests that the majority of the studies of the IPV phenomenon are conducted within quantitative frameworks making it difficult to address their complexity to an appropriate extent. It is therefore suggested that more research

adapting qualitative or mixed methods is required in the field of IPV. For instance, the overview of IPV effects indicates that there is still a limited number of qualitative studies investigating the consequences of IPV for women as well as women's experiences of other aspects of IPV victimisation. In addition, although the research literature on counselling and therapeutic interventions for victims of IPV provides a range of encouraging findings, it is relatively sparse, especially when it comes to qualitative studies exploring women's perspectives of therapy and counselling for victim survivors. More research is needed in order to help increase the efficacy of currently available interventions, to possibly develop new ones through understanding the specific needs of this population group and to provide scientific evidence for the importance of establishing specialist services for victims of IPV.

Importantly, literature review suggests that there is a lack of specialist services for victims of IPV across the UK and those that exist are unequally distributed, therefore hindering the provision of adequate help and support (Coy, Kelly, Foord, & Bowstead, 2011). There also appears to be a lack of research into what constitutes practice recommendations of 'best practice' for victim-survivors of IPV, notably in terms of specialist services' effectiveness and therapy interventions for victims of IPV.

Further research is needed to investigate long-term consequences of exposure to IPV and the effects of treatment for IPV survivors. Given that the present study aimed to explore women's experiences of therapy for victims of IPV within a specialist domestic violence service, it would be beneficial to gain an insight into the views and perspectives of other population groups and also within other specialist services across

the UK and other countries. Gaining more insight into the specifics of therapy for IPV survivors, as well as the victim's views of what constitutes desirable interventions across different services, might help to shape policies and recommendations for best practice. Applying methods of data collection other than interviews and visual methods might help to broaden the understanding of various contextual factors related to IPV phenomenon and enhance the existing body of knowledge in both practice and research.

Finally, given that a large proportion of research into IPV phenomenon has been conducted through a feminist perspective, it might be beneficial to broaden conceptual and theoretical frameworks, as preconceived ideas and narrow theoretical focus might exclude potentially important exploratory factors (Dixon & Graham-Kevan, 2011).

4.7. Conclusion

Findings from this qualitative study suggest that participants seem to perceive their experience of therapy within a broader context of their journey towards recovery. Most of the women described this journey as a process of moving towards the realisation that abuse was occurring, that some degree of change was required, and were beginning to consider their options of how this change could be executed, and seeking help. Therapy was a part of their journey and they emphasised the importance of continuous support, holistic nature of the treatment, signposting and being aware of ways in which they could access further help once the therapy was concluded. Being informed and educated

throughout therapy about various components of IPV, its potential causes, effects and 'most common' responses among victims, appears to have served as a therapy tool for rationalising women's experiences of abuse. It also seems to have consequently promoted empowerment, and helped women to move on in their journeys towards recovery.

Overall, the findings highlight the importance of an individually tailored approach to treatment encompassing unique experiences from each of the women and a complex interplay of various contextual factors.

REFERENCES

Abbott, J., Johnson, R., Koziol-McLain, J., & Lowenstein, S. R. (1995). Domestic violence against women: incidence and prevalence in an emergency department population. *Jama, 273*(22), 1763-1767.

Abrar, S., Lovenduski, J., & Margetts, H. (2000). Feminist ideas and domestic violence policy change. *Political studies, 48*(2), 239-262.

Alexander, P. C., Tracy, A., Radek, M., & Koverola, C. (2009). Predicting stages of change in battered women. *Journal of Interpersonal Violence, 24*(10), 1652-1672.

Ali, P. A., Dhingra, K., & McGarry, J. (2016). A literature review of intimate partner violence and its classifications. *Aggression and Violent Behavior, 31*, 16-25.

Alsaker, K., Moen, B. E., & Kristoffersen, K. (2008). Health-related quality of life among abused women one year after leaving a violent partner. *Social Indicators Research, 86*(3), 497-509.

Anderson, S. A., & Holgerson, K. (2013). Psychological Abuse in Family Studies: A Psychoeducational and Preventive Approach. *The Craft of Teaching About Families: Strategies and Tools*, 225.

Anitha, S. (2010). No recourse, no support: State policy and practice towards South Asian women facing domestic violence in the UK. *British Journal of Social Work, 40*(2), 462-479.

Ansara, D. L., & Hindin, M. J. (2011). Psychosocial consequences of intimate partner violence for women and men in Canada. *Journal of Interpersonal Violence, 26*(8), 1628-1645.

Åström, S., Bucht, G., Eisemann, M., Norberg, A., & Saveman, B. I. (2002). Incidence of violence towards staff caring for the elderly. *Scandinavian journal of caring sciences, 16*(1), 66-72.

Avdibegović, E., & Sinanović, O. (2006). Consequences of domestic violence on women's mental health in Bosnia and Herzegovina. *Croatian medical journal, 47*(5), 730-741.

Ayub, M., Irfan, M., Nasr, T., Lutufullah, M., Kingdon, D., & Naeem, F. (2009). Psychiatric morbidity and domestic violence: a survey of married women in Lahore. *Social psychiatry and psychiatric epidemiology, 44*(11), 953.

Babcock, J. C., Miller, S. A., & Siard, C. (2003). Toward a typology of abusive women: Differences between partner-only and generally violent women in the use of violence. *Psychology of Women Quarterly, 27*(2), 153-161.

Bailey, M. (2010). Understanding Attrition in Domestic Violence Cases. *International Journal of Interdisciplinary Social Sciences, 5*(3).

Bandura, A. (1973). *Aggression: A social learning analysis*: Prentice-Hall.

Barkham, M., Connell, J., Stiles, W. B., Miles, J. N., Margison, F., Evans, C., & Mellor-Clark, J. (2006). Dose-effect relations and responsive regulation of treatment duration: the good enough level. *Journal of consulting and clinical psychology, 74*(1), 160.

Barnett, O., Miller-Perrin, C. L., & Perrin, R. D. (2005). *Family violence across the lifespan: An introduction*: Sage Publications, Inc.

Barocas, B., Emery, D., & Mills, L. G. (2016). Changing the Domestic Violence Narrative: Aligning Definitions and Standards. *Journal of Family Violence, 31*(8), 941-947.

Barrett, B. J., & Pierre, M. S. (2011). Variations in women's help seeking in response to intimate partner violence: Findings from a Canadian population-based study. *Violence against women, 17*(1), 47-70.

Beck, C. J., Anderson, E. R., O'Hara, K. L., & Benjamin, G. A. H. (2013). Patterns of intimate partner violence in a large, epidemiological sample of divorcing couples. *Journal of family psychology, 27*(5), 743.

Beck, J. G., McNiff, J., Clapp, J. D., Olsen, S. A., Avery, M. L., & Hagewood, J. H. (2011). Exploring negative emotion in women experiencing intimate partner violence: Shame, guilt, and PTSD. *Behavior therapy, 42*(4), 740-750.

Becker, K. D., Stuewig, J., & McCloskey, L. A. (2010). Traumatic stress symptoms of women exposed to different forms of childhood victimization and intimate partner violence. *Journal of Interpersonal Violence, 25*(9), 1699-1715.

Bell, K. M., & Naugle, A. E. (2008). Intimate partner violence theoretical considerations: Moving towards a contextual framework. *Clinical psychology review, 28*(7), 1096-1107.

Bell, M. (2007). Empowerment and disempowerment for victims of intimate partner violence: An overview of the effects of criminal justice system practices. *Intimate partner violence*, 1-15.

Bell, M. E., Perez, S., Goodman, L. A., & Dutton, M. A. (2011). Battered women's perceptions of civil and criminal court helpfulness: The role of court outcome and process. *Violence against women, 17*(1), 71-88.

Bender, K., & Roberts, A. R. (2007). Battered women versus male batterer typologies: Same or different based on evidence-based studies? *Aggression and Violent Behavior, 12*(5), 519-530.

Bennett, L., Riger, S., Schewe, P., Howard, A., & Wasco, S. (2004). Effectiveness of hotline, advocacy, counseling, and shelter services for victims of domestic violence: A statewide evaluation. *Journal of Interpersonal Violence, 19*(7), 815-829.

Berzenski, S. R., & Yates, T. M. (2010). A developmental process analysis of the contribution of childhood emotional abuse to relationship violence. *Journal of Aggression, Maltreatment & Trauma, 19*(2), 180-203.

Bhowon, U., & Munbauhal, H. (2005). Violence against women: Experiences of women in Mauritius. *Gender and Behaviour, 3*(1), 383-395.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology, 5*(3), 214-224.

Blasco-Ros, C., Sánchez-Lorente, S., & Martinez, M. (2010). Recovery from depressive symptoms, state anxiety and post-traumatic stress disorder in women exposed to physical and psychological, but not to psychological intimate partner violence alone: A longitudinal study. *BMC psychiatry, 10*(1), 98.

Bliss, M. J., Ogley-Oliver, E., Jackson, E., Harp, S., & Kaslow, N. J. (2008). African American women's readiness to change abusive relationships. *Journal of family violence, 23*(3), 161-171.

Boden, Z., & Eatough, V. (2014). Understanding more fully: A multimodal hermeneutic-phenomenological approach. *Qualitative Research in Psychology, 11*(2), 160-177.

Bogat, G. A., Garcia, A. M., & Levendosky, A. A. (2013). Assessment and psychotherapy with women experiencing intimate partner violence: integrating research and practice. *Psychodynamic psychiatry, 41*(2), 189-217.

Bogat, G. A., Levendosky, A. A., & Eye, A. v. (2005). The Future of Research on Intimate Partner Violence: Person-Oriented and Variable-Oriented Perspectives. *American journal of community psychology, 36*(1-2), 49-70.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2007). Health outcomes in women with physical and sexual intimate partner violence exposure. *Journal of Women's Health, 16*(7), 987-997.

Bonomi, A. E., Thompson, R. S., Anderson, M., Reid, R. J., Carrell, D., Dimer, J. A., & Rivara, F. P. (2006). Intimate Partner Violence and Women's Physical, Mental, and Social Functioning. *American Journal of Preventive Medicine, 30*(6), 458-466. doi:http://dx.doi.org/10.1016/j.amepre.2006.01.015

Bridges, A. J., Karlsson, M., & Lindly, E. (2015). The effect of brief, passive psychoeducation on knowledge and ratings of intimate partner violence in the United States and Argentina. *Journal of Interpersonal Violence, 30*(2), 272-294.

Briere, J. N., & Scott, C. (2014). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment (DSM-5 update)*: Sage Publications.

British Psychologcial Society. (2009). Code of Ethics and Conduct. Retreived February 12th 2014 from https://beta.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct-2009

British Psychologcial Society. (2014). Code of Human Research Ethics. Retreived March 18th 2015 from http://www.bps.org.uk/publications/policy-and-guidelines/research-guidelines-policy-documents/research-guidelines-poli

Burke, J. G., Denison, J. A., Gielen, A. C., McDonnell, K. A., & O'Campo, P. (2004). Ending intimate partner violence: An application of the transtheoretical model. *American journal of health behavior, 28*(2), 122-133.

Burkitt, K. H., & Larkin, G. L. (2008). The transtheoretical model in intimate partner violence victimization: stage changes over time. *Violence and victims, 23*(4), 411-431.

Burman, E., & Chantler, K. (2005). Domestic violence and minoritisation: legal and policy barriers facing minoritized women leaving violent relationships. *International journal of law and psychiatry, 28*(1), 59-74.

Burman, E., Smailes, S. L., & Chantler, K. (2004). 'Culture'as a barrier to service provision and delivery: domestic violence services for minoritized women. *Critical social policy, 24*(3), 332-357.

Buschel, B. S., & Madsen, L. H. (2006). Strengthening connections between mothers and children: Art therapy in a domestic violence shelter. *Journal of Aggression, Maltreatment & Trauma, 13*(1), 87-108.

Butchart, A., Mikton, C., Dahlberg, L. L., & Krug, E. G. (2015). Global status report on violence prevention 2014. *Injury prevention, 21*(3), 213-213.

Campbell, R. (2006). Rape Survivors' Experiences With the Legal and Medical Systems Do Rape Victim Advocates Make a Difference? *Violence against women, 12*(1), 30-45.

Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner abuse, 3*(2), 231-280.

Carbone-López, K., Kruttschnitt, C., & Macmillan, R. (2006). Patterns of intimate partner violence and their associations with physical health, psychological distress, and substance use. *Public health reports, 121*(4), 382-392.

Caringi, J., & Pearlman, L. (2009). Living and working self-reflectively to address vicarious trauma. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide; Guilford Press: New York City, NY, USA*, 202-222.

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316-1328.

Cartwright, D. (2014). *Containing states of mind: Exploring Bion's' container model'in psychoanalytic psychotherapy*: Routledge.

Cascardi, M., & Vivian, D. (1995). Context for specific episodes of marital violence: Gender and severity of violence differences. *Journal of family violence, 10*(3), 265-293.

Cattaneo, L. B., & Goodman, L. A. (2005). Risk factors for reabuse in intimate partner violence: A cross-disciplinary critical review. *Trauma, Violence, & Abuse, 6*(2), 141-175.

Celani, D. P. (1999). Applying Fairbairn's object relations theory to the dynamics of the battered woman. *American journal of psychotherapy, 53*(1), 60.

Chamberlain, K. (2000). Methodolatry and qualitative health research. *Journal of Health Psychology, 5*(3), 285-296.

Chandra, P. S., Satyanarayana, V. A., & Carey, M. P. (2009). Women reporting intimate partner violence in India: associations with PTSD and depressive symptoms. *Archives of women's mental health, 12*(4), 203.

Chang, J. C., Cluss, P. A., Ranieri, L., Hawker, L., Buranosky, R., Dado, D., . . . Scholle, S. H. (2005). Health care interventions for intimate partner violence: what women want. *Women's Health Issues, 15*(1), 21-30.

Chang, J. C., Dado, D., Ashton, S., Hawker, L., Cluss, P. A., Buranosky, R., & Scholle, S. H. (2006). Understanding behavior change for women experiencing intimate partner violence: Mapping the ups and downs using the stages of change. *Patient education and counseling, 62*(3), 330-339.

Chang, J. C., Dado, D., Hawker, L., Cluss, P. A., Buranosky, R., Slagel, L., . . . Scholle, S. H. (2010). Understanding turning points in intimate partner violence: factors and circumstances leading women victims toward change. *Journal of Women's Health, 19*(2), 251-259.

Chen, P.-H., Rovi, S., Vega, M., Jacobs, A., & Johnson, M. S. (2009). Relation of domestic violence to health status among Hispanic women. *Journal of health care for the poor and underserved, 20*(2), 569-582.

Chiffriller, S. H., Hennessy, J. J., & Zappone, M. (2006). Understanding a new typology of batterers: Implications for treatment. *Veictims and Offenders, 1*(1), 79-97.

Childress, S. (2013). A meta-summary of qualitative findings on the lived experience among culturally diverse domestic violence survivors. *Issues in mental health nursing, 34*(9), 693-705.

Chronister, K. M., & McWhirter, E. H. (2006). An experimental examination of two career interventions for battered women. *Journal of Counseling Psychology, 53*(2), 151.

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2007). *Psychotherapy for borderline personality: Focusing on object relations*: American Psychiatric Pub.

Cluss, P. A., Chang, J. C., Hawker, L., Scholle, S. H., Dado, D., Buranosky, R., & Goldstrohm, S. (2006). The process of change for victims of intimate partner violence: support for a psychosocial readiness model. *Women's Health Issues, 16*(5), 262-274.

Cobb, A. R., Tedeschi, R. G., Calhoun, L. G., & Cann, A. (2006). Correlates of posttraumatic growth in survivors of intimate partner violence. *Journal of traumatic stress, 19*(6), 895-903.

Cohen, L. R., Field, C., Campbell, A. N., & Hien, D. A. (2013). Intimate partner violence outcomes in women with PTSD and substance use: A secondary analysis of NIDA Clinical Trials Network “Women and Trauma” Multi-site Study. *Addictive behaviors, 38*(7), 2325-2332.

Cohen, L. R., Field, C., Campbell, A. N. C., & Hien, D. A. (2013). Intimate partner violence outcomes in women with PTSD and substance use: A secondary analysis of NIDA Clinical Trials Network “Women and Trauma” Multi-site Study. *Addictive Behaviors, 38*(7), 2325-2332. doi:http://dx.doi.org/10.1016/j.addbeh.2013.03.006

Coleman, K., Kaiza, P., Hoare, J., & Jansson, K. (2008). Homicides, firearm offences and intimate violence 2006/07. *London, UK: Home Office Research Development And Statistics Directorate*.

Constantino, R., Kim, Y., & Crane, P. A. (2005). Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: A pilot study. *Issues in mental health nursing, 26*(6), 575-590.

Cooper, M., O'Hara, M., Schmid, P. F., & Bohart, A. (2013). *The handbook of person-centred psychotherapy and counselling*: Palgrave Macmillan.

Cort, N. A., Cerulli, C., Poleshuck, E. L., Bellenger, K. M., Xia, Y., Tu, X., . . . Talbot, N. L. (2014). Interpersonal psychotherapy for depressed women with histories of intimate partner violence. *Psychological trauma: theory, research, practice, and policy, 6*(6), 700.

Coy, M., Kelly, L., Foord, J., & Bowstead, J. (2011). Roads to nowhere? Mapping violence against women services. *Violence against women, 17*(3), 404-425.

Crespo, M., & Arinero, M. (2010). Assessment of the efficacy of a psychological treatment for women victims of violence by their intimate male partner. *The Spanish journal of psychology, 13*(02), 849-863.

Daigneault, I., Hébert, M., & McDuff, P. (2009). Men's and women's childhood sexual abuse and victimization in adult partner relationships: A study of risk factors. *Child abuse & neglect, 33*(9), 638-647.

Davies, J., & Lyon, E. (2013). *Domestic violence advocacy: Complex lives/difficult choices* (Vol. 7): Sage Publications.

DeKeseredy, W. (1997). *Woman abuse: A sociological story*. Toronto: Harcourt Brace.

Devries, K. M., Mak, J. Y., Garcia-Moreno, C., Petzold, M., Child, J. C., Falder, G., . . . Rosenfeld, L. (2013). The global prevalence of intimate partner violence against women. *Science, 340*(6140), 1527-1528.

Dienemann, J., Campbell, J., Landenburger, K., & Curry, M. A. (2002). The domestic violence survivor assessment: a tool for counseling women in intimate partner violence relationships. *Patient education and counseling, 46*(3), 221-228.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. *International journal of family medicine, 2013*.

Dixon, L., & Browne, K. (2003). The heterogeneity of spouse abuse: A review. *Aggression and Violent Behavior, 8*(1), 107-130.

Dixon, L., & Graham-Kevan, N. (2011). Understanding the nature and etiology of intimate partner violence and implications for practice and policy. *Clinical psychology review, 31*(7), 1145-1155.

Dobash, R. E., & Dobash, R. P. (1978). Wives: The appropriate victims of marital violence. *Victimology*.

Dobash, R. P., & Dobash, R. E. (2004). Women's violence to men in intimate relationships working on a puzzle. *The British Journal of Criminology*, 324-349.

Dobash, R. P., Dobash, R. E., Wilson, M., & Daly, M. (1992). The myth of sexual symmetry in marital violence. *Social problems, 39*(1), 71-91.

Dude, A. M. (2011). Spousal intimate partner violence is associated with HIV and other STIs among married Rwandan women. *AIDS and Behavior, 15*(1), 142-152.

Dutton, D. G. (2011). *Rethinking domestic violence*: UBC Press.

Dutton, M. A. (1992). Understanding women's responses to domestic violence: A redefinition of battered woman syndrome. *Hofstra L. Rev., 21*, 1191.

Dutton, M. A. (2000). *Empowering and healing the battered woman: A model for assessment and intervention*: Springer Publishing Company.

Dutton, M. A. (2009). Pathways linking intimate partner violence and posttraumatic disorder. *Trauma, Violence, & Abuse, 10*(3), 211-224.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International journal of qualitative methods, 8*(1), 54-63.

Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner abuse, 4*(2), 196-231.

Edwards, K. M., Murphy, M. J., Tansill, E. C., Myrick, C., Probst, D. R., Corsa, R., & Gidycz, C. A. (2012). A qualitative analysis of college women's leaving processes in abusive relationships. *Journal of American College Health, 60*(3), 204-210.

Edwards, V. J., Black, M. C., Dhingra, S., McKnight-Eily, L., & Perry, G. S. (2009). Physical and sexual intimate partner violence and reported serious psychological distress in the 2007 BRFSS. *International Journal of Public Health, 54*, 37-42.

Ehrensaft, M. K., Moffitt, T. E., & Caspi, A. (2006). Is domestic violence followed by an increased risk of psychiatric disorders among women but not among men? A longitudinal cohort study. *American Journal of Psychiatry, 163*(5), 885-892.

El-Bassel, N., Witte, S. S., Wada, T., Gilbert, L., & Wallace, J. (2001). Correlates of partner violence among female street-based sex workers: substance abuse, history of childhood abuse, and HIV risks. *AIDS patient care and STDs, 15*(1), 41-51.

Eldén, S. (2013). Inviting the messy: Drawing methods and 'children's voices'. *Childhood, 20*(1), 66-81.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet, 371*(9619), 1165-1172. doi:http://dx.doi.org/10.1016/S0140-6736(08)60522-X

Enright, R. D., & Fitzgibbons, R. P. (2000). *Helping clients forgive: An empirical guide for resolving anger and restoring hope*: American Psychological Association.

Ergöçmen, B. A., Yüksel-Kaptanoğlu, İ., & Jansen, H. A. (2013). Intimate partner violence and the relation between help-seeking behavior and the severity and frequency of physical violence among women in Turkey. *Violence against women, 19*(9), 1151-1174.

Erikson, E. H. (1963). *Childhood and Society. 2d ed., rev. and enl*: New York, Norton.

Eshelman, L., & Levendosky, A. A. (2012). Dating violence: Mental health consequences based on type of abuse. *Violence and victims, 27*(2), 215-228.

Evans, I. (2007). *Battle-scars: Long-term effects of prior domestic violence*: Centre for Women's Studies and Gender Research, Monash University Clayton.

Evans, I., & Lindsay, J. (2008). *Incorporation rather than recovery: Living with the legacy of domestic violence.* Paper presented at the Women's studies international forum.

Fairclough, N., Jessop, B., & Sayer, A. (2004). 2 Critical realism and semiosis. *Realism discourse and deconstruction*, 23.

Feder, G., Davies, R. A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., . . . Ramsay, J. (2011). Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *The lancet, 378*(9805), 1788-1795.

Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006). Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Archives of internal medicine, 166*(1), 22-37.

Fedovskiy, K., Higgins, S., & Paranjape, A. (2008). Intimate partner violence: how does it impact major depressive disorder and post traumatic stress disorder among immigrant Latinas? *Journal of Immigrant and Minority Health, 10*(1), 45-51.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of clinical psychology, 58*(11), 1433-1441.

Finkelhor, D., Turner, H., Ormrod, R., & Hamby, S. L. (2010). Trends in childhood violence and abuse exposure: evidence from 2 national surveys. *Archives of pediatrics & adolescent medicine, 164*(3), 238-242.

Fleury-Steiner, R. E., Bybee, D., Sullivan, C. M., Belknap, J., & Melton, H. C. (2006). Contextual factors impacting battered women's intentions to reuse the criminal legal system. *Journal of Community Psychology, 34*(3), 327-342.

Follingstad, D. R., & Rogers, M. J. (2014). The nature and prevalence of partner psychological abuse in a national sample of adults. *Violence and victims, 29*(1), 3-23.

Forbes, D., Fletcher, S., Parslow, R., Phelps, A., O'Donnell, M., Bryant, R. A., . . . Creamer, M. (2012). Trauma at the hands of another: longitudinal study of differences in the posttraumatic stress disorder symptom profile following interpersonal compared with noninterpersonal trauma. *The Journal of clinical psychiatry, 73*(3), 372-376.

Fortin, I., Guay, S., Lavoie, V., Boisvert, J.-M., & Beaudry, M. (2012). Intimate partner violence and psychological distress among young couples: Analysis of the moderating effect of social support. *Journal of family violence, 27*(1), 63-73.

Foshee, V. A., Bauman, K. E., Ennett, S. T., Suchindran, C., Benefield, T., & Linder, G. F. (2005). Assessing the Effects of the Dating Violence Prevention Program “Safe Dates” Using Random CoefficientRegression Modeling. *Prevention Science, 6*(3), 245.

Frías, S. M. (2013). Strategies and help-seeking behavior among Mexican women experiencing partner violence. *Violence against women, 19*(1), 24-49.

Frith, H., & Harcourt, D. (2007). Using photographs to capture women's experiences of chemotherapy: Reflecting on the method. *Qualitative Health Research, 17*(10), 1340-1350.

García-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *The lancet, 385*(9977), 1567-1579.

Garcia-Moreno, C., Heise, L., Jansen, H. A., Ellsberg, M., & Watts, C. (2005). Violence against women. *Science, 310*(5752), 1282-1283.

García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., . . . Watts, C. (2015). Addressing violence against women: a call to action. *The lancet, 385*(9978), 1685-1695.

Gass, J. D., Stein, D. J., Williams, D. R., & Seedat, S. (2010). Intimate partner violence, health behaviours, and chronic physical illness among South African women. *SAMJ: South African Medical Journal, 100*(9), 582-585.

Gavey, N. (2013). *Just sex?: The cultural scaffolding of rape*: Routledge.

Gerber, M. R., Wittenberg, E., Ganz, M. L., Williams, C. M., & McCloskey, L. A. (2008). Intimate partner violence exposure and change in women’s physical symptoms over time. *Journal of general internal medicine, 23*(1), 64.

Gilbert, P., & Leahy, R. L. (2007). *The therapeutic relationship in the cognitive behavioral psychotherapies*: Routledge.

Gillies, V., Harden, A., Johnson, K., Reavey, P., Strange, V., & Willig, C. (2005). Painting pictures of embodied experience: The use of nonverbal data

production for the study of embodiment. *Qualitative Research in Psychology, 2*(3), 199-212.

Glantz, N. M., Halperin, D. C., & Hunt, L. M. (1998). Studying domestic violence in Chiapas, Mexico. *Qualitative Health Research, 8*(3), 377-392.

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of family violence, 14*(2), 99-132.

Gondolf, E. W. (1988). Who are those guys? Toward a behavioral typology of batterers. *Violence and victims, 3*(3), 187-203.

Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health, and justice*: American Psychological Association.

Gordon, M. (2000). Definitional Issues in Violence Against Women Surveillance and Research from a Violence Research Perspective. *Violence against women, 6*(7), 747-783.

Gottman, J. M., Jacobson, N. S., Rushe, R. H., & Shortt, J. W. (1995). The relationship between heart rate reactivity, emotionally aggressive behavior, and general violence in batterers. *Journal of family psychology, 9*(3), 227.

Grauwiler, P. (2008). Voices of women: Perspectives on decision-making and the management of partner violence. *Children and Youth Services Review, 30*(3), 311-322.

Guez, G., & Gill-Lev, I. (2009). A psychoeducational group for adolescent girls to facilitate egalitarian, non-abusive relationships. *International journal of group psychotherapy, 59*(3), 385-405.

Guillemin, M. (2004). Understanding illness: Using drawings as a research method. *Qualitative Health Research, 14*(2), 272-289.

Guillemin, M., & Drew, S. (2010). Questions of process in participant-generated visual methodologies. *Visual studies, 25*(2), 175-188.

Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health, 7*(1), 12.

Gwartney-Gibbs, P. A., Stockard, J., & Bohmer, S. (1987). Learning courtship aggression: The influence of parents, peers, and personal experiences. *Family Relations*, 276-282.

Hague, G., Mullender, A., & Aris, R. (2003). *Is anyone listening?: Accountability and women survivors of domestic violence*: Psychology Press.

Ham-Rowbottom, K. A., Gordon, E. E., Jarvis, K. L., & Novaco, R. W. (2005). Life constraints and psychological well-being of domestic violence shelter graduates. *Journal of family violence, 20*(2), 109-121.

Hamberger, L. K., & Hastings, J. E. (1986). Personality correlates of men who abuse their partners: A cross-validation study. *Journal of family violence, 1*(4), 323-341.

Hamberger, L. K., Lohr, J. M., Bonge, D., & Tolin, D. F. (1996). A large sample empirical typology of male spouse abusers and its relationship to dimensions of abuse. *Violence and victims, 11*(4), 277-292.

Hamdan, A. (2009). Reflexivity of discomfort in insider-outsider educational research. *McGill Journal of Education, 44*(3), 377-404.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: science and practice, 9*(3), 329-343.
Hardesty, J. L., Oswald, R. F., Khaw, L., & Fonseca, C. (2011). Lesbian/bisexual mothers and intimate partner violence: Help seeking in the context of social and legal vulnerability. *Violence against women, 17*(1), 28-46.
Hardesty, J. L., Oswald, R. F., Khaw, L., Fonseca, C., & Chung, G. H. (2008). Lesbian mothering in the context of intimate partner violence. *Journal of lesbian studies, 12*(2-3), 191-210.
Harne, L., & Radford, J. (2008). *Tackling Domestic Violence: Theories, Policies And Practice: Theories, Policies and Practice*: McGraw-Hill Education (UK).
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.
Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior therapy, 35*(4), 639-665.
Hegarty, K. (2011). Domestic violence: the hidden epidemic associated with mental illness. *The British Journal of Psychiatry, 198*(3), 169-170.
Hegarty, K., Hindmarsh, E. D., & Gilles, M. T. (2000). Domestic violence in Australia: definition, prevalence and nature of presentation in clinical practice. *The Medical Journal of Australia, 173*(7), 363-367.
Helfrich, C. A., Fujiura, G. T., & Rutkowski-Kmitta, V. (2008). Mental health disorders and functioning of women in domestic violence shelters. *Journal of Interpersonal Violence, 23*(4), 437-453.
Henderson, A. D. (2002). Nurses and workplace violence: nurses' experiences of verbal and physical abuse at work. *Nursing Leadership (Toronto, Ont.), 16*(4), 82-98.
Herman, J. L. (1998). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences, 52*(S1), S98-S103.
Hernández, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies, 29*(1), 67-83.
Hien, D., & Ruglass, L. (2009). Interpersonal partner violence and women in the United States: An overview of prevalence rates, psychiatric correlates and consequences and barriers to help seeking. *International journal of law and psychiatry, 32*(1), 48.
Hindin, M. J., Kishor, S., & Ansara, D. L. (2008). Intimate partner violence among couples in 10 DHS countries: predictors and health outcomes.
Hines, D. A., & Douglas, E. M. (2011). The reported availability of US domestic violence services to victims who vary by age, sexual orientation, and gender. *Partner abuse, 2*(1), 3-30.
Hoffman, K. L., & Edwards, J. N. (2004). An integrated theoretical model of sibling violence and abuse. *Journal of family violence, 19*(3), 185-200.
Holt, V. L., Kernic, M. A., Lumley, T., Wolf, M. E., & Rivara, F. P. (2002). Civil protection orders and risk of subsequent police-reported violence. *Jama, 288*(5), 589-594.

Holtzworth-Munroe, A. (2000). A typology of men who are violent toward their female partners making sense of the heterogeneity in husband violence. *Current Directions in Psychological Science, 9*(4), 140-143.

Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. L. (2000). Testing the Holtzworth-Munroe and Stuart (1994) batterer typology. *Journal of consulting and clinical psychology, 68*(6), 1000.

Holtzworth-Munroe, A., & Stuart, G. L. (1994). Typologies of male batterers: three subtypes and the differences among them. *Psychological bulletin, 116*(3), 476.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of consulting and clinical psychology, 61*(4), 561.

Houry, D., Kemball, R., Rhodes, K. V., & Kaslow, N. J. (2006). Intimate partner violence and mental health symptoms in African American female ED patients. *The American journal of emergency medicine, 24*(4), 444-450.

Humphreys, J. (2003). Resilience in sheltered battered women. *Issues in mental health nursing, 24*(2), 137-152.

Hunnicutt, G. (2009). Varieties of patriarchy and violence against women: Resurrecting" patriarchy" as a theoretical tool. *Violence against women*.

Hurwitz, E. J. H., Gupta, J., Liu, R., Silverman, J. G., & Raj, A. (2006). Intimate partner violence associated with poor health outcomes in US South Asian women. *Journal of Immigrant and Minority Health, 8*(3), 251-261.

Husso, M., Virkki, T., Notko, M., Holma, J., Laitila, A., & Mäntysaari, M. (2012). Making sense of domestic violence intervention in professional health care. *Health & social care in the community, 20*(4), 347-355.

Hyder, A. A., Noor, Z., & Tsui, E. (2007). Intimate partner violence among Afghan women living in refugee camps in Pakistan. *Social science & medicine, 64*(7), 1536-1547.

Ingram, E. M. (2007). A comparison of help seeking between Latino and non-Latino victims of intimate partner violence. *Violence against women, 13*(2), 159-171.

Ishida, K., Stupp, P., Melian, M., Serbanescu, F., & Goodwin, M. (2010). Exploring the associations between intimate partner violence and women's mental health: evidence from a population-based study in Paraguay. *Social science & medicine, 71*(9), 1653-1661.

Jin, X., Eagle, M., & Yoshioka, M. (2007). Early exposure to violence in the family of origin and positive attitudes towards marital violence: Chinese immigrant male batterers vs. controls. *Journal of family violence, 22*(4), 211-222.

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.

Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family*, 283-294.

Johnson, M. P. (2001). Conflict and control: Symmetry and asymmetry in domestic violence. *Couples in conflict*, 95-104.

Johnson, M. P. (2006). Violence and Abuse in Personal Relationships: Conflict, Terror, and Resistance in Intimate Partnerships.

Jones, L., Hughes, M., & Unterstaller, U. (2001). Post-Traumatic Stress Disorder (PTSD) in victims of domestic violence a review of the research. *Trauma, Violence, & Abuse, 2*(2), 99-119.

Joseph, S. (2004). Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications. *Psychology and Psychotherapy: Theory, Research and Practice, 77*(1), 101-119.

Josephs, L. L., & Abel, E. M. (2009). Investigating the relationship between intimate partner violence and HIV risk-propensity in Black/African-American women. *Journal of family violence, 24*(4), 221-229.

Kaplan, A. (1973). *The conduct of inquiry*: Transaction Publishers.

Kaslow, N. J., Leiner, A. S., Reviere, S., Jackson, E., Bethea, K., Bhaju, J., . . . Thompson, M. P. (2010). Suicidal, abused African American women's response to a culturally informed intervention. *Journal of Consulting and clinical Psychology, 78*(4), 449.

Kasturirangan, A. (2008). Empowerment and programs designed to address domestic violence. *Violence against women, 14*(12), 1465-1475.

Kaur, R., & Garg, S. (2010). Domestic violence against women: a qualitative study in a rural community. *Asia-Pacific Journal of Public Health, 22*(2), 242-251.

Kearney, M. H. (1999). *Understanding women's recovery from illness and trauma* (Vol. 4): Sage Publications.

Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family court review, 46*(3), 476-499.

Kennedy, A. C. (2005). Resilience among urban adolescent mothers living with violence: Listening to their stories. *Violence against women, 11*(12), 1490-1514.

Khadra, C., Wehbe, N., Lachance Fiola, J., Skaff, W., & Nehmé, M. (2015). Symptoms of post-traumatic stress disorder among battered women in Lebanon: an exploratory study. *Journal of Interpersonal Violence, 30*(2), 295-313.

Khaw, L., & Hardesty, J. L. (2007). Theorizing the process of leaving: Turning points and trajectories in the stages of change. *Family Relations, 56*(4), 413-425.

Kilpatrick, D. G. (2004). What is violence against women defining and measuring the problem. *Journal of interpersonal violence, 19*(11), 1209-1234.

Kim, S., & Kim, J. (2001). The effects of group intervention for battered women in Korea. *Archives of psychiatric nursing, 15*(6), 257-264.

Klugman, J., Hanmer, L., Twigg, S., Hasan, T., McCleary-Sills, J., & Santamaria, J. (2014). *Voice and agency: Empowering women and girls for shared prosperity*: World Bank Publications.

Knowles, J. G., & Cole, A. L. (2008). *Handbook of the arts in qualitative research: Perspectives, methodologies, examples, and issues*: Sage.

Knox, K., & Roberts, A. (2001). The crisis intervention model. *Theoretical perspectives for direct social work practice: A generalist-eclectic approach*, 183-202.

Kortesluoma, R.-L., Punamäki, R.-L., & Nikkonen, M. (2008). Hospitalized children drawing their pain: the contents and cognitive and emotional characteristics of pain drawings. *Journal of Child Health Care, 12*(4), 284-300.

Koss, M. P. (2000). Blame, shame, and community: justice responses to violence against women. *American Psychologist, 55*(11), 1332.

Kramer, A., Lorenzon, D., & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Women's Health Issues, 14*(1), 19-29.

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The lancet, 360*(9339), 1083-1088.

Kruh, I. P., Frick, P. J., & Clements, C. B. (2005). Historical and personality correlates to the violence patterns of juveniles tried as adults. *Criminal Justice and Behavior, 32*(1), 69-96.

Kubany, E. S., Hill, E. E., & Owens, J. A. (2003). Cognitive trauma therapy for battered women with PTSD: Preliminary findings. *Journal of traumatic stress, 16*(1), 81-91.

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.

Kulkarni, S., Herman-Smith, R., & Ross, T. C. (2015). Measuring intimate partner violence (IPV) service providers' attitudes: The development of the Survivor-Defined Advocacy Scale (SDAS). *Journal of family violence, 30*(7), 911-921.

Kumar, A., Nizamie, S. H., & Srivastava, N. K. (2013). Violence against women and mental health. *Mental Health & Prevention, 1*, 4-10.

Lakeman, L. (2000). Why" law and order" cannot end violence against women: and why the development of women's (social, economic and political and civil) rights might. *Canadian Woman Studies, 20*(3), 24.

Lammers, M., Ritchie, J., & Robertson, N. (2005). Women's experience of emotional abuse in intimate relationships: A qualitative study. *Journal of Emotional Abuse, 5*(1), 29-64.

Langhinrichsen-Rohling, J., Huss, M. T., & Ramsey, S. (2000). The clinical utility of batterer typologies. *Journal of family violence, 15*(1), 37-53.

Larkin, M., & Thompson, A. (2003). Interpretative phenomenological analysis. *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, 101-116.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*(2), 102-120.

LeBlanc, M. M., & Kelloway, E. K. (2002). Predictors and outcomes of workplace violence and aggression. *Journal of Applied Psychology, 87*(3), 444.

Leonard, K. E., & Senchak, M. (1996). Prospective prediction of husband marital aggression within newlywed couples. *Journal of abnormal psychology, 105*(3), 369.

Levitt, H. M., & Ware, K. (2006). "Anything With Two Heads Is a Monster" Religious Leaders' Perspectives on Marital Equality and Domestic Violence. *Violence against women, 12*(12), 1169-1190.

Lewis, S. F., & Fremouw, W. (2001). Dating violence: A critical review of the literature. *Clinical psychology review, 21*(1), 105-127.

Li, Y., Marshall, C. M., Rees, H. C., Nunez, A., Ezeanolue, E., & Ehiri, J. (2014). Intimate partner violence and HIV infection among women: a systematic review and meta-analysis. *Journal of the international AIDS society, 17*(1).

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *American journal of community psychology, 36*(1-2), 71-84.

Literat, I. (2013). “A pencil for your thoughts”: Participatory drawing as a visual research method with children and youth. *International Journal of Qualitative Methods, 12*(1), 84-98.

Löbmann, R., Greve, W., Wetzels, P., & Bosold, C. (2003). Violence against women: Conditions, consequences, and coping. *Psychology, Crime and Law, 9*(4), 309-331.

Logan, T., & Cole, J. (2007). The impact of partner stalking on mental health and protective order outcomes over time. *Violence and victims, 22*(5), 546-562.

López, J., & Potter, G. (2005). *After postmodernism: An introduction to critical realism*: A&C Black.

Lowe, P., Humphreys, C., & Williams, S. J. (2007). Night terrors: women's experiences of (not) sleeping where there is domestic violence. *Violence against women, 13*(6), 549-561.

Loxton, D., Schofield, M., Hussain, R., & Mishra, G. (2006). History of domestic violence and physical health in midlife. *Violence against women, 12*(8), 715-731.

Ludermir, A. B., Schraiber, L. B., D'Oliveira, A. F., França-Junior, I., & Jansen, H. A. (2008). Violence against women by their intimate partner and common mental disorders. *Social science & medicine, 66*(4), 1008-1018.

Luxenberg, T., Spinazzola, J., & Van der Kolk, B. A. (2001). Complex trauma and disorders of extreme stress (DESNOS) diagnosis, part one: Assessment. *Directions in psychiatry, 21*(25), 373-392.

Lynn, N., & Lea, S. J. (2005). Through the looking glass: Considering the challenges visual methodologies raise for qualitative research. *Qualitative Research in Psychology, 2*(3), 213-225.

Macy, R. J., Giattina, M., Sangster, T. H., Crosby, C., & Montijo, N. J. (2009). Domestic violence and sexual assault services: Inside the black box. *Aggression and Violent Behavior, 14*(5), 359-373.

Macy, R. J., Giattina, M. C., Parish, S. L., & Crosby, C. (2010). Domestic violence and sexual assault services: Historical concerns and contemporary challenges. *Journal of Interpersonal Violence, 25*(1), 3-32.

Macy, R. J., Johns, N., Rizo, C. F., Martin, S. L., & Giattina, M. (2011). Domestic violence and sexual assault service goal priorities. *Journal of Interpersonal Violence, 26*(16), 3361-3382.

Macy, R. J., Nurius, P. S., Kernic, M. A., & Holt, V. L. (2005). Battered women's profiles associated with service help-seeking efforts: Illuminating opportunities for intervention. *Social Work Research, 29*(3), 137-150.

Maiuro, R. D. (2001). *Psychological abuse in violent domestic relations*: Springer Publishing Company.

Malpass, A., Sales, K., Johnson, M., Howell, A., Agnew-Davies, R., & Feder, G. (2014). Women's experiences of referral to a domestic violence advocate in UK primary care settings: a service-user collaborative study. *Br J Gen Pract, 64*(620), e151-e158.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review: American Psychological Association.

Martino, S. C., Collins, R. L., & Ellickson, P. L. (2005). Cross-lagged relationships between substance use and intimate partner violence among a sample of young adult women. *Journal of studies on alcohol, 66*(1), 139-148.

Mason, J. (2006). Mixing methods in a qualitatively driven way. *Qualitative research, 6*(1), 9-25.

Matheson, F. I., Daoud, N., Hamilton-Wright, S., Borenstein, H., Pedersen, C., & O'Campo, P. (2015). Where did she go? The transformation of self-esteem, self-identity, and mental well-being among women who have experienced intimate partner violence. *Women's Health Issues, 25*(5), 561-569.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *BMJ: British Medical Journal, 320*(7226), 50.

McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Salvatory, A., & Steven, E. (2016). Stigma, shame and women's limited agency in help-seeking for intimate partner violence. *Global public health, 11*(1-2), 224-235.

McFeely, C., Whiting, N., Lombard, N., & McGowan, M. (2013). Domestic Abuse and Gender Inequality: An overview of the current debate.

McLaughlin, J., O'Carroll, R., & O'Connor, R. (2012). Intimate partner abuse and suicidality: a systematic review. *Clinical psychology review, 32*(8), 677-689.

McLeod, A. L., Hays, D. G., & Chang, C. Y. (2010). Female intimate partner violence survivors' experiences with accessing resources. *Journal of Counseling & Development, 88*(3), 303-310.

McMahon, M., & Pence, E. (1996). Replying to Dan O'Leary. *Journal of Interpersonal Violence, 11*(3), 452-455.

Mearns, D., Thorne, B., & McLeod, J. (2013). *Person-centred counselling in action*: Sage.

Mechanic, M. B., Weaver, T. L., & Resick, P. A. (2008). Mental health consequences of intimate partner abuse a multidimensional assessment of four different forms of abuse. *Violence against women, 14*(6), 634-654.

Merritt-Gray, M., & Wuest, J. (1995). Counteracting abuse and breaking free: The process of leaving revealed through women's voices. *Health care for women international, 16*(5), 399-412.

Mertens, D. M. (2014). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods*: Sage Publications.

Mihalic, S. W., & Elliott, D. (2005). A social learning theory model of marital violence. *Readings in family theory*, 98.

Miller, E., McCaw, B., Humphreys, B. L., & Mitchell, C. (2015). Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. *Journal of Women's Health, 24*(1), 92-99.

Miller, I. J. (1996). Time-limited brief therapy has gone too far: The result is invisible rationing. *Professional Psychology: Research and Practice, 27*(6), 567.

Miller, S., Pagan, D., & Tross, S. (1998). Women's Health Education: Peer activism for female partners of injection drug users. *Unpublished treatment manuscript, Columbia University, New York*.

Mitchell, C., Theron, L., Stuart, J., Smith, A., & Campbell, Z. (2011). Drawings as research method *Picturing research* (pp. 19-36): Springer.

Morgan, M., & Coombes, L. (2013). Empowerment and advocacy for domestic violence victims. *Social and Personality Psychology Compass, 7*(8), 526-536.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology, 52*(2), 250.

Moyer, V. A. (2013). Screening for intimate partner violence and abuse of elderly and vulnerable adults: US preventive services task force recommendation statement. *Annals of internal medicine, 158*(6), 478-486.

Murphy, S., Lemire, L., & Wisman, M. (2009). Complex personhood as the context for intimate partner victimization: One American Indian woman's story. *American Indian and Alaska native mental health research (Online), 16*(1), 39.

Murray, C. E., & Welch, M. L. (2010). Preliminary construction of a service provider—informed domestic violence research agenda. *Journal of Interpersonal Violence, 25*(12), 2279-2296.

Myers, D. L. (1995). Eliminating the battering of women by men: Some considerations for behavior analysis. *Journal of Applied Behavior Analysis, 28*(4), 493-507.

Nagae, M., & Dancy, B. L. (2010). Japanese women's perceptions of intimate partner violence (IPV). *Journal of Interpersonal Violence, 25*(4), 753-766.

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*: Guilford Press.

Nathanson, A. M., Shorey, R. C., Tirone, V., & Rhatigan, D. L. (2012). The prevalence of mental health disorders in a community sample of female victims of intimate partner violence. *Partner abuse, 3*(1), 59.

Naved, R. T., & Akhtar, N. (2008). Spousal violence against women and suicidal ideation in Bangladesh. *Women's Health Issues, 18*(6), 442-452.

Naved, R. T., Azim, S., Bhuiya, A., & Persson, L. Å. (2006). Physical violence by husbands: magnitude, disclosure and help-seeking behavior of women in Bangladesh. *Social science & medicine, 62*(12), 2917-2929.

Nerøien, A. I., & Schei, B. (2008). Partner violence and health: results from the first national study on violence against women in Norway. *Scandinavian Journal of Public Health, 36*(2), 161-168.

Nixon, R. D. V., Resick, P. A., & Nishith, P. (2004). An exploration of comorbid depression among female victims of intimate partner violence with posttraumatic stress disorder. *Journal of Affective Disorders, 82*(2), 315-320. doi:http://dx.doi.org/10.1016/j.jad.2004.01.008

Nowicka-Sauer, K. (2007). Patients' perspective: lupus in patients' drawings. *Clinical rheumatology, 26*(9), 1523-1525.

Nur, N. (2012). The effect of intimate partner violence on mental health status among women of reproductive ages: A population-based study in a middle Anatolian city. *Journal of Interpersonal Violence, 27*(16), 3236-3251.

O'campo, P., Kub, J., Woods, A., Garza, M., Jones, A. S., Gielen, A. C., . . . Campbell, J. (2006). Depression, PTSD, and comorbidity related to intimate partner violence in civilian and military women. *Brief treatment and crisis Intervention, 6*(2), 99.

O'Doherty, L. J., MacMillan, H., Feder, G., Taft, A., Taket, A., & Hegarty, K. (2014). Selecting outcomes for intimate partner violence intervention trials: Overview and recommendations. *Aggression and Violent Behavior, 19*(6), 663-672. doi:http://dx.doi.org/10.1016/j.avb.2014.09.010

O'leary, K. D., Smith Slep, A. M., & O'leary, S. G. (2007). Multivariate models of men's and women's partner aggression. *Journal of consulting and clinical psychology, 75*(5), 752.

O'Doherty, L. J., Taft, A., Hegarty, K., Ramsay, J., Davidson, L. L., & Feder, G. (2014). Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis. *Bmj, 348*, g2913.

O'Moore, M. (2006). Defining violence: Towards a pupil based definition. *NoVAS RES CONNECT Initiative*.

Organization, W. H. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*: World Health Organization.

Oswald, R. F., Fonseca, C. A., & Hardesty, J. L. (2010). LESBIAN MOTHERS'COUNSELING EXPERIENCES IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE. *Psychology of Women Quarterly, 34*(3), 286-296.

Othman, S., Goddard, C., & Piterman, L. (2014). Victims' barriers to discussing domestic violence in clinical consultations: A qualitative enquiry. *Journal of Interpersonal Violence, 29*(8), 1497-1513.

Overstreet, N. M., & Quinn, D. M. (2013). The intimate partner violence stigmatization model and barriers to help seeking. *Basic and applied social psychology, 35*(1), 109-122.

Oweis, A., Gharaibeh, M., Al-Natour, A., & Froelicher, E. (2009). Violence against women: Unveiling the suffering of women with a low income in Jordan. *Journal of Transcultural Nursing, 20*(1), 69-76.

Pakman, M. (2004). The epistemology of witnessing: Memory, testimony, and ethics in family therapy. *Family process, 43*(2), 265.

Palermo, T., Bleck, J., & Peterman, A. (2014). Tip of the iceberg: reporting and gender-based violence in developing countries. *American journal of epidemiology, 179*(5), 602-612.

Parks, S. E., Kim, K. H., Day, N. L., Garza, M. A., & Larkby, C. A. (2011). Lifetime self-reported victimization among low-income, urban women: The relationship between childhood maltreatment and adult violent victimization. *Journal of Interpersonal Violence, 26*(6), 1111-1128.

Patton, S. (2003). Pathways: How women leave violent men.

Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. *Journal of Women's Health, 20*(11), 1743-1749.

Petersen, R., Moracco, K. E., Goldstein, K. M., & Clark, K. A. (2002). Women's perspectives on intimate partner violence services: the hope in Pandora's

box. *Journal of the American Medical Women's Association (1972), 58*(3), 185-190.
Petersen, R., Moracco, K. E., Goldstein, K. M., & Clark, K. A. (2005). Moving beyond disclosure: women's perspectives on barriers and motivators to seeking assistance for intimate partner violence. *Women & health, 40*(3), 63-76.
Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health, 15*(5), 599-611.
Pill, N., Day, A., & Mildred, H. (2017). Trauma responses to intimate partner violence: A review of current knowledge. *Aggression and Violent Behavior*.
Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system: policy and practice implications. *Trauma, Violence, & Abuse, 8*(2), 226-239.
Plichta, S. B., & Falik, M. (2001). Prevalence of violence and its implications for women's health. *Women's Health Issues, 11*(3), 244-258. doi:http://dx.doi.org/10.1016/S1049-3867(01)00085-8
Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*: Sage.
Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: a discussion and critique. *Nurse researcher, 18*(3), 20-24.
Prochaska, J. O. (2013). Transtheoretical model of behavior change *Encyclopedia of behavioral medicine* (pp. 1997-2000): Springer.
Radley, A., & Taylor, D. (2003). Images of recovery: A photo-elicitation study on the hospital ward. *Qualitative Health Research, 13*(1), 77-99.
Ramsay, J., Rutterford, C., Gregory, A., Dunne, D., Eldridge, S., Sharp, D., & Feder, G. (2012). Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. *Br J Gen Pract, 62*(602), e647-e655.
Reavey, P., & Johnson, K. (2008). Visual methodologies: using and interpreting images in qualitative psychology. *Handbook of qualitative research in psychology. London: Sage*.
Reed, G. L., & Enright, R. D. (2006). The effects of forgiveness therapy on depression, anxiety, and posttraumatic stress for women after spousal emotional abuse. *Journal of Consulting and clinical Psychology, 74*(5), 920.
Reisenhofer, S., & Taft, A. (2013). Women's journey to safety–The Transtheoretical model in clinical practice when working with women experiencing Intimate Partner Violence: A scientific review and clinical guidance. *Patient education and counseling, 93*(3), 536-548.
Renner, L. M., & Markward, M. J. (2009). Factors associated with suicidal ideation among women abused in intimate partner relationships. *Smith college Studies In social work, 79*(2), 139-154.
Rhatigan, D. L., Moore, T. M., & Street, A. E. (2005). Reflections on partner violence 20 years of research and beyond. *Journal of Interpersonal Violence, 20*(1), 82-88.

Riggs, D. S., Caulfield, M. B., & Street, A. E. (2000). Risk for domestic violence: Factors associated with perpetration and victimization. *Journal of clinical psychology, 56*(10), 1289-1316.

Riggs, D. S., & O'Leary, K. D. (1996). Aggression between heterosexual dating partners an examination of a causal model of courtship aggression. *Journal of Interpersonal Violence, 11*(4), 519-540.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*: Sage.

Robinson, A. L. (2006). The Dyn Project: Supporting men experiencing domestic abuse. *Final Evaluation Report*.

Roddy, J. K. (2013). Client perspectives: The therapeutic challenge of domestic violence counselling–a pilot study. *Counselling and Psychotherapy Research, 13*(1), 53-60.

Roddy, J. K. (2015). Working with Domestic Violence Clients *Counselling and Psychotherapy after Domestic Violence* (pp. 141-165): Springer.

Roe-Sepowitz, D. E., Bedard, L. E., Pate, K. N., & Hedberg, E. (2014). Esuba: A psychoeducation group for incarcerated survivors of abuse. *International journal of offender therapy and comparative criminology, 58*(2), 190-208.

Rogers, C. (2012). *Client Centred Therapy (New Ed)*: Hachette UK.

Rogers, C. R., & Koch, S. (1959). A theory of therapy, personality, and interpersonal relationships: as developed in the client-centered framework. Retreived March 6th 2017 from http://bibliotecaparalapersona-epimeleia.com/greenstone/collect/ecritos2/index/assoc/HASH01a5/4583605e.dir/doc.pdf

Romito, P., Molzan Turan, J., & De Marchi, M. (2005). The impact of current and past interpersonal violence on women's mental health. *Social Science & Medicine, 60*(8), 1717-1727. doi:http://dx.doi.org/10.1016/j.socscimed.2004.08.026

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *The British Journal of Psychiatry, 198*(3), 189-194.

Rose, G. (1996). Teaching visualised geographies: towards a methodology for the interpretation of visual materials. *Journal of Geography in Higher Education, 20*(3), 281-294.

Rose, G. (2016). *Visual methodologies: An introduction to researching with visual materials*: Sage.

Ross, J. M., & Babcock, J. C. (2009). Proactive and reactive violence among intimate partner violent men diagnosed with antisocial and borderline personality disorder. *Journal of family violence, 24*(8), 607-617.

Ruiz-Pérez, I., Plazaola-Castaño, J., & del Río-Lozano, M. (2007). Physical health consequences of intimate partner violence in Spanish women. *The European Journal of Public Health, 17*(5), 437-443.

Sagrestano, L. M., Heavey, C. L., & Christensen, A. (1999). Perceived power and physical violence in marital conflict. *Journal of Social Issues, 55*(1), 65-79.

Sanderson, C. (2008). *Counselling survivors of domestic abuse*: Jessica Kingsley Publishers.

Savas, N., & Agridag, G. (2011). The relationship between women's mental health and domestic violence in semirural areas: a study in Turkey. *Asia Pacific Journal of Public Health, 23*(3), 399-407.

Sayer, A. (2000). *Realism and social science*: Sage.

Scheffer Lindgren, M., & Renck, B. (2008). 'It is still so deep-seated, the fear': psychological stress reactions as consequences of intimate partner violence. *Journal of psychiatric and mental health nursing, 15*(3), 219-228.

Schei, B., Guthrie, J., Dennerstein, L., & Alford, S. (2006). Intimate partner violence and health outcomes in mid-life women: a population-based cohort study. *Archives of women's mental health, 9*(6), 317-324.

Schneider, R., Burnette, M. L., Ilgen, M. A., & Timko, C. (2009). Prevalence and correlates of intimate partner violence victimization among men and women entering substance use disorder treatment. *Violence and victims, 24*(6), 744-756.

Schwandt, T. (2007). The SAGE Dictionary of Qualitative Inquiry. doi:10.4135/9781412986281

Sellers, C. S., Cochran, J. K., & Branch, K. A. (2005). Social learning theory and partner violence: A research note. *Deviant Behavior, 26*(4), 379-395.

Senter, K. E., & Caldwell, K. (2002). Spirituality and the maintenance of change: A phenomenological study of women who leave abusive relationships. *Contemporary Family Therapy, 24*(4), 543-564.

Shamai, M. (2000). Rebirth of the self: How battered women experience treatment. *Clinical Social Work Journal, 28*(1), 85-103.

Shinebourne, P. (2011). The Theoretical Underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis, 22*(1).

Shook, N. J., Gerrity, D. A., Jurich, J., & Segrist, A. E. (2000). Courtship violence among college students: A comparison of verbally and physically abusive couples. *Journal of family violence, 15*(1), 1-22.

Shorey, R. C., Tirone, V., Nathanson, A. M., Handsel, V. A., & Rhatigan, D. L. (2013). A preliminary investigation of the influence of subjective norms and relationship commitment on stages of change in female intimate partner violence victims. *Journal of Interpersonal Violence, 28*(3), 621-642.

Shurman, L. A., & Rodriguez, C. M. (2006). Cognitive-affective predictors of women's readiness to end domestic violence relationships. *Journal of Interpersonal Violence, 21*(11), 1417-1439.

Siegel, J. P., & Forero, R. M. (2012). Splitting and emotional regulation in partner violence. *Clinical Social Work Journal, 40*(2), 224-230.

Silver, J., Reavey, P., & Anne Fineberg, N. (2010). How do people with body dysmorphic disorder view themselves? A thematic analysis. *International journal of psychiatry in clinical practice, 14*(3), 190-197.

Smith, D. (2012). *A new response to youth crime*: Routledge.

Smith, J., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory. *Method and Research London: Sage*.

Smith, J. A. (1999). Towards a relational self: Social engagement during pregnancy and psychological preparation for motherhood. *British journal of social psychology, 38*(4), 409-426.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39-54.
Smith, J. A. (2015). *Qualitative psychology: A practical guide to research methods*: Sage.
Smith, M. E. (2003). Recovery from intimate partner violence: A difficult journey. *Issues in mental health nursing, 24*(5), 543-573.
Smith-Pittman, M. H., & McKoy, Y. D. (1999). *Workplace violence in healthcare environments.* Paper presented at the Nursing Forum.
Sonego, M., Gandarillas, A., Zorrilla, B., Lasheras, L., Pires, M., Anes, A., & Ordobás, M. (2013). Unperceived intimate partner violence and women's health. *Gaceta sanitaria, 27*(5), 440-446.
Spermon, D., Darlington, Y., & Gibney, P. (2010). Psychodynamic psychotherapy for complex trauma: targets, focus, applications, and outcomes. *Psychology research and behavior management, 3*, 119.
Stanko, E. A. (2001). The day to count: Reflections on a methodology to raise awareness about the impact of domestic violence in the UK. *Criminal Justice, 1*(2), 215-226.
Stephenson, R., Koenig, M. A., & Ahmed, S. (2006). Domestic violence and symptoms of gynecologic morbidity among women in North India. *International Family Planning Perspectives*, 201-208.
Straus, M. A. (1977a). Sexual inequality, cultural norms and wife beating. *Sage Yearbooks in Women Policy Studies, 2*.
Straus, M. A. (1977b). Wife beating: How common and why? *Victimology*.
Straus, M. M. A., Gelles, R. J., & Steinmetz, S. K. (1980). *Behind closed doors: Violence in the American family*: Transaction Publishers.
Strauss, A., & Corbin, J. (1990). *Basics of qualitative research* (Vol. 15): Newbury Park, CA: Sage.
Sugarman, D. B., & Frankel, S. L. (1996). Patriarchal ideology and wife-assault: A meta-analytic review. *Journal of family violence, 11*(1), 13-40.
Sullivan, C. M. (2012). Examining the work of domestic violence programs within a “social and emotional well-being promotion” conceptual framework. *Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved February, 23*, 2014.
Swahn, M. H., & Donovan, J. E. (2004). Correlates and predictors of violent behavior among adolescent drinkers. *Journal of Adolescent Health, 34*(6), 480-492.
Swanberg, J. E., & Logan, T. (2005). Domestic violence and employment: a qualitative study. *Journal of occupational health psychology, 10*(1), 3.
Testa, M., Livingston, J. A., & VanZile-Tamsen, C. (2011). Advancing the study of violence against women using mixed methods: Integrating qualitative methods into a quantitative research program. *Violence against women, 17*(2), 236-250.
Tetterton, S., & Farnsworth, E. (2011). Older women and intimate partner violence: Effective interventions. *Journal of Interpersonal Violence, 26*(14), 2929-2942.
Thompson, R. S., Bonomi, A. E., Anderson, M., Reid, R. J., Dimer, J. A., Carrell, D., & Rivara, F. P. (2006). Intimate partner violence: Prevalence, types, and

chronicity in adult women. *American journal of preventive medicine, 30*(6), 447-457.

Tjaden, P. (2004). What is violence against women? Defining and measuring the problem: A response to Dean Kilpatrick. *Journal of interpersonal violence, 19*(11), 1244-1251.

Tomasulo, G. C., & McNamara, J. R. (2007). The relationship of abuse to women's health status and health habits. *Journal of family violence, 22*(4), 231-235.

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative inquiry, 16*(10), 837-851.

Tutty, L., Rothery, M., & Roberts, A. (2002). Beyond shelters: Support groups and community-based advocacy for abused women. *Handbook of domestic violence intervention strategies Policies, programs, and legal remedies*, 396-418.

Vaddiparti, K., & Varma, D. S. (2009). Intimate partner violence interventions. *Contemporary topics in women's mental health: Global perspectives in a changing society*, 387-403.

Vanderende, K., Mercy, J., Shawa, M., Kalanda, M., Hamela, J., Maksud, N., . . . Hillis, S. (2016). Violent experiences in childhood are associated with men's perpetration of intimate partner violence as a young adult: a multistage cluster survey in Malawi. *Annals of epidemiology, 26*(10), 723-728.

Vives-Cases, C., Ruiz-Cantero, M. T., Escribà-Agüir, V., & Miralles, J. J. (2011). The effect of intimate partner violence and other forms of violence against women on health. *Journal of Public Health, 33*(1), 15-21.

Vos, T., Astbury, J., Piers, L., Magnus, A., Heenan, M., Stanley, L., . . . Webster, K. (2006). Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. *Bulletin of the World Health Organization, 84*(9), 739-744.

Vung, N. D., & Krantz, G. (2009). Childhood experiences of interparental violence as a risk factor for intimate partner violence: a population-based study from northern Vietnam. *Journal of epidemiology and community health, 63*(9), 708-714.

Vyas, S., & Watts, C. (2009). How does economic empowerment affect women's risk of intimate partner violence in low and middle income countries? A systematic review of published evidence. *Journal of international Development, 21*(5), 577-602.

Wall, L., & Quadara, A. (2014). Acknowledging complexity in the impacts of sexual victimisation trauma: Australian Institute of Family Studies Melbourne.

Waltz, J., Babcock, J. C., Jacobson, N. S., & Gottman, J. M. (2000). Testing a typology of batterers. *Journal of consulting and clinical psychology, 68*(4), 658.

Wareham, J., Boots, D. P., & Chavez, J. M. (2009). A test of social learning and intergenerational transmission among batterers. *Journal of Criminal Justice, 37*(2), 163-173.

Whitaker, D. J., Morrison, S., Lindquist, C., Hawkins, S. R., O'Neil, J. A., Nesius, A. M., . . . Reese, L. R. (2006). A critical review of interventions for the primary prevention of perpetration of partner violence. *Aggression and Violent Behavior, 11*(2), 151-166.

White, J. W., & Koss, M. P. (1991). Courtship violence: Incidence in a national sample of higher education students. *Violence and victims, 6*(4), 247.

White, J. W., Merrill, L. L., & Koss, M. P. (2001). Predictors of premilitary courtship violence in a Navy recruit sample. *Journal of Interpersonal Violence, 16*(9), 910-927.

Whitfield, C. L., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent childhood experiences and the risk of intimate partner violence in adults: Assessment in a large health maintenance organization. *Journal of Interpersonal Violence, 18*(2), 166-185.

World Health Organisation. (1996a). Global consultation on violence and health. *Violence: a public health priority. Geneva: WHO*.

World Health Organisation. (1996b). *WHO Global Consultation on Violence and Health. Violence: a public health. Geneva*. Retrieved from

World Health Organisation. (2002). *The world health report 2002: reducing risks, promoting healthy life*: World Health Organization.

World Health Organisation. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*: World Health Organization.

Widiss, D. A. (2007). Domestic violence and the workplace: The explosion of state legislation and the need for a comprehensive strategy. *Fla. St. UL Rev., 35*, 669.

Wilkinson, D. L., & Hamerschlag, S. J. (2005). Situational determinants in intimate partner violence. *Aggression and Violent Behavior, 10*(3), 333-361.

Williamson, E., & Abrahams, H. (2014). A review of the provision of intervention programs for female victims and survivors of domestic abuse in the United Kingdom. *Affilia, 29*(2), 178-191.

Willig, C. (2001). Qualitative research in psychology: A practical guide to theory and method. *Buckingham: OUP*.

Willig, C. (2013). *Introducing qualitative research in psychology*: McGraw-Hill International.

Wilson, J. P. (2014). *Trauma, Transformation, And Healing.: An Integrated Approach To Theory Research & Post Traumatic Therapy*: Routledge.

Wilson, J. P., & Thomas, R. B. (2004). *Empathy in the treatment of trauma and PTSD*: Routledge.

Wilson, K. S., Silberberg, M. R., Brown, A. J., & Yaggy, S. D. (2007). Health needs and barriers to healthcare of women who have experienced intimate partner violence. *Journal of Women's Health, 16*(10), 1485-1498.

Winstok, Z. (2007). Toward an interactional perspective on intimate partner violence. *Aggression and Violent Behavior, 12*(3), 348-363.

Wong, J. Y.-H., Tiwari, A., Fong, D. Y.-T., Humphreys, J., & Bullock, L. (2011). Depression among women experiencing intimate partner violence in a Chinese community. *Nursing Research, 60*(1), 58-65.

Woods, S. J., Hall, R. J., Campbell, J. C., & Angott, D. M. (2008). Physical health and posttraumatic stress disorder symptoms in women experiencing intimate partner violence. *Journal of Midwifery & Women's Health, 53*(6), 538-546.

Wuerch, M. A., Zorn, K. G., Juschka, D., & Hampton, M. R. (2016). Responding to Intimate Partner Violence Challenges Faced Among Service Providers in

Northern Communities. *Journal of Interpersonal Violence*, 0886260516645573.

Wuest, J., & Merritt-Gray, M. (2016). Beyond survival: Reclaiming self after leaving an abusive male partner. *Canadian Journal of Nursing Research Archive, 32*(4).

Wuest, J., Merritt-Gray, M., Lent, B., Varcoe, C., Connors, A. J., & Ford-Gilboe, M. (2007). Patterns of medication use among women survivors of intimate partner violence. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, 460-464.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health, 15*(2), 215-228.

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology, 12*(3), 295-296. doi:10.1080/17439760.2016.1262624

Yllö, K. (1983). Sexual equality and violence against wives in American states. *Journal of Comparative Family Studies*, 67-86.

Yllö, K. (1988). *Political and methodological debates in wife abuse research.* Paper presented at the An earlier draft of this chapter was presented at the 1986 National Council on Family Relations Theory and Methods Workshop, Dearborn, Michigan.

Yoshihama, M., Horrocks, J., & Kamano, S. (2009). The role of emotional abuse in intimate partner violence and health among women in Yokohama, Japan. *American Journal of Public Health, 99*(4), 647-653.

Zeman, L. D. (2004). Domestic violence: a review for case managers of regulations, women's center services, and referral questions. *Care Management Journals, 5*(1), 13-18.

Zlotnick, C., Capezza, N., & Parker, D. (2011). An interpersonally based intervention for low-income pregnant women with intimate partner violence: a pilot study. *Archives of Women's Mental Health, 14*(1), 55-65. doi:10.1007/s00737-010-0195-x

Zlotnick, C., Johnson, D. M., & Kohn, R. (2006). Intimate partner violence and long-term psychosocial functioning in a national sample of American women. *Journal of Interpersonal Violence, 21*(2), 262-275.

Zweig, J. M., & Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: what matters to program clients? *Violence against women, 13*(11), 1149-1178.

PART III

PUBLISHABLE ARTICLE[1]

Experience of therapy in women exposed to Intimate Partner Violence within a specialist Domestic Violence Service: qualitative enquiry

[1] To review submission guidelines for the Journal of Counselling Psychology please refer to http://www.apa.org/pubs/journals/cou/?tab=4

Experience of therapy in women exposed to Intimate Partner Violence within a specialist Domestic Violence Service: qualitative enquiry

Anastasia Burelomova
City University, London

Author Note

Anastasia Burelomova, Psychology Department, City University, London

Correspondence concerning this article should be addressed to
Anastasia Burelomova, Psychology Department, City University, London; Tel: XXXXX, Postal address: XXXXXX, Email: XXXXXXX

Abstract

This qualitative study explores women's experiences of therapy for victims of Intimate Partner Violence within a specialist domestic violence service. Eight women, all over 18 years old with the experience of exposure to IPV, who have undergone 18 weeks of person-centred therapy for victim-survivors of IPV at a specialist domestic violence service took part in this study. Individual semi-structured interviews were conducted to gain insight into participant's experiences of therapy and were analysed using Interpretative Phenomenological Analysis (IPA). Derived from the IPA is one over-arching theme: 'recovery as a process', with four inter-related constituent themes: 'abuse as disintegrating the self', 'oblivion of abuse and awakening', 'therapy as a journey of empowerment', and 'therapy as a continuous experience'. Each constituent theme consists of a number of different sub-themes. Together, these findings highlight the complexity of the phenomenon and suggest that women's experiences of therapy for victims of IPV might be better understood within the broader context of recovery as a process. All women emphasised the significance of a therapeutic relationship, having an opportunity to explore and process difficult thoughts and feelings, importance of specialist knowledge, empowerment and promoting insight in therapy. The results are considered in relation to the wider literature and within sociocultural context suggesting the need for holistic treatment in IPV victims and increased awareness of IPV phenomenon.

Keywords: Intimate partner violence, psychotherapy, counselling

Intimate Partner Violence (IPV) perpetrated by men against women is reported to be one of the most common forms of violence worldwide (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). The Global Status Report On Violence Prevention conducted by The World Health Organisation states that at some point in their life, one in three women have been a victim of physical or sexual violence by an intimate partner (Butchart, Mikton, Dahlberg, & Krug, 2015).

IPV can be defined as a threatened, attempted or completed act of physical, emotional or sexual aggression conducted by a current or a former intimate partner (Nathanson, Shorey, Tirone, & Rhatigan, 2012). There is a growing body of research suggesting that a substantial proportion of women exposed to IPV might experience various physical and mental health problems including chronic pains, cardiovascular and respiratory problems, bone and muscle conditions, gynaecological problems and sexually transmitted diseases, as well as anxiety, phobias, post-traumatic stress disorder, substance abuse and suicidality (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Devries et al., 2014; Dude, 2011; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; García-Moreno et al., 2015; Golding, 1999; Kramer, Lorenzon, & Mueller, 2004; Loxton, Schofield, Hussain, & Mishra, 2006; Schei, Guthrie, Dennerstein, & Alford, 2006). A growing body of research points out the effects of IPV on women as individuals, as well as the weight it places on social and health care providers (Miller, McCaw, Humphreys, & Mitchell, 2015; O'Doherty et al., 2014; World Health Organisation, 2013). It has been proposed that counter therapeutic actions from health care professionals involved in counselling and psychotherapy services for victims of IPV may pose a risk of re-traumatisation (Hattendorf & Tollerud, 1997) and therefore a specialist approach to treatment might be required.

Research suggests that community-based services for victims of IPV can be effective in promoting survivor's safety, health, and wellbeing (Bennett, Riger, Schewe, Howard, & Wasco, 2004; Campbell, 2006; Petersen, Moracco, Goldstein, & Clark, 2002). However, it appears that there is little research on how those services should be delivered (Macy, Giattina, Parish, & Crosby, 2010). Macy, Giattina, Sangster, Crosby, and Montijo (2009) described the current state of service delivery in the US as a 'black box', suggesting that the inner workings of these services remain largely unknown. Notably, the literature on the topic of specialist services for victims of IPV within the UK also appears to be relatively limited (Burman & Chantler, 2005; Burman, Smailes, & Chantler, 2004; Harne & Radford, 2008; Stanko, 2001). For

instance, Williamson and Abrahams (2014) reviewed evaluations of three UK intervention programs for IPV victims named the Freedom Program, the Phoenix Program, and the Pattern Changing Program. They suggested the need for much more rigorous evaluations.

However scarce, there have been a number of studies investigating interventions for IPV survivors (Bair-Merritt et al., 2014; Eckhardt et al., 2013; Feder et al., 2009; Jahanfar, Janssen, Howard, & Dowswell, 2013). In their review of Intervention programs for IPV Eckhardt et al. (2013) concluded that although enthusiastic and inventive, this research area is at the early stage of its development, with considerable distance left to achieve the goal of establishing effective programs to eliminate IPV. In addition, research on what constitutes a recommended approach to counselling and therapy interventions for victim survivors of IPV, within a specialist service, often provides a different and sometimes controversial scope of suggestions (Dienemann, Campbell, Landenburger, & Curry, 2002; Eckhardt et al., 2013; Hague, Mullender, & Aris, 2003; Murray & Welch, 2010; Wall & Quadara, 2014; Zeman, 2004). Macy et al. (2009) recommended that researchers, community-based providers and violence survivors work collaboratively on investigating the effectiveness of community-based services for victims of domestic violence. However, the psychological experience of service users, particularly women undergoing therapy as victims of IPV within specialist services, is relatively unknown (Sanderson, 2008; Sullivan, 2012). Given the high prevalence of IPV victims among female population and the fact that majority or specialist service users are women (Anitha, 2010; Hines & Douglas, 2011; Peek-Asa et al., 2011), exploring their experiences of therapy shows to be of great importance.

Furthermore, although there is some degree of recognition that IPV should be studied within the context, and qualitative or mixed methods of research might be more appropriate (Chang et al., 2010; Gavey, 2013; Testa, Livingston, & VanZile-Tamsen, 2011), it appears that there is a tendency for researchers in the field to focus on particular constructs (e.g. efficacy, symptom-reduction, or violence prevention) and rely on constructed quantitative measures. Qualitative exploration of experiences, specific needs, and concerns of female service-users can potentially facilitate therapy outcomes and provide grounds for the further provision of specialist services – in particular for IPV victims as well as policy recommendations for service provides.

The current study therefore adopts a qualitative framework. We used in-depth, semi-structured individual interviews and Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) in an attempt to explore women's experiences of therapy for victims of IPV within a specialist domestic violence service. The term 'domestic' violence here does not refer to a theoretical orientation of the researchers, but rather represents the terminology most commonly utilised by service providers and the general population.

Method

Participants

Eight women, all over 18 years old, who have undergone 18 weeks of person-centred therapy for victim-survivors of IPV within a specialist domestic violence service 6-12 months prior to the study were recruited. All of them were permanently residing in the UK, had been in relationships with a male partner for the period of at least a year, had experienced IPV exposure, and all were divorced or separated from their former partners at the time when the interviews were conducted. Participants were compensated 10 GBP for their participation and travel expenses were reimbursed. They are referred to by the following pseudonyms throughout the study: Nina, Claire, Beth, Jenny, Mary, Ann, Sam and Kelly.

Procedures

Participants were recruited from the Women's Trust, the registered UK charity and mental health service, providing help and support for women affected by domestic violence. Primary risk assessment has been conducted for all potential participants within the service. Those women who presented with high suicidality risk prior or post therapy at Woman's Trust were not approached. Participants responded to the advert sent from the official email at Woman's Trust explaining aims and nature of the research. They were provided with a copy of the information sheet and were asked to contact the researchers if they were interested, or if they had any further questions. Women approached the researcher directly, either by telephone or email. None of the participants reported high levels of distress and none were suicidal.

Eight semi-structured individual interviews were conducted at the Woman's Trust premise where participants met the researcher for the first time face-to-face. They were invited to one of the therapy rooms where the interviews took place. Prior to starting each interview, participants were given a print out of the information sheet

that was emailed to them during the recruitment process. They were asked to go through it again and let the researcher know if they had any further questions. Participants were then asked to sign a consent form to show they understood the purpose of the study, what was required from them and their rights. After the interview participants were debriefed and given contact details of helplines and counselling support services should they feel they might require any support. Confidentiality rules were strictly followed throughout the research process.

Data Analysis

The interviews were recorded on a digital device and then transcribed verbatim. Pauses longer than 2 seconds were indicated by (pause), laughter and other non-linguistic forms of expression were also noted. If any descriptive comments or associations came up during transcription, they were noted for future analysis. The data obtained from the transcripts was analysed using Interpretative Phenomenological Analysis (IPA). The six stages outlined by Smith et al. (2009) were used as a guideline rather than a definitive procedure.

Results

Table 1 displays the results the IPA represented through one over-arching theme with four inter-related constituent themes each of which consists of a variety of subthemes.

Recovery as a Process

'Recovery as a process' is an over-arching theme that appears to encapsulate the variety of lived experiences of women who took part in this study. Although women often conveyed their stories in a chronological way, it is important to emphasise that this 'process of recovery' does not appear to be linear. It is instead a unique journey of each of the women and is being lived through in the present.

The results will be presented as described by the women – in a sequential manner, starting from how participants experienced themselves, others and the world before, throughout and after therapy, followed by their lived experiences of 'now' at the time of the interview.

Table 1

Appearance of IPA emergent themes

Overarching theme	Constituent theme	Subtheme	Participants who display this theme
Recovery as a process	1. Abuse as disintegrating the Self		All participants
		1.1. Confusion and being overwhelmed	6/8 (All except Mary and Ann)
		1.2. Losing the sense of Self	5/8 (All except Mary, Sam and Kelly)
		1.3. Self-condemnation	5/ 8 (All except Jenny, Mary and Ann)
		1.4. Questioning Self-worth	5/8 (All except Jenny, Ann, and Kelly)
		1.5. Lack of control	7/8 (All except Kelly)
	2. Oblivion of abuse and awakening		All participants
		2.1. Becoming aware of abuse	6/ 8 (All except) Jenny and Ann)
		2.2. Lack of awareness about available support	7/8 (All except Kelly)
		2.3. Looking for a way out	8/8
		2. 4. Abuse, mental health and legal issues	8/8
		2.5. Specialist knowledge as a catalyst of insight	8/8
	3. Therapy as a journey of empowerment		All participants
		3.1. Communicating thoughts and feelings	8/8
		3.2. Therapy as a safe place	6/8 (All except Jenny and Mary)
		3.3. Connecting with a therapist	6/8 (All except Beth and Ann)
		3.4. Empowerment as a unique experience	8/8
	4. Therapy as a continuous experience		All participants
		4.1. Therapy as taking through	7/8 (All except Sam)
		4.2. Importance of therapy duration	6/8 (All except Mary and Kelly)
		4.3. Importance of continuous support	Beth, Mary,

		4.4. The enabled Self and new ways of coping	8/8
		4.5. Gratitude for the help	7/ 8 (All except Kelly)

Abuse as disintegrating the Self. Although none of the participants were explicitly asked about their experience of abuse, all of them described it in one way or another. The theme 'Abuse as disintegrating the Self' emerged from these descriptions capturing women's sense of how their experiences might have affected their sense of self. As most of them were talking about how they felt prior to starting therapy, one might assume that in some ways those feelings were brought into therapy.

"I was a totally different person, and you don't think you'll ever get back to being that person really" (Nina)

Nina conveyed losing her true self and becoming a different person. It appears that the change she portrays felt permanent and that there was no way of going back to whom she was before the abuse. There is a deep sense of despair and loss, which appeared to have been addressed in therapy as she then goes on talking about how through therapy she 'learned skills and ways' of trying to get back to her real self:

"I just learnt a lot of skills and ways of thinking to help me to - get back to being me, because I'd just lost myself"

Ann explained the sense of loosing herself through having her life goals shattered, denigrated and laughed at for many years. She portrays a picture of humiliation and belittlements resulting in a pervasive change in herself:

"I have this thing - because I was 20 years in that marriage, and all of me was change, and all my goals were stifled, sort of stamped away or laughed at…"

Participants also described experiencing a shattered sense of self-value. They used different terms and ways of unfolding it, but it appears that most of them experienced some kind of disparagement resulting in them questioning their self-worth. Beth talked about wondering why she even "mattered to people":

"Because you know, why am I mattering to people, and that was a great support actually, you know, women saying 'well you shouldn't have been treated this

way, no matter what you did no one has the right to treat you this way and you do matter'"

Perhaps, Beth was questioning self-worth to an extent when she could not comprehend that someone would be compassionate and encouraging, and that people would be concerned and acknowledge that she was treated the way no one should have been. This statement also makes one wonder whether it represents feelings of self-blame, as if she "did something" to deserve being abused and therefore did not matter anymore. She later on describes addressing these feelings in therapy as promoting self-acceptance and shifting self-blame through realisation:

"She [therapist] could say 'well he would have done this because he was trying to get you to do that' sort of thing - because with me I'm very sort of straightforward - say what you mean, mean what you say - but she was very good at reading between the lines and I think it sort of stopped me punishing myself so much. Thinking: 'why didn't I do this or why didn't I do that'…"

There is a sense of confusion and it seems that as a "straightforward" person Beth might have been struggling with understanding the perpetrator's motives and behaviours. Perhaps, gaining more insight with the help of her therapist, who could "read between the lines", enabled Beth to recognise her choices of behaviour as ones that would be natural and logical in the given circumstances. In turn, this might have helped her to validate these responses and therefore alleviate guilt around doing or not doing things differently.

Kelly also depicts shifting the responsibility from oneself onto the abuser through realisation:

"And that led me then to self-study that personality type and that's been helpful that I know I'm not the crazy one"

She describes it as recognising that she is "not the crazy one", but instead presumes the perpetrator has a particular "personality type". Perhaps this is a representation of the internal work resulting in some kind of movement from feeling confused, when "nothing made sense" to gaining more insight and therefore alleviating feelings of self-blame.

The sense of lack of control echoes through the transcripts. Participants mainly described it in a context of how they felt being in abusive relationships, but rarely talked about it explicitly.

Claire portrayed a sense of dreamlike reality, as if someone has simultaneously put her to sleep, almost hypnotised her, and therefore made her more vulnerable and oblivious to what was going on. There is again a deep sense of helplessness and complete lack of control:

"Because it just felt like someone had clicked (she clicks her fingers) their fingers, and I had fallen asleep. And someone could take so much advantage"

Ann also talked about being detached from reality:

"I see myself - I was in those bubbles that you blow. I saw myself in those. I was in a sort of bubble, and I didn't know I was in that bubble until I got my counselling..."

This gives one a feeling of being trapped, powerless and isolated. There is a sense of depersonalisation and very little control over one's life, as if she was locked up in a drifting bubble and had no power over its direction. She expressed having limited awareness of her way of being, and later on talked about how she managed to get more insight through therapy.

Oblivion of abuse and awakening. Not only women talked about having little control over their lives throughout abusive relationships, they also described having little awareness of what was going on. The constituent theme 'oblivion of abuse and awakening' encapsulates women's experiences of their journeys starting from "not knowing", moving towards "realising something is wrong" and "looking for a way out". The subthemes capture some components of participants' experiences of these journeys as well as their experiences of therapy as a part of the journey.

It appears that one of the "turning points" in the women's journey was realising that they were in abusive relationships. Sam described being lost and struggling to understand what was happening in her relationship or why the perpetrator was acting the way he did. She conveys that a "turning point" for her was realising that something was not right which appears to have enabled her to start looking for answers and mapping the course of her own actions:

"I was lost to what to do, and gradually I got some answers from people who helped. I think the key thing was saying 'something's wrong'"

Nina also described looking for some kinds of answers in her attempts to restore a failing relationship:

"I went to see a counsellor after my relationship was breaking up, and at the time I didn't actually realise it was domestic abuse…"

She conveys not realising that she was in abusive relationships and says it was the counsellor who advised her to see someone who specialises in domestic abuse.

Beth also described "not knowing" why the perpetrator acted the way he did or what the reasons of her own responses to his behaviours were. She seems to convey the importance of becoming aware, understanding motives of perpetrator's behaviour and complexity of IPV.

"I had no idea why he was the way he was, or why I would - why I handled it the way I did […] So she [therapist] was able to shed light on it – put it into perspective which really-really helped to me, because I had no idea. Just no idea"

Most of the participants described feeling lost and disempowered in their relationships. In such situations being able to get appropriate help can become vital. Unfortunately, most of the participants reported lack of awareness about the availability of such support.

Jenny assumed that if she knew she could get help, she might have avoided having to face physical and mental health consequences of IPV and associated stress:

"So I was thinking if I'd known all this before this one - even if I'd known there was a Woman's Trust somewhere, maybe I wouldn't have this high blood pressure. Maybe I wouldn't even be depressed"

Mary also described not being aware of whether or how she could get help:

"I didn't know I could get help, but once I started the procedures [they] said 'we can get you counselling, we can help you fight your case, we can get injunctions on him', because I was adamant that I didn't want to leave home, which can be dangerous and it turned out to be quite dangerous. But I took risk…"

It appears that knowing her options served as a push in decision making, promoting change and moving forward. Having support from professionals has enabled her to "take a risk" and perhaps being aware of the available support had affected her reluctance to leave the abuser.

Participants who took part in this study had left abusive relationships and during the interview reflected on their experiences. Exploring these experiences

seems important in the context of this study as it might help to shed light on women's journeys towards recovery and therefore, the phenomenon under investigation.

Women described their experiences of leaving/deciding to leave abusive relationships in different ways. They expressed how they were feeling towards the end of the relationship, what happened after they had left or why they decided to leave. Kelly described having no other option and having to run for her life:

"I felt like I was dying inside and it was manifesting itself physically in illnesses, and that I had to do something about it. So my first step was to run away"

For Nina leaving was also the only way out:

"There is nothing anyone could say or anything, it was only when I left that situation that I started to feel better"

Ann described being at a different stage of her life now, whilst at some point it felt as if she was also on the edge:

"But I never dreamt I could reach that stage because when you're in there you think that that's the end, you know, there's no way out"

It appears that for some of the women who took part in this study deciding to leave the abusive relationships felt like a life or death decision. Perhaps, for some of them this might have been a turning point in their journeys and it makes one wonder how those decisions might have been affected if those women have had appropriate and timely professional support.

All participants described their experiences of having to go through some legal procedures in relation to their experiences of abuse or separation. Most of those experiences appear to be traumatic in some ways and have had an effect on the women's psychological wellbeing:

"So it's like there's two abuses — there's the abuse in the relationship and now you're going to escalate it by saying 'ha-ha-ha, it's all in my name, you chose to leave'. And I felt like I'd been shot in my heart"

Kelly described feeling like she has been "shot in her heart", perhaps, implying the deep disappointment, helplessness and feeling betrayed. She portrayed preparing herself "for a fight ahead" of her and continued with saying:

"I felt as though with the Woman's Trust, I'd recruited an army in group counselling. That we are going to march together to march through and bring you through the other side"

It appears that for Kelly being a part of a group of women with similar experiences to her own gave her a sense of belonging, as well as a tremendous sense of empowerment when she felt that she was a part of an army – a large and powerful source able to get her through any struggles she might face when standing up to the abuser. Women's descriptions of their experiences with legal services convey a very disturbing picture.

"I'd just had a court case - the final hearing for the contact - and it didn't go well at all. So it really got me down…" (Nina)

"We're a problem, because many a time the police don't help you. They make it worse for you. Many a time…" (Claire)

"And in between I got a bit ill. I went through a breakdown. My kids were given to their Dad, but when I went back I was very distort, and again she [therapist] sort of tried to pull me together" (Mary)

Not only were these women continuously abused by their partners in intimate relationships, it appears as if the abuse continued when they tried to get out of it. The adequacy of the legal response to IPV is outside the scope of this discussion, however, it seems that for each of the participants who took part in this study those experiences have caused a great deal of distress. This emphasises even more the importance of on-going practical and psychological support for victims of IPV. It raises questions and concerns regarding provision of specialist services for victim-survivors of IPV.

All participants talked about importance of specialist knowledge in therapy. It appears that for many of them their therapist's knowledge about specifics of IPV, motives or 'personality type' of perpetrators, as well as their ability to clarify and explain victim's behaviours, played a very important role in promoting insight and consecutively, empowered them, helped them feel more in control, alleviated self-blame and much more.

Claire described her experience of gaining insight into motives of the perpetrator behaviour with the help of her therapist as 'awakening':

"I kept saying: 'I'll never forget this, I'm awake". I kept saying: "I'm awake, I'm awake, I'm awake'"

It appears that for Mary attaining insight was related to a sense of empowerment:

"When you know what you're dealing with and you're informed - an informed being is very powerful rather just being sort of left to talk about yourself every day or every session'

Mary seems to imply a more active role from the therapist is needed in promoting empowerment through guidance and enabling the client's insight as opposed to a more passive role where Mary felt she was being "left to talk about herself every session".

It appears that acquiring knowledge or explanations about constituents of IPV, motives of perpetrator's behaviours, as well as women's own responses to it, has been a positive therapeutic experience for participants who took part in this study. One can assume that this can be an indication that a specialist approach might be required when working with victims of IPV.

Therapy as a journey of empowerment. The theme 'Therapy as a journey of empowerment' consists of four subthemes representing empowerment as a process in therapy. All those themes appear to be interrelated and affect each other. For instance, experiencing therapy as a safe place and establishing connection with one's therapist seems to have facilitated participants' ability to communicate their thoughts and feelings more freely. Consequently, all the above would promote empowerment and be a part of it. Participants described various components of empowerment as a process and for each of the women moving towards feeling empowered, it appears to have been a unique experience. All of then however described importance of having opportunity to explore and process their thoughts and feelings in therapy. Some of them had no one to talk to about their experiences of abuse or chose not to, so having the ability to "talk through it", "let things out", and "give it all" in therapy appears to have been a valuable experience for all participants:

***"…**everything was in my head. Everything was in my mind, no one to tell. Until I came to counselling" (Jenny)*

"I just thought it'd be good to go and talk to someone and let things out" (Nina)

"I started to feel a little bit happier because I was talking through it" (Claire)

"…just the whole being able to go somewhere and talk about whatever was troubling me once a week" (Beth)

Ability and willingness to communicate one's thoughts and feeling appears to be linked with experiencing therapy as safe. Participants talked about their experience of feeling safe in therapy in different ways: physical safety, atmosphere in the room, confidentially and being able to talk freely or being in an environment that is positively different from their everyday life:

"I guess it was nice atmosphere in the room. I felt safe in there and very supported" (Nina)

"I had a very nice place to go to once a week, it was a nice comfy room, it was all very safe" (Beth)

"I knew it was a safe environment in which to try and heal yourself" (Sam)

Ann described being able to express herself freely and safely without having to worry about confidentiality issues:

"Talk about anything I wanted to talk about - anything. I know that it would stay within those walls, and that's what helped I think"

Jenny also emphasised importance of confidentiality in therapy and discussed its importance in establishing trust and therapeutic relationships:

"What you've discussed with them, you start hearing somewhere else. So I just said: 'I am not going to trust anyone again, not until I meet this lady'. And she was really-really helpful. And since I've finished with her I've not heard anything I discussed with her from anywhere"

It appears that for Jenny feeling safe in therapy seems to be a part of a therapeutic relationship and is closely related to the ability to connect with her therapist. Claire described her experience of connecting with the therapist at a human level:

"…as long as you build up a rapport as an individual with your counsellor, you'll be good"

Similarly, Mary talked about her therapist being 'heart focused', so they seem to have also been able to connect "at a different level":

"They don't have to think things. They sort of connect to you at a different level - if you're thinking things over you can never say things. But if you connect with your client you know, there's like a flow, so you sort of – and then instantly whatever you [therapist] say, either it will make sense to you – which it usually did…"

It appears that Mary was describing an experience whereby having this connection with the therapist would help not only to establish a rapport, but also promote understanding. She then explains it further:

"…so that's what I'm trying to say, that I think if you're a thinker, you can refrain yourself from saying many important things, but if you sort of initiate from a heart level […] I know there's professional sort of guidelines, but for me, every time something was said, it made sense to me. Rather than just sitting there noting things and thinking 'if I said this or if I said that', then that sort of – it becomes very flat rather than multidimensional"

Mary seems to reflect on the therapist's ability to remain congruent and open to a free dialogue. She describes it as a natural flow of a conversation where both the client and the therapist are not restricted by a set of rules. Rather, they form a genuine connection that, perhaps, enables them to meet at the level of therapeutic depth. Mary described it as being multidimensional, perhaps, referring to having a relationship that would promote deeper level of connection, encouraging openness and free exploration.

All participants talked about feeling empowered in therapy, but described it in different and multifaceted ways. It appears that for each of the women who took part in the study, empowerment was a big part of their therapeutic experience and enabled them to move forward in their journey towards recovery.

Therapy as a continuous experience. This constituent theme encapsulates participants' experiences of therapy as an enduring experience that is prolonged in time and presumably having an effect on their lives as it is experienced in the present. Women described their experiences of therapy in the context of their "journeys of moving forward". It appears that for some of them therapy might have served as a mean of support throughout this journey and enabled them to progress.

Nina conveyed her experience of therapy as support throughout leaving the abuser:

"…it took me from when I was at my low, to when I'd left - yes - the whole journey. It was amazing, I wouldn't have got so far without counselling. It's such a big thing"

She seems to talk about therapy as supporting her throughout the progression of her journey and emphasises how vital this support has been. Similarly, Claire also talks about moving through stages or levels:

"Trying to move you on. From one level, to another level. That's the therapist's job. To move you on from one level, one stage of your life to the other stage"

It appears that for Claire her experience of therapy has been about the developmental context of moving forward in her journey. She describes it as moving through stages of her life and an active role of therapist in this progression. Some participants described therapy as a mean of support that would help them go on from one week to another:

"So you live from one week to the next. So I'm here today at counselling and I take away what I need to make me live one more week and then at the counselling I get to live one more week" (Kelly)

Kelly's intense description seems to encapsulate her experience of therapy as a source of power enabling her to continue her "fight". This continuous support appears to have been vital, providing her "petrol in a motor", as described earlier.

Most of the participants emphasised importance of therapy duration. It appears that although appreciative of the relatively lengthy treatment duration when compared to some other services (up to 18 sessions), some of the participants expressed that they would benefit from further treatment:

"Maybe [the sessions] for a longer period. I would like to continue having them" (Ann)

"So I sort of think now - if I have more counselling, [it] probably would be beneficial…" (Beth)

"The 18 weeks is generous and I know it's generous and I was very grateful to have the maximum, you know. But I don't expect to have- to keep going forever but it's nice..." (Sam)

Sam seems to describe a struggle of trying to rationalise her feelings about the ending of therapy. It appears that despite having "the maximum number of sessions" and understanding that therapy cannot "go forever", she still experienced it as a loss.

Jenny described struggling with the ending and at the time of the interview seemed deeply distraught with the fact that she "was not allowed" to contact her therapist once the therapy stopped:

"Which is why they should let the contact - even if it's once or twice in a year - for her just to say 'how're you getting on? Are you ok? Everything alright with you?' They should let us maintain that. Instead of just cutting it…"

Jenny talked about her journey of allowing herself to trust her therapist and establishing a good therapeutic relationship. She described having very little social support and her therapist appears to have been the only person she could turn to for help. She seems to have struggled a lot with separation and ending, seeking to have further contact with her therapist.

Claire seems to have had a different experience following therapy termination. She appears to have experienced the ending of therapy as a big loss and reflected on the importance of further treatment:

"It just needs to go on longer. It don't - it's like a big loss, it's a loss because you just feel like you're sitting. You're stuck. Because you're still not getting that support, so for it to go on longer"

This statement gives one the feeling of a very abrupt ending, as if Claire was struck by surprise and totally unprepared. She described feeling stuck and unable to move on when deprived from the support. Perhaps, this could point out the importance of one's 'readiness' to face termination of therapy and sufficient independence to move forward on their own. Possibly, Claire's experience might represent the importance of continuous on-going support for victims of IPV.

Participants described their experiences of therapy ending in different ways. Some of them have reflected on whether, or how, they would have liked it to be different and what they believe could have been done after the therapy stopped. Ann called this 'the after-life':

"More information on [life after counselling] - because these sessions have to come to an end. […] some people they may need more or whatever, so the after-life. After the counselling allocation"

Ann seems to describe the importance of having some sort of guidance after the therapy ends. She referred to "some people" who, perhaps, might be at the stage

of their journey when they would need further support. Similarly, to Ann, Nina has also pointed out the importance of continuous support once the therapy stops:

"Maybe if they had an information pack with numbers of different organisations that you could get help from, or some phone numbers or addresses with legal help, things like that. So when you finish the session you can find your own practical help"

Kelly described her experience of abuse as multimodal and reflected on the importance of having support that would incorporate different modalities of help:

"You have the man that is giving you the problem or has given you the problem. Then you have the practical things that you're trying to do to cope with the effects of being in an abusive relationship is erm, psychological in terms of how you're thinking. It's physical in terms of the way you are to make sure you're not physically in that space, and it's the practicalities of keeping it going, you know, how do you get help to disentangle yourself from this person. Erm, so I think that there needs to be more signposting"

Kelly described having to deal with various effects of being in an abusive relationship and talked about different stages of the journey towards recovery. She emphasised the importance of having both psychological and practical support that would continue throughout the whole process of "disintegrating oneself" from the abuser.

Participants reflected on how they have been experiencing their journeys towards recovery and how a place of therapy throughout this journey is enabling them to move on. Nina described feeling more capable of coping with difficulties through rationalisation and more balance way of thinking:

"But that's the good thing about counselling. It's that it's helped me…Ok things might come up, problems might come up, but I can deal with them a lot better now and kind of try to see through – ok, things didn't go quite to plan, but try to see the positives – and not dwell on things, or think about him or his reaction. So although I've had a few dips, I'm able to get over them"

Claire talked about attaining to therapy and points of reference her therapist presumably might have suggested as a way of managing her emotions:

"There is still certain things in me, the counsellor has instilled things into me, and as much as I might be emotional, I try to keep things there"

Kelly also described still “having her moments”, but it appears that rationalisation has helped her to become more capable of managing disturbing emotions:

“It's not so - I don't feel so despairing. I sort of have my moments, I don't sleep still hardly but I have learnt, I have some rationalisation tools, I prove to myself why this happened and that helps”

Ann described being determined to move on. She appears being adamant that her past experiences have to be left behind as looking back might affect her ability to change and be in control of her future:

“I'm moving forward and I'm not going to look back like Lot's wife in the Bible who looked back and turned to salt. I'm not going to do that”

Sam appears to have reflected on her experience as both challenging and transforming:

“I know there's this phrase 'whatever doesn't kill you makes you stronger', but it — there is something in that. I now love my own company up to a point, and I now love being at home, and I'm not chasing after a man. No way. No way”

She seems to describe being more attentive to herself and perhaps more appreciative of simple things in life. She described changes in her behaviours and standpoints that she appears to perceive as positive.

Regardless of the specifics of their journeys towards recovery and individual experiences of therapy, the majority of participants talked about feeling appreciative of the help they got:

“I don't know what to say except I am so grateful for the Trust” (Claire)

“…so they really helped me, this organisation. I don't know how to thank them really” (Jenny)

“I'm only crying though because I'm so happy with the help I got. I'm so appreciative of it” (Sam)

“I mean when I first needed them, God they were such a lifesaver, literally…” (Mary)

“It's amazing how different it can make you feel. I think it's like invaluable for women…” (Nina)

The above quotes appear to be reflective of how participants seem to feel about their encounter with the specialist service providing support for victims of IPV,

their experiences of therapy within the service and presumably overall feelings about being supported and encouraged throughout their journeys towards recovery. However, it is important to emphasise participants' own roles during this journey. Ann expressed in the following way:

"That is how I've survived and that's why I am so happy to just give back because yeah the system has helped me, but I've manipulated it in a way that with my own conviction, I've made sure that I've used the resources for my own advantage as opposed to you know…yeah, I could've easily stopped working and decided to go on benefits. No, I didn't want to do that because that wouldn't get me where I want to get because I want to do another degree, I want to do another Masters. I want to do lots of things"

This statement not only represents Ann's experience of getting support from the service for victims of IPV, but notably, it also reflects on her own active role during the journey towards recovery, her determination to move on, how she refused to give up and continued to fight for her future. It is important to pay tribute to the fortitude and inner strength of the participants as well as other women who managed to find internal forces, seek help and move towards changing their lives.

Discussion

The present study aimed to explore women's experiences of therapy for victims of IPV within a specialist domestic violence service. The results highlight the complexity of the phenomenon and suggest that women's experience of therapy for victims of IPV might be better understood within the broader context of recovery as a process. When describing their experiences of therapy women emphasised the significance of therapeutic relationship, having an opportunity to explore and process difficult thoughts and feelings, empowerment and promoting insight in therapy. They talked about the importance of specialist knowledge, therapist's resilience and acknowledging the complex nature of IPV, as well as the provision of continuous support and multimodal approach to treatment. Women described therapy as promoting empowerment and independence, increased self-esteem and self-confidence, improved coping strategies and gaining better insight into their experiences of abuse. They talked about being more capable of managing distressing

emotions associated with their past experiences and feeling more hopeful for their future.

However, it appears that regardless of the overall experience of therapy as being beneficial for their psychological wellbeing and taking certain steps in moving forward, participants who took part in this study have not yet been able to fully overcome the experience of IPV and some of them described requiring further support. In addition, it appears that for some of the participants the experience of IPV might have instilled some degree of permanent damage, both physical and psychological, leading to women questioning their ability to ever recover fully. This once again raises questions about the importance of continuous support for victims of IPV.

All women who took part in this study received therapy for victim survivors of IPV within a specialist domestic violence service. All of them described a variety of adverse consequences of being exposed to IPV and explained how some of them were a focus of their therapy. The main therapeutic approach applied in the service is Person-Centred (Rogers, 2012), however, it appears that participants described a variety of therapeutic techniques from other approaches being incorporated into therapy. Those included psychoeducation around IPV or physical symptoms of anxiety, interventions often applied in Cognitive Behavioural Therapy (e.g. breathing techniques and role-plays) or exploration of how childhood experiences might have an effect on client's life at present. Adapting different approaches to therapy or incorporating a variety of techniques into the main approach whilst working with victims of IPV have been documented across various studies (Bogat, Garcia, & Levendosky, 2013; Cort et al., 2014; Kubany et al., 2004; Vaddiparti & Varma, 2009; Zlotnick, Capezza, & Parker, 2011). There seems to be no consensus as to which therapeutic approach might be the most appropriate for this population group, however, there is recognition that due to the multifaceted nature of IPV phenomenon 'one-size-fits-all' approach to treatment might be inadequate and disempowering for women (Kulkarni, Herman-Smith, & Ross, 2015). Many scholars in the field of IPV advocate for a survivor-defined approach to treatment that takes into account variation of client's situations, different goals they might pursue and thus diverse kinds of support they might need (Davies & Lyon, 2013; Kulkarni et al., 2015). It can be therefore assumed, that whilst providing therapy for victims of IPV it is important to

consider a multifaceted nature of IPV phenomenon, a variety of contextual and underlying factors, and therefore tailor the treatment according to client's individual needs.

Although the effects of being exposed to IPV have not been a primary focus of this research, women discussed those in the context of their experiences of therapy. They described that the experiences of IPV has negatively affected their mental and psychological wellbeing, physical health and ability to cope with everyday life, which appears to be in conjunction with other research in the field (Childress, 2013; García-Moreno et al., 2015; Golding, 1999). Participants described that as a result of abusive relationships they were feeling confused and overwhelmed, felt little control over their lives and were questioning their sense of self-worth and overall identity (Matheson et al., 2015). They talked about constant fear of the perpetrator, decreased self-esteem and self-efficacy, having their life goals shattered, whilst feeling ashamed and guilty, blaming themselves for abuse or not being able to sustain their relationship (Bonomi, Anderson, Rivara, & Thompson, 2007; Mechanic, Weaver, & Resick, 2008; Overstreet & Quinn, 2013; Zlotnick, Johnson, & Kohn, 2006).

All participants described having to encounter legal services in relation to or as a direct consequence of being exposed to IPV. Research suggests that often legal response to IPV can be considered as inadequate whilst re-traumatising and exacerbating survivor's self-blame (Koss, 2000), with some authors questioning whether laws or legal reforms can be used to help victims of IPV (Lakeman, 2000). There are studies reporting significant rates of re-abuse during or after court prosecution, or violation of protective orders (Fleury-Steiner, Bybee, Sullivan, Belknap, & Melton, 2006; Holt, Kernic, Lumley, Wolf, & Rivara, 2002). However, there are also empirical findings suggesting that legal interventions have the potential to contribute to abuse cessation (Bell, 2007), whilst it is important to consider victims perspectives (Goodman & Epstein, 2008). Given the number of women who come in contact with legal services as a result of exposure to IPV, it appears that the justice system interventions can have a tremendous impact on the wellbeing of IPV victims.

These findings highlight the multifaceted nature of IPV consequences as significantly affecting physical, psychological and legal domains of women's wellbeing. It is therefore essential that both health and legal professionals attain to the complexity of IPV phenomenon, its impacts, consequences and adequate ways of prevention to facilitate women's journeys towards recovery.

Women who took part in this study described having limited knowledge about IPV in general, their legal rights or avenues of available support prior to starting therapy or prior to deciding to seek help. They portrayed feeling confused and bewildered, lost as to what their options were should they decide to seek help and even motives of their own behaviours when encountering IPV. All participants talked about the importance of specialist knowledge of IPV throughout their journey towards recovery. They often described that prior to starting to seek help, they either were not aware that the abuse was occurring or were 'in denial' about what was happening. Research indicates that most of the women exposed to IPV pass through a stage when they do not perceive violence as such (Petersen, Moracco, Goldstein, & Clark, 2005). Psychodynamic theory suggests that minimisation of IPV can sometimes reflect client's defence mechanisms (denial, dissociation), distorted guilt and self-blame, intentions to protect a perpetrator (Siegel & Forero, 2012), or could also be a part of woman's developmental history (Celani, 1999). From the Person-Centred theory perspective traumatic experience might lead to the process of breakdown and disorganisation of the self-structure (Rogers & Koch, 1959). Experiences that are incongruent with the self-structure are perceived as threatening and not allowed to be symbolised in awareness. The denial to the awareness of the experience occurs in an attempt to keep the experience consistent with the self-structure (Joseph, 2004). Empirical studies indicate that at the stage when IPV is unperceived, women still often report feeling depressed, experiencing anxiety and/or other psychological and physical symptoms, but do not relate those to IPV (Sonego et al., 2013). When considering population sample, the data from the British Crime Survey (Coleman, Kaiza, Hoare, & Jansson, 2008) indicates that 65% of respondents who reported exposure to IPV in the last 12 months did not perceive it as 'domestic violence', however, women were more likely to view the abuse as domestic violence compared to men (39% and 30% respectively). Importantly, 29% of victims described it as 'just something that happens' (36% males and 23% females repectively), 30% thought that 'it was wrong, but not a crime' and only 19% perceived it as 'a crime' (p.70). In addition, half of the people who took part in the survey thought that too little is being done about the problem by the government and agencies and one-third said they did not know whether they are doing enough or not. All these figures raise questions of whether professionals are implementing appropriate actions to ensure that the

population perceives IPV for what it is and considers it to be a criminal act rather than an inherent part of everyday relationships.

All participants discussed importance of specialist knowledge of IPV during the process of therapy. They reflected on being educated about the complexities of IPV, discussing personality types of perpetrators, and exploring their own reactions and feelings in relation to IPV exposure. It appears that this exploration served as a way of gaining insight into perpetrator's motives of behaviours with consequent realisation that abuse was not the victim's fault or was not caused by her actions, but rather a perpetrator was prone to committing violence due to having a particular type of personality (Cattaneo & Goodman, 2005; Kelly & Johnson, 2008; Ross & Babcock, 2009). In addition, women described that gaining better insight into their own feelings and behaviours allowed them to perceive those as a 'normal' reaction to a given situation (Dutton, 1992; Herman, 1998). This in turn, might have elevated distress and shifted self-blame for being abused or for the failed relationships (Dutton, 2000).

Most of the women talked about having an opportunity to explore and process difficult thoughts and feelings in a safe, non-judgemental environment of therapy, allowing them to focus on their individual needs and attend to what they wanted in their lives. Shamai (2000) referred to it as the "discovery and recognition of the right to be someone with legitimate feelings, thoughts, and desires" (p.90). The author suggests that exposure to abuse often involves a space-invading experience of intrusion into women's entire existence space. Therefore, therapy space can be experienced as the only place where a woman can be "herself" so she could rediscover herself and attune to her own needs and desires (Shamai, 2000). In addition, a non-judgemental and attentive attitude of a therapist appears to have enabled women to accept their experiences and lifted feelings of guilt and self-blame by shifting the responsibility for the abuse from victim onto perpetrator (Beck et al., 2011; Grauwiler, 2008). Generally, emotional support and caring attitude of professionals working with IPV survivors has been widely discussed as an important intervention tool (Grauwiler, 2008; Othman, Goddard, & Piterman, 2014; Zweig & Burt, 2007). It is also suggested that a strong therapeutic relationship can provide a holding space for working through affects of deregulation and dissociation, distorted

perceptions of the self, others and the world that are often seen as a result of trauma in women exposed to IPV (Spermon, Darlington, & Gibney, 2010).

Two women stressed the importance of a therapist's resilience and ability to contain their own distressing emotions following the disclosure of IPV experience. Various authors explored possible impacts of traumatic material in therapy, how it might influence a therapeutic relationship and the Self of the therapist (Caringi & Pearlman, 2009; Pakman, 2004; Wilson & Thomas, 2004). Figley (2002) discussed the impacts of traumatic stress, secondary stress and cumulative stress on professionals working with victims of trauma and calls this process "compassion fatigue". He suggests that the compassionate quality of therapists' responses will depend on their ability to protect or isolate themselves from the pain and their perception on achievement whilst providing help, and their ability to handle stress in therapy by utilising various means of support. Failure to address their own personal material such as their own historical trauma or disruptions in therapist's personal or professional life, and impacts of secondary traumatisation when doing trauma work might result in negative impacts on both the clients and the therapists themselves (Hernández, Engstrom, & Gangsei, 2010).

Although feeling empowered in therapy appears to have been important for all participants, they described different factors and components of therapy as promoting empowerment, suggesting a multifaceted nature of the process and unique experiences or viewpoints of each of the women. This highlights the multidimensional nature of women's experiences in regard to IPV itself, the process of therapy for victim survivors, and empowerment as a fundamental component of it (Barocas, Emery, & Mills, 2016; Kasturirangan, 2008; Macy, Johns, Rizo, Martin, & Giattina, 2011; Reisenhofer & Taft, 2013; Winstok, 2007).

Participants also described therapy as an enduring experience. For instance, majority of the women discussed therapy as a means of support that was gradually enabling them to move forward through active practical guidance, emotional support and empowerment. They emphasised importance of the prolonged and consistent nature of this support, including therapy duration or enabling clients to seek further help once the therapy was terminated. This highlights the importance of flexibility, long-term commitment and on-going nature of the support required for women exposed to IPV (Morgan & Coombes, 2013).

Finally, participants portrayed their experiences of therapy within a broader context of their journey towards recovery. This appears to conform to the wider literature describing IPV as a complex phenomenon that encapsulates a variety of multifaceted lived experiences whilst its counterparts are interrelated and affect each other (Burkitt & Larkin, 2008; Childress, 2013; Oweis, Gharaibeh, Al-Natour, & Froelicher, 2009; Prochaska, 2013; Wareham, Boots, & Chavez, 2009). Most of the women described their journey towards recovery as a process of moving towards realising that abuse was occurring, some degree of change was required, and starting to consider their options of how this change could be executed (Chang et al., 2010; Khaw & Hardesty, 2007). Experience of therapy appears to have been a part of this journey. It appears that women who took part in this study were at different stages of their unique and non-linear journeys. Some were still experiencing low mood or anxiety, flashbacks and unwanted memories of the abuse, have had financial difficulties as a result of separation from the abuser or were in the middle of a court case (Childress, 2013; Dillon, Hussain, Loxton, & Rahman, 2013; Evans, 2007; Ham-Rowbottom, Gordon, Jarvis, & Novaco, 2005). Although all participants reported significant improvements in their overall wellbeing following leaving the abuser and engaging in therapy for victim survivors of IPV (Constantino, Kim, & Crane, 2005; Edwards et al., 2012; Johnson, Zlotnick, & Perez, 2011; Kaslow et al., 2010; Roddy, 2013; Zlotnick et al., 2011), some of them were still experiencing adverse effects of having been exposed to IPV. They emphasised the importance of continuous support, holistic nature of the treatment, signposting and being aware of the ways of accessing further help once the therapy was commenced (Bailey, 2010; Malpass et al., 2014; Roddy, 2015).

Evans and Lindsay (2008) argue that experience of abuse is not something one can “get over”; instead, it causes fundamental alterations in the victims that cannot be erased. They suggest that the term “incorporation” might be more appropriate than ‘recovery’ when describing the process by which IPV survivors subsume or integrate traumatic experiences within their sense of self. Wuest and Merritt-Gray (2016) identified it as “taking on a new image” (p. 89) – a process of leaving behind an image of abused woman or survivor of violence and taking pride in the new person one has become. Results from the study of Evans and Lindsay (2008) indicate that exposure to IPV will impact women in a variety of ways for the remainder of the lives of most survivors. This once again indicates the importance of on-going continuous

support for victims of IPV, enabling them to incorporate their experiences into their sense of self and post-relationship journey.

Yardley (2017) suggests that procedures for ensuring and demonstrating a good quality of qualitative research can be grouped into four key dimensions: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Yardley, 2000). These guidelines have been considered throughout the research, however, it is important to point out the limitations of the study. One of the limitations lies in the recruitment procedure. First, only those women who completed therapy 6-12 months prior to the starting point of the recruitment were approached. Second, only those women who either separated from their partner or those who considered themselves as being safe from the abuser were invited to take part. Third, only those women who did not describe high levels of distress or suicidal ideation were recruited. These considerations were taken to minimise the risks of secondary traumatisation and ensure participants physical and psychological safety. However, this might have affected the findings as these restrictions in recruitment could have possibly undermined the influence and interplay of various contextual factors. In addition, this approach might have missed the women who were less motivated to participate in the research. The findings suggest that all participants were generally satisfied with the therapy they had, considered it to be beneficial and expressed gratitude for the help they got. It is possible that women who did not respond to the advert might have felt that their experience was not as positive.

Additionally, the study explored only perspectives of female victims of IPV as perpetrated by male partner. It might be beneficial to adopt a variety of perspectives on the topic including male survivors of IPV or women's in other types of relationships – for instance, same-sex couples. It might be the case that participant's experiences would vary across different population groups. Furthermore, all participants were recruited from the same service, whilst their experiences could have been different having they undergone therapy at a different service for victim survivors. It is worth noting, that although making generalisations was not the aim of this study, it would be interesting to explore other avenues of the research on the topic. In addition, general limitations of the IPA (Willig, 2013) can be applied to this study. For instance, employing non-verbal methods of data collection in future

research could potentially help to overcome IPA limitation as relying upon the representational validity of language.

Overall, the results of this study highlight the importance of an individually tailored approach to treatment for IPV survivors encompassing unique experiences of each of the women and a complex interplay of various contextual factors. It is suggested that using specialist knowledge of IPV in therapy, whilst adopting holistic and continuous approach to treatment, might be beneficial when providing help and support for IPV survivors.

References

Anitha, S. (2010). No recourse, no support: State policy and practice towards South Asian women facing domestic violence in the UK. *British Journal of Social Work, 40*(2), 462-479.

Bailey, M. (2010). Understanding Attrition in Domestic Violence Cases. *International Journal of Interdisciplinary Social Sciences, 5*(3).

Bair-Merritt, M. H., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., . . . Cronholm, P. (2014). Primary Care–Based Interventions for Intimate Partner Violence: A Systematic Review. *American journal of preventive medicine, 46*(2), 188-194.

Barocas, B., Emery, D., & Mills, L. G. (2016). Changing the Domestic Violence Narrative: Aligning Definitions and Standards. *Journal of Family Violence, 31*(8), 941-947.

Beck, J. G., McNiff, J., Clapp, J. D., Olsen, S. A., Avery, M. L., & Hagewood, J. H. (2011). Exploring negative emotion in women experiencing intimate partner violence: Shame, guilt, and PTSD. *Behavior therapy, 42*(4), 740-750.

Bell, M. (2007). Empowerment and disempowerment for victims of intimate partner violence: An overview of the effects of criminal justice system practices. *Intimate partner violence*, 1-15.

Bell, M. E., Perez, S., Goodman, L. A., & Dutton, M. A. (2011). Battered women's perceptions of civil and criminal court helpfulness: The role of court outcome and process. *Violence against women, 17*(1), 71-88.

Bennett, L., Riger, S., Schewe, P., Howard, A., & Wasco, S. (2004). Effectiveness of hotline, advocacy, counseling, and shelter services for victims of domestic violence: A statewide evaluation. *Journal of Interpersonal Violence, 19*(7), 815-829.

Beydoun, H. A., Beydoun, M. A., Kaufman, J. S., Lo, B., & Zonderman, A. B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: a systematic review and meta-analysis. *Social science & medicine, 75*(6), 959-975.

Bogat, G. A., Garcia, A. M., & Levendosky, A. A. (2013). Assessment and psychotherapy with women experiencing intimate partner violence: integrating research and practice. *Psychodynamic psychiatry, 41*(2), 189-217.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2007). Health outcomes in women with physical and sexual intimate partner violence exposure. *Journal of Women's Health, 16*(7), 987-997.

Burkitt, K. H., & Larkin, G. L. (2008). The transtheoretical model in intimate partner violence victimization: stage changes over time. *Violence and victims, 23*(4), 411-431.

Burman, E., & Chantler, K. (2005). Domestic violence and minoritisation: legal and policy barriers facing minoritized women leaving violent relationships. *International journal of law and psychiatry, 28*(1), 59-74.

Burman, E., Smailes, S. L., & Chantler, K. (2004). 'Culture'as a barrier to service provision and delivery: domestic violence services for minoritized women. *Critical social policy, 24*(3), 332-357.

Butchart, A., Mikton, C., Dahlberg, L. L., & Krug, E. G. (2015). Global status report on violence prevention 2014. *Injury prevention, 21*(3), 213-213.

Campbell, R. (2006). Rape Survivors' Experiences With the Legal and Medical Systems Do Rape Victim Advocates Make a Difference? *Violence against women, 12*(1), 30-45.

Caringi, J., & Pearlman, L. (2009). Living and working self-reflectively to address vicarious trauma. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide; Guilford Press: New York City, NY, USA*, 202-222.

Cattaneo, L. B., & Goodman, L. A. (2005). Risk factors for reabuse in intimate partner violence: A cross-disciplinary critical review. *Trauma, Violence, & Abuse, 6*(2), 141-175.

Celani, D. P. (1999). Applying Fairbairn's object relations theory to the dynamics of the battered woman. *American journal of psychotherapy, 53*(1), 60.

Chang, J. C., Dado, D., Hawker, L., Cluss, P. A., Buranosky, R., Slagel, L., . . . Scholle, S. H. (2010). Understanding turning points in intimate partner violence: factors and circumstances leading women victims toward change. *Journal of Women's Health, 19*(2), 251-259.

Childress, S. (2013). A meta-summary of qualitative findings on the lived experience among culturally diverse domestic violence survivors. *Issues in mental health nursing, 34*(9), 693-705.

Coleman, K., Kaiza, P., Hoare, J., & Jansson, K. (2008). Homicides, firearm offences and intimate violence 2006/07. *London, UK: Home Office Research Development And Statistics Directorate*.

Constantino, R., Kim, Y., & Crane, P. A. (2005). Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: A pilot study. *Issues in mental health nursing, 26*(6), 575-590.

Cort, N. A., Cerulli, C., Poleshuck, E. L., Bellenger, K. M., Xia, Y., Tu, X., . . . Talbot, N. L. (2014). Interpersonal psychotherapy for depressed women with histories of intimate partner violence. *Psychological trauma: theory, research, practice, and policy, 6*(6), 700.

Davies, J., & Lyon, E. (2013). *Domestic violence advocacy: Complex lives/difficult choices* (Vol. 7): Sage Publications.

Devries, K. M., Child, J. C., Bacchus, L. J., Mak, J., Falder, G., Graham, K., . . . Heise, L. (2014). Intimate partner violence victimization and alcohol consumption in women: a systematic review and meta‐analysis. *Addiction, 109*(3), 379-391.

Dienemann, J., Campbell, J., Landenburger, K., & Curry, M. A. (2002). The domestic violence survivor assessment: a tool for counseling women in intimate partner violence relationships. *Patient education and counseling, 46*(3), 221-228.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. *International journal of family medicine, 2013*.

Dude, A. M. (2011). Spousal intimate partner violence is associated with HIV and other STIs among married Rwandan women. *AIDS and Behavior, 15*(1), 142-152.

Dutton, M. A. (1992). Understanding women's responses to domestic violence: A redefinition of battered woman syndrome. *Hofstra L. Rev., 21*, 1191.

Dutton, M. A. (2000). *Empowering and healing the battered woman: A model for assessment and intervention*: Springer Publishing Company.

Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for

perpetrators and victims of intimate partner violence. *Partner abuse, 4*(2), 196-231.

Edwards, K. M., Murphy, M. J., Tansill, E. C., Myrick, C., Probst, D. R., Corsa, R., & Gidycz, C. A. (2012). A qualitative analysis of college women's leaving processes in abusive relationships. *Journal of American College Health, 60*(3), 204-210.

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet, 371*(9619), 1165-1172. doi:http://dx.doi.org/10.1016/S0140-6736(08)60522-X

Evans, I. (2007). *Battle-scars: Long-term effects of prior domestic violence*: Centre for Women's Studies and Gender Research, Monash University Clayton.

Evans, I., & Lindsay, J. (2008). *Incorporation rather than recovery: Living with the legacy of domestic violence.* Paper presented at the Women's studies international forum.

Feder, G., Ramsay, J., Dunne, D., Rose, M., Arsene, C., Norman, R., . . . Hague, G. (2009). How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health technology assessment (Winchester, England), 13*(16), 1-+.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of clinical psychology, 58*(11), 1433-1441.

Fleury‐Steiner, R. E., Bybee, D., Sullivan, C. M., Belknap, J., & Melton, H. C. (2006). Contextual factors impacting battered women's intentions to reuse the criminal legal system. *Journal of Community Psychology, 34*(3), 327-342.

Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The lancet, 368*(9543), 1260-1269.

García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., . . . Watts, C. (2015). Addressing violence against women: a call to action. *The lancet, 385*(9978), 1685-1695.

Gavey, N. (2013). *Just sex?: The cultural scaffolding of rape*: Routledge.

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of family violence, 14*(2), 99-132.

Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health, and justice*: American Psychological Association.

Grauwiler, P. (2008). Voices of women: Perspectives on decision-making and the management of partner violence. *Children and Youth Services Review, 30*(3), 311-322.

Hague, G., Mullender, A., & Aris, R. (2003). *Is anyone listening?: Accountability and women survivors of domestic violence*: Psychology Press.

Ham-Rowbottom, K. A., Gordon, E. E., Jarvis, K. L., & Novaco, R. W. (2005). Life constraints and psychological well-being of domestic violence shelter graduates. *Journal of family violence, 20*(2), 109-121.

Harne, L., & Radford, J. (2008). *Tackling Domestic Violence: Theories, Policies And Practice: Theories, Policies and Practice*: McGraw-Hill Education (UK).

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.

Herman, J. L. (1998). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences, 52*(S1), S98-S103.

Hernández, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies, 29*(1), 67-83.

Hines, D. A., & Douglas, E. M. (2011). The reported availability of US domestic violence services to victims who vary by age, sexual orientation, and gender. *Partner abuse, 2*(1), 3-30.

Holt, V. L., Kernic, M. A., Lumley, T., Wolf, M. E., & Rivara, F. P. (2002). Civil protection orders and risk of subsequent police-reported violence. *Jama, 288*(5), 589-594.

Jahanfar, S., Janssen, P. A., Howard, L. M., & Dowswell, T. (2013). Interventions for preventing or reducing domestic violence against pregnant women. *The Cochrane Library*.

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.

Joseph, S. (2004). Client‐centred therapy, post‐traumatic stress disorder and post‐traumatic growth: Theoretical perspectives and practical implications. *Psychology and Psychotherapy: Theory, Research and Practice, 77*(1), 101-119.

Kaslow, N. J., Leiner, A. S., Reviere, S., Jackson, E., Bethea, K., Bhaju, J., . . . Thompson, M. P. (2010). Suicidal, abused African American women's response to a culturally informed intervention. *Journal of Consulting and clinical Psychology, 78*(4), 449.

Kasturirangan, A. (2008). Empowerment and programs designed to address domestic violence. *Violence against women, 14*(12), 1465-1475.

Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family court review, 46*(3), 476-499.

Khaw, L., & Hardesty, J. L. (2007). Theorizing the process of leaving: Turning points and trajectories in the stages of change. *Family Relations, 56*(4), 413-425.

Koss, M. P. (2000). Blame, shame, and community: justice responses to violence against women. *American Psychologist, 55*(11), 1332.

Kramer, A., Lorenzon, D., & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Women's Health Issues, 14*(1), 19-29.

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.

Kulkarni, S., Herman-Smith, R., & Ross, T. C. (2015). Measuring intimate partner violence (IPV) service providers' attitudes: The development of the Survivor-Defined Advocacy Scale (SDAS). *Journal of family violence, 30*(7), 911-921.

Lakeman, L. (2000). Why" law and order" cannot end violence against women: and why the development of women's (social, economic and political and civil) rights might. *Canadian Woman Studies, 20*(3), 24.

Loxton, D., Schofield, M., Hussain, R., & Mishra, G. (2006). History of domestic violence and physical health in midlife. *Violence against women, 12*(8), 715-731.

Macy, R. J., Giattina, M., Sangster, T. H., Crosby, C., & Montijo, N. J. (2009). Domestic violence and sexual assault services: Inside the black box. *Aggression and Violent Behavior, 14*(5), 359-373.

Macy, R. J., Giattina, M. C., Parish, S. L., & Crosby, C. (2010). Domestic violence and sexual assault services: Historical concerns and contemporary challenges. *Journal of Interpersonal Violence, 25*(1), 3-32.

Macy, R. J., Johns, N., Rizo, C. F., Martin, S. L., & Giattina, M. (2011). Domestic violence and sexual assault service goal priorities. *Journal of Interpersonal Violence, 26*(16), 3361-3382.

Malpass, A., Sales, K., Johnson, M., Howell, A., Agnew-Davies, R., & Feder, G. (2014). Women's experiences of referral to a domestic violence advocate in UK primary care settings: a service-user collaborative study. *Br J Gen Pract, 64*(620), e151-e158.

Matheson, F. I., Daoud, N., Hamilton-Wright, S., Borenstein, H., Pedersen, C., & O'Campo, P. (2015). Where did she go? The transformation of self-esteem, self-identity, and mental well-being among women who have experienced intimate partner violence. *Women's Health Issues, 25*(5), 561-569.

Mechanic, M. B., Weaver, T. L., & Resick, P. A. (2008). Mental health consequences of intimate partner abuse a multidimensional assessment of four different forms of abuse. *Violence against women, 14*(6), 634-654.

Miller, E., McCaw, B., Humphreys, B. L., & Mitchell, C. (2015). Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. *Journal of Women's Health, 24*(1), 92-99.

Morgan, M., & Coombes, L. (2013). Empowerment and advocacy for domestic violence victims. *Social and Personality Psychology Compass, 7*(8), 526-536.

Murray, C. E., & Welch, M. L. (2010). Preliminary construction of a service provider—informed domestic violence research agenda. *Journal of Interpersonal Violence, 25*(12), 2279-2296.

Nathanson, A. M., Shorey, R. C., Tirone, V., & Rhatigan, D. L. (2012). The prevalence of mental health disorders in a community sample of female victims of intimate partner violence. *Partner abuse, 3*(1), 59.

O'Doherty, L. J., Taft, A., Hegarty, K., Ramsay, J., Davidson, L. L., & Feder, G. (2014). Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis. *Bmj, 348*, g2913.

Othman, S., Goddard, C., & Piterman, L. (2014). Victims' barriers to discussing domestic violence in clinical consultations: A qualitative enquiry. *Journal of Interpersonal Violence, 29*(8), 1497-1513.

Overstreet, N. M., & Quinn, D. M. (2013). The intimate partner violence stigmatization model and barriers to help seeking. *Basic and applied social psychology, 35*(1), 109-122.

Oweis, A., Gharaibeh, M., Al-Natour, A., & Froelicher, E. (2009). Violence against women: Unveiling the suffering of women with a low income in Jordan. *Journal of Transcultural Nursing, 20*(1), 69-76.

Pakman, M. (2004). The epistemology of witnessing: Memory, testimony, and ethics in family therapy. *Family process, 43*(2), 265.

Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. *Journal of Women's Health, 20*(11), 1743-1749.

Petersen, R., Moracco, K. E., Goldstein, K. M., & Clark, K. A. (2002). Women's perspectives on intimate partner violence services: the hope in Pandora's box. *Journal of the American Medical Women's Association (1972), 58*(3), 185-190.

Petersen, R., Moracco, K. E., Goldstein, K. M., & Clark, K. A. (2005). Moving beyond disclosure: women's perspectives on barriers and motivators to seeking assistance for intimate partner violence. *Women & health, 40*(3), 63-76.

Prochaska, J. O. (2013). Transtheoretical model of behavior change *Encyclopedia of behavioral medicine* (pp. 1997-2000): Springer.

Reisenhofer, S., & Taft, A. (2013). Women's journey to safety–The Transtheoretical model in clinical practice when working with women experiencing Intimate Partner Violence: A scientific review and clinical guidance. *Patient education and counseling, 93*(3), 536-548.

Roddy, J. K. (2013). Client perspectives: The therapeutic challenge of domestic violence counselling–a pilot study. *Counselling and Psychotherapy Research, 13*(1), 53-60.

Roddy, J. K. (2015). Working with Domestic Violence Clients *Counselling and Psychotherapy after Domestic Violence* (pp. 141-165): Springer.

Rogers, C. (2012). *Client Centred Therapy (New Ed)*: Hachette UK.

Rogers, C. R., & Koch, S. (1959). A theory of therapy, personality, and interpersonal relationships: as developed in the client-centered framework.

Ross, J. M., & Babcock, J. C. (2009). Proactive and reactive violence among intimate partner violent men diagnosed with antisocial and borderline personality disorder. *Journal of family violence, 24*(8), 607-617.

Sanderson, C. (2008). *Counselling survivors of domestic abuse*: Jessica Kingsley Publishers.

Schei, B., Guthrie, J., Dennerstein, L., & Alford, S. (2006). Intimate partner violence and health outcomes in mid-life women: a population-based cohort study. *Archives of women's mental health, 9*(6), 317-324.

Shamai, M. (2000). Rebirth of the self: How battered women experience treatment. *Clinical Social Work Journal, 28*(1), 85-103.

Siegel, J. P., & Forero, R. M. (2012). Splitting and emotional regulation in partner violence. *Clinical Social Work Journal, 40*(2), 224-230.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research: London: Sage.

Sonego, M., Gandarillas, A., Zorrilla, B., Lasheras, L., Pires, M., Anes, A., & Ordobás, M. (2013). Unperceived intimate partner violence and women's health. *Gaceta sanitaria, 27*(5), 440-446.

Spermon, D., Darlington, Y., & Gibney, P. (2010). Psychodynamic psychotherapy for complex trauma: targets, focus, applications, and outcomes. *Psychology research and behavior management, 3*, 119.

Stanko, E. A. (2001). The day to count: Reflections on a methodology to raise awareness about the impact of domestic violence in the UK. *Criminal Justice, 1*(2), 215-226.

Sullivan, C. M. (2012). Examining the work of domestic violence programs within a “social and emotional well-being promotion” conceptual framework. *Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved February, 23*, 2014.

Testa, M., Livingston, J. A., & VanZile-Tamsen, C. (2011). Advancing the study of violence against women using mixed methods: Integrating qualitative methods into a quantitative research program. *Violence against women, 17*(2), 236-250.

Vaddiparti, K., & Varma, D. S. (2009). Intimate partner violence interventions. *Contemporary topics in women's mental health: Global perspectives in a changing society*, 387-403.

Wall, L., & Quadara, A. (2014). Acknowledging complexity in the impacts of sexual victimisation trauma: Australian Institute of Family Studies Melbourne.

Wareham, J., Boots, D. P., & Chavez, J. M. (2009). A test of social learning and intergenerational transmission among batterers. *Journal of Criminal Justice, 37*(2), 163-173.

World Health Organisation. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*: World Health Organization.

Williamson, E., & Abrahams, H. (2014). A review of the provision of intervention programs for female victims and survivors of domestic abuse in the United Kingdom. *Affilia, 29*(2), 178-191.

Willig, C. (2013). *Introducing qualitative research in psychology*: McGraw-Hill International.

Wilson, J. P., & Thomas, R. B. (2004). *Empathy in the treatment of trauma and PTSD*: Routledge.

Winstok, Z. (2007). Toward an interactional perspective on intimate partner violence. *Aggression and Violent Behavior, 12*(3), 348-363.

Wuest, J., & Merritt-Gray, M. (2016). Beyond survival: Reclaiming self after leaving an abusive male partner. *Canadian Journal of Nursing Research Archive, 32*(4).

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health, 15*(2), 215-228.

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology, 12*(3), 295-296. doi:10.1080/17439760.2016.1262624

Zeman, L. D. (2004). Domestic violence: a review for case managers of regulations, women's center services, and referral questions. *Care Management Journals, 5*(1), 13-18.

Zlotnick, C., Capezza, N., & Parker, D. (2011). An interpersonally based intervention for low-income pregnant women with intimate partner violence: a pilot study. *Archives of Women's Mental Health, 14*(1), 55-65. doi:10.1007/s00737-010-0195-x

Zlotnick, C., Johnson, D. M., & Kohn, R. (2006). Intimate partner violence and long-term psychosocial functioning in a national sample of American women. *Journal of Interpersonal Violence, 21*(2), 262-275.

Zweig, J. M., & Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: what matters to program clients? *Violence against women, 13*(11), 1149-1178.

PART IV

5. CLINICAL CASE STUDY

5.1. Introduction

The present case study aims to provide a critical overview of my work with the client I saw for a course of short-term psychodynamic therapy (STPD). I have decided to reflect on my work with this particular client as I consider it to be not only one of the most challenging cases I have ever worked with, but also one of the most significant for my professional development. Some of the issues discussed throughout this case study are also represented throughout the empirical study and research paper sections of this portfolio.

A variety of factors that have influenced and complicated the process of therapy will be discussed: the complexity of the client's presentation and multifaceted nature of client's needs, long-term history of mental health problems and suicide attempt, possible learning disability, poor physical health, complex family history, difficulties engaging with therapy, very prominent transference feelings and many more.

In addition, my limited experience of working in a psychodynamic way, particularly with such a complex presentation has caused a lot of anxiety and at times made me question my abilities to help this client. I believe that strong countertransference feelings and my need to be 'helpful' as a therapist became over-activated following difficulties with client's engagement and might have disrupted my focus of listening and trying

to understand what my client was trying to communicate. It took time and a lot of reflection during supervision to start feeling comfortable with the idea that exploring and revealing personal meanings as well as making sense *together* lies in the heart of psychodynamic psychotherapy (Haglund & Buirski, 2001), whilst one needs to accept that as a therapist they can only address something but not everything in the course of time-limited therapy (Gardner, 2013).

Once I came to this realisation, as well as managed to address strong transference and countertransference feelings, there seemed to have been a shift in the therapeutic relationship: the engagement issues became less prominent, and I could feel my client becoming more trusting – perhaps more confident in my ability to tolerate her pain.

This piece of work has helped me to evolve as a therapist working in a psychodynamic way, not only in terms of enhancing my theoretical understanding of the approach, but also the ways of applying it in practice, and I believe it is important to reflect on the challenges associated with this process.

Furthermore, I suggest that reflecting on my work with Naomi might be helpful when conceptualising some of the issues discussed in my empirical study and research paper.

Like my participants, Naomi has been exposed to IPV and although it has not been the primary focus of our work, we briefly discussed it in therapy in relation to Naomi's responses to traumatic events of her life and current presentation. The presenting symptoms such as anxiety,

depression, identity issues, fear, isolation and loneliness, defences like splitting and depersonalisation following trauma strikingly resonate with the ones described by participants in the qualitative study. Difficulties with establishing trust in therapy and importance of strong therapeutic relationship, complex and multifaceted nature of client's needs are the themes weaving throughout my research study, publishable article and our work with Naomi.

Moreover, one of the central research findings was the importance of adapting a holistic approach to treatment that would encompass a variety of client's needs, including physical and psychological wellbeing, as well as legal help and advocacy. These findings appear to be valid for Naomi's case who has been treated by a multidisciplinary team, utilising both social prescribing and psychotherapy. My colleagues have also helped her to get in touch with the legal professionals in regards to the on-going situation with her neighbour, whilst we have all have been actively communicating with Naomi's GP to provide comprehensive support.

Overall, the main themes linking the research study with the case study incorporate history of IPV exposure, presenting issues and some of the common defence mechanisms, the complexity of contextual factors and client's responses to traumatic events as well as, importance of flexible, individually-tailored and multimodal approach to treatment.

5.1.1. Summary of theoretical orientation

It has been argued that although the main treatment techniques applied in the STPD include those described in the psychoanalytic literature, the

therapist's theoretical viewpoints will shape their approach to those basic techniques and drawing from different psychoanalytic theories might be helpful when adjusting interventions to a particular client's presentation (Barber, Crits-Christoph, & Luborsky, 1996; Tuckett, 2008). Taking the above into consideration, the summary of the theoretical orientation in the sections below will provide a brief overview of the various theoretical standpoints that I believe are relevant to this particular case. Having said that, I acknowledge that those might not be fully applicable to some other clinical cases and I might have chosen to refer to other theories of psychoanalysis.

5.1.1.1. Melanie Klein: theory of positions

One of the major contributions of Melanie Klein to psychoanalytic theory is her formulation of the paranoid-schizoid and depressive positions (Klein, 1946; Segal, 2012). A simplified account of Klein's theory of the positions will be presented here as a relevant one to this case study.

The term paranoid-schizoid position (PSP) refers to a constellation of early anxieties, defences, and object relationships that is characteristic of the early infancy, but also continues to a certain extent into adulthood. In PSP the ego of a young child is split into 'good' and 'bad', and the object is experienced as purely 'good' or 'bad' with little or no integration between them initially. The loving and hating feelings of a child are therefore being projected out separately - 'the bad' is being projected outwards while the 'good' is being retained internally. The opposite process of the retention of the bad and projection of the good

is also occurring, leading to the experiences of prosecution and feelings of omnipotence on one side and idealisation on the other. At this stage bad experiences are being omnipotently denied, whilst the good ones are idealised and exaggerated.

The psychological situation of PSP is highly conflictual and divided; there is a sense of vagueness and unreality. As a result of the split-off, a person is in a state of struggle with the outer world. The ability to test the reality is very limited, as the object and the self are not experienced as a whole. What once seemed to have possessed negative qualities can rapidly appear in the opposite form – it is therefore a very confusing time. The very basic emotions can be experienced with great intensity, the splits between love and hate make the self and the object being subject to idealisation and denigration, so one might feel superior in the world of minor feelings and figures and feel impotent in a world of gains (O'Connor, 2002).

According to Klein, the DP can be described as an integration of the parts of an objects to form the whole object when an individual begins to recognise that his feelings of love and hate can be directed to the same whole object. The object is therefore no longer idealised or denigrated, it is seen as an equal and there is a move towards a more accurate sense of reality. DP normally develops in infancy, but is never fully worked thorough and therefore the development continues throughout the whole life (Ogden, 1992). People tend to move from one position to another throughout their lives. Some of them however live predominantly in PSP when the splitting of the ego and the object is

predominant.

The therapeutic aim therefore is to help clients bring the good and the bad experiences together so the world can take on realistic proportions and the power of projections onto the object will fade (O'Connor, 2002). The PSP can be also seen as a developmental phase foregoing the DP (Carstairs, 1992; Robbins & Goicoechea, 2005), as a defence against it (Wetherell, 2003) or as a regression from it (Britton, 2010)

It is worth noting that the interest in the anxieties and defences of the PSP has been developed further in contemporary psychodynamic theory (Bergstein, 2003; Brennan & Shaver, 1998; Britton, 2010; Meltzer, 2008; Smith, 1999; Spillius, 1994; Steiner, 2003). Importantly, there has been a move from Kleinian fantasy-oriented notions of mental processes towards intersubjective perspective with an emphasis on social experiences (Aron, 2013). Following Klein, Ogden (1992) characterises PSP as 'a historical, relatively devoid of the experience of an interpreting subject mediating between the sense of I-ness and one's lived sensory experience, part-object related, and heavily reliant on splitting, idealization, denial, projective identification and omnipotent thinking as modes of defence and ways of organizing experience. This paranoid-schizoid mode contributes to the sense of immediacy and intensity of experience' (p. 614).

In the context of this case study it might be worth looking closer at the concept of projective identification. The concept has been widened since Klein's first definition and one of the ideas that is particularly relevant

here was proposed by Wilfred Bion (1952) and further developed by Herbert Rosenfeld (1987) in the context of its use for communication.

It was suggested that a client makes a therapist understand their feelings through subjecting a therapist to the experiences that a client has been facing themselves. Bion (1962) argues that a therapist must play a role of the (m)other to contain a client's primitive anxieties. This containment is essential as some of the clients, being deeply regressed, are unable to communicate through language and instead they are communicating through impact, essentially projecting their anxieties 'onto' the therapist.

There are various conceptions of projective identification and an ambiguity surrounding the concept has been extensively discussed in the literature (Rosenfeld, 2008; Sandler, 1987; Whipple, 1986). In the context of this case study it might be worth referring to the works of Joseph, Feldman, and Spillius (1989) where projective identification is seen as the pressure a client puts on the therapist to comply with his/her projections. The therapist therefore is able to use his own feelings to understand the client's dynamics (Spillius, 1994).

5.1.1.2. Thirdness

Most of the contemporary psychodynamic ideas about thirdness and intersubjectivity have, in their basis, Freud's notion of the Oedipus complex. Contemporarily post-Kleinian and intersubjective traditions theorising the Oedipal triangle are mainly focused on the importance of symbolic thirdness in thinking about the self and the other (Flaskas, 2012). Some authors argue that Oedipal situation first emerges with the

DP when a child recognises that the (m)other is a separate person with her own dyadic relationship (Britton, 1992; Caper, 1997; M. C. Dillon, 1978).

In general terms a triadic relationship is the one where a person has a relationship with each of the two people, while any pair also has a relationship which is separate from the third person. According to Britton, this kind of relationship provides a 'limiting boundary' that enables the triangular space of thinking. This triangular space provides 'the possibility of being a participant in a relationship and observed by a third person as well as being an observer of a relationship between two people' (Britton, 2004, p. 47). In other words, one develops a capacity to relate to himself as both subject and object and therefore can reflect on the self, the others and the self-in-relationship.

It has been argued that the third position also enables one to distinguish between a belief and a fact and enhances the capacity of finding new perspectives of some kind – to symbolise as well as create coherent narratives (Bondi, 2012; Flaskas, 2012). Importantly, the triangular space of thinking allows us to be observers of our own experience, to think about it creatively and generate new meanings (Britton, 2003, 2004). Some authors suggest that one of the key tasks of psychotherapy is to help the client to recover or enhance this capacity to symbolise, that is linked in some ways, to a shift from two-person relating to three-person relating (Flaskas, 2012).

The Britton's concept of triangular thinking space is closely linked to the concepts of mentalization and reflective functioning as the ability to think about the other-as-other, and about our own self-in-relationship (Flaskas, 2002, 2009; Fonagy, Gergely, & Jurist, 2004; Lemma, Target, &

Fonagy, 2011a, 2011b). Those in turn closely correspond with the object relations theorists (E.g. Winnicot, 1963).

5.1.2. Referral and context of work

The client is referred to as Naomi[2]. She was seen at the NHS psychotherapy service (PTS)[3] that aims to engage clients who do not meet the referral thresholds or find it difficult to engage with the existing services or any 'mental health labelled services'. It aims to address the gaps in mental health provisions and the majority of the clients have complex conditions characterised by comorbidity and risk. The operational context of the service contains significant heterogeneity and diversity, thus it adopts a varied approach to interventions, but the therapies are mainly informed by brief dynamic therapy models.

Naomi is a 48-year old English woman who was referred by her GP following the assessments for other services, but either did not meet the criteria or did not engage. The iCope team suggested that a referral to PTS might be more appropriate. The GP was hoping for advice regarding the future management and was wondering about the link between the stress Naomi was under, her complex physical health needs and her anxiety and depression. She has a long history of anxiety, panic attacks, depression and multiple physical health problems.

---

[2] *All names and identifiers have been changed to protect client's confidentiality*
[3] *All names and identifiers have been changed to protect client's confidentiality*

Naomi reported being depressed, relatively lonely and isolated and had difficult relationships with family members, other than her father. At the time of the initial assessment she was suffering from various bodily pains and seemed very invested in physical problems. She was mourning the loss of her nephew who died just over a year ago, aged 23. She was also frightened and intimidated by her upstairs neighbour. As a result of the initial assessment by one of the psychologists at the PTS, Naomi was referred for social prescribing and offered an 8-session trial of individual STPD within the service, with the possibility to extend it to 16 sessions.

5.1.3. Initial assessment and presenting problem

I saw Naomi six weeks after the initial assessment. She arrived 40 minutes late, was very anxious and seemed ambivalent about starting the therapy. She was late because she received a call from her father regarding some family arrangements. As a result she had to stay home and talk to her sister. It was a very confusing story, but unfortunately we did not have time to explore it further.

Prior to our meeting Naomi cancelled the first two sessions with me, every time calling the office halfway through the session, being very apologetic and keen on rebooking the appointment. She requested to change the time of her sessions to the afternoon as she has been experiencing sleep problems and found it difficult to wake up. I happened to have a free slot in the afternoon and after consulting with my supervisor we agreed to change the time of her appointment.

Naomi also did not attend the fourth session, again calling 30 minutes into the session. This time though, she asked the receptionist to transfer the call to the consulting room so she could speak to me directly. She apologised for 'wasting my time' and explained that again, she had barely slept at night due to feeling physically unwell and therefore, still could not wake up on time for the session.
She arrived 10 minutes late for the fifth session, saying she 'could not believe she was finally there'. Again, she seemed very anxious, reported having poor sleep and feeling physically unwell. I reflected on how difficult it must have been for her to come in today and she seemed appreciative of that.

Naomi reported being depressed for as long as she could remember. The way she was conveying her story was very dreamlike, with a sense of great confusion, unworthiness, being unloved and rejected. At the same time there was a pronounced sense of anger and fury. I felt as if it was also directed towards me and the transference seemed to be very prominent. She described her difficulties as being a buoy in the ocean, staying above the water when the ocean is calm, but going underneath it once her depression suddenly intrudes.

Naomi had 18 months of counselling before. Her therapist was 'a lovely Greek lady with a fancy title of psychodynamic psychotherapist', but she could never get to the bottom of Naomi's problems. When I told Naomi that we could have an 8-sessions trial of therapy with a possibility to extend up to 16, she seemed surprised and somewhat irritated. She

explained that her previous therapist extended their therapy for 6 months following a 1-year treatment, as she believed Naomi needed it.
I was thinking of how she might have been feeling towards me. Like her previous therapist, I am coming from a non-British background, offering her only 8 sessions of therapy despite the complexity of her difficulties that the previous therapist was unable to help her with. She asked me whether my 'senior' colleague (the assessor) told me about her problems and was keen on knowing what her opinion was. I explained that the 8-week trial is a standard service policy and although it might be difficult to 'get to the bottom of her problems', we can work together on trying to explore and make sense of her low mood. If later on she felt that she might benefit from the eight extra sessions, we could extend the treatment. As the first session progressed Naomi did seem more interested in her own mind and links to her early life, so she agreed to an 8-session trial.

5.1.4. Personal/Family history

Naomi believes her mother drank alcohol during her pregnancy with her, and she is sure that she was drinking almost immediately after her birth. Her mother left the family home when Naomi was three and went to live with another man. She would see her intermittently through her early life. Half way through the therapy Naomi mentioned that her mother died in 2003 and it became apparent that they did have some kind of communication throughout Naomi's life. I was struck by this news, as I was under the strong impression that their communication ended when Naomi was a child. I will elaborate on that further in the sections below.

Naomi feels very close to her father who brought her up, sees him frequently and refers to him as 'daddy'. He re-married when she was a young girl, but his new wife was always very clear that Naomi was not her daughter. Naomi has very vague, dream-like memories of her childhood, most of which seem to be somewhat hostile and mainly filled with feelings of confusion, fear, rejection and loneliness.

She has two older sisters who seem to also have had difficulties. One of her sisters is an alcoholic and Naomi has fallen out with her in the past. She was close to this sister's son who died over a year ago, at the age of 23, from leukaemia. He very much wanted the two sisters to make up, and Naomi has been trying to relate to her sister, especially about them both mourning her son, but she finds it very difficult. She often talks about her sisters as a single entity, as if they do not have a separate personality and reports always feeling excluded from their dyadic relationship.

Naomi struggled at school, thinking now that she had a learning difficulty but 'such things were not considered at the time'. She did, nonetheless, manage to get qualifications at the age of 16, 'guessing her way through the school'. Naomi believes her learning difficulty is due to foetal alcohol syndrome (FAS) and she seems sure that she has the facial features of FAS, as she sees them each time she looks in the mirror, but wants a proper diagnosis. I wondered about the meaning behind being diagnosed with FAS in her 40s, perhaps as a way of antagonising her mother, but also connecting with her.

She described having had one romantic relationship when she was in her early 20s. She got engaged, but her partner was mentally and physically abusive, so they broke up after 3 years. At one point of their relationship they had an argument, her sister was involved and took the side of Naomi's partner, forming some kind of coalition against her. She felt impotent and excluded once again and took an overdose of paracetamol hoping then that she would be taken seriously. Currently she does not have suicidal thoughts.

She described enjoying working in a charity shop and her involvement with the local dogs charity fostering dogs in the past. Caring for the dogs meant she stopped working. Her illnesses (balance condition, on-going pain from gastric band surgery 2 years ago and gall bladder removal surgery) appear to have taken over this role for her now – keeping her inside, not grabbing hold of life. She has had a long history of ill health. She lost a lot of weight over the last couple of years after gastric band surgery and although she is pleased with this achievement, she is in pain after this and subsequent surgery, and is now under the care of the pain team. During our first session I got the impression that Naomi is fairly wrapped up in a bodily world, and this is the route through which a lot of her distress is communicated.

5.1.5. Current circumstances

Naomi lives alone in a flat. She has felt intimidated by her upstairs neighbour for years. Her nephew caused things to improve in the past by confronting the neighbour, but now he has died. The neighbour moved in years ago to take care of his father who was permanently ill, but was a

‘very kind old man’ with whom Naomi had a very good relationship. She reports that the neighbour was neglectful and abusive towards his father. She described fantasy like, very vivid pictures of the father laying in his own faeces after his colostomy bag would burst whilst the son would scream at him.

The neighbour makes loud noises, often all night (she said it’s like living underneath Riverdance, which sounded like humour, but her face was totally dead pan) and she hears frightening altercations in the flat above and also notices bodily fluids, including blood, splattered on her window. She has reported this to the police and the council have called her to be a witness in the eviction proceedings against this neighbour, but she is frightened to do this. She has sought help from her downstairs neighbour when she has felt particularly frightened. The council have suggested that she could move, but she does not want to. She thinks the council would re-house her outside London and she wants to stay close to her father and to maintain her relationship with her GP.

Naomi smokes and uses painkiller medication, but does not drink. She is pleased that she has managed not to become alcohol dependant when other family members are.

5.1.6. Formulation

Naomi is a timid, almost bird-like woman; it is extremely difficult to imagine her ever being overweight. She appears mild mannered with sometimes limited agency, yet she seems to be able to see beneath the surface, which comes out mostly in bodily pain and is projected outwards, for instance onto the upstairs neighbour. At times she talks in

a psychologically minded, informed way, but then suddenly becomes very chaotic and childlike.

She wants to maintain a special closeness to her dad by being a 'good daughter', and finds it difficult that other women have got in the way. She doesn't have a partner herself and had one over 20 years ago saying that 'not much has happened on this side of her life'. She described him being physically and psychologically abusive, and they separated after 3 years of relationship. Naomi is uncomfortable talking about this relationship, however, mentioned that her ex-partner and one of her sister formed some kind of 'coalition' against her, were intimidating and continuously made fun of her. One of those situations resulted in Naomi's suicide attempt. She seems to perceive the majority of her relationships as her being excluded from a couple (mother-father, father-stepmother, mother-stepfather, her-sisters, neighbour-neighbours' son). There is a lot of hatred and rage towards the members of her family and perhaps, the world around which are followed by guilt and fear of destruction. Her desire for a diagnosis of FAS may be a way of explaining her difficulties and validating the rage towards her mother. She seems in need of someone who would be able to tolerate the hideous sides of her hatred.

Naomi appears to be somewhat regressed, frozen in time, at times very childlike, being very invested in her childhood memories and seems to escape to a fantasy world. There is a lot of splitting – the good nephew, the good dad, the bad mother, sisters and neighbour. She lives in a pretty persecuted place, but did show some interest in using her mind

and thinking, saying that she has always known that a lot about her current situation is to do with her early life.

Naomi seems to live predominantly in PSP whereby the reality appears split into purely ‘good’ or ‘bad’, in this defensive regression her symbolising capacity is somewhat limited, the fantasy and reality are often not well differentiated and the boundaries between the self and the other are diffuse. She seems to struggle with triadic relationships, whilst the triangular space of thinking seems somewhat disabled. Her rage and anger seem to be projected outwards, resulting in ‘being angry with the whole world’, followed by guilt and fear of destruction. Alongside other defences of the PSP, the harsh super ego is acting as a defence against the needy side of herself, therefore preventing her from allowing herself to ‘want’ and go with her needs. It can be therefore assumed that the general aim of therapy could be to work towards the move to the depressive position by enabling insight and awareness and promoting a more balanced perception of the world.

It appears that Naomi’s ego function can be described as somewhat distorted. She seems to struggle at times to distinguish between her fantasies, fears and reality, and defensive depersonalisation appears to be manifested in a variety of ways. Although, she experiences a wide range of emotions, at times she finds it difficult to be emotionally present and interpersonally engaged. This can be particularly prominent within the context of transference interpretations, when she finds it difficult to recover from regressive reactions.

5.2. The development of the therapy

From the beginning of therapy it was apparent that Naomi finds it very difficult to commit to it. It seemed that she struggled with trusting me and being in the position of wanting help, allowing herself to be dependent, seemingly due to the relational development context of her past experiences. I was aware that the formation of new ways of organising one's experience can only take place in a new relational engagement (Haglund & Buirski, 2001), whilst the channel of healing is primarily the therapeutic relationship (Gardner, 1999). However, this requires time and client's engagement, none of which we had.

At one point I became very anxious and felt impotent, as although Naomi seemed engaged at one level – she would call every time to rebook her appointment, she still did not attend regularly, or was significantly late. My supervisor's input was very helpful at this point. By suggesting that allowing space for being in contact with Naomi's pain, even if she is not physically present might be already beneficial, my supervisor helped me come into terms with my own feelings of not being a 'good enough therapist' who is not succeeding in engaging her client. I believe these feelings were activated by my subconscious fear of failing as a psychodynamic therapist, as if at that stage of my training I should have already been competent at least in engaging a client. Sharing those fears during supervision enabled me to explore and normalise my feelings in a safe environment of supervision and revise the treatment plan. We agreed that the primary focus of the therapy during the 8-session trial would be establishing trust, engaging Naomi and formulating her difficulties, rather than focusing on the presenting

problem (Ornstein, 2015). Luckily, the service DNA policy is also relatively flexible, so I was able not to count the first two cancellations.

Throughout our work I had to be very careful with any interpretations. Naomi seemed to be fairly wrapped in her childhood experiences and presumably escaped into fantasy world, her memories were very dream-like. I often struggled to distinguish between the fantasy and the reality; her narratives were extremely confusing and at one point I almost gave up on trying to create links between them. Once again I was struck by my supervisor's interpretations and her ability to make links between Naomi's presentation, her past experiences and what was happening in the room. I remember that at some point I began wondering how I was not seeing what she was seeing and whether I would even get to that level of professionalism and in depth understanding of the process. I believe at this point my own defences became activated and I began engaging with the approach more actively thorough reflection and reading. Once I shared these feelings with my supervisor, she was very encouraging and pointed out that some components of therapeutic process should be understood also through time and personal reflections upon years of experience. Therefore, my anxieties were normal and inalienable parts of becoming a therapist.

There was a lot of sadness in the room and I wondered how unbearable Naomi's feelings must have been if she seems confused as to what is real and what is a part of her fantasy. Once again my supervisor was extremely helpful by reminding me to pay more attention to the process and the here and now, rather than being more focused on the content and the facts. It was important to illuminate the personal meaning

behind the story and how it is being communicated rather than what has actually happened (Atwood & Stolorow, 2014; Larner, 2000).

Naomi managed to attend 4 out of the 8 sessions (not including the first two cancellations). One of the cancellations was for the holiday trip, prearranged and did not count. She also did not attend the session after and called the admin right after the appointment to explain that she just got back from that trip and forgot to let me know it will take longer than initially expected. The rest of the unattended sessions were due to her feeling unwell. When Naomi did manage to attend, she was at least 10 minutes late and although I knew how ambivalent she was about the therapy, how much she was struggling with committing, I was wondering why she had been depriving herself from the full 50 minutes. She seemed to have continuously questioned my ability to hold her and comfort her, and although to a much lesser extent, this was happening up until the very end of therapy.

I had to be very careful with the matter of ending, actively trying to address the anxiety around it. I was wondering whether the very limited number of sessions stopped Naomi from allowing herself to be fully present and being herself whilst there would be a separation. Her concern about the continuity of the connection could also be seen through her behaviour. Although we discussed that there was no need to report to the reception every time she came in and that she could go directly to the room, she kept queuing every time to ask the receptionist whether I was in the room. Perhaps, the harsh super ego was telling her to keep things on a rational level, follow the rules and 'be in line'. I was wondering whether this was a defence against the 'demanding baby'

that lead the mom to flee and now Naomi had to stay ‘good’ so everyone will be connected to her.

Despite my attempts to bring up the issue of ending, Naomi seemed surprised and became very anxious once I told her the 8-sessions trial was nearly over. I asked whether she wanted to extend the therapy for another 8 sessions and she seemed very keen on it. By this time she became much more trusting and has attended a few sessions in a row.
After consulting with my supervisor, we agreed it might be time to shift the focus of therapy towards working through Naomi’s fury and hatred. It seemed apparent that there was a lot of very profound anger towards her mother, however this anger was also displaced and projected elsewhere. She mentioned at times finding herself being ‘angry with the whole world’. I was aware that there is very little we could do in the very few sessions we have left, so after consulting with my supervisor it has been decided that through careful interpretation I could help Naomi bring some parts of the unconscious to consciousness. I did find it hard though as I understood this would not only depend on how receptive Naomi would be, but largely on my professional abilities, particularly working with the transference and defences (Racker, 2012; Segal, 2012; Ursano, Sonnenberg, & Lazar, 1991).
In the ideal world I would be aiming to work towards the move to the depressive position, however, this would require the long-term treatment. I was hoping that by processing the anger towards her mother (as well as her idealised father who also abandoned her by marrying another woman), Naomi would be able to become more aware of her feelings and move towards a more balanced thinking.

5.2.1. Transference and projective identification

I have been referring to transference throughout the case study, but would like to mention the few very profound moments. The transference feelings were very present from the first session, when Naomi was describing her previous therapist. Her remark about my senior colleague, the fact that she was continuously trying to talk over me, dominate the session or disregard some of my questions made me wonder what she was trying to communicate. It seemed like she was testing me and it became apparent that she was questioning my ability to tolerate her pain; there was an atmosphere of sullenness and resentment. Perhaps, like with her mother, Naomi felt a lot of anger towards me, but still wanted to connect, so she cancelled the sessions continuously, but was calling every time to rearrange. It struck me how she would call half way through the session each time or right after it was supposed to end just to let me know she was not coming. It made me think of how, as a child, she was left wondering where her mother was, whether she was coming, but every time was left alone waiting. When our relationship strengthened, I tried to address it, carefully making links between the behavioural pattern and her childhood experiences. She became silent for a while, and said that there is a lot going on for her now and she finds it difficult to attend. She seemed appreciative though that I noticed.

It seemed that Naomi had been testing my ability to contain her and at one point I felt threatened. Nothing was said directly to me or about me,

however she would often express her anger towards other people. Doing that, she was looking directly into my eyes, barely blinking, her tone was very sullen. Many of the stories she was conveying were full of graphic pictures, hostility and despair. I will give some brief examples below:

- ‘He is a horrible-horrible person! You can’t treat anyone like that! The poor man was lying in his own faeces and he was screaming at him: ‘you, dirty old bastard! When will you die finally?!’
- ‘He is spitting on my windows. Once I saw blood streaming, I was terrified! Who on Earth would do it?!’
- ‘There was a smell of this cheap perfume, it was disgusting, I felt I was about to vomit’
- ‘We were 13year old girls! She [her mother] gave us martini! Who would give alcohol to a child?! We ended up vomiting into our dinner!’
- ‘He was so tiny, the poor thing, it was horrible! The blood was coming out of everywhere’

There were many more examples, I knew Naomi was testing me, but sometimes I felt very uncomfortable, almost scared and was wondering as to what I do with all this hostility. My supervisor has helped me to make sense of my own feelings and encouraged me to acknowledge Naomi’s anger through showing that I am willing to tolerate the hideous sides of her hatred. This discussion enabled me to further reflect on the transference and countertransference feelings. I have been able to notice, that although it seemed like I felt sad every time Naomi failed to attend her appointment, I wondered whether the actual feeling was anger that I was trying to supress. Perhaps Naomi would have benefited

from me expressing my feelings more openly, yet in an appropriate manner. At the very least this might have communicated some reality about how she might be disserving her own best interests. It appears that I did generally consider her to be too fragile to bear some difficult feedback and perhaps my 'helpful' over focus was stopping me from being attuned to what my client was trying to communicate. In many of the stories Naomi told me, she presented as being extremely vulnerable and at one point I acknowledged her pain, but also wondered if one would perhaps feel very angry about what has happened. I believe this was a turning point in therapy. Naomi seemed very appreciative of what I said. Perhaps it helped her to feel more comfortable with allowing herself to be real and connect.

5.2.2. Rupture in a therapeutic process

Once we seemed to have established a more trusting relationship and Naomi was perhaps questioning me as a good object to a lesser extent (Brenman, 2012), there was a rupture in the process which I believe has affected the therapy in both good and bad ways. At one point I was unwell and asked the admin to cancel the appointment. I later found out that they could not reach her and left a message that Naomi did not see. She therefore arrived for the session and was 'running up and down' trying to find me, as I was not in the room.

Next week she called the admin to find out whether I was coming. She arrived on time for the session, explained what happened and that no one has ever called her. I tried to reflect on how she must have been feeling, but she was not willing to talk about it, saying 'it is fine now, I

am here. I knew something was wrong, there was no sign on the door and I know it is not like you'. We agreed that I would talk to the admin and try to find out what happened. She did not attend next week. When I rang her up later on that day, she explained that could not sleep at night and just woke up.

She arrived for the next session 15 minutes late, apologetic and very anxious. She explained that once again she had to wait in the queue at the reception to report that she has arrived. She then said that she had found the message from the admin letting her know about the cancellation two weeks ago, so it was 'her fault', but she was very dismissive of what happened as perhaps re-experiencing how she felt was too painful. I felt it was important though to explore her true feelings and bring them to the surface (Malan, 2012).

I also felt it was a good opportunity for some interpretations and making links with her childhood experiences, so I wondered how she must have been feeling while looking for me and being unable to find me, whether it might have brought back some memories from the past when she was left waiting for her mother who never showed up. I was very anxious making such an interpretation and wondered how she might take it considering her fragile state.

Naomi seemed struck by my comment, became visibly upset and said that lots of her current difficulties are due to 'the way she had to be with her mother'. She told me that parents are supposed to be 'protectors' and moved on telling me about a situation when she had to protect her nephew from a man who was significantly taller and stronger than her, whilst her nephew's mother was 'vomiting and had diarrhoea from shock'. She mentioned that she would kill for her nephew, as 'auntie

[Naomi] takes no shit'. Although I did not reflect on it at the time, I wondered later what she was trying to communicate. It seemed like the reaction was formed as a defence against how small and vulnerable she feels (Gabbard, 2010), or perhaps she was trying to tell me that she was expecting me to 'protect' her from the admin failing to notify her about the cancellation. Although very challenging in terms of the therapeutic process, it might have helped Naomi to see her therapist as both 'good' and 'bad' and perhaps this was a tiny step towards a more integrated view of the world (Flaskas, 2002).

5.2.3. The diagnosis of Foetal Alcohol Syndrome and toxicity

I wondered whether Naomi's desire of having the exact diagnosis of FAS was a way of validating the rage about her mother. She talked a lot about alcohol, people drinking and how toxic it is. It made me think that there was something toxic about Naomi – the stories filled with blood, excrements, spit, vomit, her having the same blood type as a cancer patient (nephew). As if the FAS was a result of the toxicity and therefore she was carrying a disorder.

She does not have children of her own, but has been very close with her nephews. She mentioned, that not everyone has to 'breed', she always questioned if she would be a good mother. I acknowledged that perhaps many of the mothers ask themselves the same question, but it seemed like there was something really terrifying for her in it. She became silent, agreed and said that she 'did not want to pass her neurosis' to children, as 'there is enough broken people in the world'. It made me think that perhaps the terrifying part was due to the fear of killing the perspective

babies by filling them with toxins, so she was ‘killing’ herself as a mother. She is still very childlike herself.

5.2.4. Paranoid-Schizoid Position, splitting and triadic relationship

It seemed that Naomi has been somewhat regressed and predominantly living in PSP. There has been a lot of splitting, she felt excluded from the dyadic relationships and struggled to integrate the ‘good’ and ‘bad’. This was particularly prominent when she was talking about her father who seemed idealised whilst the mother – denigrated (Britton, 2010; Carstairs, 1992; Steiner, 2003). This split seemed to be very persistent long into the therapy and Naomi did not seem to be willing to consider different perspectives. However, at one point in therapy the shift seemed to have occurred.

Most of Naomi’s childhood memories, which she did not seem to have many of, were very vague and dreamlike, as if she was erasing the consciousness of something that is disturbing, and therefore erasing the emotional pain. For a long time she did not mention that she had been in touch with her mother till the latter passed away in 2003. Again, the memories of their intermitted meetings were full of sadness and confusion, and always involved alcohol.

Those memories were very painful and it seemed as if Naomi has withdrawn from them, perhaps thinking that no one, including her therapist, could possibly face her pain (Brenman, 2012). However, at one point in therapy she said that she ‘must have blocked out all the horrible things’, as she finds it strange that she does not remember many things from the past. I was puzzled by this comment. Although we discussed the vagueness of her memories throughout therapy and what

this might mean, we have never addressed it directly and I was very pleased with this insight.

Naomi went on wondering about what happened when her mother left. She said that there was a constant battle between her mother and father and she was in between. She then told me about the time when she was 10, she was in her friend's house and it was a week before her birthday. Her friend asked what she would be getting as a present and Naomi broke down in tears, because she knew she would not be getting any special gift. She said her father had never given her any toys; only 'practical' presents, there were no celebrations and if she got something it always happened a few days later. I was aware of Naomi's memories about receiving toys which she assumed were from her mother, but then they would disappear. She presumed that her father must have been taking them away, because he did not want the children to have anything in common with their mother. The word 'mother' was a swearing word in their house. I brought up this memory of Naomi, hoping this might help to address with her the 'bad' dad and the 'good' mom. She responded unconsciously with another story, perhaps as a way of holding both sides.

She was 13 at the time, and her father bought her a doll whilst she was 'well past the age of dolls'. Someone at his work place must have bought it for their daughter, so he decided to do the same. She preferred to be out with friends and was not interested in dolls any more. She said he could never get what she wanted. Her story made me really sad, and I wondered how it must have been for her as a child, - not having a 'special day' or getting presents from her mother, but then being deprived from them. Later I discussed with my supervisor whether this

story was a representation of the shift from the PSP, whereas this time her father was not so idealised and her mother – not entirely horrible.

She then told me that her friend's mother once asked her what she *really* wanted. There were this china dolls that she described with great detail. Her friend's mom bought them for her and Naomi treasured these dolls. Perhaps, this was a positive transference between us and I felt grateful that she shared it with me.

5.3. The conclusion and review of therapy

5.3.1. The therapeutic ending

Naomi attended the rest of the sessions without any cancellations. However, she was late most of the times and very anxious about the lateness. When I wondered what was the anxiety about, she said – 'I don't like being late'. Perhaps, she was expecting that I would notice, she was still ambivalent about the therapy, and was still reporting to the reception once she arrived.

I assumed Naomi was already concerned about the continuity of our connection and as the therapy was coming to an end, became increasingly anxious about it. Once again there was a loss of the unit and even though we talked about the ending a lot, the referral for further therapy was in place and she decided to reengage with the social prescribing team, I could sense her anger and disappointment (Jones, 2000).

She arrived late for the final session, visibly tense and reported having a burning sensation in her chest. She appeared anxious, perhaps, as a reaction to the threat of loss of our relationship (Bateman, Brown, & Pedder, 2010). For a good part of the session she was talking about the meeting with a counsellor whom she met on the street the other day and asked to come in to her place. Although she did not mean to, she broke down in tears and told him about the situation with her neighbour. He promised to help her and 'just before' our today's session 'they' knocked on her door, but she had to go and see me instead. I

appreciated her coming in, reflected on how important it seemed to her as well as on her progress. I wondered about her feelings about having to give up one of two important things, but she did not seem willing to explore it further saying it was fine and they would 'probably come back another time'. It was a very sad session and although I could sense Naomi's anger, it was not so prominent any more, there was much more sadness instead. Perhaps, about the loss of another relationship (Penn, 1990; Safran, 2002; Weiss, 1971).

At one point I felt angry about the ending myself, questioning the meaning of providing time-limited therapy for very complex clients who one would assume will require a longer-term work. I felt sad that we had to end the therapy once the good rapport had been established; and impotent, because there was nothing I could do about it. At the same time though, there was a sense of relief. It was a very challenging case and so much anger was continuously projected on me, that although I felt Naomi needs more help, I was exhausted and one part of me was happy that it had come to an end. At the same time I was aware that Naomi sees herself as a burden and perhaps my feelings were related to her own. It made me wonder once again how other people might be feeling around her and why she has been bounced from one service to another. It seems our work will stay in my memory for a very long time.

5.3.1. Conclusion

I believe one of the most important learning curves for me was realising the power of working with what is happening in the room. I was struck

by how client's feelings can be projected onto their therapist and how it made me feel.

Working with Naomi was very challenging, but I was also pleased to see that sometimes meaningful results can be achieved within the time-limited frames (Binder, 2004), though one needs to bear in mind a clear focus of therapy (Gardner, 2013), realise that they can only address something, but not everything (Ornstein, 2015) and have their supervisor's support (Binder, 1999).

I now seem to be more confident working and formulating in a psychodynamic way and find great pleasure in this kind of work.

I have come to realise that sometimes the presenting problem is not necessarily the focus of work, but rather the formulation that explains the presenting problem (Ornstein, 1995). Once I was able to formulate Naomi's difficulties, the potential focus of work became much clearer, it was easier to make sense of her feelings and how those unfold in transference. I believe it also helped us to establish a more trusting relationship. My supervisor's help was invaluable not only in terms of formulation or using particular techniques, but also processing and making sense of my own feelings.

Although challenging and far from the ideal, I believe overall it was a good piece of work. While it seems that Naomi will benefit from further therapy, I hope we still managed to get something started.

REFERENCES

Aron, L. (2013). *A meeting of minds: Mutuality in psychoanalysis* (Vol. 4): Routledge.

Atwood, G. E., & Stolorow, R. D. (2014). *Structures of subjectivity: Explorations in psychoanalytic phenomenology and contextualism*: Routledge.

Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1996). Effects of therapist adherence and competence on patient outcome in brief dynamic therapy. *Journal of consulting and clinical psychology, 64*(3), 619.

Bateman, A., Brown, D., & Pedder, J. (2010). *Introduction to psychotherapy: An outline of psychodynamic principles and practice*: Routledge.

Bergstein, M. (2003). Verdi's Rigoletto: The dialectic interplay of the psychic positions in seemingly 'mindless' violence. *The International Journal of Psychoanalysis, 84*(5), 1295-1313.

Binder, J. L. (1999). Issues in teaching and learning time-limited psychodynamic psychotherapy. *Clinical Psychology Review, 19*(6), 705-719.

Binder, J. L. (2004). *Key competencies in brief dynamic psychotherapy: Clinical practice beyond the manual*: Guilford Press.

Bion, W. (1952). Group dynamics: A review. *The International Journal of Psycho-Analysis, 33*, 235.

Bion, W. (1962). A theory of thinking. *The International Journal of Psycho-Analysis, 43*, 306.

Bondi, L. (2012). Research and therapy: generating meaning and feeling gaps. *Qualitative Inquiry*, 1077800412462978.

Brenman, E. (2012). *Recovery of the lost good object*: Routledge.

Brennan, K. A., & Shaver, P. R. (1998). Attachment styles and personality disorders: Their connections to each other and to parental divorce, parental death, and perceptions of parental caregiving. *Journal of personality, 66*(5), 835-878.

Britton, R. (1992). *The Oedipus situation and the depressive position*: Tavistock/Routledge.

Britton, R. (2003). *Belief and imagination: Explorations in psychoanalysis*: Routledge.

Britton, R. (2004). Subjectivity, objectivity, and triangular space. *The Psychoanalytic Quarterly, 73*(1), 47-61.

Britton, R. (2010). Developmental uncertainty versus paranoid regression. *Psychoanalytic review, 97*(2), 195.

Caper, R. (1997). A mind of one's own. *The International Journal of Psycho-Analysis, 78*(2), 265.

Carstairs, K. (1992). Paranoid-schizoid or symbiotic? *The International Journal of Psycho-Analysis, 73*(1), 71.

Dillon, M. C. (1978). Merleau-Ponty and the Psychogenesis of the Self. *Journal of Phenomenological Psychology, 9*(1), 84.

Flaskas, C. (2002). Comment–Border crossing and the integrity of frameworks1. *Journal of Family Therapy, 24*, 222-231.

Flaskas, C. (2009). The therapist's imagination of self in relation to clients: Beginning ideas on the flexibility of empathic imagination. *Australian and New Zealand Journal of Family Therapy, 30*(3), 147-159.

Flaskas, C. (2012). The space of reflection: thirdness and triadic relationships in family therapy. *Journal of Family Therapy, 34*(2), 138-156.

Fonagy, P., Gergely, G., & Jurist, E. L. (2004). *Affect regulation, mentalization and the development of the self*: Karnac books.

Gabbard, G. O. (2010). *Long-term psychodynamic psychotherapy: A basic text*: American Psychiatric Pub.

Gardner, J. R. (1999). Chapter 2 Using Self Psychology in Brief Psychotherapy. *Psychoanalytic Social Work, 6*(3-4), 43-85.

Gardner, J. R. (2013). Using Self Psychology in brief psychotherapy. *Progress in Self Psychology, V. 16: How Responsive Should We Be?*, 219.

Haglund, P., & Buirski, P. (2001). Making sense together: The intersubjective approach to psychotherapy. *Northvale, NJ: Hason Aronson*.

Jones, E. E. (2000). *Therapeutic action: A guide to psychoanalytic therapy*: Jason Aronson, Incorporated.

Joseph, B., Feldman, M., & Spillius, E. B. (1989). *Psychic equilibrium and psychic change: Selected papers of Betty Joseph* (Vol. 9): Psychology Press.

Klein, M. (1946). 1991. Notes on some schizoid mechanisms. In. Juliet Mitchell (ed.) The Selected Melanie Klein: London: Penguin.

Klein, M. (1952). Some theoretical conclusions regarding the emotional life of the infant. *The Writings of Melanie Klein, 3*, 61-93.

Larner, G. (2000). Towards a common ground in psychoanalysis and family therapy: on knowing not to know. *Journal of Family Therapy, 22*(1), 61-82.

Lemma, A., Target, M., & Fonagy, P. (2011a). *Brief dynamic interpersonal therapy: A clinician's guide*: Oxford University Press.

Lemma, A., Target, M., & Fonagy, P. (2011b). The development of a brief psychodynamic intervention (Dynamic Interpersonal Therapy) and its application to depression: A pilot study. *Psychiatry, 74*(1), 41-48.

Malan, D. H. (2012). *Toward the validation of dynamic psychotherapy: A replication*: Springer Science & Business Media.

Meltzer, D. (2008). *Sexual states of mind*: Karnac Books.

O'Connor, J. (2002). Type A, Type B, and the Kleinian positions: Do they relate to similar processes? *Psychoanalytic psychology, 19*(1), 95.

Ogden, T. (1992). The dialectically constituted/decentred subject of psychoanalysis. II: the contributions of Klein and Winnicott. *The International Journal of Psycho-Analysis, 73*(4), 613.

Ornstein, A. (1995). The fate of the curative fantasy in the psychoanalytic treatment process. *Contemporary Psychoanalysis, 31*(1), 113-123.

Ornstein, P. H. (2015). On Choosing a Guiding Theory for Treatment in a Pluralistic Psychoanalytic World: My Personal Journey. *International Journal of Psychoanalytic Self Psychology, 10*(2), 107-117.

Penn, L. S. (1990). When the therapist must leave: Forced termination of psychodynamic therapy. *Professional Psychology: Research and Practice, 21*(5), 379.

Racker, H. (2012). *Transference and countertransference*: Karnac Books.

Robbins, B. D., & Goicoechea, J. (2005). The Psychogenesis of the Self and the Emergence of Ethical Relatedness: Klein in Light of Merleau-Ponty. *Journal of Theoretical and Philosophical Psychology, 25*(2), 191.

Rosenfeld, H. (1987). Projective identification in clinical practice. *Impasse and interpretation*, 157-190.

Rosenfeld, H. (2008). Contribution to the psychopathology of psychotic states: the importance of projective identification in the ego structure and the object relations of the psychotic patient1. *Rosenfeld in Retrospect: Essays on His Clinical Influence*, 131.

Safran, J. D. (2002). Brief relational psychoanalytic treatment. *Psychoanalytic Dialogues, 12*(2), 171-195.

Sandler, J. (1987). The concept of projective identification. *Bulletin of the Anna Freud Centre*.

Segal, H. (2012). *Introduction to the work of Melanie Klein*: Karnac Books.

Smith, L. (1999). Individual and institutional defences against primitive anxieties: Counselling in prison. *Psychodynamic Counselling, 5*(4), 429-442.

Spillius, E. B. (1994). Developments in Kleinian thought: Overview and personal view. *Psychoanalytic Inquiry, 14*(3), 324-364.

Steiner, J. (2003). organizations and the paranoid-schizoid and depressive positions. *Melanie Klein Today, Volume 1: Mainly Theory: Developments in Theory and Practice*, 324.

Tuckett, D. (2008). *Psychoanalysis comparable and incomparable: The evolution of a method to describe and compare psychoanalytic approaches*: Routledge.

Ursano, R. J., Sonnenberg, S., & Lazar, S. (1991). Psychodynamic psychotherapy. *Textbook o Psychiatry*, 1637-1654.

Weiss, J. (1971). The emergence of new themes: A contribution to the psychoanalytic theory of therapy. *The International Journal of Psycho-Analysis, 52*, 459.

Wetherell, M. (2003). Paranoia, ambivalence and discursive practices: Concepts of position and positioning in psychoanalysis and discursive psychology. *The self and others: Positioning individuals and groups in personal, political, and cultural contexts*, 99-120.

Whipple, D. (1986). Discussion of" The merits and problems with the concept of projective identification" by Janet Finell. *Psychoanalytic review, 73*(2), 121.

Winnicott, D. W. (1963). From dependence towards independence in the development of the individual. *The maturational processes and the facilitating environment*, 83-92.

APPENDIX 1
Recruitment advert

Version 11/10/2014

Department of Psychology
City University London

PARTICIPANTS NEEDED FOR RESEARCH IN *DOMESTIC VIOLENCE*

We are looking for volunteers to take part in a study on
experience of therapy in women exposed to intimate partner violence

You would be asked to:

Complete a 10-minute questionnaire (by phone)
If you decide to go further with taking part in our research we will also ask you to

Attend 1-1.5 hours interview
(in appreciation for your time, you will receive ***10 pounds in cash***).

For more information about this study, or to take part, please contact:

Researcher:
Anastasia Burelomova,
DPsych City University London
Tel: [redacted]
E-mail: Anastasia.burelomova.1@city.ac.uk

Research Supervisor:
Marina Gulina
Professor of Psychology, C. Psychol.,
City University London
E-mail: Marina.Gulina.1@city.ac.uk
Office tel.: [redacted]

This study has been reviewed by, and received ethics clearance
through the *Psychology* Research Ethics Committee, City University London
PSYCH (P/F) 14/15 194

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

APPENDIX 2
Information sheet

Version 11/10/2014

Title of study *Childhood Maltreatment, Attachment Styles, Early Maladaptive Schemas and experience of therapy in women exposed to Intimate Partner Violence.*

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The project is a part of a doctoral thesis in Counselling Psychology at City University, London. It is hoped that it could provide valuable information on how women exposed to domestic violence experience therapy within specialist domestic violence service and will hopefully help to deliver additional scientific evidence for the importance of specialist Domestic Violence services for women.

Why have I been invited?
You have been invited to take part in this research because you have recently completed a course of therapy at Woman's trust and we are interested in your experience of it. We are also interested to understand whether you think there has been any change in the way you feel before and after therapy, either positive or negative and whether or not those experiences had an effect on your everyday life. We would also like to find out more about your past and current life experiences, the ways you communicate with people and see the world.
We aim to interview eight women who completed therapy at Woman's Trust within last 6-12 months.

Do I have to take part?
Participation in the project is voluntary, and you can choose not to participate in part or the whole project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way.
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?
First part of the study will take approximately 10 minutes of your time. You will be asked a set of questions from the questionnaire you have already completed whilst undergoing therapy at Woman's Trust. We will then compare your current answers to the ones we gathered before.
We will also ask if you are willing to take part in the second part of the study that will involve a 1.5 - 2 hours interview. You are absolutely free not to go forward with any part of the study if you do not feel like it.
There will be one interview where we will be asking you questions about your experiences of therapy and how you feel at the present moment. During the interview we will also ask you to draw a picture of your counselling experience
When the study is completed, we will produce the summery of the findings and will be more than happy to send it to you if you are interested.

Expenses and Payments (if applicable)
- Travel expenses will be paid.
- You will be given 10 pounds in cash for taking part in the study. We appreciate your time and effort and want to offer this gratuity for helping us with the research.

What do I have to do?

APPENDIX 2 continued

If you take part in the first part of the research, we will ask you to complete one questionnaire (either by phone or email) you are already familiar with, it will take you approximately 10 minutes. If you decide to go forward with the second part, the researcher will ask you a few questions about your experience of therapy at Woman's Trust and we will also ask you to draw a picture of your counseling experience. This will take approximately 1,5- 2 hours.

What are the possible disadvantages and risks of taking part?
You will be asked about your views on your experience during therapy. Depending on your experiences some of those questions might be difficult talking about or may rise unpleasant memories. The researcher will do her best to establish warm therapeutic environment during the study and help you process any difficult feelings. You will be free to contact the researcher at any time during the study. If you feel you need extra support you will be given phone numbers of local counselling services.

What are the possible benefits of taking part?
You may find it interesting to take part in the study, as it will give you a chance to reflect on your experiences of therapeutic journey and share how you feel. The results of the study may help to understand how to improve therapy for women exposed to domestic violence and help them to move on.

What will happen when the research study stops?
If the project is stopped before it has been planned initially, all the collected data will be destroyed straight away; no identifiable personal information will be disclosed to third parties at any time of the research. After the research is completed, any personal information will be untraceable back and your answers will remain anonymous, it will be stored in a secure location for the next 5 years and destroyed afterwards.

Will my taking part in the study be kept confidential?

If you agree to take part, your name or any other identifiable information will not be disclosed to other parties. You can be assured that if you agree to take part in the research you will remain anonymous. Only the researcher will have access to the information. Questionnaires, drawings and audio recordings will be stored in a secure place, password-protected, will not have your name on it and will be destroyed after the study is conducted.

What will happen to the results of the research study?
Results of the study will be published as a doctoral thesis and might be possibly published in scientific journals, however no identifiable personal information will be included. We will ask you to indicate if you are interested in the results and want to receive a summary once results are analysed.

What will happen if I don't want to carry on with the study?
You are absolutely free to withdraw from the study without an explanation or penalty at any time.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: *Cognitive schemas, attachment styles and experience of therapy in women exposed to Intimate Partner Violence.*
You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square

APPENDIX 2 continued

Version 11/10/2014

London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been approved by City University London *[insert which committee here]* Research Ethics Committee, PSYCH (P/F) 14/15 194

Further information and contact details

Researcher:
Anastasia Burelomova,
DPsych City University London
Tel:
E-mail: Anastasia.burelomova.1@city.ac.uk

Research Supervisor:
Marina Gulina
Professor of Psychology, C. Psychol.,
City University London
E-mail: Marina.Gulina.1@city.ac.uk
Office tel.:

Thank you for taking the time to read this information sheet.

APPENDIX 3
The CORE questionnaire

CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

OUTCOME MEASURE

Site ID

letters only — numbers only

Client ID

Therapist ID — numbers only (1) — numbers only (2)

Sub codes

D D / M M / Y Y Y Y

Date form given

Age

Male

Female

Stage Completed
S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

	Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1	I have felt terribly alone and isolated	0	1	2	3	4	F
2	I have felt tense, anxious or nervous	0	1	2	3	4	P
3	I have felt I have someone to turn to for support when needed	4	3	2	1	0	F
4	I have felt O.K. about myself	4	3	2	1	0	W
5	I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	P
6	I have been physically violent to others	0	1	2	3	4	R
7	I have felt able to cope when things go wrong	4	3	2	1	0	F
8	I have been troubled by aches, pains or other physical problems	0	1	2	3	4	P
9	I have thought of hurting myself	0	1	2	3	4	R
10	Talking to people has felt too much for me	0	1	2	3	4	F
11	Tension and anxiety have prevented me doing important things	0	1	2	3	4	P
12	I have been happy with the things I have done.	4	3	2	1	0	F
13	I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	P
14	I have felt like crying	0	1	2	3	4	W

Please turn over

Survey : 151

Copyright MHF and CORE System Group.

Page : 1

APPENDIX 4
Consent form

Version 11/10/2014

Title of Study: *Cognitive schemas, attachment styles and experience of therapy in women exposed to Intimate Partner Violence.*
Ethics approval code: PSYCH (P/F) 14/15 194

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • being asked to draw a picture of my counselling experience • allowing the interview to be audiotaped • completing questionnaires asking me about my demographics and experience of therapy • allowing the access to the data collected during therapy (questionnaires)	
2.	This information will be held and processed for the following purpose: to answer the research questions. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

____________________ ____________________ ____________________
Name of Participant Signature Date

Anastasia Burelomova
____________________ ____________________ ____________________
Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

APPENDIX 5
Debrief information

Version 11/10/2014

Title of study: Childhood Maltreatment, Attachment Styles, Early Maladaptive Schemas and experience of therapy in women exposed to Intimate Partner Violence.

DEBRIEF INFORMATION

Thank you for taking part in this study! Now that it's finished we'd like to explain the rationale behind the work.

This project aims to explore your experiences during therapy at Woman's Trust. We were also interested to understand whether you think there has been any change in the way you feel before and after therapy, either positive or negative and whether or not those experiences had an effect on your everyday life.

We appreciate your time and effort and hope that taking part in this research was interesting for you, gave you a chance to reflect on your experiences of past and your therapeutic journey, share how you feel and increased your self-awareness.

The results we obtained from this study would provide valuable information on how women exposed to domestic violence experience therapy within specialist domestic violence service and will hopefully help to deliver additional scientific evidence for the importance of specialist Domestic Violence services for women.

If taking part in the research has raised any concerns, please, feel free to contact the researcher at any time. You can also request contact details of your local counselling service or self-refer back to Woman's Trust by calling

Alternatively, you can call:

Samaritans 24 hour helpline:

Maytree: 0207 263 7070

Victim support helpline:

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Further information and contact details:

Researcher: Anastasia Burelomova,

DPsych City University London

Tel:

E-mail: Anastasia.burelomova.1@city.ac.uk

Research Supervisor: Marina Gulina
Professor of Psychology, C. Psychol.,
City University London
E-mail: Marina.Gulina.1@city.ac.uk
Office tel.:

Ethics approval code: PSYCH (P/F) 14/15 194

APPENDIX 6
Gratuity and travel expenses receipt

I have accepted the gratuity of 10GBP from the researcher, Anastasia Burelomova for participating in the study '*Childhood Maltreatment, Attachment Styles, Early Maladaptive Schemas and experience of therapy in women exposed to Intimate Partner Violence'*. My travel expenses have reimbursed.

Participant's signature___________________ date______________________

Researcher's signatur____________________ date______________________

APPENDIX 7
Interview schedule

1. What brought you to counseling at Woman's Trust?

   Prompt questions:
   How did you feel about starting counseling?
   What were your expectations from counseling?

2. How would you describe yourself (the way you feel, experience the world and people around you) before having counseling at Woman's Trust? How would you describe it now?

3. How would you describe counseling you had?

4. How did you find your counseling?

   Prompt questions:
   What was the most helpful for you?
   What was the most frustrating/challenging for you?
   What was unexpected?

5. Is there anything you would like to have been different in therapy and if yes, what is it?

6. What is your understanding about your therapist's work with you?

   Prompt question:
   If you were to give one piece of advice to therapists working with people who had similar experiences to yourself, what would it be?

7. Would you mind drawing a picture of your counseling experience at Woman's Trust? How would you call it?

8. How has it been for you talking with me today?

APPENDIX 8
Exemplar of the analysis (IPA)

1 How were you feeling when you started
2 counselling?
3
4 INTERVIEWEE 1
5
6 Well it was good to speak to someone else who
7 didn't know me or the situation. [redacted] was really -
8 because she understands a lot about domestic
9 abuse. It was good to speak to her because she was
10 able to understand why I might be feeling this way,
11 and reassure me that this was normal. Because you
12 start to think you're going crazy or something. I
13 don't know, you feel guilty, you shouldn't be feeling
14 this way and you're thinking a lot about how he is
15 feeling or how he's thinking, because he's been the
16 main person that I've been trying to please. I still
17 thought a lot about what he was thinking and how
18 he'd react. Basing my decisions or anything on him.
19 What's his reaction going to be? But gradually
20 throughout the counselling I was able to stop doing
21 this so much and that really helped me. During the
22 time I was in the counselling that was when I left as
23 well - left the house. So it was just the support I got
24 throughout the whole thing, and I really looked
25 forward to it every Friday. I looked forward to that
26 hour, because I could just talk, and she understood,
27 and could make me feel better about things and
28 empower me, because I had no self-esteem. Self-
29 confidence had gone, and she really tried to build
30 that up. With encouragement you can gradually get
31 back your self-esteem and not feel guilty. So that
32 really helped.
33
34 INTERVIEWER
35
36 And how would you describe yourself now?
37
38 INTERVIEWEE 1
39
40 I'm a lot better now. You know when you sent the
41 form? It wasn't a good week, because I'd just had a
42 court case - the final hearing for the contact - and it
43 didn't go well at all. So it really got me down. I feel a
44 lot better now, but it took me a few weeks to kind of
45 get back on track. But that's one of the good things
46 about counselling. It's that it's helped me. Ok things
47 might come up, problems might come up, but I can
48 deal with them a lot better now and kind of try to
49 see through - ok this didn't go quite to plan, but try

3

APPENDIX 8 continued
Exemplar of the analysis (IPA)

and see the positives - and not dwell on things, or think about him or his reaction. So although I've had a few dips, I'm able to get over them. Actually the contact was my worst case scenario. It's been my biggest fear all through the counselling my biggest fear was that my ex-partner would get a lot of extra contact, and that's exactly what happened. But then I started thinking - well, that was my worst fear, and it's happened now, and I've got through it - so that's made me feel a bit better. Yeah, I guess it's given me different ways of dealing with situations so I'm able to get through them a lot easier.

INTERVIEWER

Ok, that sounds good. Ok, so you mentioned some details about your counselling, but if I ask you a general question about your counselling - how would you describe the counselling you had?

INTERVIEWEE 1

I guess it was nice atmosphere in the room. I felt safe in there and very supported. ████ had such a good understanding of the domestic abuse, and I felt comfortable in telling her everything, and she just listened and asked questions when she needed to, and I liked that style of counselling. I'd been to a couple of other counselling sessions when either people ask too many questions or they don't say anything at all. So it was a good balance, and I think because it was over such a long period it really helped, because I had another counselling session just before hers that was just for 6 weeks, and it was good but it wasn't long enough. This was great for 18 weeks, because it took me from when I was at my low, to when I'd left - yes - the whole journey. It was amazing, I wouldn't have got so far without counselling. It's such a big thing.

INTERVIEWER

What would you find the most helpful [from the sessions]?

INTERVIEWEE 1

Just realising that it wasn't me imagining things in my head, like this was the situation, and it wasn't

4

APPENDIX 9
Exemplar of the analysis (master themes and subthemes for Claire)

Interview 2

1. ***Therapy as a continuous experience***

a. Empathising importance of therapy duration

11; 29-31 It just needs to go on longer. It don't - it's like a big loss, it's a loss because you just feel like you're sitting. You're stuck. Because you're still not getting that support so for it to go on longer

b. Building relationships take time

5; 42-45 So build up a rapport and it's not usually - it doesn't happen in one day, it doesn't happen in two visits, it doesn't happen in three visits. It's over a time when you realise to yourself 'ok, I think I like her! She's ok'.

a. Grieving loss of therapy

2; 4-5 I didn't want to stop going to one-to-one, because I built up a bond with the counsellor
2; 34 Now I don't have nothing. And I've gone ten steps backwards…
2; 9-10 I just would like to have one-to-one again, so I could continue to try and build my life.
14; 8-9 But now there's a big teardrop because I'm not doing no counselling because I've still got it going on for me.

2. ***Abuse as transforming the Self***

a. Religious abuse as a mean of degrading the Self

1; 10-12 I've got a very complex relationship, and religion was involved. I got brainwashed into Islam.
1; 27-31 …because I was brainwashed into Islam and I used to wear a hijab, which I don't wear no more […]but I found it difficult because some mornings I just wouldn't know what to put on.
1; 34-36 What this person would call you because you didn't have the hijab on or I had tight fitting clothes on, I'd question myself - I still do question myself.
5; 31-34 I've come for you to help support me, to try to work through my mess, to work through my puzzle, to work through this big maze, to work through this wheel-spin
7; 5-6 But we're still at the stage of working through my mess.
8; 8-10 I didn't know myself. As I said I was brainwashed into Islam. A very militant Islam, where people don't like other colours. And I've kept myself above board.

b. Self-doubt

1; 32-36 Things - psychological abuse in my brain would make me [..]
I'd question myself - I still do question myself.
2; 36-37 I would somewhat think that it's a little bit better but - I still question myself
3; 43-45 But you will still have in the back of your brain somewhere that it is your fault…

c. Loss of self

8; 8 I didn't know myself.
8; 14-18 Or sometimes little attributes of me - of that person occurs and then I have the quickly shake myself and realise 'that's not you, that's what someone's done to you'. So it comes back, you know, all your dignity taken away from you, you just feel a real different person.
8; 39-40 Because that's what abuse does to you, it makes you lose all form of dignity.

d. Blaming yourself

3; 22-24 And not looking to yourself in a bad way just look into what you keep questioning yourself about, and keep blaming yourself about

e. Dreamlike reality

8; 48-49; 9; 1 Because it just felt like someone had clicked (she clicks her fingers) their fingers, and I had fallen asleep. And someone could take so much advantage.

f. Sense of being mad

7; 19- 21 I just can't afford to go crazy, […] I - I believe I have some form of mental issues.
7; 21-24 Things play on my mind a lot. How people treat other people. Sometimes I get caught up in rubbish, when I know that 'hey, you've been here before'.

g. Loss of control

8; 48-49; 9; 1 Because it just felt like someone had clicked (she clicks her fingers) their fingers, and I had fallen asleep. And someone could take so much advantage.

h. Loss of trust

4; 16-18 When you've been abused, and so forth, it's a big trust - your trust goes through the window, you don't trust people how you used to trust people
2; 38-40 My guard is up so high, and sometimes I drop my guard, but then I realise and I have to put the gate back up again.

i. Death metaphor as a mean of expressing feelings

8; 42-44 They slowly take you right down to the grave, and you're not even realising you're taking yourself down - they're taking you down to the grave.

3. Therapeutic relationship

a. Importance of bonding with your therapist

2; 4-5 I didn't want to stop going to one-to-one, because I built up a bond with the counsellor.
3; 31-33 So, you have to build up - personally - if you build up a rapport with your counsellor, it's even greater.
4; 14-16 it's hard as I said, so you have to build that rapport up with the counsellor, because you have to be able to trust that counsellor.
4; 35-38 I think that's the challenging bit: them getting to know you and understand you. So you have to build that rapport up with the counsellor.
6; 35-37 But overall I didn't have a problem, because as I said I had a good rapport. I built up a really good rapport, it was just that tiny little thing.
12; 26-27 …as long as you build up a rapport as an individual with your counsellor, you'll be good.

b. Different level of rapport/connection

3; 26-28 I believe that perhaps, that some of the women what do play the part of the counselling, obviously they don't reveal, but they may have been through something for themself.
4; 46-48 You'd get a feel - I'm a person, I get a 'feel' on people. I don't know, just get a feel by looking at the person, body language, how much they're making you feel comfortable.
5; 45-47 That individual person what's actually come in for the counselling, they know who they grasp on to, from who they don't grasp on to.
16; 31-34 As I said, you got to get that feel- you can feel. You feel that person's energy. You got to remember not everybody gets on with everybody but you can feel and pick up on energy.

c. Building relationships take time

5; 42-45 So build up a rapport and it's not usually - it doesn't happen in one day, it doesn't happen in two visits, it doesn't happen in three visits. It's over a time when you realise to yourself 'ok, I think I like her! She's ok'.

APPENDIX 10
Appearance of themes for each participant

Recovery as a process

Theme	Participants who display this theme	Participant, page, line number
1.Abuse as disintegrating the Self	All participants	
1.1. Confusion and being overwhelmed	6/8 (All except Mary and Ann)	**Nina:** 1; 48-49; 2; 1 **Claire:** 5; 31-34 **Beth:** 4; 18-19 **Jenny:** 4; 6-8 **Sam:** 7; 1-5 **Kelly:** 17; 8-10
1.2. Losing the sense of Self	5/8 (All except Mary, Sam and Kelly)	**Nina:** 9; 47-49; 10; 1-2 **Claire:** 8; 8 **Beth:** 6; 18 **Jenny:** 1; 45-46 **Ann:** 4; 17-21
1.3. Self-condemnation	5/ 8 (All except Jenny, Mary and Ann)	**Nina:** 3; 12-14 . **Claire: 3; 22-24** **Beth**: 7; 42-45 **Sam:** 5; 29-31 **Kelly;** 8; 34-36
1.4. Questioning Self-worth	5/8 (All except Jenny, Ann, and Kelly)	**Nina:** 3; 28-30 **Claire:** 1; 32-36 **Beth:** 12; 8- **Mary:** 7; 2-4 **Sam:** 5; 25-28
1.5. Lack of control	7/8 (All except Kelly)	**Nina:** 2; 42-45 **Claire:** 8; 48-49; 9; 1 **Beth:** 4; 16-17 **Janny:** 6; 1-3 . **Mary:** 6; 47-48 **Ann;** 6; 33-36 **Sam:** 7; 5-7
2. Oblivion of abuse and awakening	All participants	
2.1. Becoming aware of abuse	6/ 8 (All except) Jenny and Ann)	**Nina:** 1; 11-14 **Claire:** 7; 2-4 **Beth:** 7; 21-22 **Mary:** 5; 10-13 **Sam:** 7; 6-10 **Kelly:** 10; 1-4
2.2. Lack of awareness about available support	7/8 (All except Kelly)	**Nina:** 5; 31-33 **Claire:** 12; 7-9 **Beth:** 3; 19-22 **Jenny:** 7; 26-30

APPENDIX 10 continued

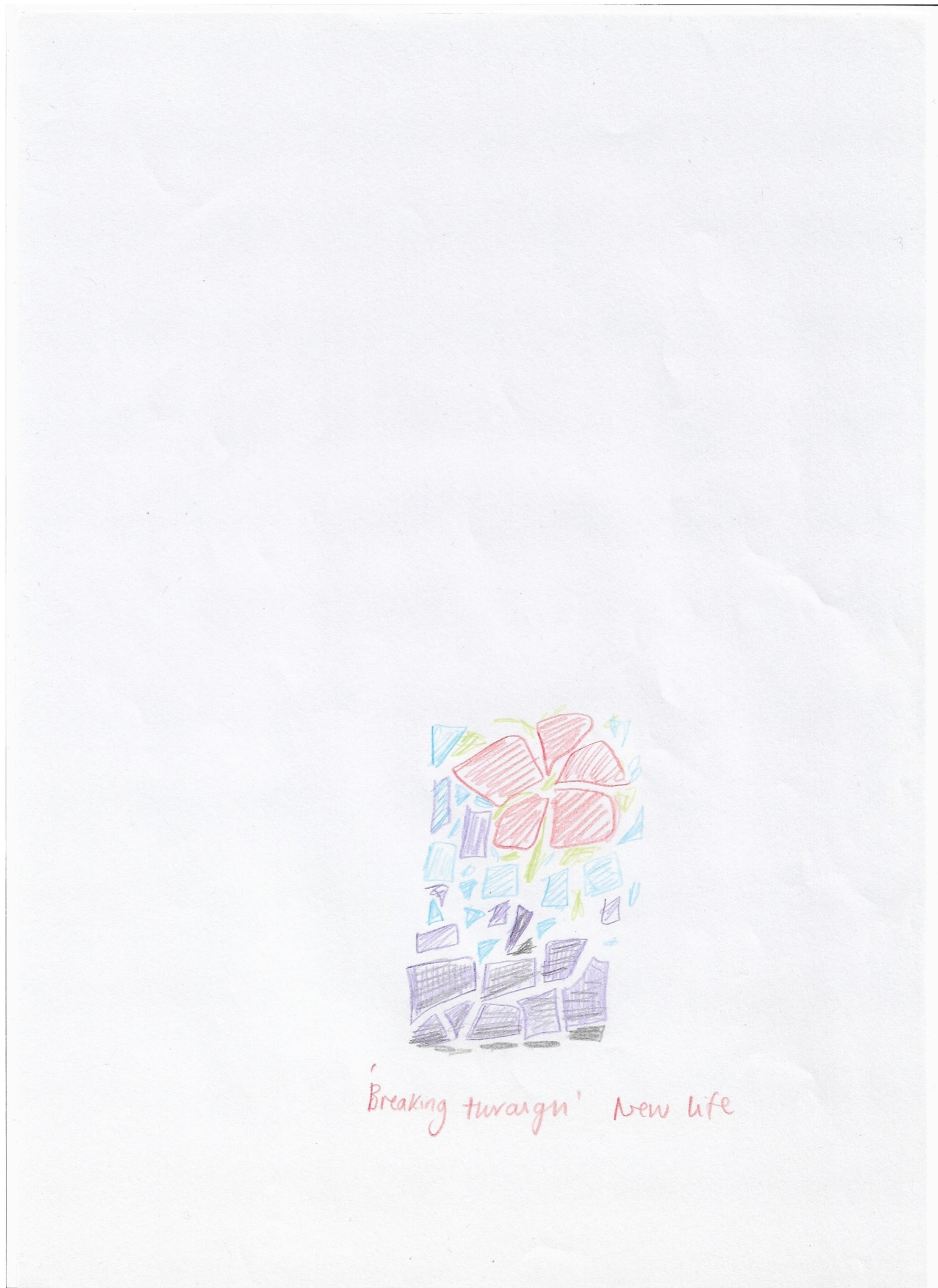
		Mary: 1; 13-17 **Ann:** 1; 37-42 **Sam:** 2; 40-44
2.3. Looking for a way out	8/8	**Nina**: 2; 29-30 **Claire:** 8; 42-44 **Beth:** 2; 40-47 **Jenny:** 1; 32-34 **Mary:** 7; 19-22 **Ann:** 21; 11-14 **Sam:** 17; 24-27 **Kelly:** 1; 34-36
2. 4. Abuse, mental health and legal issues	8/8	**Nina:** 3; 41-43 **Claire**: 7; 33-35 **Beth:** 4; 27-30 **Jenny:** 1; 29-33 **Mary:** 1; 40-43 **Ann:** 1; 12-17 **Sam:** 1; 18-20 **Kelly:** 2; 1; 3; 1-3
2.5. Specialist knowledge as a catalyst of insight	8/8	**Nina:** 6; 39-42 **Claire:** 8; 46-48 **Beth:** 7; 17-21 **Jenny;** 8; 11-14 **Mary:** 5; 16-19 **Ann**: 16; 5-7 **Sam:** 6; 21-25 **Kelly:** 10; 39-42; 11; 1
3. Therapy as a journey of empowerment	All participants	
3.1. Communicating thoughts and feelings	8/8	**Nina:** 1; 47-48; 5; 21-22 **Claire**: 14; 6-7 **Beth:** 9; 27-29 **Jenny:** 6; 21-22 **Mary:** 14; 17-21 **Ann:** 2; 4-8 **Sam:** 12; 12-17 **Kelly:** 6; 35-38
3.2. Therapy as a safe place	6/8 (All except Jenny and Mary)	**Nina:** 4; 23-24 **Claire:** 2; 31-33 **Beth:** 9; 25-26 **Ann:** 5; 9-11 **Kelly:** 1; 39-43
3.3. Connecting with a therapist	6/8 (All except Beth and Ann)	**Nina:** 3; 26-27 **Claire:** 12; 26-27 **Jenny:** 3; 11-14 **Mary:** 6; 22-25 **Sam:** 14; 28-30

APPENDIX 10 continued

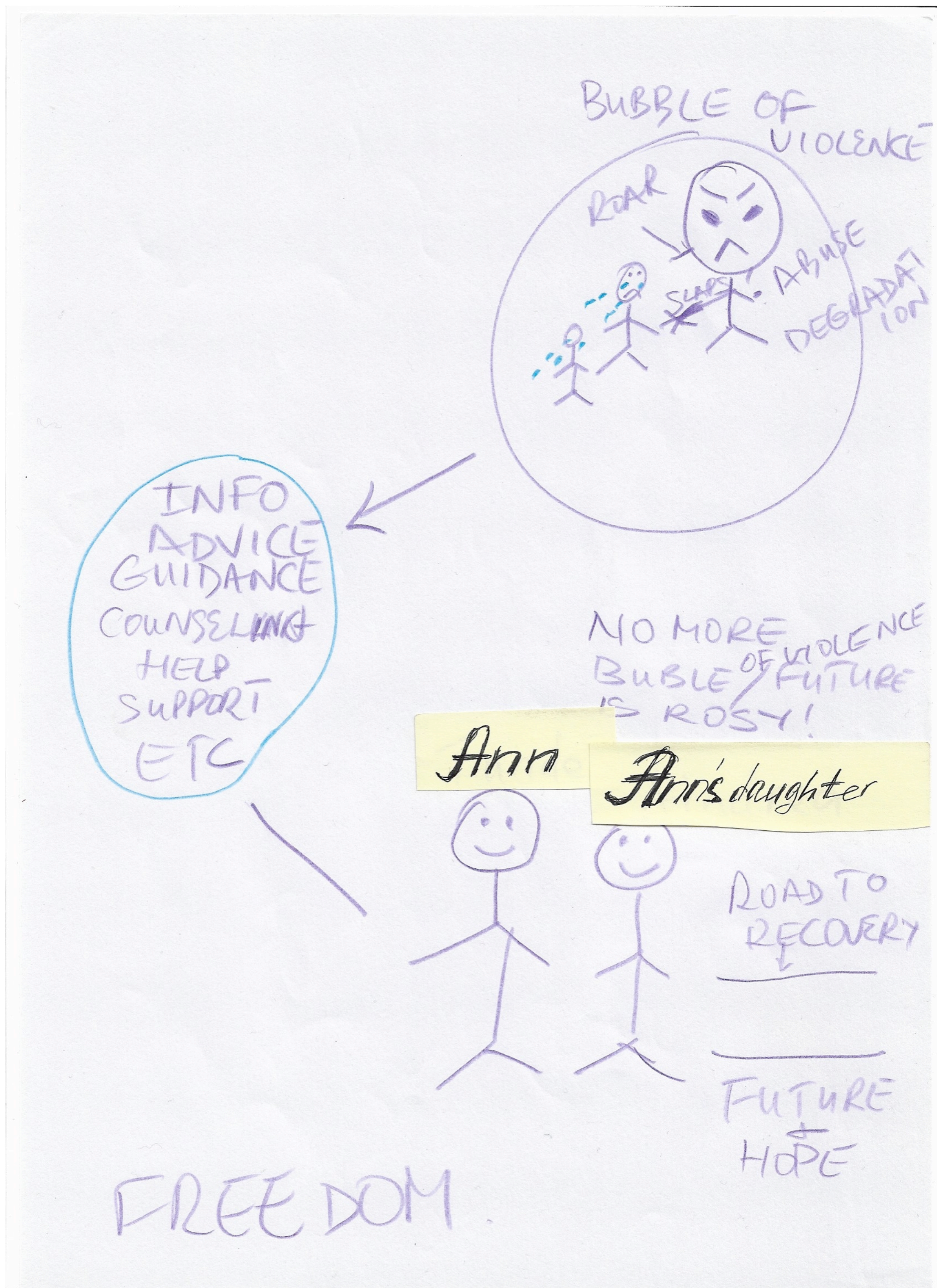
		Kelly: 7; 39-42
3.4. Empowerment as a unique experience	8/8	**Nina:** 3, 26-32 **Claire:** 3:20-25 **Beth:** 12; 3-6 **Jenny:** 12; 1-7 **Mary:** 5; 14-19; 13; 20-23 **Ann:** 15; 41-46; 2; 8-10**;** 2; 30-31 **Sam:** 15; 35-41; 5; 31-36 **Kelly:** 13; 29-32; 16; 2-8
4. Therapy as a continuous experience		
4.1. Therapy as taking through	7/8 (All except Sam)	**Nina:** 4; 36-39 **Claire:** 8; 27-29 **Beth:** 15; 38- 42 **Jenny:** 6; 24- **Mary:** 19; 39-44 **Ann:** 8; 6-11 **Kelly:** 7; 23-26
4.2. Importance of therapy duration	6/8 (All except Mary and Kelly)	**Nina:** 4; 31-38 **Claire:** 11; 29-31 **Beth:** 6; 14-16 **Jenny:** 3; 22-27 **Ann:** 12; 13-14 **Sam:** 14; 14-18
4.3. Importance of continuous support	Beth, Mary,	**Nina:** 5; 31-36 **Claire**: 14; 8-9 **Jenny:** 7; 20-24 **Ann:** 8; 13-18 **Sam:** 13; 6-9 **Kelly:** 16; 6-7
4.4. The enabled Self and new ways of coping	8/8	**Nina:** 3; 46-49 **Claire:** 9; 5-8 **Beth** 6; 47-49; 6; 1-4 **Jenny:** 12; 5-9 **Mary:** 10; 20-25 **Ann:** 6; 16-21 **Sam:** 8; 19-24 **Kelly:** 11; 35-38
4.5. Gratitude for the help	7/ 8 (All except Kelly)	**Nina:** 8; 36-37 **Claire:** 7; 35-36 **Beth:** 1; 30-31 **Jenny:** 2; 34-35 **Mary:** 24; 47-48 **Ann:** 11; 42-47 **Sam:** 2; 28-29

APPENDIX 11
'Confused emotions at the Trust' by Claire

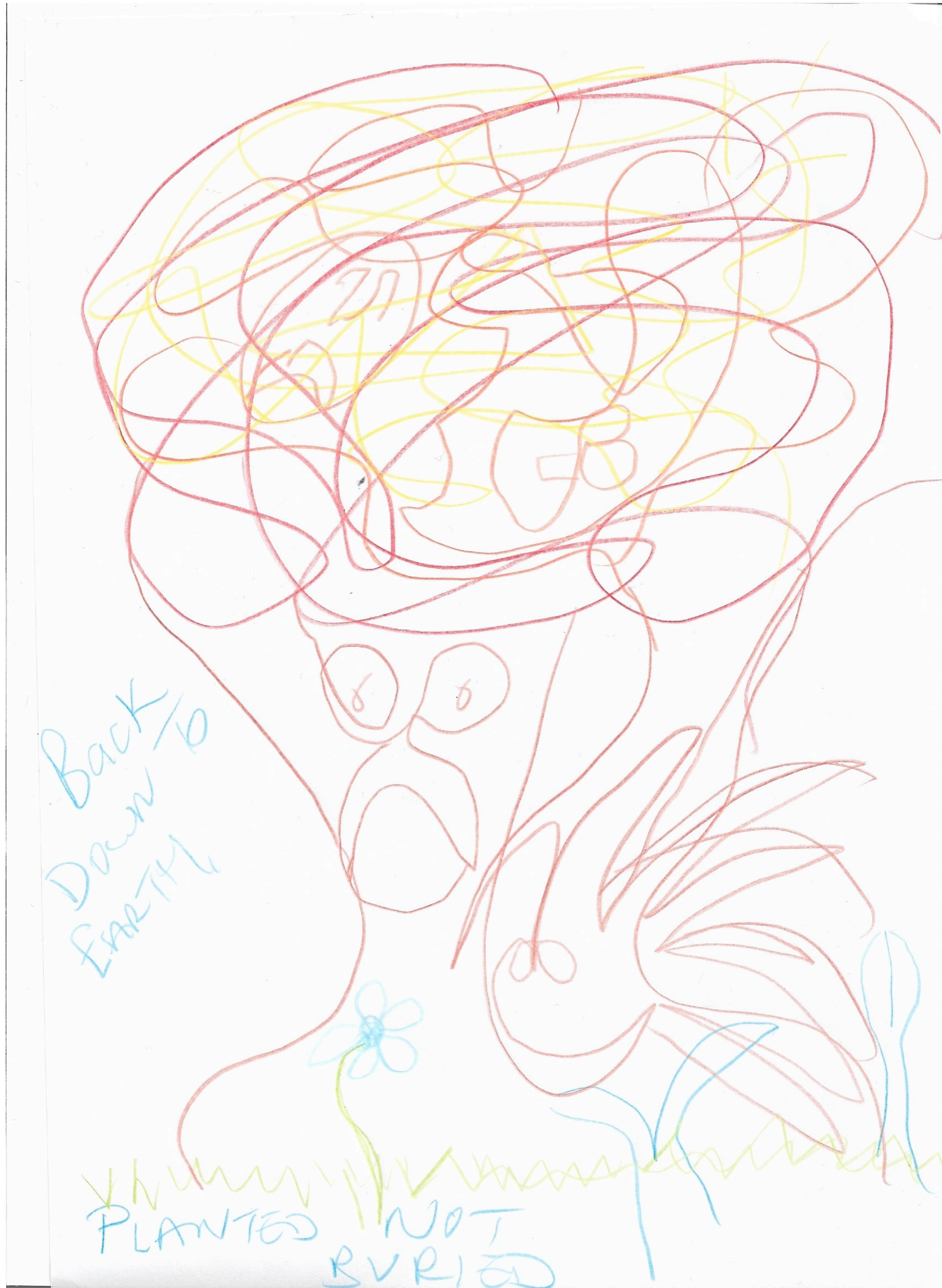
APPENDIX 12
'Breaking through' by Nina



APPENDIX 13
‘Freedom’ by Ann

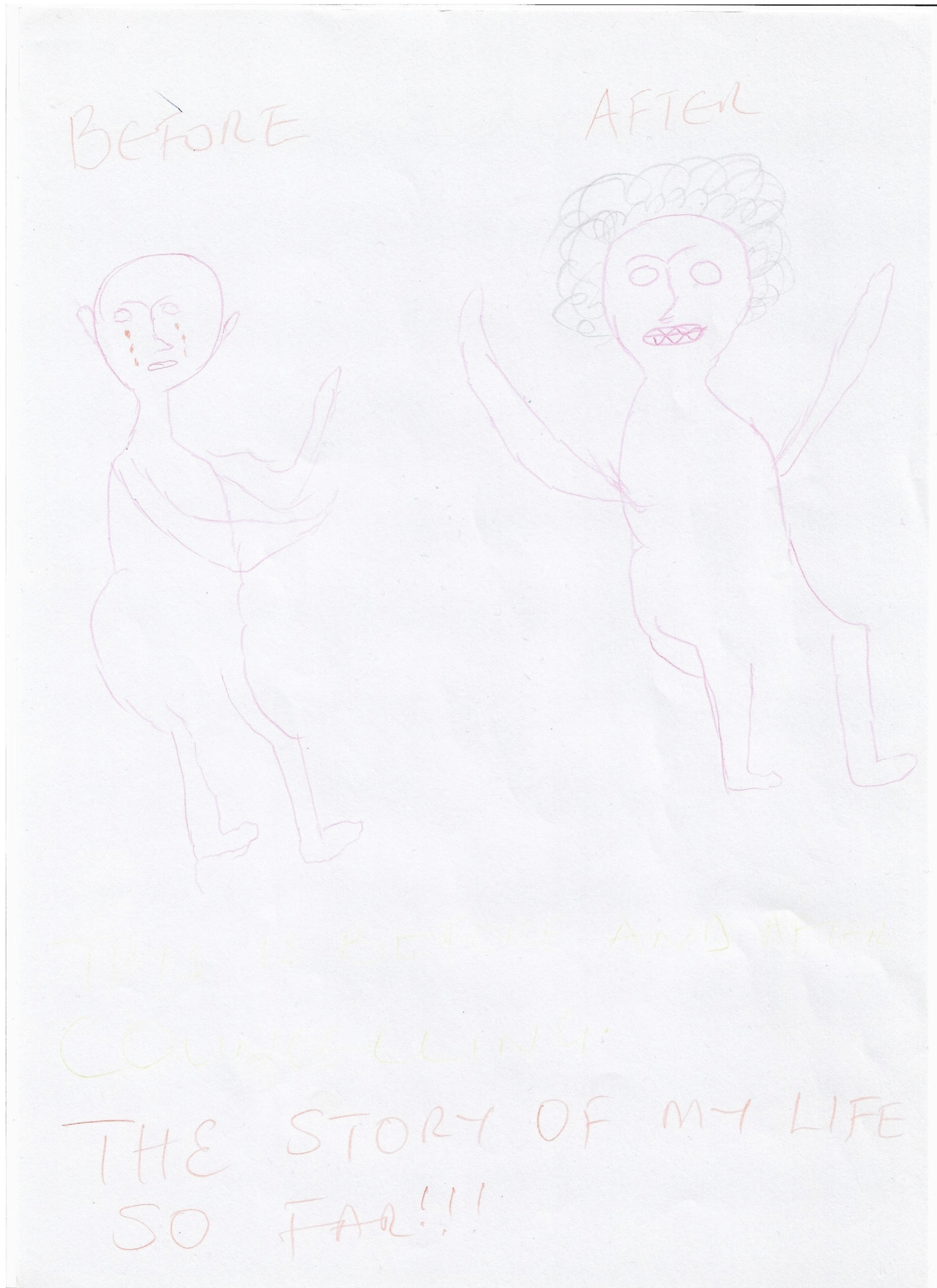


APPENDIX 14
'Planted not buried' by Kelly

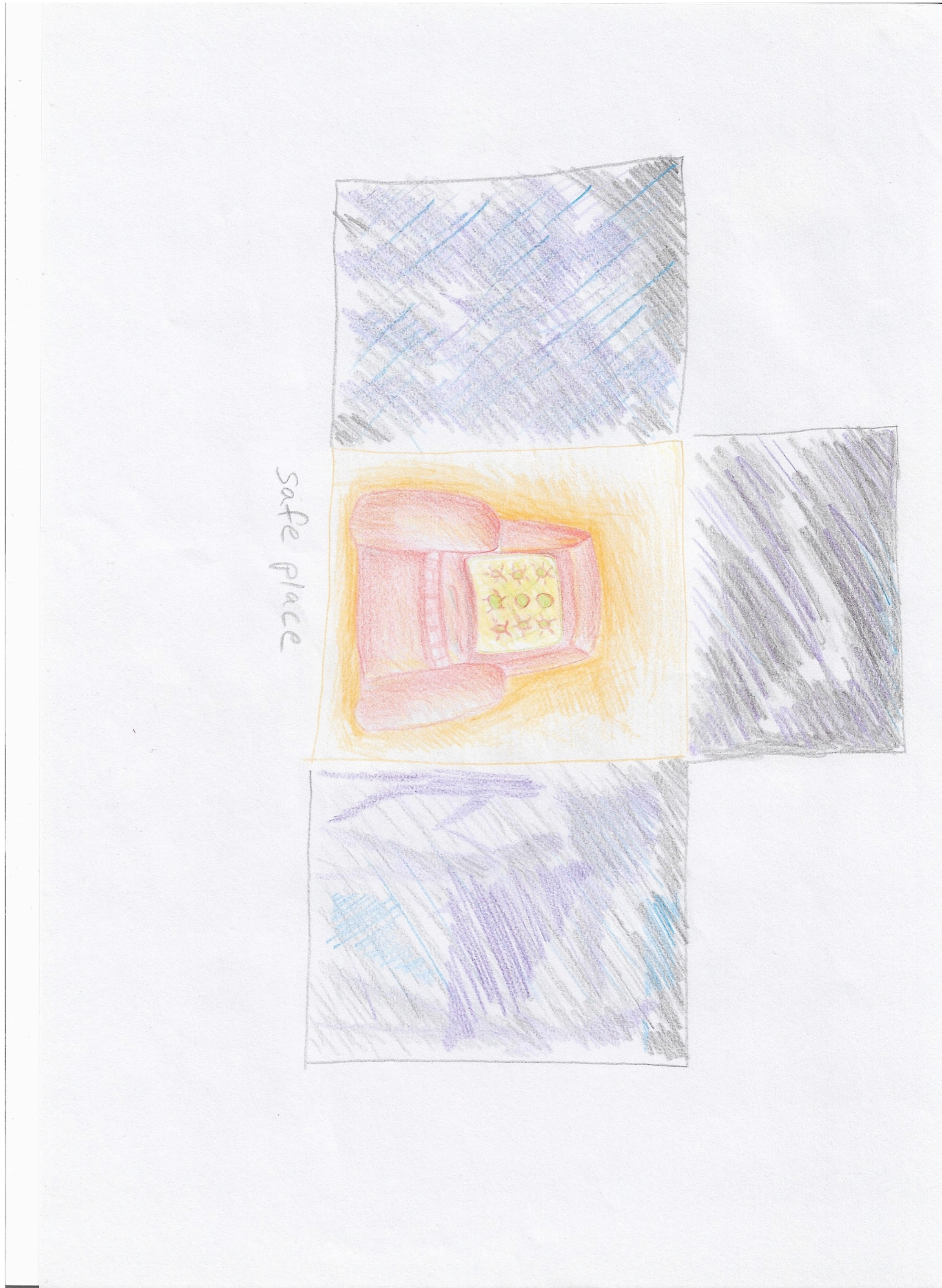


APPENDIX 15

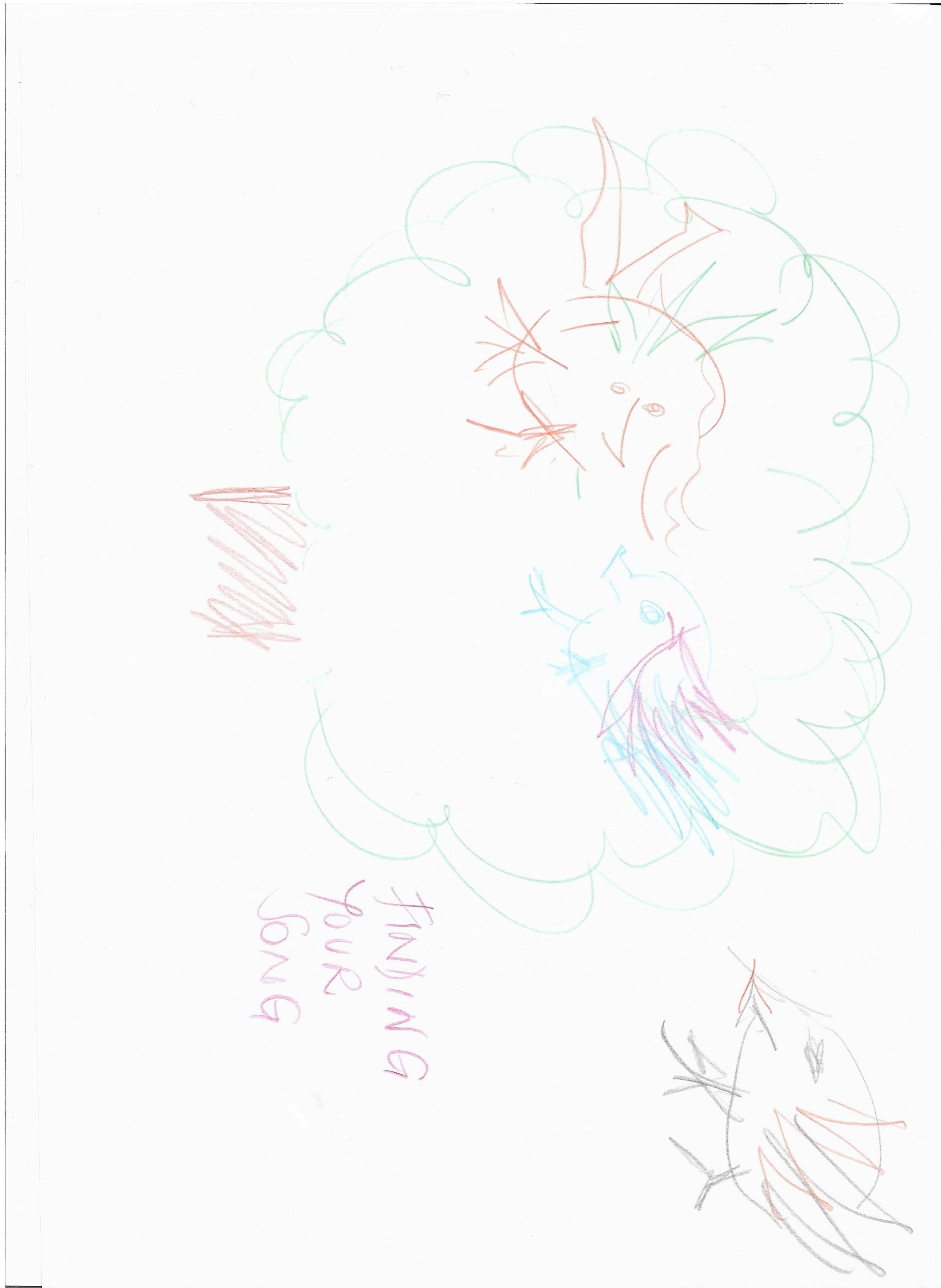
'The story of my life so far' by Jenny



APPENDIX 16
'Safe place' by Beth



APPENDIX 17
'Finding your song' by Sam



APPENDIX 18
'Complex situation' by Mary