

# **How Do Women Experience Navigating Support After Domestic Abuse?**

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## **ABSTRACT**

Research has highlighted the multiple barriers women who have experienced domestic violence and abuse (DVA) face in 'disclosing' abuse. However, 'disclosure' is but the first step in women accessing 'support' for a wide range of needs; less is known about women's experiences once they have accessed 'support'. Existing research has frequently identified what is termed 'secondary victimisation' within services, however this has typically been studied within separate spheres - medical, legal and so on – preventing a more integrated understanding of women's experiences. This research applies a feminist perspective to explore how women experience accessing 'support' from formal and informal systems after DVA, and considers what constitutes support, for them.

The research involved consultation and collaboration with service users and staff at a specialist DVA organisation. Nine women who were engaged with the organisation took part in semi-structured interviews. The interviews were analysed using thematic analysis within a critical realist contextualist epistemology.

Three main themes were identified: theme one, "It's the Seeing It and Acknowledging It": Who, Where and How?; theme two, The Duality of Help, and theme three, "We've Had Enough". Theme one considers how constructing experiences as abuse intersected with women's experiences of 'help'. The second theme explores the paradoxes associated with navigating 'support systems' and their possible harms. The final theme explores how women describe being impacted by and responding to their experiences, both of abuse and within 'support systems'.

Results of the analysis are discussed in relation to empirical and theoretical literature. In discussing findings, the use of power within services is explored and the importance of relational aspects of care. Implications are considered at a community, service and research level.

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## **LIST OF ABBREVIATIONS**

<b>CBT</b>	Cognitive Behavioural Therapy
<b>DVA</b>	Domestic Violence and Abuse
<b>LGBT</b>	Lesbian, Gay, Bisexual and Transgender
<b>LO</b>	Linked Organisation
<b>NHS</b>	National Health Service
<b>PTSD</b>	Post Traumatic Stress Disorder
<b>TA</b>	Thematic Analysis
<b>UN</b>	United Nations
<b>VAW</b>	Violence Against Women
<b>WHO</b>	World Health Organisation

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## 1. INTRODUCTION

In this chapter I introduce some background context to the research, with reference to the current UK socio-political context and women's engagement with 'support' systems.

### 1.1. Contextualising Language and Definitions

Domestic abuse- also referred to as domestic violence, spousal abuse, intimate partner violence- is a construct without a universal definition. How violence against women (VAW) is conceptualised is historically and socio-culturally located and subject to change. Historically, DVA was associated with physical violence, however the current UK cross-Government definition of domestic violence and abuse (DVA) is:

*"Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial, emotional."* (Home Office, 2013)

It is important to recognise that DVA- and other terms- are constructs, which is not to say that the experiences that constitute them are not valid or real, but that how we think about them and represent them using language changes. The UN (1993) for example includes DVA within a broader spectrum of domestic forms of VAW which includes sexual abuse of female children and dowry-related violence.

Terminologies are continually debated and refined; 'domestic' connotes the home and obscures abuse women experience beyond the home, i.e. post-

separation violence and harassment. 'Violence' typically connotes physical harm and yet advocates have centralised issues of power and control in DVA since the 1970s (Schechter, 1982). To allow for consistency with the literature, the UK definition and term DVA will be adopted here, whilst acknowledging the limitations, and that many women experience multiple, intersecting forms of VAW (Office for National Statistics; ONS, 2017).

There is no entirely satisfactory vocabulary to describe women who have experienced DVA and the people who abuse them. Dichotomous identity labels such as survivor/victim and victim/perpetrator locate women within discourses in which women are passive victims and men are active abusers (Boonzaier, 2008; Leisenring, 2006). Throughout this thesis 'women' will be therefore used as shorthand to refer to 'women who have experienced DVA', unless otherwise specified. The terms perpetrator/abuser are retained, whilst acknowledging their reductionism (Lawrence, 2012). Abusers are not always men; however, some areas of the literature overwhelmingly discuss men, e.g. child contact.

In this thesis I refer to 'support' and 'help', meaning avenues to which women turn-or which involve themselves- to gain or resolve something. However, I recognise that these systems are often far from helpful or supportive. I use inverted commas when discussing concepts that may have multiple meanings or are contested, including diagnostic labelling.

## **1.2. A Gendered Focus**

Overall, 35% of women worldwide are estimated to experience domestic or sexual violence in their lifetime (WHO, 2013). In the UK one in four women are estimated to experience DVA in their lifetime and eight percent in a given year (ONS, 2017). Increasingly, VAW is recognised as both a human rights and major public health issue (WHO, 2005). Despite the intimate context, DVA and other forms of VAW are recognised as strongly linked with gender inequality, attitudes towards women and violence, and other socio-political factors (WHO, 2016).

My focus in this thesis is the experiences of women who have experienced DVA. This is not to deny that men do not experience DVA, or that women are not capable of enacting violence towards men. My rationale for focusing on women is threefold: 1) in recognition of the gendered nature of abuse- the dominant pattern is violence by men against women (Johnson, 2008; Myhill, 2015; Stark, 2010); 2) to consider DVA as part of broader systems of structural violence towards women (WHO, 2016); and 3) from a pragmatic desire to work collaboratively with a DVA organisation; typically women-only spaces.

Family violence researchers argue that women and men perpetrate similar levels of DVA (Straus, 2010). However, feminist researchers have separated 'situational couple violence' which is bi-directional abuse (Johnson, 2008), from what has come to be termed 'intimate terrorism' (Johnson, 2008), or 'coercive control' (Stark, 2007). The traditional association of DVA has been with physical violence, with a violence model based on assessment of threatened or actual assault driving the legal and policy response. However, a body of research indicates that the tactics, impact and future harm of DVA is better captured within a model that centralises patterns of control and dominance (See e.g., Myhill, 2015; Stark, 2012). In addition to living in fear of actual or threatened violence, coercive control entails a pattern of domination based on tactics to isolate, intimidate, regulate, exploit and undermine the independence of a partner in their every day life. The effect of such behaviours is a hostage-like condition of entrapment in which the partner's ability to escape or resist the abuse is systematically compromised (Stark, 2012). The use of such tactics is argued to be highly gendered, with the gender asymmetry of power in society reflected in patterns of power and control in intimate relationships (see Johnson, 2008; Stark, 2010). The UK government has only recently recognised and criminalised coercive control, with section 76 of the Serious Crime Act 2015 creating a new offence of controlling or coercive behaviour in December 2015.

#### 1.2.1. Situating Myself and Feminist Research

Feminist research differs from traditional research on gender by its agenda for change; its purpose is the construction of new knowledge and the pursuit of social change (Maynard & Purvis, 1994). As a researcher I approached this

topic from a feminist stance, beginning with a desire to improve something for women who have experienced DVA, which necessarily influences the research.

Characteristic of feminist research is an acknowledgement of the relationship between knowledge and power. Whilst I have attempted a thorough and transparent review of the literature, I acknowledge my influence throughout this thesis in producing, not just reflecting, a social reality (Stanley & Wise, 2002). I have therefore chosen to write in the first person as a more transparent reflection of this.

### **1.3. The UK Context**

The current Conservative and previous Coalition Government has targeted DVA in policy, legislation and public campaigns. The Call to End Violence Against Women and Girls paper (Home Office, 2010) and 2014 Action Plan states that the government is committed to “nothing less than the elimination of violence against women and girls” (Home Office, 2014, p.7). The last decade has seen the introduction of new legislation on coercive control, forced marriage, domestic violence protection orders and a disclosure scheme allowing people to discover whether their partner has a history of abuse offences.

However, a decade of austerity measures introduced in the UK has substantially impacted women and the services they rely on, with extensive funding cuts made to DVA services, police, criminal justice system, and legal aid (Bennhold, 2012; Rights of Women, Women’s Aid and Welsh Women’s Aid, 2016; Women’s Aid, 2017). According to The All Party Parliamentary Group on Domestic and Sexual Violence (2016), 85% of cuts have been at the expense of women in general.

There has been considerable fragmentation of services since the Coalition Government’s approach to local commissioning that “combines the rhetoric of devolution of power to local government with significant cuts to local government funding” (Bowstead, 2015, p. 328). Specialist DVA services are currently non-statutory or ‘discretionary’ services and have no ring-fenced

funding, resulting in a paradox between the national policy framework and local implementation (Sanders-McDonagh, Neville & Nolas, 2016; Ishkanian, 2014). The UK specialist violence sector lost £2.4 million in cuts between 2010 and 2012, equivalent to 31% of its funding (Fahmy, Williamson & Pantazis, 2015); some 10% of DVA organisations received no funding at all from their local authority in 2015/16 (Women's Aid, 2017). Thus, despite a strong public stance on tackling DVA, in real terms women's safety and rights are still systematically neglected.

Austerity measures have also cut funding to the wider constellation of 'support' that women with complex needs rely on, including the NHS, the welfare system and social housing (Kelly et al., 2015). This affects women's ability to escape violence as poverty and DVA are interlinked in complex mechanisms of interdependency (Fahmy, Williamson, & Pantazis, 2014). A Solace Women's Aid project tracking 100 women over three years (Kelly, Sharp & Klein, 2015) observed the impact of legal and policy changes during 2011-2014 in constructing barriers to resources women needed to rebuild their lives, including housing, financial resources and employment. Arguably, systematically depriving women and their dependent children of key services needed to escape abuse and violence creates a form of double victimisation. In addition to suffering intimate violence, they face structural violence (Galtung, 1969) from the state through the government's failure to provide sufficient 'support' services.

#### **1.4. Accessing Support**

Much of the research on women's 'help-seeking' focuses on barriers to 'help' in terms of leaving the relationship. It is important to acknowledge the fundamental challenges in this. Being under the control of an abusive person reduces both perceived and actual feasibility of seeking formal 'help' (Schreiber, Renneberg & Maercker, 2009). The full impact of the abuser's control over women may not be fully understood by others, particularly the psychological impact of threats to hers, her children's, and sometimes their own life. They may not be aware of

the myriad ways abusers isolate women from those who could offer 'support' (Herman, 2015).

Given low rates of 'disclosure' to formal services, research has also often focused on women's perceived barriers to 'support', identifying individual characteristics such as self-efficacy, self-esteem and cognitive appraisals of their circumstances (Cluss et al., 2006; Tilley & Brackley, 2004; Zink, Jacobson & Klostermann, 2004). Large scale quantitative studies have sought to identify patterns of 'help-seeking' behaviours and associated demographics (e.g. Cerulli et al., 2015; Ford-Gilboe et al., 2015; Han & Levchenko, 2017; Hollenshead et al., 2006; Lewis, 2003). Whilst such research can be useful in identifying factors – such as that marginalised women are less likely to access formal 'support' (Amstadter et al. 2008; El-Khoury et al. 2004; Kaukinen 2004; Lipsky et al. 2006) – the focus often remains on women's behaviour, rather than the factors influencing and constraining her decision making. Kennedy et al.'s (2012) model of 'help'-attainment emphasises the role of social location; women's experiences with cumulative sexual and physical violence interact with factors of oppression such as poverty, discrimination, and social isolation to influence choices. This non-linear process involves recursive influence from previous experiences of 'help-seeking', which inform her future attempts (Liang et al. 2005).

#### 1.4.1. Beyond Barriers to 'Disclosure'

'Disclosure' is a term which, at its most basic, refers to a speaker telling someone that they have experienced abuse; a deceptively simple term which masks the complexity involved in understanding, naming and talking about abuse. Research and policy developments have in recent years focussed on removing barriers to 'disclosure'. This focus serves to construct 'disclosure' as a single speech act, rather than a multi-faceted, ongoing form of meaning making and story-telling about abuse (Livesey, 2002). The focus on barriers to 'disclosure' implies that once women have 'disclosed' DVA they will immediately receive the 'help' and 'support' needed. However, the opposite is often the case; research illustrates how the most frequently contacted services are often regarded as the least effective (Gordon, 1996; Hamilton & Coates, 1993;

Postmus et al., 2009). According to Hague & Mullender (2006), women in the UK typically encounter inadequate or unsafe services, which are fragmented between a range of agencies, and often difficult to access. Despite the shift in policy from the Department of Health (Chang et al., 2005) towards multi-agency working, evidence of if and how effectively this is implemented is still forthcoming and often based in local, internal evaluation (e.g. Peckover, Golding & Cooling, 2013). Practitioner understandings, e.g. of coercive control have been found to lag behind legal and policy frameworks (Robinson, Myhill & Wire, 2018).

Additional to difficulties accessing 'support', many women encounter harmful treatment from those they seek 'support' from. Researchers have used 'secondary victimisation' or 'secondary rape' to describe the institutional experiences that can compound the abuse women have experienced (Campbell, 1998; Campbell & Raja, 1999). These including reacting with disbelief, blaming women for their experience, failing to react with empathy and/or reacting dispassionately.

Despite professional training, research has documented how professionals are more likely to hold victims responsible for abuse than the abuser (Carlson & Worden, 2005). Police officers and social workers' interactions have been found to be influenced by attitudes and beliefs based on prior personal experiences (McMullan, Carlan, & Nored, 2010). Whilst professionals have been found to be less likely than students to see DVA as justified (Drout, 1997), research has also observed professionals to be more likely to hold victims responsible for abuse than the abuser Carlson and Worden (2005). Much of the attitudes and behaviour women encounter link to wider societal discourses and beliefs about women, gender roles, and world views. This includes so called 'information myths'; beliefs such as that DVA only involves physical abuse; people who perpetrate abuse are pathological, rare and easily identifiable; women could easily leave if they wanted to, and victims are to blame for the violence (McCauley, Bonomi, Maas, Bogen & O'Malley, 2018; Policastro & Payne, 2013; Westbrook, 2009).

Furthermore, women have ongoing 'support' needs that extend beyond leaving a relationship; not just in keeping safe but living with the legacy of violence

(Evans & Lindsay, 2008). They often have long-term involvement with a range of statutory, non-statutory and civil services including, but not limited to: police; criminal justice system; health and mental health services, and specialist DVA services, in addition to their ongoing social relationships (Kelly et al., 2015).

### **1.5. The Relevance for Clinical Psychology**

There is substantial evidence of the psychological impact of DVA (Trevillion, Oram, Feder & Howard, 2012; Okuda et al., 2011; Lagdon, Armour, & Stringer, 2014; WHO 2013) and mental health service users report high rates of DVA (Alhabib, Nur & Jones, 2010; Howard, Trevillion & Agnew-Davies, 2010; Oram, Trevillion, Feder, & Howard, 2013). Psychological difficulties do not necessarily abate after achieving safety (Mechanic, 2004) and women can experience psychological consequences years after escaping violence (Dutton, 1992; Herman, 2015). The impact of DVA on wellbeing extends beyond psychiatric diagnoses; some women self-harm or attempt suicide, become addicted to drugs or alcohol, and enter pathways to homelessness or prison (AVA and Agenda, 2017).

Despite the impact of DVA on mental health, mental health services rarely address DVA and DVA services are rarely able to provide psychological support (Howard, Feder & Agnew-Davies, 2013). Psychological services may be the hardest to reach for women who must overcome numerous individual, interpersonal, structural and sociocultural barriers to access any informal or formal support (see O'Doherty, Taft, McNair & Hegarty, 2016). For example, whether women decide to seek help is affected by sociocultural factors, such as gender-role expectations and the relative acceptability of control or violence within relationships (Liang et al., 2005; Ting & Panchanadeswaran, 2009); her beliefs about herself and perceptions of her circumstances and options (Cluss et al., 2006; Tilley & Brackley, 2004; Zink, Elder, Jacobson, & Klostermann, 2004); interpersonal factors such as relationship to the perpetrator (Chang et al., 2010; Crawford, Liebling-Kalifani, & Hill, 2009; Eisikovits, Buchbinder, & Mor, 1998), presence of children or pregnancy (Chang et al., 2010; Edin,



Dahlgren, Lalos, & Hogberg, 2010; Zink, Elder, & Jacobson, 2003), and the nature of relationships with others who might offer support (Cluss et al., 2006; Liang et al., 2005; Taket, O'Doherty, Valpied, & Hegarty, 2014). If and when women do decide to seek help they face further structural barriers in this such as the availability and accessibility of support (Sullivan & Bybee, 1999), poverty and economic instability (Campbell, Rose, Kub, & Nedd, 1998; Goodman, Smyth, Borges, & Singer, 2009), immigration status (Bui, 2003; Liang et al., 2005; Ting & Panchanadeswaran, 2009), negative attitudes and poor understanding of DVA (Keeling & van Wormer, 2012), and lack of culturally diverse understanding or resources (Donnelly, Cook, van Ausdale, & Foley, 2005).

Given these wide-ranging influences on women's help-seeking, there is arguably a need for psychologists to think more broadly about women's emotional wellbeing- and what we can contribute as psychologists- than psychological therapy and intrapsychic processes. Critical community psychologists critique traditional ways of understanding and intervening in systems that maintain collective oppression; instead seeking to directly challenge forms of oppression such as sexism and violence (Watkins & Ciofalo, 2011). Actions to promote wellbeing can take place anywhere along intersecting axes of preventative to reactive and individual to collective approaches (Prilleltensky, 2013). Clinical psychologists typically intervene reactively (once mental health problems have developed) at an individual level (offering individual therapy). However, from a community psychology perspective there are numerous ways in which psychologists might intervene to promote wellbeing, ranging from violence prevention strategies, to influencing women's experiences of support after to DVA to minimise transition to chronic or severe psychological distress. Indeed, clinical psychologist's roles entail more than clinical work but also strategic roles, such as policy and service development (Division of Clinical Psychology, 2010).

Furthermore, women do not experience 'support' systems in isolation and yet services often offer fragmented approaches to DVA with competing priorities or concerns (Peckover, et al., 2013). In reconciling social work, trauma practice and ecological theory, Adamson (2005) argues for contemporary practice to deny any one 'logic' and work interactively with multiple 'logics' in a negotiated,

cross-cultural practice. There is important value in psychologists engaging with understandings of women's experiences across services, not just within the medical or psychological sphere.

## **2. EMPIRICAL REVIEW**

In this chapter I summarise and discuss the results of a systematic search for empirical research into women's experiences and perspectives on navigating 'help' and 'support'. In summarising the literature, I will outline my rationale for the current research and end this section with my research questions.

### **2.1. Introduction**

Much of the research into help-seeking experiences is conducted in North America. Whilst we can anticipate – and do find – significant overlap in attitudes, beliefs and behaviours relating to DVA within 'Western' affluent cultures, grouping 'Western' countries such as the UK and the USA together obscures significant differences in terms of the structure of public health services and legal practices; structural political, social and economic differences, and dominant attitudes in terms of traditional, religious and political values. It is important to specifically identify and evaluate practices within the UK to drive localised change. A preliminary search of the literature revealed only a small number of UK studies and the search criteria (Appendix A) was expanded to include European studies, whilst recognising that there are significant cultural differences within Europe. However, few non-UK European studies were identified (Appendix B) and the review below predominantly focusses on the UK literature.

Existing DVA literature predominantly includes research with professionals and quantitative analyses of factors relating to 'help-seeking', in addition to qualitative research prioritising women's voices. Whilst there is no single 'truth' about women's experiences, it is vital to differentiate between self-reported and reported-on experiences by professionals. The following review solely includes women's accounts, to explore their self-reported experiences in a localised context. Specifically, the review is of women's experiences beyond 'disclosure',

although in some studies this distinction may not have been clearly drawn. The full search methodology is included in Appendix A.

The review considers women's experiences with a range of 'support' systems, which broadly fall into the following categories: statutory services; specialist DVA services, and informal support. Research is typically spread across disciplines, with each system- social, legal, medical, mental health and so on- studied in isolation (Campbell, 1998). The research will therefore be considered under these headings, before summarising the smaller body of research into women's experiences across systems.

## **2.2. Statutory Services**

### **2.2.1. Police**

During the last two decades range of police interventions have been introduced in the UK to improve the response to DVA, such as the introduction of specialist Domestic Violence Units (now often closed or subsumed into other services); specialist police officers; specialist DVA training; Independent Domestic Violence Advocates (IDVAs); Domestic Homicide Reviews and Clare's Law (the right to ask and the right to disclose the name of domestic violence perpetrators to potential victims), and trialling practices such as pro-arrest policies, perpetrator programmes, co-ordinated community responses and the use of police body cameras (Westmarland, Johnson & McGlynn, 2018). However, there exists an academic-practice gap (Westmarland, Thorlby, Wistow & Gadd, 2014), in which innovative police practice is not based in, or evaluated within, academic research and is therefore absent in the literature.

Despite these innovations, survey research by Her Majesty's Inspectorate of Constabulary (HMIC, 2014) identified that a third of respondents felt no safer or less safe after police response. The HMIC focus group data revealed a majority also experienced poor attitudes; not being taken seriously; feeling judged and officers lacking empathy and understanding. Other UK-based research illustrates problems such as failures of the police to act protectively or to arrest

the perpetrator after multiple reports of abuse; disappointment with bail decisions (Madoc-Jones & Roscoe, 2010); inconsistent or unpredictable responses (Wilcox, 2000); delays; being pressured to take action (Belur, 2008); lack of or incorrect information (Hester, Pearce & Westmarland, 2008; Madoc-Jones et al. 2010; Vallely, Robinson, Burton & Tregidga, 2005), and perceived discrimination based on mental health diagnosis (Trevillion et al., 2014). In Brooks and Burman (2017), women reported being reluctant to engage further with the police after arrests, due to fearing them. In Wilcox (2000), negative experiences with the police reportedly increased with multiple experiences of victimisation due to experiencing increased negative attitudes from police after repeated incidents (see also Hanmer, Wilcox, Curteis, & Griffiths, 1998; Wilcox, 1997).

Positive experiences with the police included quick response times, non-judgmental attitude, helpful officers, arrests being made, information about specialist services (HMIC, 2014); emotional support; individual consideration of needs; case updates (Vallely et al., 2005) and practical support such as changing locks (Robinson et al. 2007; Vallely et al., 2005).

In contrast, Lewis, Dobash, Dobash and Cavanagh (2000) found a majority of women surveyed experienced the police as 'helpful' or 'very helpful'. The authors highlight that in all positive instances the perpetrator had been successfully charged and prosecuted. Service users interviewed by Hague and Mullender (2006) commented on improvements over years; almost all were associated with specialist units and officers, indicating the value of specialist provision. A large interview survey by Robinson & Stroshine (2005) confirms that the strongest predictor of women's satisfaction with the police is the extent to which their expectations about police behaviour (e.g. making a report) and demeanour (e.g. concerned, respectful) are fulfilled. In both positive and negative cases, research highlights how women want desired outcomes (protection from further violence) but also appear to place high value on forms of emotional support and how they are treated during this process.

### 2.2.2. Legal and criminal justice services

Women entering criminal justice proceedings after DVA enter a system with a long history of failing to protect women from violence in intimate relationships. The right of men to beat, reprimand or force sexual intercourse on their wives was enshrined in UK common law since the 17<sup>th</sup> century (see Smith & Powell, 1989). The significant lag in overturning property-based concepts of marriage is illustrated in the relative recent criminalisation of marital or acquaintance rape in 1991<sup>1</sup> whilst extra-marital rape has been considered an offence in common law for centuries<sup>2</sup>. Specific legislation on domestic violence was only introduced in 1976<sup>3</sup> and significant reform only began in the 1990s and 2000s<sup>4</sup> (Graca, 2017). European research into women's experiences with criminal justice services after abuse has tended to focus on women's experiences after rape or sexual assault by strangers; concepts of 'secondary victimisation after DVA' and 'domestic violence myths' have been adapted from earlier research-based concepts of 'secondary rape' and 'rape myths' (Burt, 1980; Campbell, 1998; Campbell & Raja, 1999). Despite legislative reform, the available evidence on women's experiences of criminal justice proceedings after DVA suggests women still encounter an adverse system, which adds to the effects of abuse.

The European research identified suggests that women report legal and criminal justice services as unsupportive due to a number of experiences: being excluded from the process; lack of information or misinformation; feeling silenced; sanctions being insufficient to prevent abuse; feeling betrayed and let down by plea bargaining and reduced sentences; encountering insensitive professionals, and having safety needs dismissed (Lewis et al., 2000; Hester et al., 2003; Orth, 2002; Temkin, 2000). Women report experiencing court personnel as obstructive in responding to their concerns and fears where this

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<sup>1</sup> The House of Lords overturned the matrimonial exception to rape in *R v R* [1991] 3 WLR 767, which led to the revision of the Sexual Offences Act 1956 and the abolition of the marital rape exemption being added to the Act in 1994

<sup>2</sup> The concept of the impossibility of marital rape is attributed to English Judge, Sir Matthew Hale in 1776, known as The Hale Proposition (Hale, 1776)

<sup>3</sup> the Domestic Violence and Matrimonial Proceedings Act 1976

<sup>4</sup> With the introduction of the Family Law Act 1996, updated by the Domestic Violence, Crime and Victims Act 2004

conflicted with goals of prosecution, denying women the opportunity to use the legal system flexibly to negotiate their safety (Lewis et al., 2000).

Whilst some women found the criminal justice system helpful in immediately responding to violence, women who experienced continuing abuse at the hands of 'chronic offenders' found the legal system to be ineffective in preventing violence and harassment, particularly coercive control (Hester et al., 2003). In Orth (2002), 67% reported negative effects from criminal proceedings; some stating that the experience of navigating criminal proceedings had been worse than the original abuse. Support was highlighted as fundamental to helping women manage the court process; this included victim support schemes but also support from police, solicitors, other agencies, family and friends (Hester et al., 2003). It is an interesting finding that women were supported by other services such as the police. This raises the question, what happens when those systems too are felt to be harmful?

In Orth's (2002) retrospective study with a mainly female sample, participants' (dis)satisfaction with the outcome and whether they perceived the process to have been 'just' (their interest and views given due consideration) predicted negative effects on coping, self-esteem, trust and faith in the legal system, future and a just world. Such findings raise the possibility that, in addition to being disappointed by outcomes, negative help-seeking experiences after abuse can have powerful intrapsychic effects, impacting on how women feel about themselves, others and the world.

Lewis et al. (2000) explored ways in which women use "active negotiation" and "strategic resistance" to navigate the system and manage their own safety. This included resisting the system by retracting statements or failing to show to protect themselves from a range of effects, including the perpetrators' behaviour; protecting finances due to lost work or a fine; protecting children's relationship with their father, and preventing the impact on children being called as witnesses. In the absence of sufficient statutory responses, some women also proactively engaged in strategies such as informing police of introduced legislation and enlisting support to ensure the perpetrator turned up to court. Lewis et al.'s (2000) approach illustrates how research is not ideologically

neutral; women's behaviour can alternately be constructed as problems, or as forms of resistance against a harmful system.

### 2.2.3. Social Services

Abusers often threaten women with having their children removed; this is a fear that can be re-enacted by social services and even realised. Research detailing women's experiences with social services includes accounts of some social workers threatening women with removing their children for not protecting them from violence, even as they were seeking divorce and injunctions, and holding women accountable for men's abuse (Buckley et al., 2011; Kelly et al., 2015). The majority of women interviewed in these two studies detailed negative experiences, including abuse being discussed in front of the perpetrator; not holding the perpetrator accountable; minimising violence; attributing violence to 'cultural differences'; ignoring or minimising their concerns; telling women to leave with nowhere to go; being made to go to joint meetings post-separation; being accused of manipulating or 'brainwashing' their children, and feeling disbelieved and let down.

Social workers were described as failing to recognise tactics of abuse, being charmed by abusers, and neglecting to consider the impact of women's safety and welfare on their children (Perks et al., 2012). Some women who actively sought 'help' reported being ignored or denied access because they did not qualify, DVA was minimised or even that they were "too articulate" (Buckley et al., 2011; Kelly et al., 2015). In Buckley et al. (2011), women reported going to increasingly desperate lengths to be heard about the impact of DVA on their children, including installing CCTV and tape recording their children. These findings illustrate the limitations of focussing on women's 'disclosure' of abuse; women were actively communicating about their experiences of abuse, but not being heard. Similar to Orth's (2002) findings in the legal sphere, this highlights how women actively engage in attempting to change their experiences within these systems.

Some women described involvement with social services as the hardest part of their experiences and that even where complaints were made the situation



worsened, leaving them feeling powerless (Buckley et al., 2011; Kelly et al., 2015; Perks et al., 2012). Herman (2015) posits that disempowerment is a core feature of abuse; having powerlessness reinforced elsewhere augments the experiences of abuse.

Positive experiences of social services included women feeling believed and reassured and individual social workers being empathic, supportive and proactive (Buckley et al., 2011; Kelly et al., 2015; Perks et al., 2012). This reiterates previous points in other services about the value of emotionally supportive responses.

#### 2.2.4. Family Courts

Separate from the criminal courts, women with children often find themselves in private law proceedings over child contact. Proceedings frequently take place with recognition of DVA, such as prior conviction for violence or injunctions being in place. However, women have consistently reported evidence of DVA being dismissed and regarded as separate to decisions regarding men's parenting capacity and their rights to access (Coy, Scott, Tweedale, & Perks, 2015; Perks et al., 2012; Holt, 2017; Radford, Hester, Humphries, & Woodfield, 1997; Hester, & Radford, 1992). As in other services, women reported being disbelieved; minimisation and dismissal of the abuse; being treated with scorn and evidence of DVA being dismissed (Coy et al. 2015; Kelly et al., 2015; Perks et al., 2012). Multiple accounts refer to judges recognising only the severest forms of physical violence as abuse (Coy et al., 2015; Perks et al., 2012).

Ultimately, this leads to unsafe practices or collusion with abuse. Women reported abuse during court proceedings, including verbal abuse; threats; intimidation, and stalking<sup>5</sup> (Kelly et al., 2015; Perks et al. 2012; Women's, Aid 2017b). Women detailed a lack of safety arrangements such as separate exits; refusal of special facilities use; revealing addresses to abusers in court and facing cross examination by their ex-partners (Kelly et al., 2015; Perks et al.

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<sup>5</sup> Defined in the Protection from Harassment Act 1997 by examples of behaviours such as: following; contacting and attempting to contact; monitoring, and watching or spying on someone, including through social media

2012; Women's, Aid 2017b). Consistent in women's accounts was that the courts do not recognise how abusive men use the system to control and harass<sup>6</sup> women (Coy et al. 2015; Kelly et al., 2015; Harrison, 2008; Perks et al. 2012). Women detail ex-partners repeatedly initiating proceedings- up to 50 times- with significant financial and emotional impact (Perks et al. 2012; Coy et al. 2015). In both social services and the family courts, research suggests a gender-neutral view is being taken on DVA, precluding understandings of the mechanisms of power and control.

Women described being emotionally and psychologically 'ground down'; stress; depression; sleeplessness; eating problems; anxiety; panic; using alcohol, therapy and counselling to cope (Coy et al. 2015; Kelly et al., 2015; Hester et al. 1992; Holt, 2017; Perks et al. 2012; Radford et al. 1997). Replicating findings in other services, some women likened involvement in proceedings to living with DVA (Coy et al. 2015; Perks et al. 2012). The need for women to seek further support to deal with their experiences of services raises further questions about if and how they can obtain that support. What happens next, and how are women impacted by these experiences over time?

Women report contact arrangements being pursued despite evidence of child abuse (Holt, 2017; Radford et al., 1997; Hestor et al., 1992); in 25 years of research the father's absence is still considered by some as more harmful to children than his abuse (Coy et al., 2005; Hestor & Radford, 1992; Holt, 2017; Kelly et al., 2015). This lack of recognition and risk assessment in court fed into unsafe contact arrangements; allowing for ongoing post-separation violence, child abuse or neglect during contact, children being used to threaten or manipulate women, and in extreme cases, the death of women and children (Coy et al. 2015; Harrison, 2008; Hester et al. 1992; Holt, 2017; Kelly et al., 2015; Radford et al. 1997; Women's Aid, 2016).

Less frequently detailed are the positive practices reported, such as feeling believed; solicitors having a good understanding of DVA and having someone always accompany her (Coy et al. 2015; Perks et al. 2012). Research into both

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<sup>6</sup> Defined as "repeated attempts to impose unwanted communications and contact upon a victim in a manner that could be expected to cause distress or fear in any reasonable person." (Crown Prosecution Service, 2018)

social services and family courts highlights how different priorities and contexts – of protecting children and determining parental access- obscure and deprioritise understandings of abuse. They diminish the importance of the mothers' safety as a woman and a human being in her own right, and children's need of protection from an abusive environment.

#### 2.2.5. Mental Health Services

In 2008 the NHS published a briefing paper outlining Department of Health policy that adult mental health services should acknowledge and address the links between violence and abuse; all mental health service users should be asked about abuse, and all staff should be trained in doing that (NHS, 2008). There is little published research examining whether this is implemented, and even less into how services respond and what support they offer (Read, Sampson & Critchley, 2016).

In the studies identified, some women described positive experiences of help-seeking in mental health services, which included acknowledgement of abuse; ongoing support; support for multiple needs (Trevillion et al., 2014); ease of access and a proactive approach (Schreiber, Maercker, & Renneberg, 2010); acts of caring; creation of trust (Örmon et al., 2014) and confirmation that they were not crazy (Humphreys & Thiara, 2015). However, most responses highlighted negative experiences accessing or receiving mental health services.

Overall, problems related to resource shortages; difficulty accessing services; lack of referral to other services providing safety or a more specialist response; helpers' insufficient knowledge about or sensitivity to DVA, and negative or harmful treatment (Humphreys & Thiara, 2015; Örmon et al., 2014; Schreiber et al., 2010; Trevillion et al., 2014). Harmful responses from mental health clinicians included ignoring or minimising abuse; discrimination; victim blaming and enacting further violence and coercion. In psychiatric care, Örmon et al. (2014) detail women being told their responses were due to mental illness and insinuations they were psychotic and had imagined abuse. Women described 'acting out', deliberate self-harm and suicidal threats as ways to elicit care and help. This highlights how viewing such behaviours as problems located within

women ignores their important context and meaning, in a system where women feel ignored and desperate. Psychiatrists were experienced as not seeing a role for themselves or other professionals in addressing mental health effects related to DVA (Humphreys & Thiara, 2015). As in other systems, abuse seems viewed as separate to the issue prioritised by the system, in this case, 'mental illness'. This fragmentation of care and understanding creates additional difficulties where there are co-occurring problems, such as complex 'comorbidity' or childhood abuse (Schreiber et al., 2010).

Where referrals to counselling or other specialist services were made, women reported experiencing long waiting times; inflexibility e.g. in timing that prevented uptake; lack of therapist availability; therapy as timebound and too short; lack of relevance to DVA; limited choices, and poor communication (Evans and Feder, 2014; Kelly et al. 2015; Larsen, Krohn, Püschel, & Seifert, 2014; Oram, Capron & Trevillion, 2016; Schreiber et al., 2010). When women were able to access counselling some had negative experiences, such as therapists not understanding 'traumatisation', or exploring childhood issues that weren't seen as relevant (Schreiber et al., 2010). Some of these issues seem related to resources and pressures on services; others suggest a lack of training or centralising of DVA. Where women were able to access counselling through specialist services, they were generally satisfied and experienced it as prompt compared to the NHS (Oram et al., 2016; Kelly et al., 2015).

Different preferences for support were identified. Oram et al. (2016) describe how some women valued support groups, whilst others found the exposure and concerns about confidentiality difficult. According to Kelly et al. (2015) a few women reportedly found post-traumatic stress disorder (PTSD) clinics very helpful. Oram et al. (2016) noted consistent preferences for female therapists and women-only spaces. Regarding pharmacological treatment, women had variable views; some were satisfied with medication being offered, other viewed this as a 'quick fix' rather than exploring the root of their distress (Evans and Feder, 2014; Humphreys & Thiara, 2015; Larsen et al., 2014). These findings suggest women have varying preferences for mental health support, not all of which will be able to be met within one service, nor pre-packaged for them.

### 2.2.6. Health Services

Women who experience DVA have high levels of physical and psychological health problems, thus healthcare professionals' role has been stressed in identifying DVA (Department of Health, 2000). Much research in this area therefore focusses on detecting DVA; less is known about women's experiences once DVA has been identified. A systematic review of the perceptions and experiences of accessing health services by women who experienced domestic violence (Louise & Karen, 2008) identified 10 studies worldwide, only five of which addressed experiences of support and referrals. Only two were conducted in the UK.

A common problem identified across healthcare studies is that even once DVA is identified and discussed, women report not being offered support or appropriate referrals, long delays in accessing specialist services and poor information and awareness (Bacchus, Mezey, & Bewley, 2003; Evans & Feder, 2014; Keeling, Fisher, June, & Colleen, 2015; Larsen et al., 2014; Peckover, 2003; Pratt-Eriksson, Bergbom, & Lyckhage, 2014). In Peckover (2003), women reported healthcare visitors to be focused on risk to children, and where children were not being directly abused, failing to support them as women. This echoes the findings in family court and social services; that women's needs are side-lined when the focus is on protecting children, and a narrow understanding of the harms to children from abuse.

Furthermore, some women reported harmful or unhelpful responses, such as offering the perpetrator help but not them; advising them to rest or take a holiday (Bacchus et al. 2003); dismissing the abuse (Larsen et al. 2014); asking why they do not leave (Peckover, 2003); lacking in care and empathy (Pratt-Eriksson et al., 2014) and ignoring requests for assistance with tests for court (Keeling et al., 2015). In Larsen et al. (2014), half of women described a disconnect between healthcare services – their first point of access – and other systems, such as the criminal justice system. This left them feeling alone without support or the information needed to access 'help'. Interviews with Swedish women (Pratt-Eriksson et al., 2014) revealed a strong sense of betrayal. Women described expecting that speaking about abuse would end their suffering and instead encountering a struggle to be heard and believed.

Women's accounts illustrated how they felt their care was hurried and they had no control over it; they also felt ignored and treated as a nuisance. As a result, most women expressed that seeking 'help' for DVA was unhelpful and pointless; they felt cut off and hopeless.

In all studies identified positive experiences of healthcare services were the minority, however some helpful responses were identified. These included suggestions for self-help and self-care strategies; helping to gather medical evidence; referrals for counselling, and personally helping contact specialist workers or services (Bacchus et al. 2003; Evans & Feder, 2014; Keeling et al., 2015; Kelly et al., 2015). Women valued the time given to them to explain their options; help to access practical support, such as benefits, and taking steps to ensure women's safety whilst discussing abuse with them (Bachhus et al., 2003).

According to Bacchus et al. (2003), women did not want health professionals to problem solve or act for them, but sought encouragement, support and information. As with other services, women identified the need for respect, trust and empathy; they stressed the importance of listening, feeling understood, less alone, and reassured of getting the help they need (Bacchus et al. 2014; Larsen et al., 2015; Pratt-Erikson).

### **2.3. Specialist DVA Services**

Most research relating to women's experiences of specialist DVA services is conducted by organisations themselves. There was little independent, peer-reviewed European research into women's accounts of specialist services identified. However, specialist services were often constructed as positive or helpful in other studies, i.e. regretting delays in accessing specialist support, or a referral to a specialist service being a valued outcome (e.g. Bacchus et al. 2014; Evans & Feder, 2014).

In all studies identified relating to advocacy services, women mentioned the value of both practical and emotional support (Brooks & Burman, 2017;

Ekström, 2017; Madoc-Jones, & Roscoe, 2010; 2011; Robinson & Tregigda, 2007). The support offered varied but women valued practical support, such as assistance accessing information and advocating on their behalf with police and courts (Brooks & Burman, 2017; Ekström, 2017; Madoc-Jones & Roscoe, 2011); support with applications for housing and benefits; ensuring safety (Madoc-Jones & Roscoe, 2011), and linking between other agencies involved (Ekström, 2017; Robinson et al., 2007). Practical support had emotional effects in giving women a feeling of security and a sense that someone was on their side (Brooks et al. 2017; Ekström, 2017; Madoc-Jones & Roscoe, 2011). Women also valued the therapeutic effects of being listened to and offered reassurance (Ekström, 2017; Madoc-Jones & Roscoe, 2011); emotional support in coping with the criminal justice process and the reactions of others (Brooks & Burman, 2017), and the non-judgemental response and openness of the women supporting them (Madoc-Jones & Roscoe, 2010). This support enabled some women to continue with criminal justice proceedings they would have otherwise dropped (Brooks & Burman, 2017; Madoc-Jones & Roscoe, 2011).

Women valued the opportunity to talk through their choices instead of steering them towards making choices (Brooks & Burman, 2017; Madoc-Jones & Roscoe, 2011). However, pro-active or assertive engagement was valued by women without the internal or external resources to search for 'help' (Madoc-Jones & Roscoe, 2010; 2011). Women reported receiving information passively e.g. via leaflets but not having engaged with this due to previous negative experiences or lacking energy.

Despite positive accounts of specialist DVA services across studies, women reported having little long-term support (Wilcox, 2000; Kelly et al., 2015). Women described finding it difficult to move on from 'crisis' interventions, where support felt abruptly withdrawn. Another noted limitation of DVA services was the ability to provide for women and children with complex needs, such as physical, mental health, or substance issues (Kelly et al., 2015).

There is value in special expertise located in DVA services, and argument for them remaining separate from government funding to be able to engage in political activity. However, specialist services are resource-limited and cannot meet all of women's needs. Partnership schemes between statutory and third-

sector services are being piloted (e.g. Vallely et al., 2005). However, it remains underexplored how women experience navigating these fragmented systems, with remarkably different-often conflicting- priorities and values (Peckover et al., 2013). Even where 'support' is helpful, the experience of navigating multiple fragmented services is likely exhausting and bewildering, or women are left without vital resources needed to rebuild hers and her children's lives.

## **2.4. Informal Support**

Despite most women not encountering formal services, most data about women's experiences of 'support' for DVA focuses on services. There is limited European data on women's accounts of informal 'support'; that is, experiences with family, friends or other personal networks. Yet, whilst women are navigating other systems, they are also interacting with others within their social networks and vice versa. How do these experiences interrelate and impact on each other?

A systematic review of 'disclosure' and 'help-seeking' for DVA within informal networks identified 41 studies (Edwards, 2015), only one of which was conducted in Europe and contained minimal survey data (Karin, Vatnar, & Bjørkly, 2008). In studies where women discussed informal 'support' their accounts varied. According to Kelly et al. (2015), over three-quarters of women surveyed named people who were involved in or aware of the abuse. Some were described as offering support by listening, offering advice and practical or financial resources. Others were unhelpful or harmful by failing to help, colluding with the abuse or siding with the abuser. There were also complex experiences of changing responses over time and divided loyalties. Again, this suggests that focus on 'disclosure' of abuse obscures the ongoing experiences women have with others when abuse is known about.

Women in both Kelly et al. (2015) and Wilcox (2000) stressed the importance of social support in both leaving violent relationships and building a new life. In Evans and Feder (2014), women indicated that typically friends offered emotional support and family practical support, such as a place to stay,



childcare or financial help. Female support was generally mentioned as most supportive, especially those who had also escaped abusive relationships (Wilcox, 2000). In Evans & Feder (2014), informal contacts sometimes facilitated access to DVA services, but only if they had personal or professional connections to DVA.

In both Wilcox (2000) and Kelly et al. (2015), women suffered from a reduction in their support network after leaving due to the perpetrator trying to turn family and friends against them and moving away from homes and communities. Material poverty, debt and health conditions also restricted their ability to build new networks. Given that in other research women have stated the importance of social support in coping with hostile systems, it would be interesting to explore these experiences together.

## **2.5. Multiple System Experiences**

Most research into women's experiences of 'support' systems after disclosure focuses on women's experiences of specific services, despite women being engaged with multiple systems simultaneously. Six studies were identified describing encounters with multiple services, which varied in aims, scope and quality. Hague & Mullender (2006) is a descriptive account of service user views within a larger project on UK DVA policy; Pratt-Eriksson et al., (2014) is a Swedish study of encounters with healthcare professionals; Coy et al. (2015) is a narrative description of interviews regarding child contact; Keeling (2011) is a PhD thesis on women's experiences of 'disclosure' (and interactions) with statutory agencies after childbirth; Evens & Feder (2014) is a qualitative study of pathways to support within a wider DVA trial, and Kelly et al. (2015) is a DVA charity report covering multiple systems.

Evans & Feder (2014) demonstrate how, for those women who ultimately were able to access DVA agencies, their path from disclosure of abuse was rarely straightforward or immediate; typically it was via a series of connections with multiple services and often women did not act on information for months or years. Thus, rather than a single act of 'disclosure', women have repeated

encounters with different services and professionals as they attempt to access 'support'.

The majority of participants interviewed by Hague & Mullender (2006) felt that their thoughts and experiences were mostly overlooked and their needs not considered or met. Furthermore, they felt regarded as unimportant, stigmatised, disbelieved, and frequently unsafe and unprotected. In characterising their experiences, Kelly et al. (2015) describe how women felt that they were being penalised for attempting to stop the violence in their lives; being met with suspicion, disinterest or obstruction by multiple service. In some cases women started to believe that their abuse was justified. In Coy et al. (2015), women's accounts included being "ground down" by the multiple onslaught of surveillance by courts and statutory agencies, recurrent attendance at court and continued encounters with the men who abused them. Similarly, in Pratt-Eriksson et al. (2014), women's accounts included feeling that they felt they were reliving the violence; feeling that they needed to continually justify and defend themselves; feeling 'retraumatised'; struggling to make various services and professionals believe them, and experiencing a sense of "existential loneliness" at being ignored by health professionals, social services and the police alike. This theme of 'secondary victimisation' is a recurrent one throughout the literature but especially prominent when multiple service experiences are considered together. Keeling (2011) explores how women's interactions with statutory agencies limited their agency, concluding that services subjected them to control parallel to the abuse.

#### 2.5.1. Minoritised women

Research with 'minoritised' women<sup>7</sup> has tended to focus on differential experiences due to 'ability', 'race' and gender or sexual identity, rather than specific services. Research typically replicates existing findings of negative experiences, with additional difficulties. For example, 'women of colour' and immigrant women report additional barriers such as poor accommodation of language; discrimination; state-sanctioned destitution; stigmatisation; invisibility;

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<sup>7</sup> To mean 'groups' having less power of representation relative to other 'groups' in society.

isolation, and professional's lack of 'cultural competency' (Anitha, 2008; 2010; Banga & Gill, 2008; Thiara & Gill, 2013). 'Disabled' women reported variable 'help' from informal networks but mostly dissatisfaction with statutory services, due to lack of knowledge of dynamics of abuse by carers; inaccessibility of services; not being taken seriously; being patronised, and lack of support options, even leading to children being removed after leaving abusers (Gill et al., 2011; Hague, Thiara, Magowan, & Mullender, 2008; Hague, Thiara, & Mullender, 2011; Thiara, Hague & Mullender, 2011). Women identifying as LGBT have raised difficulties with heterosexuality within services; gender-binary services (i.e. excluding trans women); lack of staff diversity, knowledge and skills; minimisation of LGBT people's experiences of abuse; gaps between services, and outright discrimination, stereotyping and abuse (Hester et al., 2012; Harvey et al., 2014; Rogers, 2013).

In considering women's experiences across systems, these studies have begun to build a more detailed picture of how multiple experiences impact women's lives, intersecting with-and sometimes compounding-experiences of abuse. However, this area is under-researched with existing research often confined within service areas.

## **2.6. Summary and Rationale**

The literature reviewed points towards a pattern whereby women must overcome numerous hurdles to escape abuse, yet once they are able to seek 'support', often encounter what they experience as the confirmation or exacerbation of abuse already suffered. Across different services women highlighted needs for empathy, understanding, validation and well-informed staff who can offer support and onward referrals. Despite generally positive views of DVA services, specialist service provision remains insufficient and under-funded.

We can piece together a picture of women's experiences but research remains fragmented between services, as are women's experiences of care. Yet women have concurrent experiences of 'help'-seeking; what are their cumulative

effects, and how do women make sense of these experiences together?

Although a range of research has been reviewed, a significant proportion of this data comes from the grey literature; charity reports, PhD theses and government documents. We still have relatively little information of what women's broad experiences are like once they manage to access formal services. Are they able to receive help for *their* self-defined needs (Kennedy et al., 2012)?

The imposition of a researcher-defined focus on a system or service also makes it challenging to determine what women's holistic needs for support are and what constitutes support, for them. Only then can we begin to explore how well this is being met by 'support systems', and what needs to change.

#### 2.6.1. Research Questions

In addition to considering the literature, consultation with service users and professionals (see Section 3.2) helped establish the following research question:

*How do women who have experienced DVA experience navigating and accessing 'support', 'post-crisis'?*

More specifically, I was interested to explore:

- What has influenced whether they have experienced something as helpful or harmful and why, from their own perspectives?
- How do they make sense of their experiences of help-seeking? What understandings and representations do they draw on in the process?

### **3. METHODOLOGY**

This chapter details my approach to the research, beginning with philosophical and methodological considerations and the relationship to feminist research on DVA. I then describe the design and procedures of the study, including consultation, ethical considerations, and analytic approach. My stance is illustrated throughout, ending with a reflexive section exploring my personal position.

#### **3.1. Epistemological and Methodological Considerations**

##### **3.1.1. Ontological and Epistemological Position**

Approaches to research and data inherently involve a theory 'of being' (ontology) and a theory 'of knowledge' (epistemology). Ontological positions exist on a spectrum from realism (reality exists independently of observers and their perceptions, beliefs etc.) to relativism (even if a material reality exist, it is inaccessible to us) (Burr, 2015). Epistemological positions vary from positivism (knowledge is based on tangible properties of reality; therefore we can observe it) to constructivism (knowledge is derived and maintained from social interactions; therefore our knowledge claims cannot be independent of these) (e.g., Derrida, 1976; Gergen, 1989).

Feminist academics have often been drawn towards post-modernist approaches conceptualising gender and gender roles as socially, rather than biologically constructed (e.g., Butler, 1990; Hepburn, 2003). However, social constructionism can arguably lead to moral and judgemental relativism, where we cannot choose between competing theories of knowledge and which voices or courses of action to support (Willig, 2013).

Critical realism has emerged as a metatheoretical position that merges ontological realism, epistemological relativism, and judgmental rationality (Archer et al., 1998; Bhaskar, 1989). Critical realists allow for claims to be made

about material reality, whilst recognising the constructivist role of language and social processes in observing and producing theories about the world (Parker, 1992; Sayer, 1992).

### 3.1.2. Critical Realism Applied to DVA Research

I have adopted critical realism as part of a contextualist approach (Madill, Jordan & Shirley, 2000), which “grounds discursive accounts [...] in social practices whose underlying logic and structure can, in principle, be discovered” (Manicas & Secord, 1983, in Parker, 1999). In adopting critical realism, I assume judgemental rationality, determining some values (e.g. equality) to be more valuable than others (e.g. sexism) (Patel & Pilgrim, 2018).

From a critical realist perspective the constructivist epistemology of DVA is acknowledged; definitions of DVA vary historically, culturally and between people, and women may have experiences that they only later come to construct as assault or abuse. However, violence and abuse are taken to exist, regardless of how they are called. Equally, so are the social and material forces that may shape and maintain DVA, such as forms of inequality operating via gender, ‘race’, class, disability and mental health (Burr, 2015). As Sayer (1992) discusses, social structures such as gender may be socially constituted, however their powers are often ‘irreducible’ to those whose lives are shaped by them.

My aim in this research was to identify and examine some of the (internal, social, material) experiences women have whilst seeking support. I have attended throughout to power and social context, including how this may have influenced and constrained how participants discussed their experiences (Willig, 2013). In exploring women’s experiences navigating access to help I was interested to explore how they may have been affected by how they have been positioned, how they appear to position themselves (Davies & Harré, 1990) and how they negotiate this. Thus, I have sought to explore contextual influences on, but not deconstruct, women’s accounts of their lived experience. I am influenced by intersectional feminist theory (Crenshaw, 1989), in focussing on how women’s experiences of violence are situated within interlocking effects of

oppression linked to social and political constructions of class, race, gender, ability, sexuality, ethnicity, violence and abuse.

### 3.1.3. Feminist Research

There is no one feminist epistemology or methodology (Reinharz & Davidman, 1992). However, some key principles include the centrality of women and gender in analysis; consciousness raising; rejection of distinctions between researcher and the researched; application of feminist principles and ethical values, and an intention to change power relations and inequality (Cook and Fonow, 1986). The latter can range from minimising the power imbalance between researcher and participant, to active attempts to involve participants in the research process (Skinner, Hester & Malos, 2005).

## 3.2. Consultation and Participation

### 3.2.1. Collaboration with a DVA Organisation

Informed by a feminist stance, I sought to collaborate with professionals and service users at a DVA organisation. Several non-governmental organisations were approached by phone and/or email, based pragmatically on their location. One organisation agreed to collaborate in the research, facilitated by contact with a former colleague. The organisation, referred to hereon as the linked organisation (LO), is a pan-London organisation offering a range of services including refuge, advice, counselling and specialist projects.

In the initial stages I held phone and face-to-face meetings with the LO to hear about their current concerns and priorities. These were considered and revisited iteratively alongside consultation from service users; discussion with my supervisor, and reviewing the literature to develop the research questions. The intention was to conduct research that would be both pragmatically useful and contribute to the knowledge base. It was agreed that additional to the thesis I would write a report for the service to enhance use and accessibility of the research.

Levels of support and resources were negotiated with the LO and a contact person agreed with whom there would be regular communication. Further discussions mostly took place via email with some telephone or face-to-face meetings.

### 3.2.2. Service user Consultation

I attended a consultation meeting, which was independently arranged, to hear the concerns and needs of service users. There I discussed the research with some women and at a service user advisory group meeting. I invited women to be involved as consultants to the research; although some expressed an interest, only one came forward to commit to this.

#### 3.2.2.1. *Model of Participation*

Participatory research can take place on a continuum of involvement (Balcazar et al., 2004) and this research aimed to maximise participation within the time and resource constraints of the study period. This entailed a low level of control (advisory) but medium collaboration (ongoing advisers, reviewers, consultants) and degree of commitment (increased ownership of the research process in the dissemination phase).

The service user consultant to the project has chosen to use her name, Amanda. Initial meetings with Amanda included discussion of her interest and desired gains; preferred level of input; support needs; limitations of involvement and practicalities of meeting. We negotiated involvement to meet mutual needs of her learning and my desire for consultation, whilst being clear about ultimate ownership of the research and seeking to minimise the risk of exploiting Amanda (see Appendix C). We agreed to monthly meetings during the design phase and meeting more flexibly during later stages.

Amanda reviewed the research questions, interview schedule and made suggestions about recruitment processes. Although Amanda did not have control over the analysis, we arranged to discuss the methods, analysis and conclusions and to collaborate during dissemination. Although Amanda did not have control over the research, I felt her influence as similar to my supervisor:



informing my decision-making, advising me, and contributing to how I approached the research.

#### **3.2.2.2. *Member Checking***

I had hoped to use member checking to gain feedback on my interpretations during analysis. This was not possible within the time-frame, but I will seek feedback from participants before writing the report for the LO.

### **3.3. Study Design**

#### **3.3.1. Qualitative Design**

Rather than inherently valuing qualitative or quantitative research, the focus consistent with my epistemology is choosing the right method for the research question (Oakley, 2000). The literature review highlighted limited UK research beginning from a starting point of women's own constructions of what is helpful, rather than a researcher-determined focus on a chosen system. This research is therefore exploratory in nature. I also sought to explore how women made sense of their experiences, suggesting value in exploring a smaller set of women's experiences in depth.

The original research design was to offer a choice of participating in a focus group or individual interview. However, challenges in recruitment led to an amendment of the methodology and recruitment process (Appendix D) to individual interviews only. Adopting individual interviews has the advantage of allowing for detailed accounts of individual's experiences (Legard, Keegan & Ward, 2003).

#### **3.3.2. Interview Schedule**

I developed the interview schedule (Appendix E); refined with help from my supervisor and Amanda. I adopted a semi-structured framework to guide an exploratory conversation, using probing questions to elicit depth, whilst exploring core topics across interviews (Legard, et al., 2003). My view was that women are the experts of their experience and what they chose to talk about

was significant. Questions were formed around subjective experiences, not specific services. Each interview began by asking the interviewee to explain how they first became involved with the organisation to build rapport (Legard et al., 2003) and to explore journeys of 'help-seeking'. I then used prompt topics (Wilkinson, Joffe & Yardley, 2004) to explore their experiences and characterisations of 'support' systems; aspects that were helpful or harmful, and their ways of understanding their experiences. After two initial pilot interviews I amended the wording of one question, based on participant feedback.

### **3.4. Participants**

#### **3.4.1. Defining Inclusion and Exclusion Criteria**

Defining criteria to recruit women who have longer-term experiences of seeking support and are out of 'crisis'<sup>8</sup> is problematic; 'crisis' being a subjective experience and construction not all women will adopt. Equally, recruitment based on when women escaped abuse produces challenges due to possible ongoing contact with abusers or multiple experiences of abuse. I therefore adopted broad research criteria related to time of involvement with the LO. This has implications for the heterogeneity of participant's experiences (Section 5.3).

Participants were able to take part in the study if they met the following criteria:

- Self-identifying as female
- Currently in receipt of services from the LO for a minimum of three months
- Over the age of eighteen years
- Speakers of English as a primary or acquired language

Exclusion criteria included:

- Lacking capacity to consent (Mental Capacity Act 2005)

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<sup>8</sup> An event or situation perceived as exceeding the person's current resources and coping mechanisms; often but not always associated with leaving abuse (James, 2008)

- Insufficient English ability to be able to understand information sheets and participate in interviews without a translator

#### 3.4.2. Recruitment Strategy

I was not solely interested in experiences with specialist DVA organisations, however recruiting through the LO was pragmatic, based on difficulties accessing women who aren't already engaged in services.

A range of recruitment strategies were used, most linked to a recovery programme which women typically attended after engaging with the service for three-to-six months; a proxy way of accessing women with medium to long-term experiences of 'support'. Practitioners at the LO did not recruit women but forwarded my recruitment emails with contact details. Practitioners were also provided with the information sheet (Appendix F), posters and flyers (Appendix G) which were distributed at the LO. I also personally attended some groups and events.

During recruitment, I was alive to the fact that most women who participate in research are white, younger, able-bodied and heterosexual. I attempted to reach women with varied life experiences and backgrounds, such as by using participant snowballing, but this did not generate further participants. I monitored participants' age and self-identified ethnonationality and continued recruiting until I felt I had a varied sample (Section 5.3)

I adopted thematic analysis (TA) for analysis (Section 3.7) and although Braun and Clarke (2013) recommend a minimum sample of six participants there are no sample size requirements. I aimed for a sample size of eight to ten participants.

### **3.5. Interview Procedure**

All women contacted me directly to arrange an interview, arranged to suit them and conducted on LO premises. Interviews lasted between 35 and 60 minutes. Before starting, women had opportunity to re-read the information sheet (Appendix F), ask questions and sign the consent form (Appendix H). I

reminded participants of my independence from the LO and confidentiality and that I would not be specifically asking about experiences of abuse. When they were ready I turned on the digital audio recorder to begin the interview. Once the interview was completed I discussed how they felt and offered time to speak more informally. I gave them a debrief sheet to take home with them if it was safe to do so (Appendix I).

### **3.6. Ethical Considerations**

#### **3.6.1. Ethical Approval**

Ethical approval for the study was granted by the University of East London Ethics Committee only (see Appendix J, K) as participants were not recruited directly through NHS services.

#### **3.6.2. Informed consent**

I gave participants information sheets during recruitment and immediately before starting the interview. In these, I conveyed their right to withdraw at any point, including during or after completion of the interview, and reiterated this verbally. They were reminded that they did not need to speak about anything they did not feel comfortable with and could take a break at any point. At the end of the interview participants were reminded of their right to withdraw after the interview but were asked to let me know as soon as possible. I discussed options for withdrawing after analysis had begun with my supervisor but this issue did not arise.

#### **3.6.3. Confidentiality**

Confidentiality, anonymity and the limits to these were explained to participants verbally and via information sheets. A standard operating procedure (SOP) detailing circumstances where confidentiality might need to be broken was agreed with the LO (Appendix L). Participant numbers- and later pseudonyms- were used and identifiable details anonymised in transcription, analysis,

discussion with supervisors and future dissemination. Some LO staff were aware of the identity of participants due to recruitment and data collection taking place on LO premises and women were made aware of a future report for the service. Care was taken to obscure identity in the selection of quotes, however women may be identifiable to the service or service users if individual stories or circumstances are well known. Women will be able to comment on this before the final report is made available to the LO.

I offered women the choice of their own pseudonym, which has complexities and controversies (Allen & Wiles, 2015) but allowed women to have input into their self-representation (see Section 5.3).

#### 3.6.4. Data Storage

Audio recordings were immediately transferred to a password-protected laptop computer after completion of the interview. Participants details were held on a password-protected excel document separate to data files.

#### 3.6.5. Considering Harm to Participants and Myself

I anticipated that talking about DVA could be distressing. I reminded participants this was not the interview focus, although they were not prevented from speaking about this. Other potential concerns included disclosure of ongoing abuse, and distress due to difficult experiences seeking 'support'. The SOP (Appendix L) details approaches to risk. I was aware of needing to be sensitive to signs of distress and giving participants options to continue, take a break, or terminate the interview. There were no instances where this was required. Debrief information with details of organisations offering support was provided to all participants (Appendix I). A further risk was women feeling pressured to participate due to existing relationships with service users or staff. This was addressed by having women contact me directly, although in some cases interest was first directed to LO staff and forwarded to me. I reiterated my independence from the LO and the lack of consequences at numerous points.

Research with women who have experienced DVA carries potential risks to the researcher. I therefore only conducted interviews on LO premises, within

working hours with staff available. A mobile phone was purchased for recruitment purposes along with an email account without connection to personal email.

#### 3.6.6. Ethical Issues in Service user Involvement

The same ethical approval standards do not apply to service users involved in consultation as participants. However, the ethics of involvement relate not only to informed consent, confidentiality, right to withdraw and distress, but also issues of power, coercion/seduction, exclusion, ownership and collective harm to a community (Faulkner, 2005; Khanlou & Peter, 2005). These issues may be navigable but not resolvable and must be considered throughout (Chevalier & Buckles, 2013). A risk analysis of potential concerns was conducted and is detailed in Appendix C.

#### 3.6.7. Ethics in Feminist Research

Feminist researchers propose additional ethical considerations in research involving women who have experienced abuse, including: not assuming that women will participate for free; catering for child-care and transportation; ensuring that data collection does not cause 're-traumatisation'; avoiding exclusionary language; enabling safe and confidential participation; offering opportunities to comment on findings; and committing efforts to apply findings to policy and practice (Hague and Mullender, 2005).

There are always factors constraining what is feasible during research, which includes methodological, ethical and pragmatic considerations and compromises. With limited resources, I sought advice from the organisation and Amanda and agreed to allocate the budget for childcare, which was raised during consultation as preventing some women accessing services. The decision not to use translators has methodological, epistemological and ethical implications (Temple & Young, 2004). An ethical compromise was to include non-primary English speakers, whilst recognising that this has methodological implications (see section 5.3).

### **3.7. Data Analysis**

#### **3.7.1. Selecting a Qualitative Analysis Framework**

Thematic Analysis (TA) is a framework that can be used across theoretical and epistemological approaches from essentialist to constructionist and can be used flexibly (Braun & Clarke, 2006). This was valuable for a contextualist critical realist approach, which acknowledges linguistic constructions but does not centre them in the analysis. However, Braun and Clarke (2006) stress that in avoiding critiques of “anything goes” (Antaki, Billig, Edwards, & Potter, 2002), researchers must explicate their epistemological (and other) assumptions (Holloway & Todres, 2003) and be transparent about the “what, why and how” of the analysis (Attride-Stirling, 2001).

#### **3.7.2. Transcription**

Transcription is an interpretive process (Willig, 2013) involving decisions about punctuation, non-verbal utterances and other material. The approach to transcribing is detailed in Appendix M. In line with the epistemology and TA I transcribed all material verbatim but added punctuation for readability.

#### **3.7.3. Analytic Approach**

A critical realist contextualist framework (Willig, 1999) informed the TA. According to Braun and Clarke (2006), themes within the data can be identified in a ‘bottom up’ (inductive) fashion or a ‘top down’ (deductive) way. My approach was to focus on what participants’ discussed, rather than imposing the research question on the analysis. In this sense, the approach was inductive. However, the data analysis will have been influenced by the literature review, my knowledge and position, the intersectional feminist framework and the epistemology. Therefore, there will have been a degree of ‘deductive’ analysis (Joffe, 2011).

The analysis primarily focused on the semantic level, moving from description to interpretation (Patton, 1990). However, in interpreting the themes, I considered possible underlying ideas, assumptions and conceptualisations that may have

shaped the semantic content. This approach to analysis reflects critical realism as a metatheoretical position that acknowledges elements of both constructivism and realism and in reality most analyses are acknowledged to contain elements of both (Clarke & Braun, 2015).

With this approach there is the risk of 'cherry-picking' which aspects of participants' accounts to attend to and "ontological gerrymandering" (Woolgar & Pawluch, 1985). However, by remaining at the semantic level when exploring accounts of DVA, there is the risk that important aspects relating to their constructed understandings of DVA may be missed. I acknowledge the impossibility of replicating my analysis, which is consistent with my epistemological position; this is not presented as 'the truth' but one version of it.

#### 3.7.4. Stages of Analysis

Braun and Clarke's (2006) six-phase approach guided the analysis. In phase one, I familiarised myself with the data through transcription, note-taking, reading and re-reading the transcripts. I then generated initial codes using a blend of manual annotating and highlighting of transcripts (see Appendix N for an example), moving to software-based analysis using NVIVO (11) in later stages (see Appendix O).

Phases three and four involved 'searching' for and developing themes. This involved collating codes within hypothesised themes and generating ideas of higher order themes and sub-themes (see Appendix P). This was an iterative process, repeating rounds of coding to minimise the possibility of "coding drift" (Clarke & Braun, 2015).

Phase five involved naming and reviewing themes. This included checking initial themes against the entire data set to determine consistency and that the analysis was meaningful, nuanced, and extended beyond description. This included characterising the themes, identifying boundaries, assessing the 'thickness' or 'thinness' of the theme and checking coherence (Clarke & Braun, 2015), involving discussions with my supervisor. I used manual mapping to visually represent connections between codes (Appendix Q), moving to digital thematic maps as themes were refined (Appendix R, S).



Finally, the write-up phase involved revisiting all the notes and identifying extracts to illustrate the themes. I have elected to use a combined analysis and discussion section, which is possible in TA, but not typical (Clarke & Braun, 2015), to allow for transparency about interpretive processes.

### **3.8. Reflexivity**

Ramazanoglu and Holland (2002) stress that “feminist methodology cannot be independent of the ontology, epistemology, subjectivity, politics, ethics and social situation of the researcher” (p. 16). Reflexivity is the researcher’s process of examining their background, assumptions, power relations and influence on the research, which has the potential to enhance the analysis, rather than something to be avoided (Ramazanoglu & Holland, 2002; Skinner et al., 2005).

To aid me in this, I kept a reflective journal throughout, noting my interests and influences at various stages. I recorded reflections and emotional responses to each interview. I have woven reflexive statements throughout the thesis and explore this in depth in section 5.2. Here I consider some personal factors I perceive to be relevant.

#### **3.8.1. My Position**

I brought both my ‘researcher self’ and ‘other selves’ to the research process (Renzetti & Lee, 1993). I identify as a cisgender white British woman; a feminist; politically left-leaning; a Trainee Clinical Psychologist at a university that emphasises power and political context; a woman with experiences on a continuum of gender-based and sexual violence; a person with lived experience of mental health services. These are just some of my identities I sensed were influencing me during the research. My past experiences working in the field of DVA have had a profound influence on me, personally and professionally. I have come to be passionate about the treatment of women who experience abuse and are labelled with ‘borderline personality disorder’ and interested in alternative ideas of ‘complex trauma’ (Herman, 2015).

I conducted this research against a backdrop of personal and cultural conversations about Harvey Weinstein (Kantor & Twohey, 2017) and other sexual abuse allegations of powerful public figures; the #MeToo movement against sexual violence (Matheson, 2017), and other campaigns associated with fourth wave feminism, which has been characterised by a focus on sexual harassment and violence against women (Chamberlain, 2017).

By being transparent about these positions and influences I hope to situate myself in relation to my approach to the research and the participants and acknowledge how I may have been influenced during data collection and analysis.

## 4. ANALYSIS AND DISCUSSION

In this chapter I introduce the participants before exploring the themes and sub-themes arrived at through the analysis. I interweave analytic comments with participant accounts to present a combined discussion of the analysis.

### 4.1. Introduction to Participants

I am aware of the importance in qualitative research of using demographics to contextualise the research. However, there is a tension with this and postmodernist feminist thought, which seeks to avoid categorical and dichotomous identity labels as reflecting and reproducing social powers<sup>9</sup> (Hammers & Brown, 2004). Including individual demographics also risks identifying participants to staff at the LO. I therefore prefer to give a summary of the sample below. I have used participant quotes to illustrate issues relating to class, 'race', gender and so on, throughout the analysis.

#### 4.1.1. Summary of Participants

Nine participants were recruited through the LO within one London borough, whose residents vary in socioeconomic status. Participants accordingly described varying social circumstances, occupations and life experiences. Participants ranged in age from 30 to 64, with an equal spread of ages in between. All but one participant self-identified as being British, regardless of where they were born or grew up. Six participants identified as White, one as

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<sup>9</sup> Power is used throughout to mean the ability to control others, events, or resources and realise their own will (Weber, 1922). Social power is used to refer to how access to this power is bound up in social stratification that favours some and disadvantages others. This occurs via membership of social identity groups based on factors such as economic status or class, gender, race, age, religion and presence or absence of disability (see e.g. Brauer & Bourhis, 2006).

mixed Black and two did not adopt a racial category, referring to national heritage as Indian and West Indian. All but one participant spoke English as a first language or were multilingual. Women were not asked to define their sexuality but all described abusive experiences with men.

Participants were not asked about frequency, nature or duration of abuse although most did discuss this to some degree. All participants had been in recent contact with the LO, although some women had previous contact and re-entered the service. Their time of contact with statutory services ranged from one year to decades of involvement.

I asked women to choose their own pseudonym (see section 5.3) and they appeared to draw on objects or names with personal significance. Three women elected not to choose, and I have chosen Autumn, Spring and May, in line with a noted trend towards natural influences.

**Table 1.** Participant Pseudonyms

Chosen Pseudonyms
Rosered
Anita
Autumn
Sally
Zion Flower
Fireweed
May
Unicorn
Spring

## 4.2. Summary of Themes

The use of TA led to three broad themes and further subthemes, presented in the table below and in Appendix S in map form.

The first theme considers the act of constructing experiences as abuse and how this intersected with women's experiences of 'help' and their journey to 'safety'. The second theme explores the paradoxes associated with navigating 'support systems' and how these could work both for women and against them. The final theme, "We've Had Enough" explores how women describe the impact and their response to experiences, both of abuse and with 'support systems'.

**Table 2.** Summary of Themes

Theme	Subtheme
<b>"It's the Seeing It and Acknowledging It": Who, Where and How?</b>	"Stuck in It"
	"Feeling Safe Enough"
<b>The Duality of Help</b>	To Let Me in or Keep Me Out?
	To Validate or Invalidate Me?
	To Help or To Harm Me?
<b>"We've Had Enough"</b>	"It Is Not Ok"
	"To Carry with Me Forever"

### 4.3. Theme 1: “It’s the Seeing It and Acknowledging It”: Who, Where and How?

This overarching or core theme explores how most participants described their experiences navigating support after abuse. Many of the ways participants described their experiences implies that constructing what they had experienced as abuse linked to a significant shift in their experiences of ‘help’ and their personal journeys. Rather than all forms of ‘help’ being equal, this theme explores participants’ journeys of finding how and where they felt supported. It explores the centrality of ‘understanding’- of abuse and themselves as people- in that process.

*I was just abused all the time by everybody that I ever came in contact with, both men and women, therefore it seemed the norm to me as a matter of fact, so, coming here, that was opening my eyes to abuse, because the women here were talking about and so...then, yeah, so then I realised that that had happened to me (Rosered)*

#### 4.3.1. “Stuck in It”

This sub-theme explores how many women spoke of existing in what seemed described an altered state of being during abuse and finding it difficult to reflect on their experiences. Rather than tied to leaving abuse, for some participants this state lasted many years, intersecting with their experiences of ‘help’ and the responses of others. This sub-theme explores not just women’s understandings but the sociocultural influences on these and the role of others in keeping them ‘stuck’ or alternately, helping to ‘unstick’ them.

*what was so interesting is my natural reaction of I want to know about everything I’ll go out and research it, but I hadn’t done that with the relationship, I don’t know why, I suppose you just get sort of stuck in it (Fireweed)*

Where they spoke about experiences of abuse, some participants described violence but mostly discussed the impact of coercive control and emotional abuse. Some spoke about the role of abuser(s) preventing them naming their experiences as abuse, by making them doubt or blame themselves.

*the night where I was raped, one thing I always remember he was saying to me whilst it was happening was oh, you never listen to me, maybe now you're gonna listen to me you're gonna do what you're told, and I would take that and still think later oh ok, if I had listened, if I didn't do this, because I was always so independent and always so strong minded, I felt like that was sort of my downfall and I used to blame myself (Unicorn)*

Several participants spoke about the impact of family and cultural influences in contributing to an internalised sense of shame about being abused, which kept them from speaking about it more openly.

*it was both embarrassing as a middle-class professional to get caught up in it, quite difficult to untangle it, it becomes very difficult to access services because A, there's a general embarrassment...(Fireweed)*

Here, Fireweed draws on the concept of class to explain why she found her experiences difficult to identify as abuse in the sense that, “*it doesn't happen to people like us*” (Fireweed, 221-222). To acknowledge DVA may threaten women's self-image as capable and together (Janoff-Bulman, 1979), which may also be tied up in notions of class. Others spoke of their cultural heritage or family values contributing to a sense of shame.

In trying to make sense of what they were experiencing, women drew on a range of sources, many of which seemed to tell them the problem was them; was normal; was not abuse. This happened both from the abuser and others they sought support from.

*my parents are kind of old school, I think the first time my mum heard I'd been hit she was kind of like, oh, loads of women go through that, that's sort of normal just get on with it (Unicorn)*

Unicorn's description of her mother as "old school" speaks to the possibility of a generational shift in the relationship of women to suffering, influenced by changing norms and values. Participants' descriptions linked with sociocultural stigma-related beliefs, such as that women should "tough it out alone"; that violence in relationships is normal; women who experience violence are stupid and to blame; and that 'what happens behind closed doors' is private, or shameful, and should be kept within the family (Alvidrez 1999; Petersen, Moracco, Goldstein & Clark, 2004; Sabina, Cuevas & Schally, 2012).

Although many participants spoke of 'not knowing' that what they experienced was abuse, they described a sense that something was wrong. May discussed the difference between 'knowing' something and 'believing it'.

*I don't even think I believed it-even though I thought about it every day, I was furious about it, I wanted to kill men, I could remember it, literally moment by moment, even though-I knew factually happened, I knew it, actually, I still didn't really believe, I still kind of thought I'd made it up to piss everyone off (May)*

For many participants the behaviour of others around them taught them to doubt their own instinct that what they were experiencing was wrong.

*because even though intellectually you know that this is not right, but if you are getting it from all the sources you're gonna, you know, believe it (Anita)*

Participants' talk suggested taking their cues about how to understand their experiences from around them. Unicorn's talk highlights the influence of broader sociocultural concepts about what constitutes abuse, referring here to the construction of rape:

*I felt like I wouldn't be believed because we were in a relationship and at that time I was younger, I was naïve, and I thought oh rapists are only people who are strangers or in alleyways or bushes, I didn't know that abuse can happen from people who are in your family or friends or whatever (Unicorn)*



Here, Unicorn is saying that she 'didn't know', yet it is implicit that there is something 'known' to be believed about, implicating others in conceptualising her own experiences. She refers to what has been termed a rape myth (Burt, 1980)- that rapists are strangers- highlighting the power of social, cultural and institutional practices in shaping women's relationship to their own experiences.

Four women spoke about multiple experiences of abuse, including previous abusive relationships, sexual assault and abuse during childhood, which may have served to normalise abuse. Some women's understanding was that they had actively suppressed the knowledge of abuse whilst it was continuing.

*I have been, so blinded, blinkered, unable to see, because I have been so defended against the, the constant abuse that has been coming at me (Rosered)*

Rosered's references to 'defences' (Freud, 1937) implies the influence of a therapist or psychological knowledge in understanding her experiences.

Without the knowledge to construct what they were experiencing as abuse and understand how it was operating, participants spoke of being trapped in repetitive cycles.

*I kept on going back, kept on going through the same situation (Unicorn)*

*I was still in contact with him um, he was apologetic, and it goes in a cycle, he's sorry for a certain amount of time (Zion Flower)*

Learning about abuse- and patterns of control and manipulation in particular- was mentioned by nearly all participants in coming to relate differently to their experiences. Some women specifically mentioned the Duluth power and control wheel (Pence & Paymar, 1993), suggesting that understanding power dynamics was an important contribution.

*Before it was just, you know, I could never understand why I could never ever leave this situation, even though I knew, from a very long time ago, that it was just not right. And that was just, for me, now I understand it all. (Autumn)*

Learning about patterns of DVA may act as a form of 'informational power' (French & Raven, 1939), initiated by others, which is then taken on by women themselves to describe and understand what they experience. Naming acts as abusive may constitute a powerful tool against people harming them, who may have used language as a resource to verbally abuse them, negatively label them, redefine experiences as consensual, or call love what is otherwise termed rape, control or abuse (Cameron, 1990).

Many of the participants spoke of the importance of public awareness and practices in raising awareness and acknowledgement of abuse.

*in public, in your face, I don't see it out there as much, and I think in those general areas, I think that's, that's lacking 'cause I think it's the seeing it and acknowledging it and that starts to trigger your awareness of it (Zion Flower)*

Being 'stuck' did not entail having no contact with others who could help them. Participants described many interactions with 'support' systems where a problem was identified but where the 'support' offered did not feel helpful. Many linked this to others not recognising or naming their experiences as abuse or affirming that it was wrong.

*I remember trying to talk about this at work in counselling at one point and it was almost like, they would say maybe he's doing this, or maybe he cares, and he says he loves you, so it's almost like, you couldn't actually get in, I couldn't get someone to take me seriously (Fireweed)*

Livesey (2002) uses 'tellability' to describe how it is the listener who controls the construction of the meaning during 'disclosure'. Building on Foucault (1976), Livesey argues that 'disclosure' of past abuse is not a unidirectional process of the speaker sharing a truth with the listener but a reciprocal relationship in which the listener, in questioning the speaker, ultimately frames and controls the discourse. In Fireweed's case this entails reframing her attempted narrative of abuse as being about love.

*well the first mediator said has he hit you? And you know straight away when someone says that they're not interested, they just see it as disagreements between the two of us (Susie)*

For Susie, being asked about physical violence reframes her narrative in terms where only violence is constructed as abuse, demonstrating to her the limits of what it is possible to say and have understood. Interactions like this acted as a barrier to women being able to speak about their experiences intimidation and control and have this understood and validated by others. Others' failure to name their experiences as abuse, or inaction, was perceived by participants as confirming their experiences as ok, undermining their own sense of wrongness.

Whose behaviour is defined as violence and under which circumstances reflects power (Baumeister, 1997). Abuse is argued to disempower women (Herman, 2015), perhaps reflected in the participants' difficulty naming what they were experiencing as wrong to others. This may particularly occur with those possessing more social power who exert greater control over the interaction, based in their profession, or their place in other hierarchies such as families.

Several participants also spoke of the mental state that they were in at the time contributing to keeping them 'stuck', and how this intersected with other people's ideas of what constitutes 'help'. Participants spoke of being in states of confusion, stress, constant crisis, or lacking energy or resources to engage with the way 'help' was offered to them.

*I couldn't pick up the phone from the victim support because I can't be on the phone on my own personal phone [at work], so I missed the call, and there was no follow up from any victim support service, and after when I tried to call them and reach them, and I was too shocked with everything that had happened to me, to you know, constantly call them up or something (Anita)*

Herman (2015) refers to this as a state of 'psychological degradation', where individuals shut down thoughts, feelings, initiative and judgement to survive. Additionally, several participants spoke of being under pressure and juggling multiple demands, including work, young children, financial difficulty, studying, and having limited internal and external resources.

*even though it's something you need it's not really something that you jump on and say oh yeah ok I'll take it, because you're not used to that, you're used to keeping your head down and do it alone (Unicorn)*

Although women were in contact with people who knew some of what they were experiencing (family, police, GP, counsellors, therapists, rape crisis services), many spoke of 'support' which felt superficial, often through lack of meaningfulness, or follow up.

*I think they did mention [linked organisation] but it wasn't really, they didn't explain to me how useful it would be, they just issued a list of numbers and you know, there were various services that I could access. (Autumn)*

For some, their interactions left them feeling hopeless about support, or that others would help them. Looking for 'help' was often characterised by women in terms of not knowing where to go, what to do, or what support was available.

*I don't believe that the police offered any support after that, maybe they did and I don't acknowledge it, but I felt kind of where to turn after that (Zion Flower)*

Zion Flower and other women sometimes expressed doubt as to whether they had been offered 'help' or not. This conveyed a sense that something about the interactions hadn't felt helpful, illustrated by Unicorn.

*I'm not being funny but if you're going through a traumatic experience the last thing you need is like, twenty different leaflets and people screaming oh we're here to help, because you're going through something, your mind isn't really at that point, you're just still trying to process oh my god, I've gone through, this has happened to me, not oh ok, I'll take that one in case this happens next time (Unicorn)*

Most women mentioned specific individuals who had been able to connect with them and made a difference in their journeys to finding the right support.

*it was a friend who knew what had been going on at home, and her husband's a police officer and she'd obviously spoken to him about it and*

*he was a colleague of somebody who knew about domestic violence and he, through my friend, gave me the number of [linked organisation], and I contacted them (Autumn)*

Women's contradictory talk about being given numbers as helpful or unhelpful suggests they experienced that being given numbers or leaflets was insufficient on its own; only when accompanied by exploring and affirming abuse with them and perceived genuine efforts to help them, did women feel that their experiences were sufficient to be deserving of help.

*you could see that they really wanted to help, and that they were interested in helping (Rosered)*

#### 4.3.2. "Feeling Safe Enough"

'Safety' was clearly an important concept to the participants, who frequently used the term. This sub-theme explores participants attaining material or emotional safety to begin 'healing' from their experiences. Key to this seemed to be having their experiences recognised and responded to in ways that facilitated feeling 'safe'.

For participants, accessing safety involved more than 'disclosing' abuse to others, accessing formal services, or leaving an abusive relationship. Rather, it meant being able to find the right support for them, a process which for some women took many years, despite involvement with formal services.

*Well what it has been like is I have wasted my life really, in this way. When I say I've wasted my life I mean none of it has been really any help at all apart from these last two years. (Rosered)*

Some women mentioned having help to attain material and physical safety, which was important for them.

*I found housing, that's one thing which I did [find helpful], um, plus housing benefits, which come from state, would be extend for this year...for benefits, now is even given later, which I very, very happy about (Spring)*

*I got help [...] I think I had a solicitor through legal aid, because I had to get an injunction (Zion Flower)*

For many, finding 'safety' represented specialist DVA support, however women encountered various practices that helped them to feel more at ease. For some, learning was highlighted as an important aspect of support, which helped them to feel 'safe' by knowing how to protect themselves in the future.

*I learnt how I could keep myself safe and my children safe, I learnt how I could access the police, or, they've taught us little things on the law and where we stand in terms of children with an ex-partner or an abusive partner, things like warning signs, how to flag up the fact that you're suffering abuse but without putting yourself in further danger (Unicorn)*

'Safety', for participants, was also about feeling 'emotionally safe', a concept which refers to the ability to express emotions openly and with vulnerability, free from the anticipation of emotional or physical harm (Catherall, 2007); something which is clearly violated during DVA. Whilst therapy was a valuable resource for those who accessed it, women spoke about the vulnerability involved in talking about their experiences.

*I went into recovery, and then I got a therapist who...I mean god, it was like everything unravelled, in a way it was quite a trauma, wasn't it? (May)*

Here, May talks about her experience of beginning therapy as a 'trauma' in itself. In reflecting on the vulnerability of connecting with their experiences, some participants spoke of needing to feel 'safe' enough to do so, such as by trusting those around them.

*But I think it was only then, that I felt safe enough...to actually...look within, in a way, or, experience what's happening around me. That's what it was. It was safe enough for it to take away the guarded armour that I had put on and actually, engage with reality, if you like. (Rosered)*

These 'safe' experiences were contrasted with those that had felt unsafe, or inappropriate.

*to be honest I think the whole thing was slightly inappropriate, firstly I had a male counsellor, for my one on ones [...] the very fact that they knew my history and gave me a male counsellor says it all, to be perfectly honest with you (May)*

Some participants described a gradual process of 'opening up', suggesting a process of beginning to acknowledge things that may have gone unspoken about.

*I'm still struggling to come to terms with, all this grief, all the loss, all these miscarriages and such and such (Fireweed)*

Several participants' talk implied they constructed support as something with an active component; generating insight, learning, having something to show for it, or facilitating change. Zion Flower talks about how important it was for her to have a non-traditional form of talking therapy, which was strengths-based and creative. She also reflects on the process of a journey through support, alluding to the idea that she may not have engaged with what was offered in the same way at different times.

*out of any counselling I've had I believe that was the most helpful [...] I believe it was because we were able to use props we wasn't just sitting there talking, it was just the processing of it, and maybe it was all of them getting added together to get in to that point, maybe if that was the first counselling I'd done it might not have been that way, but I found it uplifting and motivating and it wasn't always about the negatives as well, it was about the positives and celebrating the achievements I'd made as well, through the counselling, before and after. (Zion Flower)*

Finding the right form of support, for several participants, seemed a transformative experience, changing how they felt within themselves.

*it helped me to look into certain situations that I had been through and look at them in a different light and not so, label myself as a victim, but label as a survivor [...] I always thought, well I'm not a victim but I also sort of had this sort of 'oh, I've been through domestic violence, it's terrible' but now after accessing that course it kind of made me feel a bit*

*more empowered, so to speak, it made me tap into things I didn't know about myself, or things I knew but I'd forgotten (Unicorn)*

Susie also talks about the value of creative forms of therapy but highlights several helpful aspects beyond the therapy itself: long term, flexible access; continuity, and help for her son helping her.

*I was doing groups on and off, and I was doing counselling through [linked organisation] and [son's name] had some, two lots of play therapy, which he loved and was brilliant [...] it definitely helped him, and that helped me, knowing that he was, and so he had one lot and then about six months to a year later he had another lot, with the same woman, same therapist, so they've helped in lots of ways, I think that's what got me through it, I'll start getting emotional in a minute but yeah, that's definitely what, yeah, got us through (Susie)*

Susie's emotionality discussing this speaks to the transformative experience of feeling supported. Susie emphasises how her son benefitting from therapy made her feel, and how something about this aspect of feeling supported enabled her to 'get through' or carry on.

Other experiences beyond therapy were spoken about as contributing to emotional 'safety'. For some participants, this was partly facilitated by finding a women-only space.

*I feel like it's by women for women, it feels very safe (May)*

*this is a safe kind of place, where it's sort of all women, that was safe, the fact that it's all women, yeah that was a safe thing about this.  
(Rosered)*

Some participants spoke of connecting with other women who had been through similar things helping them feel less isolated and alone, and how this interpersonal connection generated intrapersonal insights.

*it also gives you a chance to, sometimes you see yourself in other people, some of the things you wouldn't say and how you would actually*



*encourage them, you could encourage yourself because you could see that in them (Zion Flower)*

*being in a room with other people where you know it's going to be confidential, it's not gonna go further, people are gonna listen to you, people are gonna console you or sort of advise you, it was, it was beautiful (Unicorn)*

Zion Flower and Unicorn's talk of being listened to, encouraged and consoled speaks to the powerful potential of interpersonal relationships for 'healing' (Herman, 2015). Most women spoke about the importance of how they were treated by others, such as being cared for and understood.

*they have been very different, yeah, I have felt understood, I have felt cared for, I've felt people have seen me accurately and have, loved me really, shown me what love is (Rosered)*

*it was kind of, it was really helpful to have a place to call which understood the problem, um yeah, that was, that's quite a big thing really, when you feel completely isolated and other people can't-don't understand it (Susie)*

Both participants refer to a difference in how they have been treated, illustrating how this has not been the norm. Although women mainly spoke about ways of being treated by professionals, some also discussed important ways family and friends treated them.

*they [friends] believe me, they don't get angry with me, or call me lazy because I can struggle to leave the house, they don't act as if, well that might have happened but you need to pull yourself together, they just don't act like that, very, refreshing (May)*

*Just being able to carry on your routine and still being accepted, being able to be understood and listened to, still being appreciated and acknowledged within the family routine, not outcast or put aside because of your experiences (Zion Flower)*

For these women, central to support seems to be understanding, 'being seen'

and acceptance. Their descriptions allude to expectations or experiences of being treated differently by abusers, or others since, and some explicitly made that contrast.

*But the men [therapists] were not, you know, misogynists, they were gentle. (Rosered)*

May talks of being treated with patience and consideration by the linked organisation after missing an appointment.

*they don't take your counselling away if you've missed an appointment [...] they're not happy about it but they're not gonna punish you either, because they understand that the majority of women accessing this are probably, not always capable of making every, appointment [...] I missed the appointment, and then they emailed to say are you ok, rather than you've missed the appointment that's that (May)*

This contrasts with some women's descriptions of statutory services, for example Anita being turned away when in 'crisis'.

*because of all these problems at work, I got discharged from the psychology treatment, the one to one trauma treatment, it was like you know, a double whammy for no rhyme or reason. I got discharged by the psychologist [...] and she said oh well, we waited for you and now we can't wait, and she discharged me just after the crisis team, how can you discharge someone when they are with the crisis team? You know, from the psychology. (Anita)*

Thus, some ways of being treated supported women to feel 'safe', and others jeopardised this further. Rosered's description of finding people who treated her well inherently juxtaposes alternative treatment by professionals.

*they treated you like equals, you know, they didn't treat you like you were sort of inadequate, morally wrong, kind of worm, that's, you know, incapable of surviving. (Rosered)*

This vivid description speaks to her visceral sense of how dehumanised and demeaned she has felt in contact with other 'support systems'.

#### 4.4. Theme 2: The Duality of Help

Theme 1 illustrates some of the variability in women's experiences accessing support. This theme centrally explores the dichotomies and tensions in women's experiences accessing support. From participants' talk, there is a vulnerability in looking to others for help, who have the power to help, or ignore, or harm them. Although power could be experienced benevolently or malevolently, all participants described not being in control of having their needs met and being subject to others who determined this for them.

*it's like a machine and you're so, powerless, you just end up going along with it and so, well you've got no choice (Susie)*

##### 4.4.1. To Let Me in or Keep Me Out?

This sub-theme explores how some women experienced long journeys to access what was ultimately helpful for them. Participants' accounts suggest they felt dependent on others who acted as gatekeepers, with the power to deny or granted them access. The use of combative language by Anita illustrates how, rather than passively waiting for help, she felt she was actively searching and being turned away.

*Well I think it's failures on the part of the police, failure on the part of the woman who took the phone call at [women's charity], failure on the part of the victim support for not following up, you know, there were multiple failures at multiple stages, and it's almost like you have to fight against the system to get help (Anita)*

Similarly, Rosered says,

*I went from place to place begging for help, basically (Rosered)*

When women were able to experience power for them, they experienced it as opening doors to resources that they had not known about or been able to get to before.

*and he went here's this number, phone them up, say we've referred you and, you know, and everything clicked into place (Fireweed)*

The realisation that help was available but kept out of their reach left some women angry at their relative lack of power and knowledge versus the power of professionals, who knew and did not help them.

*on this occasion, I was given a referral here, but previously it has happened that the referrals haven't been made by the police and, if they were not made then I would not even be aware that there is quite a lot of help (Anita)*

Where women did experience power working in their favour their talk implied a sense of having been rescued by this benevolent force.

*people's perception of them [social services] is always negative [...] maybe it's only when you actually have a positive experience that you realise well, actually without these people, my life wouldn't have changed, I wouldn't be on this journey to a much better place (Autumn)*

Women who had better experiences of accessing support sometimes acknowledged this not to be the norm and situated themselves as 'lucky' or 'privileged'.

*It seems to me that I walked into the housing office and...I've had nothing but help, from beginning to end, and I've had no problem accessing anything, in fact I've had people come to my house and tell me what I can access. My experience has been I've had so much help (May)*

Here, May draws on concepts of class and white privilege to understand how power in this instance may have been working for her, rather than against her.

*you see I think I've been very lucky, but, I wonder how much of that is based on the fact that I'm very well spoken, pretty well presented, you know, quite, white (May)*

May's account contrasts with those of less privileged participants who highlighted how their nationality or 'race' had been used against them.

*and then they suggested that "no, you should go to [country of family origin], that will really help you" (Anita)*

*I went to there actually, [borough] council and they said "no, no help at all". They even accused me not to be legally in the United Kingdom (Spring)*

Some participants alternately felt their relative power worked against them; in being seen as middle-class and capable, they felt viewed as less vulnerable and in need of help.

*and whether that again was-is this a perception of here I am as this competent professional I can do it myself I don't know (Fireweed)*

Several participants spoke about feeling powerless to get the help they needed by being turned away from services, for various reasons.

*they now have this thing where if you live in [borough] and you aren't linked in then you can't access the service, and [borough] has nothing, [borough] has absolutely nothing (Anita)*

*so they sort of basically closed that case and said "no, we can't do anything, you need to go and get yourself referred" (Fireweed)*

Anita and Rosered describe feeling required to behave in certain ways to get their needs met, and without this, not being able to access support.

*And I also felt that, even with mental health services...if you're-unless you're falling on the floor crying, no one will touch you, you know (Anita)*

*They expected me to behave exactly the way that they think I should behaved and if I didn't, which I don't, I'm seen as a naughty, sort of nasty, abusive person (Rosed)*

Faced with being situated as relatively powerless, some women described desperate appeals to powerful figures, such as government officials, in the hope of being heard and getting their needs met.

*I did complain to the ministry of justice, how I've been treated, how I've been kept on the street, and I get in. (Spring)*

*and finally I had to contact the Mayor's office that this is endangering my life, my voice will be lost, but yours will be heard, so can you please deal with it? (Anita)*

#### 4.4.2. To Validate or Invalidate Me?

This sub-theme explores participants accounts of coming up against practices and ideas bound up in powerful individuals (e.g. GPs), systems (e.g. mental health services) and institutions (e.g. the law). It explores validation as a form of social power held by others, to validate women's experiences and name them as abusive, or to dismiss them, and how this links with forms of power based in professional expertise or authority.

Susie and Anita's accounts illustrate this dichotomy.

*I suppose the key to it really was, it was somebody who acknowledged there was a problem and that the problem wasn't necessarily with me, and that his behaviour was abusive (Susie)*

*it took a courage to make that call and then, instead of signposting to me to a number that could help me, she was quite steadfast that, you know, that what I was experiencing was not domestic abuse (Anita)*

Anita here illustrates the importance of naming to access resources. Some women's talk about this process suggested that even when intended to help, this power could sometimes be used quite forcefully.

*And I said to her, I can't possibly be in an abusive relationship, you know, I said to her I have the power in this relationship. And she said well you don't, you have no power whatsoever and...she made me understand,*

*and it was her really who identified it and, you know, she told me to come and do this course (Autumn)*

Autumn here uses language indicative of force; “made me”, “told me” and being told “you have no power whatsoever”. Autumn experiences this as supportive and reflected on needing a strong message to reach her, yet it illustrates the power imbalance in determining whether women need ‘help’ and what this should be. Some women described being told they were abused. Defining someone as an unacknowledged victim of sexual or domestic violence presents a paradox for those whose intent is women’s liberation (Muehlenhard & Kimes, 1999).

Several participants described being told what they needed, which in some cases aligned with their perceptions of their own needs.

*And told her all this stuff instead of always being terribly calm and organized and she said to me, “look, it sounds to me like you need some counselling”, so I said “ok” (Fireweed)*

Unicorn recounts her experiences during therapy, which she described as helpful but does not know why she was told to do certain things:

*I still don’t understand why she told me to do them, but she sort of said, you know, because I have this thing with punctuality and having things in order, and I think she kind of just set me them, to kind of like throw me out of that and help me realise (Unicorn)*

Raven (2008) highlights ‘understanding the reason’ as differentiating ‘informational power’ from ‘expert power’, where the ‘expert’ retains power over the information. These experiences of being told what to do to feel better were not experienced as problematic by the participants, perhaps being conceived as forms of ‘legitimate power’ (French & Raven, 1959). However, in other cases women’s perceptions of their needs did not align with a professional’s perception. Anita illustrates how she disagreed with her GP over whether she needed treatment for depression:

*So 14 years of domestic abuse in the marriage and, because I was still working he perceived it to mean that I couldn’t be depressed, but I was*

*depressed, why would you go and tell your GP you were depressed if you weren't depressed, who in their right mind would do it? You know, generally it's the other way round, the GP will tell you you're depressed and you say no I think you got it wrong...so he kind of didn't take it seriously (Anita)*

Anita characterises people's relationships with their GP as argumentative; in general GPs try to tell people what is wrong with them. Unicorn gives an illustrative example of this:

*they diagnosed me with depression with me and put me on all sorts of tablets and things, and at first I wouldn't take them because I didn't trust it, I did take them after a while [...] it was just not the right thing, I didn't think about medication I just wanted to talk to somebody (Unicorn)*

In both instances the women describe an interaction with professionals where their sense of their needs is not listened to and is overruled by the GP's determination of their needs, who holds professional power.

Anita describes how when another professional validated her concerns she was listened to and given a referral to a psychiatrist.

*she said your body language shows that you're experiencing trauma and it's quite severe, so I kind of fed back that GP, and that's when he took it seriously and started observing, and he said ok, you have PTSD (Anita)*

Expertise therefore becomes a powerful tool, which can act in women's favour or against them. In some cases, women's talk suggested that expertise was used to lend authority to their concerns, which they voiced to me.

*Spring: I even [had an] appointment to [London] hospital, went with my stomach assessment, show him, he just look at me, pretty (whistles) and say, "out!", I say, "doctor?" "come with me" and literally just open door and say, "out!"*

*EE: Ok, and why was that?*

*Spring: "I is not treating stomachs!"*



Here, Spring presumably reconstructs her interaction with a psychiatrist in a way that gives a more powerful voice to her disagreement with her key worker over whether she has mental health or physical needs:

*because she don't understand what kind of illness I have, "no you need the mental health!" I say, "no it's not mental health issues, it's a surgical procedure" (Spring)*

Anita illustrates the sense of powerlessness that characterised her interactions with mental health services following her experiences of abuse.

*So on one hand you tell me I have PTSD, then you tell me I have emotionally unstable personality disorder, severe depression, chronic anxiety, all you do is give me medication, then you're telling me you're gonna discharge me without therapy, what is that? (Anita)*

The power of the psychiatrist in this case is to validate her distress and label it with powerful names, and yet the power to withhold 'support'. Rosared alludes to how accepting an unwanted experience, being labelled with a 'personality disorder', is a form of conditional entry to the support she needs.

*And so they said yes they do, there's two communities, um, that exist in the NHS for this particular thing, which is called, as you probably know, personality disorder. Umm, I don't like having been labelled like that particularly, but, anyway...(Rosared)*

She goes on to say:

*I think they were trying to analyse my personality, uh, aside from the difficulties with men, but I don't think they ever understood me, as a person (Rosared)*

By being treated as someone whose difficulties are located in her personality, Rosared has experienced an erasure of herself as a full person. For some participants their diagnostic label is apparently seen as having more explanatory power than their experiences of abuse. Indeed, Becker (1997) suggests that 'borderline personality disorder' is the "new hysteria" as a diagnosis of oppression that silences women.

These accounts illustrate how mental health services can unintentionally contribute to victim blaming through invoking concepts of personal responsibility, as well as overt victim blaming (Örmon et al. 2014).

*they did my head in, because it's all this bullshit of the twelve steps...everything-this is what they say in the twelve steps right is, everything that's ever happened to you, what's your part in it? [...] Ok, so well I was abused as a baby and you're telling me, I'm gonna sit here and go through this, and you're gonna tell me it's my fault? I don't think so. But at the time I couldn't say that because at the time I was going to AA meetings and I was thinking, god, what is my part in this? (May)*

May expresses outrage at being asked to take responsibility for being abused as a child and yet reflects on how at the time the power of the organisation influenced her to take seriously the message being given to her.

Participants' accounts suggested victim blaming was a hazard to be negotiated when accessing services. Susie discusses being shamed and blamed by a lawyer during child contact negotiations.

*He was a lawyer, I mean...it was just the wrong type, it wasn't really helpful, he was...he'd say things like, well you're not exactly a Muslim wife are you? (Susie)*

From Susie's account, the lawyer both draws on a stereotype of Muslim women as meek, submissive and deferential to men, and appears to suggest this is preferential behaviour that would have prevented her experiencing abuse. His position as a lawyer likely gives him authority which is difficult to challenge; women also spoke of the power institutionalised in the law acting against them:

*I've obviously seen a solicitor where that was spelled out to me and that was shocking, the injustice of it, because the laws are just not, they haven't caught up with society you know (Autumn)*

#### 4.4.3. To Help or to Harm Me?

This sub-theme explores the paradoxes inherent in systems intended to 'support' women through exploring participants' talk about their harms.

All participants described forms of power by individuals or systems used against them. Several women described feeling that they had made forced or constrained choices, particularly in relation to children, where there was a threat present if they did not comply.

*they also did say to me if you don't do something about it, your child may be taken into care, you know (Autumn)*

Being subject to the powers of the court left some women feeling that they had little control over outcomes that were fundamentally important to their and their children's lives.

*I think the most sort of distressing thing of the whole thing was the prospect of my son being taken away fifty percent of the time to his dad who was behaving like a mad person (Susie)*

Some participants described processes which may have been done 'in their interest', but in which they felt they did not have control.

*I think I did try to withdraw my statement but they told me I couldn't, because it was domestic violence at the time, because he'd been violent they couldn't withdraw it. (Zion Flower)*

Zion Flower illustrates how legal processes can take over when there is a crime, whereby investigation and prosecution can become prioritised over the person's needs, wishes or experiences. This is a paradoxical use of a power intended to help women – or victims of crimes.

Some women talked about how their relative lack of power led to them feeling exploited or being abused by those who were in a position to help them, detailing forms of institutionalised abuse.

*it's creepy, they call it thirteenth stepping, it's like part of it, and there's people-you know there's loads of meetings where people know people in*

*that room have raped newcomers, and the group looks after that person, because the attitude is, you know, we're all really bad, we're all mad, we're all addicts (May)*

Women who spoke about feeling further abused or exploited whilst seeking support also spoke about feeling powerless to object to their treatment or to change things.

*they do a formulaic thing and if you object, they call you abusive, and, it isn't abusive to question or object to people treating you in a particular way (Rosered)*

Rosered and Anita could be said to be describing a form of double bind (Bateson, 1972) in which the systems available to seek support from seem harmful and feel like further abuse, but they are otherwise left with no way to recover from the effects of abuse, which also leaves them suffering. This paradoxical situation of being trapped by conflicting demands is also argued to characterise interpersonal abuse (Herman, 2015).

*So it just feels like, you have domestic abuse, [...] you're struggling to pick up the pieces of your life, you end up with mental health, as soon as you get this, so-called mental health, you will get discriminated [against] by mental health services themselves, and then you will get discriminated at [the] workplace, and that kind of feeds into the cycle of low self-esteem, low self-worth, and it's very hard to break that cycle then (Anita)*

In understanding this negative treatment some women drew on individualistic concepts of unfit individuals, who misused the power of their position.

*I think, you know, some people are predisposed to be, uh, not fit really to be, working in mental health, yet they are working in mental health, and they find, you know, these are vulnerable adults, we can shout at them, we're not gonna be challenged about it, so it actually endorses this kind of behaviour rather than, you know, if it was you know, taken as seriously. (Anita)*

Fox (1995) has argued that 'the essence of care' can be delivered out of altruism or narcissism and that both can lead to controlling behaviours by professionals.

Alternately, some institutions were considered to be hostile in their way of operating. For example, Susie characterises the court system as adversarial.

*I think there's so much, and it's in every aspect, and it's a massive thing that probably will-may never change, it's the adversarial legal system, the family courts just shouldn't be like that really (Susie)*

Participants described both positive and negative practices within all systems mentioned, including the police, social services, legal systems, mental health services, charities, psychology services and informal support networks. In addition to active harm by 'support systems', all participants spoke of a sense of passive harm done to them by being ignored or neglected by those who had the power to help them and did not.

*at the risk of sounding ungrateful, it's almost too little too late, because how I feel now about it, if I had accessed it at the times of need, and when I was actually going through certain things, I definitely-I feel like it would have made a huge difference (Unicorn)*

In addition to feeling harmed by having to wait for support that they could have accessed sooner, some participants felt betrayed by the silence or inaction of those they'd looked to for help.

*and then you almost begin to realise, all the things that you'd called support systems in your life, like family or friends or peer group or community that you came from was actually complicit in the abuse (May)*

This led some women to begin distancing themselves from forms of 'support' they found harmful, although not all were able to, being still in need of 'help' unavailable elsewhere.

#### 4.5. Theme 3: “We’ve Had Enough”

This final theme explores how women described resistance and objection to how they had been treated; on an interpersonal, systems and societal level. It explores this resistance in relation to women’s experiences of victimisation and lasting harm, and how this intersects with notions of ‘victimhood’, ‘trauma’ and ‘recovery’.

##### 4.5.1. “This Is Not Ok”

This sub-theme explores women’s objection to their treatment and ways of asserting their needs, both during and after abuse.

Some women, in talking about leaving an abusive situation, noted a crisis point of not feeling able to cope any longer.

*I thought, I can’t live like this and I’d reached my crisis point (Autumn)*

*I started [the court] case because I can’t bear it, his behaviour, that’s one reason, and my health started deteriorate (Spring)*

Rather than accepting abuse, women talked about ways in which they’d resisted and attempted to take charge of the situation.

*I woke up one morning, and I was like no, enough is enough, and I literally just called my cousin and said you’ve gotta help me get rid of all his stuff that’s here and in my home, I literally packed it all up and threw it out (Unicorn)*

*I just said leave me alone, if you don’t leave me alone I’m gonna call the police, and that’s what I did, in the end (Susie)*

Although participants described many ways of feeling powerless to get their needs met, they also described various ways in which they had reflected on their needs and actively sought help.

*I got away because I wanted to know what to do, I didn't know what to do, I fled the country because I felt that my higher being or god was telling me to leave the country, so I followed that instinct and left the country, and that was when I started to seek advice (Zion Flower)*

*so then I went to the local um, mental health team, borough mental health team, and I said to them, I know that's what need, do you have anything like that? (Rosered)*

The previous theme explores women's sense of dependency on other's social power to validate their needs. However, women also asserted their needs to others. For example, in finding that her experiences weren't being recognised, Fireweed starts using the power to name her experiences as abuse herself.

*and then I actually started using the term an abusive relationship, and then the woman who I was speaking to sort of twigged (Fireweed)*

In pursuing their needs, I perceived a sense of grit and determination in many of the women's accounts.

*I actually gritted my teeth and you know, made an appointment, got myself together (Fireweed)*

This self-assertion may relate to the development over time of increased limit-setting and centralising of their needs, including not accepting things - friends, family, partners, service providers- that are not good for them and finding ones that are (Stenius & Vesey, 2005).

*do you know what, now I'm gonna come and I'm gonna get counselling to heal me. Fuck you lot, fuck talking about you lot, fuck going over it any more, I'm doing it for me from now on (May)*

In order to take care of herself, May speaks of needing to become "aggressive".

*it made me become very aggressive again, because I realized that in AA you had to be really aggress-really look after yourself (May)*

These forms of 'aggression' are often pathologised in women, rather than recognised as ways of resisting their exploitation and abuse (Burstow, 1992).

Parallel to their accounts of resisting abuse, women's talk illustrated ways in which they had resisted and protested their treatment by 'support systems'.

*and finally I had to tell her, don't tell me that I cannot come here, because [...] you can go anywhere if you feel suicidal, so please don't be telling me that I can't come here (Anita)*

*Well I had one ten year period where the person who was um, abused me and exploited me, just like everybody else has done, and I took him to court in the end (Rosered)*

Some participants' talk indicated that, similarly to their experiences with people who abused them, they had reached a breaking point at which they could not take any more.

*so I sent an email to [organisations] saying that...this is happening. If I died, because you are pushing me to my breaking point, and I slashed my wrists and died, I will hold the [organisation] responsible for it (Anita)*

Anita's description here parallels other women's descriptions of delivering ultimatums to the men abusing them in a state of desperation to make the abuse stop. At other times, women described compliant strategies to prevent the situation from worsening.

*he wouldn't agree to go on this parenting course, the only way he'd agree was if I went on it too, so I went on it as well (laughs) so we both- it's almost kind of covering tracks (Susie)*

In circumstances where she risks losing custody of her children, Susie describes complying despite her sense that it is wrong, to protect herself and her child. People who have been abused are argued to use a range of strategies to protect themselves and others during abuse (Herman, 2015) and also when navigating hostile systems (Greeson & Campbell, 2011).

Throughout their accounts, nearly all participants communicated a powerful sense of disbelief and outrage at what they had experienced from both people abusing them and 'support systems', often communicated to me in rhetorical questions.



*I was like, what? That's not right, you're my mum...I couldn't imagine my daughter telling me that and I'm just like oh yeah, what's on tv sort of thing (Unicorn)*

*Call this court, you have to prepare, you have to do your job, or why you sit in this chair, and this, this not ok, yes? (Spring)*

*And I'm thinking, here I'm feeling suicidal and you're telling me this is [London borough] and this is [London borough] and we can't see you, and what kind of a crap is that? (Anita)*

Participants used words such as 'ridiculous', 'shocking', 'unbelievable' to convey their disbelief at how they had been treated in addition to stating that they could not understand or imagine it.

*This is a ridiculous story isn't it? (Rosered)*

*I mean you'll have heard that story hundreds of times and things, it's just ridiculous (Fireweed)*

*so that sort of, unbelievable kind of attitude (Susie)*

Rather than making sense of their experiences, it seemed to me that participants had found themselves in a world in which the 'rules' as they knew them to exist had been shattered and broken (Lerner, 1980), and they now found themselves navigating a system that did not operate according to their moral code, which they could not comprehend.

#### 4.5.2. "To Carry with Me Forever"

This sub-theme explores what it is that women have "had enough" of; their sense of the lasting impact and harm of abuse, and how 'healing' was not a short-term process, or one that necessarily ended.

*when I have a good guy it's like, I almost sort of push them away, it sounds clichéd but it's almost like I don't know how to just be like yeah,*

*it's a good person, it's fine. It gives you trust issues, it gives you all sorts of things (Unicorn)*

Rather than 'trauma' being something that can be recovered from and forgotten, some of the participants spoke about how their experiences stay with them, even after receiving specialist support and therapy; Evans and Lindsay (2008) refer to 'incorporation' rather than 'recovery'.

*that's something that I will have to carry with me forever, now I'm thirty and I feel like there's issues that I now have as a thirty-year-old, that I wouldn't have if I didn't go through that nine years ago (Unicorn)*

*you know, you're never healed from trauma, you've never got over it and y'know, you need to...you need to be able to talk to some-I need to be able to talk to a woman who...I respect...and who, shows me respect (May)*

For May, rather than the need to 'recover', she talks about needing someone to talk to, perhaps to be alongside her in her experiences, which she may continue to carry with her. This contrasts with the recovery agenda which has infused mainstream mental health services, with the aim of returning people to work (Perkins and Slade, 2012; Harper & Speed, 2014). Anita seemingly draws on this perspective.

*If you can get treatment quickly then you can work quickly, so in a way you are still helping-it's still helpful because it's helping the economy that you're in work quickly, rather than being left with symptoms you know, then you can't struggle with work (Anita)*

Anita here appears to feel obligated to make an economic argument for her own need to be treated for psychological distress, which speaks to the power of these ideas in the current UK context.

In response to their victimisation, some women's talk suggested that language to express victimhood may have become a necessary tool to navigate systems they experienced as harmful or abusive. At times they communicated this to me as seemingly forming a part of their self, or identity.

*the tragedy that has been my life if you like, the sort of loss and everything, you know, has not been my responsibility really, in as much as, well, you know, I was terribly abused in my childhood and exploited also, and therefore all relationships have been like that, and that's had a terrible effect on my psyche if you like (Rosered)*

Anita positions herself as both a victim of domestic abuse and a PTSD patient to protest her experience of being shouted at and a seemingly cold or indifferent response to her suicidal ideation. Perhaps it is only in protesting her victimhood that Anita feels able to be heard in mental health services.

*the psychiatric nurse with the crisis team was shouting at me and telling me "so you haven't...you want to die, you want to kill yourself, what is stopping you from killing yourself?" I really don't need, as a PTSD patient, you know, to have somebody shouting at me, because I'm a victim of domestic abuse (Anita)*

Rather than a nihilistic pessimism based on their victimisation, women in this study however continued to advocate for their rights, perhaps drawing on, what Nichols & Feltey (2003) identify as "claims based on resistance for equality [...] and for transformation". Most women spoke about being altered by their experiences in a way that created a desire for change, or to help other women.

*I feel like I could help a lot of women, young or old, that have been in similar situations to me, I've processed it, I've had counselling, I've been through the woods, I'm on the other side. Before I'd never have been able to speak about this stuff, I'd have been in pieces but now I'm just like yeah, it's part of my story, I would like to help and share it with other people (Unicorn)*

Some women spoke about the need for wider cultural change, or noticing that change is happening, with examples being the recent responses to Harvey Weinstein allegations and the change in UK legislation around coercive control. May talks of being sustained by being part of a wider movement for change amongst women and reflects on the reasons for this.

*I don't really know why it's changed, maybe it's just that's over time,  
women have finally got into places where our voices just can't be shut  
down any more, like physically can't be shut down any more, and enough  
women are brave enough and angry enough now to say we've had  
enough (May)*

## **5. FURTHER DISCUSSION**

In this chapter I further discuss the analyses in Chapter 3, in addition to considering the quality of this research and limitations, reflexivity, and implications for practice and future research.

### **5.1. Research Question: How Do Women Experience Navigating Support After Abuse?**

My main question was how do women who have experienced DVA experience navigating and accessing 'support', 'post-crisis'? I was interested to explore how they understand and make sense of their experiences, and what influences whether they experience something as helpful or harmful. Three main themes (with sub-themes) emerged during the analysis – Theme 1: 'It's the Seeing It and Acknowledging It': Who, Where and How?; Theme 2: The Duality of Help, and Theme 3: 'We've Had Enough'. These will be discussed together, along with my understandings of what may have influenced participants' experiences and considering how the findings relate to existing literature.

My research question relates to experiences 'post-crisis' in the interest of exploring the under-explored question, what happens when women manage to access 'support systems'? 'Disclosure' and 'crisis' are often constructed as discrete points in time related to leaving abuse. However, from participants' accounts, experiences of talking about abuse- and how others respond to this- are ongoing experiences. I therefore do not impose this distinction on the findings and discuss all findings together.

#### **5.1.1. Accessing Support: The Politics of Naming**

An overarching concept linking Theme 1 - 'It's the Seeing It and Acknowledging It': Finding My Way to Safety - and Theme 2 - The Duality of Help – was the importance of naming and understanding abuse to access support. Within the

area of violence and abuse, a primary focus has been on using language to make its numerous forms “visible and speakable” (Kelly, Burton & Regan, 1996, p. 85); without this, experiences become ‘unspeakable’ or even ‘unknowable’. The ability to speak out about experiences depends not just on having access to the language, but the context in which this language will be heard and believed. The analysis illustrates ways in which participants had varying access to both and neither.

Despite the introduction of UK legislation on coercive control in 2015, several participants found their experiences of controlling behaviour to be less well recognised as abuse, a finding replicated elsewhere (Coy et al., 2015; Home Office, 2013; Perks et al. 2012; Robinson et al., 2018). As in other research (Peckover et al., 2013), some participants’ accounts suggest that others took a gender-neutral position on their experiences, rather than recognising the gendered power dynamics influencing women’s experiences of power and control. Participants commented on the level of public awareness about abuse; the importance of this in shaping theirs and others’ perceptions, and a desire for better professional awareness.

A noted paradox within this research was the power of naming women’s experiences as abusive for them, which is a difficult tension to resolve. There remain significant barriers to women naming their experiences as abuse besides lacking the words, including abusers and others’ silencing tactics, minimisation as a coping strategy and the consequences of telling (Liang et al., 2005; Schreiber, Renneberg & Maercker, 2009). Both Liang et al. (2005) and Burke et al. (2001) describe transitional models of help-seeking in which women move through phases including non-recognition and problem acknowledgement before deciding to seek help, identifying and selecting sources of support. Having someone else name their experiences as abusive for them seemed to give participants permission to do so. Similarly, women have expressed desire to be “pulled out” of their situation and for someone to take the decision out of their hands or “parent them” during extreme stress (Evans & Feder, 2014) and pro-active offers of help increase DVA detecting rates (Meichenbaum & Keeley, 2004).

Although this may be helpful for some women, it could have unintended consequences if ‘telling them’ becomes the dominant mode of interaction. An

alternative to naming abuse *for* women may be to share information and concerns; learning and information was clearly valued by participants, who recalled specific books and exercises, as was time to 'process'. French & Raven (1959) refer to 'informational power' as independent from expert power, being based on characteristics like logic or 'self-evident facts', which individuals are more likely to assimilate rather than locate in an 'expert' or authority figure. Women elsewhere have valued being able to "talk about" rather than being "talked to" (Nichols & Feltey, 2003) and research frequently emphasises women valuing choice and support that enhances their agency (Kulkarni et al., 2012; Nichols & Feltey, 2003; Stenius & Veysey, 2005).

#### 5.1.2. Navigating Support: As Victims, Survivors, Both or Neither?

In addition to protecting themselves and their children during abuse, participants' accounts also revealed agency - their actions and agendas- in their interactions with support systems. Participants demonstrated varying forms of resistance, which could be conceptualised as compliance, defiance through noncompliance, and defiance by challenging (Greeson & Campbell, 2011); this characterised the theme, 'We've Had Enough'. This exemplifies how women maintain forms of agency and resistance, even in systems which constrain and limit their ability to freely navigate what they need and want, echoing findings in the legal sphere (Frohmann, 1998; Konradi, 2007)

Typical of findings elsewhere (e.g. Evans & Feder, 2014), several participants detailed long delays in accessing support and a sense of being neglected or failed. Rather than defeatism, participants' insistence on better treatment implies they were drawing on rights or justice-based frameworks, which may have developed over time as women develop greater confidence in asserting their rights (Stenius & Vesey, 2005). Research indicates that specialist services play a key role in supporting women to make claims for themselves and women find it helpful when services reinforce their rights (Kulkarni et al., 2012; Nichols & Feltey, 2003). Participants' ability to self-advocate in this research may be based on their somewhat successful experiences of accessing help that affirmed their right to it.

All participants gave accounts that could be defined as being active, resourceful, determined, angry, resistant and fighting back; common terms used to describe 'survivors'. At the same time, participants talk suggested they felt victimised, damaged, confused, controlled, powerless, ashamed and guilty; common terms used to describe 'victims' (Kelly, Burton & Regan, 1996). This victim/survivor model characterises much of modern research and practice (Phillips & Daniluk, 2004; Warner & Feltey, 1999), whereby women are conceptualised as either/or victim/survivor but more commonly as a journey from one to the other. Although some women's talk implied a journey and finding self-belief or confidence, other (and sometimes the same) women talked of ongoing harm or vulnerability.

Although it is important to recognise the ways in which women have coped and resisted, or to recognise the agency underpinning forms of compliance, to construct them as 'survivors' in positive ways may be to deny or problematise some women's long-term support needs (Evans & Lindsay, 2008). What struck me was the righteous indignation, pain and anger in some women's stories. Some women have experienced extensive harm and we must be able to acknowledge that, rather than paper over this with the notion of 'surviving'. Indeed, many women reject both the role as a victim or as a survivor, or of being neatly labelled (Hunter, 2010; Leisenring, 2006; Phillips & Daniluk, 2004; Warner, 2003).

Some participants felt expected to behave in certain ways and detailed defensive or attacking responses towards systems they found harmful. Kelly, Burton & Regan (1996) posit that systematic abuse and oppression does not usually produce 'nice', 'well-behaved' people. These ways of responding could be problematised within participants, rather than being understood as ways of responding to what has often been a lifetime of harm and violation of trust by others. The notion of needing to be a 'good victim' has been noted elsewhere (Fassin & Rechtman, 2007; Martinez & Casado-neira, 2016; Pajak, Ahmad, Jenney, Fisher & Chan, 2014); women to try and present themselves in the 'right' way to service providers to receive the help that they needed, which typically means being passive, submissive, vulnerable and traumatised. A lack of recognition of the ongoing ways in which women are victimised, and respond to victimisation, limits women's ability to access support.



### 5.1.3. Navigating Support: Issues of Power and Identity

Participants' accounts suggested that being understood was key to feeling supported and was also personally transformative. Participants' descriptions highlighted how experiences of abuse impacted on their sense of self and their capacity to assert their needs to others. Additionally, their interactions with others indicate an intersection of power and identity, whereby individuals with social power can affirm or deny women's needs, selfhood and own intuitive understandings. Issues of power and control are typically associated with the behaviour of perpetrators as representing the core of violence against women (Daly & Chesney-Lind, 1998). Participants' narratives replicated numerous findings from the literature review; that power and control may also be directed from professionals, or personal contacts (e.g. Campbell & Raja, 1999; Keeling, 2011). This characterised the theme, 'The Duality of Help'. Participants' accounts reveal how they experienced navigating access to support as an exercise in power; power over material factors such as access to support, resources and safety, but also power of their concept of self and their future.

Participants described powerful individuals, but also forms of power operating in systems and cultures. In characterising their experiences and difficulties navigating support some women appeared to refer to structural inequalities, a finding replicated elsewhere (Nichols & Feltey, 2003). They highlighted the need for changes in the legal system and government priorities, better training and information, more resources, and change in the public domain. Some women also drew on concepts of racism, discrimination, patriarchy and privilege and at an interpersonal level spoke of the impact of shame, cultural norms and values and familial expectations. It may therefore be helpful to understand women's help-seeking experiences within an ecological model that accounts for the influence of various individual, interpersonal, community, and socio-cultural factors (O'Doherty et al., 2016). For example, at an interpersonal level, women are influenced by social support (Cluss et al., 2006), family and friends' attitudes and behaviour (Taket et al., 2014), actual and anticipated stigma (Overstreet & Quinn, 2013) and ways of relating to others (Liang et al., 2005). At a macro-level, women are influenced by social norms and cultural beliefs

regarding gender roles and violence, and rape or DVA myths (Burt, 1980; Liang et al., 2005; Ting & Panchanadeswaran, 2009).

These interactions have implications for women's self-concept; for participants, experiences of validation or invalidation had powerful effects. Previous research into women's difficulties leaving abuse has sometimes drawn on concepts of learned helplessness (Walker, 1984), locating perceived self-defeating behaviour within them. However, Moe (2007) explores how women who received unconditional and empathetic institutional or social support felt legitimated and were 'empowered' to pursue safe, productive, and independent lives. Those whose abuse had been ignored or downplayed felt as if they had been abandoned, silenced, and blamed.

Based on participants' accounts, it appears that women's help-seeking experiences may reciprocally shape a socially and relationally formed identity. According to Brewer (2001), social identity/ties refers to the link between representation of self and the structure and function of social groups. Individuals respond to the behaviours and expectancies of others and self-define (and evaluate themselves) based on relationships with significant others (Breckler & Greenwald, 1986). DVA is frequently understood to undermine self-identity (Hague, Mullender, & Aris, 2003; Moss, Pitula, Campbell, & Halstead, 1996) by undermining life goals, agency, ability to control the world (Liang et al., 2005), self-worth and self-esteem (Fleming & Courtney, 1984) and self-efficacy (Cluss et al., 2006). However, less explored is the impact of help-seeking experiences on identity (O'Doherty et al., 2016).

Some participants talked of needing to be 'seen', suggesting a struggle to assert their identity as they wanted to be seen and known, rather than how others imposed an identity on them. Moe (2007) similarly found that negative help-seeking experiences led to greater likelihood of internalising hurt (e.g. through depression, self-harm, or suicide attempts) and self-blame. In some women's accounts, using power against them seemed to lead to a 'spoiled identity', for example by diagnosis with 'personality disorder' or where they came to view themselves and their beliefs as untrustworthy. Connections with others and forms of validation countered this, offering participants the opportunity to reconstruct a positive self-identity. Participants talked about valuing connection with other women, women-only spaces and wanting to help

other women, suggesting the emergence of a collective identity based on shared experiences (O'Doherty et al., 2016).

Foucault's work on power-knowledge relations is useful to draw on to understand these hypothesised links between power and identity. Foucault argued that "human beings are made subjects" (Foucault, 1982, p.208). They are made subject to others in the sense that their "subjective identity" (Foucault, 1982, p.212)- who or what they understand themselves to be-, is produced by becoming 'tied' to a specific identity. This is a dynamic process involving, at its heart, power. Women in this study were subject to power-knowledge relations in various forms; the police who made judgements about how seriously to take their experiences of violence, or who to hold accountable; social workers and legal professionals who decided their capacity as mothers, how to treat the person who harmed them, and whether to take seriously their experiences and safety needs; health professionals who decided how to name and treat their suffering; therapists and DVA workers who decided what abuse is and how it should be understood. For participants in this study, discourses and ideas what it means to be a 'good woman'; what domestic violence looks like; how a victim should behave, and discourses of psychiatric diagnosis, all convened to produce a 'subjective identity'. Those discourses and practices act to transform and delimit how a person understands themselves and, significantly, who or what others understand them to be. For some women in this study the consequences have been profound and long-lasting.

This plausible impact of help-seeking experiences on identity highlights the importance of positive relational experiences whilst seeking support.

#### 5.1.4. What Constitutes Support?: Not What but How

Participants gave positive and negative accounts of the same statutory services and although therapy and material support to be safe were valued, most consistent was the desire for an empathic response. Women wanted to be believed, validated, listened to, understood and treated with patience, respect and compassion. Despite describing interactions demonstrating others' attempts to give information, these were not always experienced by participants as helpful when perceived to be perfunctory, superficial or lacking in

genuineness. Other research (Feder, Hutson, Ramsay, & Taket, 2006; Kulkarni, Bell & Wylie, 2010; Kulkarni et al., 2012; Stenius & Veysey, 2005) has similarly highlighted women's prioritising of being treated non-judgementally; sensitively; respectfully; encouragingly; with understanding; supporting their choices, and to be fundamentally "treated like a human being" (Kulkarni et al., 2012). Although there was insufficient data to draw conclusions, the relational aspects of therapy were generally spoken of over the extra-relational aspects such as therapeutic models, learning and techniques.

These findings support theories such as relational cultural theory (Miller & Stiver, 1997) and trauma theory (Herman, 2015), in positing that when there has been interpersonal abuse, 'healing' needs to be interpersonal and relational. The findings also support the notion that women need different things at different times and have individual needs; choice is paramount and there is no 'one size fits all' approach to providing DVA support (Keeling, 2011; Kulkarni et al., 2012; Pajak et al., 2014; Rhidian, 2016; Stenius & Veysey, 2005). All participants who had received therapy or counselling highly valued it, perhaps reflecting their current stage in seeking support. In other research women have de-prioritised therapy against tangible support such as food, housing, and financial assistance (Postmus et al., 2009).

## **5.2. Reflexivity**

All research is carried out from a particular 'standpoint' (Banister, Burman, Parker, Taylor & Tindall, 1994). Here, I seek to explore my personal impact on the research in terms of personal, epistemological and critical language reflexivity (Willig, 2013).

### **5.2.1. Personal Reflexivity**

I was acutely aware of my own influence in the interview and how I might be seen and responded to but was unprepared for the complexity of this. I felt compelled to validate and affirm participants- especially because they were communicating the importance of this to me. However, I was uncertain how to navigate this as a researcher, being concerned about my 'bias' or influence.

Some women shared with me that they were abused in childhood or raped, raising questions about whether the researcher's role should include offering counsel or comfort (Holland & Ramazanoglu, 1994). I sometimes felt I was betraying or invalidating them with my apparent neutrality, stemming from a fear of slipping into a therapist role.

This may have influenced the interviews in various ways: women may have perceived my 'neutrality' as hostility; I may have stayed too close to the interview schedule for fear of leading participants; I may have closed down lines of questioning for fear of a seeming failure to understand; I may have excessively refrained from guiding the interaction so as to make room for them. I felt an urge to make myself smaller and less influential, to make room for their voices; something that is not conducive to gathering a depth of information. However, at the same time I do feel that a less directive stance made room for women to talk about what was most important to them, in line with my original intention.

In seeing myself as an ally, I was unprepared that participants may not see me the same way. Participants variously seemed to relate to me as someone who wanted information; as someone with pre-existing knowledge; as naïve or uninformed, or potentially unsympathetic. I was upset when one participant seemed annoyed by my questions. Some interviews felt like a power struggle and these interactions left me feeling variably invigorated, exhausted and upset. In approaching interviews as information gathering I had neglected to consider them as social interactions (Thompson, 1989) with all the complexities of power relations involved (Holland & Ramazanoglu, 1994). My emotional reactions during the interview are likely to have affected my behaviour, even if unconsciously, and my feelings after the interview (Ullman, 2014). It may have made it harder to listen to some participants and conversely, by being aware of this reaction, I doubled down on my efforts not to be biased against individuals. I may have given their stories more attention than others. This is a parallel process to the counter-transference that therapists likely experience with their clients, but I did not have the same space to explore this in research supervision as I do in my clinical work.

Over time, I became less worried about the influence of my 'therapist self' and saw opportunities to use some of my skills to enhance the interviews, such as

summarising and 'signposting'. I developed my introduction and debrief to better discuss with participants their experience of being interviewed, sharing my reflections too. This aspect of research as a learning process for me as a researcher (Thomson, 1989) felt like an important but neglected part of my teaching and supervision.

Willig posits that "personal reflexivity involves thinking about how the research may have affected and possibly changed us, as people and as researchers" (2001, p. 10). My immersion in this research led me to attend relevant public events and to think more about the intersections of clinical work, research and public engagement. Hearing women's stories gave me courage in my professional and personal life; to challenge unhelpful practices where I saw them; to use what participants found helpful in my own clinical work, and to centralise the dynamics of abuse when working with abuse survivors in mainstream NHS services.

#### 5.2.2. Epistemological Reflexivity

I have adopted a critical realist position, in which I treat as 'real' abuse, in the literal sense of people being treated cruelly or violently, whilst recognising the discursive and extra-discursive powers in shaping what is thought of as abuse, and who has the power to name it as such. I developed more of a critical awareness of language and positioning during the research, partly through my experiences during the interviews and noticing my reactions to some of the powerful dialogue and word choices. If I were to repeat the research I would likely revise my language use further, such as around 'crisis' or 'help'.

I believe I have been consistent with an interest in the constructivist power of language within critical realism and a post-modernist feminist epistemology, rather than committing myself to 'micro social constructionism' (Burr, 2015). Attention to language has a long history within feminist research (Cameron, 1985) in terms of the power to both limit and expand what it is possible to say. My comments on language in the analysis remains largely on the power of naming, rather than conversational analysis, although I do use examples of how this may have been illustrated or replicated within our interactions. I acknowledge that I may not always have been epistemologically consistent; a

challenge for a junior researcher when conceptualisations of epistemological positions are contested and debated (Brown, 1995; Burr, 2015).

### 5.2.3. Critical Language Reflexivity

How I have chosen to use language may have influenced participants' responses. By describing my interest in 'helpful' or 'harmful' experiences during recruitment I may have invited participants who framed their experiences in either of these ways; the interview sample was somewhat dichotomised by this.

Brannen (1988) highlights how important it is not to prejudge the research problem by labelling or defining it too closely, allowing interviewees to define the problem themselves. I was keen to avoid focussing in on experiences of particular services but by labelling things broadly as 'support' I may have created a vagary that influenced participants' accounts. I found that I did steer interviewees towards expanding on encounters once they had mentioned individual services. My reluctance to impose frameworks on participants meant that I stayed close to asking about 'experience', which may have been understood as warranting descriptive accounts of events, rather than exploring intrapsychic processes.

I may have treated both service users and staff at the LO as having less of a critical understanding of language than myself, although they disabused me of that notion. My preference for using the word 'support' stems from early meetings with the LO, where the word 'help' was highlighted as potentially disempowering. A service user at an early consultation meeting also disputed the term 'recovery', a perspective I share. These encounters enhanced my awareness of linguistic constructions as I developed the research.

## 5.3. **Critical Issues in The Research**

In this section I will explore critical issues in the research- both ethical and methodological- and discuss these with reference to feminist research and theory.

### 5.3.1. Ethical Concerns

#### 5.3.1.1. *Recruitment*

Difficulties in recruitment led me to send repeated email requests and attending events at the LO to speak to women. All participants were given my details and had to initiate contact, however once women had expressed an interest in meeting I continued to contact them to arrange this, exchanging multiple messages, which had the potential to be experienced as coercive. It was difficult to know whether to desist when women detailed their busy schedules and difficulty finding a mutually suitable time, and to know whether these were attempts to communicate reluctance to take part.

It is my understanding that all the women who participated exercised their choice to do so, although perhaps with varying degrees of interest. All but one interviewee who discussed meeting times eventually attended an interview and continued to demonstrate their willingness in their ongoing involvement e.g. requesting to be informed about the findings and contacting me after the interview.

#### 5.3.1.2. *Exclusionary Practices*

Only individuals who could speak English were permitted to take part in the study, due to decisions about limited resource allocation (Section 3.6). This continues to concern me as non-English speakers and other marginalised people are frequently excluded from research, the evidence base, professional knowledge and ultimately the construction of service provision in a vicious cycle of exclusion (Beresford, 2007). Non-English speaking or ethnically marginalised women are also documented to have vastly different and more difficult experiences seeking help (Anita, 2017; Banga & Gill, 2008; Harvey et al., 2014; Thiara & Gill, 2013).

As a compromise I included women who spoke English as an acquired language well enough to participate in an interview. One participant met this criteria and had capacity to consent but during the interview her speech became what I would call 'disorganised' and difficult to follow, perhaps due to emotionality and other possible factors affecting her speech in addition to the



language barrier. The participant was determined to continue and be heard and so we completed the interview. I discussed this with my supervisor and agreed to keep the interview in the analysis, however it was not possible to code and analyse her transcript in the same depth as others. It seems unlikely that I have done justice to her concerns or her story, but my preference has been to include what I can from my interview with her, whilst recognising this as less than satisfactory.

#### 5.3.1.3. *Interpreting Women's Experiences*

In academic feminist research there is a risk of moving away from 'useful knowledge' (knowledge produced to understand and change women's oppression) to abstract theory (Kelly, Burton & Regan, 1996). Interpretation is a key process that distances the researched from the research, which Holland & Ramazanoglu (1994) characterise as a "site of struggle" (p.131). Some may argue that to do anything more than 'let women speak for themselves' is a violation, however this ignores that *all* research is theoretically grounded and there is no such thing as 'raw experience'; even participants' own accounts involve construction and interpretation (Maynard & Purvis, 1994), some of which I have attempted to understand in the analysis.

In addition, TA as an approach privileges overall themes and consistencies over individual nuance, contradictions and emphasis within individual's stories. I am aware that some stories may be told more loudly than others, and not all participants may equally recognise their perspectives in the conclusions drawn. Interviewees likely have significantly different interest in their life stories than what the researcher treats as significant (Gluckman, 1994). I was reminded of this in asking participants to name themselves, whereby participants chose personally meaningful names and ways of representing themselves. This was a poignant reminder to me of the contrast between the importance to *them* of their individual identities, and the research which aggregates their experiences.

These issues of power in the research process are not entirely resolvable but should be discussed nonetheless. Glucksmann (1994) argues that the participants' and researcher's relationship to the research process is always different, even where the researcher intends to 'give back', and the line between subject and objects "exists, more likely than not, in the researcher's head"

(p.156). However, it remains an uncomfortable question, whose research is this and for whom? For a doctorate thesis I have needed to show my own thinking, to a determined academic standard. This context prohibits the development of knowledge more collectively; even with co-produced research I would have sole power over write-up. I have sought a compromise by: producing a report for the LO in addition to the thesis, which I will consult participants on; involving a research consultant, Amanda, and committing myself to dissemination of findings. One way of enhancing this would have been to spend more time exploring women's experiences of being participants and their hopes and desires for the research.

### 5.3.2. Limitations

#### 5.3.2.1. *Sample*

The study sample was small, from one inner-city area within the UK (London); findings would undoubtedly vary with different participants. Women were recruited via a linked specialist women's organisation, both for pragmatic reasons and to develop a collaborative project. Many women do not encounter formal services at all (ONS, 2017), let alone specialist services, and this will undoubtedly have influenced the research. Women who have never told anyone or reached out for help are clearly a much more difficult population to study and it would be difficult to access and discuss help-seeking after abuse with women who do not think of themselves as having been abused. These groups of women will likely have different, and equally important, perspectives.

Unfortunately, DVA is widespread and women are a complex non-homogenous group; this research cannot and does not presume to speak for all women who have experienced DVA. However, I hope this research identifies some of women's common challenges and diverse responses (Collins, 2000).

Qualitative research does not aim for generalisability but to develop a rich understanding of participants' experiences and can be used to explore the experiences of disadvantaged people, whose voices may be missing from 'generalisable' quantitative data (Prilleltensky & Nelson, 2002).

The characteristics of the sample could be viewed as a limitation for the TA methodology. The sample was both homogenous, in terms of women accessing

a service in the same area of London, and heterogeneous as women varied in age, ethnonationality, social circumstances and background, length of time in contact with services, their experiences of DVA and other forms of abuse. Recruitment was a challenge and in earlier stages I perceived divisive groupings by participants' experiences and background. A minor ethics amendment to broaden recruitment (Appendix D) led to a further three women being interviewed whose experiences created more of a range. Heterogeneity/homogeneity is a trade-off and whilst commonality across a diverse group of people may strengthen the findings, the diversity may have reduced the likelihood of developing meaningful cross-case themes (Robinson, 2014).

#### *5.3.2.2. Methodological*

Braun and Clarke (2006) posit that a disadvantage of a simple TA is the inability to explore continuity and contradiction through any one individual account, despite these potentially being revealing. I elected to use a combined analysis and discussion section (Clarke & Braun, 2015) to explore some of the variation in participants' talk and experiences, and for transparency about my interpretations, which felt important. Narrative Analysis (e.g. Riessman, 2008) may have been an alternative methodology, permitting in depth exploration of the ways that people make sense of and communicate their experiences. Greater use of PAR or other forms of power sharing and data verification (such as checking transcripts, member checking) may have addressed some concerns about interpreting women's experiences for them.

By focussing on UK literature in the empirical review conducted for this thesis I may have missed important findings worth integrating, due to the greater number of North American studies that were excluded (See Appendix B). Cross-national studies are rare but DVA related attitudes and behaviours are likely to be more similar than different within Western affluent cultures, as virally trending social media discussions such as #MeToo and #MaybeHeDoesntHitYou reflect (Mcauley et al., 2018). Critical consideration of international research is of vital importance in service development, where services can learn from and trial successful practices first evaluated in other nations (see e.g. Westmarland et al., 2014). Whilst the literature review may lack the depth and nuance afforded by including North American studies it is

important to highlight existing UK knowledge – and gaps in this – if we are to make improvements in a UK context.

#### 5.4. Evaluating Quality

There are significant challenges in evaluating qualitative research due to the vast epistemological and methodological plurality; a general rejection of realist forms of ‘truth’ and ‘objectivity’ and a typical rejection of the possibility of universal codes of practice (Yardley, 2000). Rather than ‘reliability’ and ‘validity’, approaches to assessing quality in qualitative research tend to adopt concepts such as rigour, integrity, credibility, dependability, transferability, confirmability, goodness and fruitfulness (Ryan, Coughlan & Cronin, 2007). I have adopted Yardley’s (2000) flexible framework, which considers the significance of language and culture. Yardley (2000) proposes four flexible criteria: sensitivity to context; commitment and rigour; transparency and coherence, and impact and importance. I consider how I may have met these criteria with reference to examples in the table below.

**Table 3.** Quality assessment criteria

Criteria	Examples
<b>Sensitivity to context</b> <i>Theoretical; relevant literature; empirical data; sociocultural setting; participants’ perspectives; ethical issues.</i>	<ul style="list-style-type: none"> <li>• Theoretical grounding in the epistemology and intellectual history of feminist theory; acknowledging different theoretical perspectives and complex arguments; linking participant examples to abstract concepts and empirical literature (‘vertical generalisation’, Johnson, 1997);</li> <li>• Sensitivity to the linguistic and dialogic contexts through combined analysis and discussion; consideration of influences on objectives and beliefs of participants and myself;</li> </ul>

	<ul style="list-style-type: none"> <li>• Selection of quotes to illustrate participant perspectives; use of service user consultation; consideration of power and ethical concerns throughout.</li> </ul>
<b>Commitment and rigour</b> <i>In-depth engagement with topic; methodological competence/skill; thorough data collection; depth/breadth of analysis.</i>	<ul style="list-style-type: none"> <li>• Transcription, note-taking, detailed coding and an iterative method of synthesis and theme development (Appendix N-S) involving immersion in the data;</li> <li>• Addressing variation and complexity through a combined analysis and discussion enabling exploration of broad themes and in depth analytic comments.</li> </ul>
<b>Transparency and coherence</b> <i>Clarity and power of description/argument; transparent methods and data presentation; fit between theory and method: reflexivity.</i>	<ul style="list-style-type: none"> <li>• Active construction of a narrative or story, rather than describing or representing the data;</li> <li>• Transparency of methods and influence in the methods section, transparency of analytic comments in the analysis section and examples of method in the Appendix (N-S);</li> <li>• Selection of method in line with epistemology and research question; use of reflexivity sections and reflecting on issues throughout.</li> </ul>
<b>Impact and importance</b> <i>Theoretical (enriching understanding); socio-cultural; practical (for community, policy makers, health workers).</i>	<ul style="list-style-type: none"> <li>• Use of critical realist approach to further understanding by contextualising participant experiences and talk;</li> <li>• Pursuing a balance between furthering theoretical knowledge and considering practical impact and application, via implications and planned dissemination.</li> </ul>

It is also important to consider the quality of this research as feminist research. I have attempted to consider throughout different aspects of feminist theory,

issues of power and ethics, and my own subjectivity (Fine, 1994). My interpretations and conclusions will be influenced by factors relating to feminist theory and political values; my standpoint and personal subjectivity; the interview as a social event; the ways in which interviewees make sense of their experiences during the interview, and the influence of their own subjectivity and values (Holland & Ramazanoglu, 1994). I have acknowledged and explored the influence of these factors. By approaching this research from a feminist perspective, I have not attempted to produce a 'better' form of knowledge, but rather a 'different' one (Maynard & Purvis, 1994) and aimed to do so with integrity and transparency.

To quote Holland & Ramazanoglu (1994, p.146):

*“the validity of our interpretations depends on the integrity of the interaction of our personal experiences with the power of feminist theory and the power, or lack of power, of the researched. Our conclusions should always be open to criticism”*

## **5.5. Implications**

### **5.5.1. Community Level**

Participants highlighted the need for changes in the legal system and government priorities, more resources, and better public and professional awareness, especially regarding coercive control. They wanted more information for those who have experienced DVA but also preventative approaches, such as school-based education about relationships. Some of this change is happening already and was recognised by participants; DVA storylines are on TV, radio shows, and discussed in the media. In an internet age social media engagement can have snowball effects and develop momentum for change.

As researchers and clinicians, we can engage more with the public domain by public speaking, writing articles, talking with traditional media, using social

media and engaging in other forms of advocacy, using our professional power. Women who have experienced abuse should be informed about and encouraged to participate in policy decisions and in training provided to services. An example is the All-Party Parliamentary Group (APPG) on Domestic Violence, which has engaged lay women. There are opportunities for innovative forms of collaboration and community research to directly share professionally gathered knowledge with the public. UK examples are The NUS Women's Campaign 'I Heart Consent', which has led to calls for similar content to be used in schools; the '100 Women I Know' project, which used community research to create a documentary film and exhibition; and Dr Nina Burrowes' (2014) book, 'The Courage to Be Me', which turned her academic research into a graphic novel. Given the scale of DVA, these public conversations and preventative approaches are sorely needed.

#### 5.5.2. Service Level

Women had both positive and negative experiences of statutory services and highlighted the importance of compassionate individuals who understood DVA. The implications here are twofold: 1) There is an ongoing need for and value in DVA training and 2) Knowledge of DVA is insufficient and needs to be combined with compassionate care. Due to the widespread nature of DVA, training would ideally be mandatory within statutory services and emphasise coercive control. Understanding of DVA must not be solely located within individuals with specialist knowledge but held by all and considered even where professional attention is focused on other issues such as mental health issues, addiction or parenting (Robinson et al., 2018). Developing compassionate services is a complex challenge, especially with fewer resources and greater pressure on statutory services. It is a challenge requiring systems and organisational re-design, with actions at policy, organisational, individual and educational levels (Crawford, Brown, Kvangarsnes & Gilbert, 2014). Centralising the voices of women who have experienced abuse and their valuing of compassion may be an important vehicle for this change. Some small but important ways of doing this might include involving them in recruitment and interviewing processes and in training delivery. Telling their stories relating to

power, control and authority could be a powerful tool to help professionals reflect on how their behaviour may mirror the behaviour of perpetrators of DVA.

Both statutory and DVA services have faced substantial cuts in the last decade and service providers are faced with difficult decisions trying to balance crisis services with providing a range of long-term resources that women need to rebuild their lives after DVA. This research supports other findings that women value choice and individualised support, with different needs at different times. Participants also valued long-term support and longer counselling than is typically offered in statutory services. Undoubtedly, DVA organisations need to be adequately funded and ideally have their funding ringfenced to support the vast array of women's needs. Kulkarni et al.'s (2012) research suggests that women were more understanding of not being able to access what they needed due to a lack of resources than when they perceived themselves to be treated disrespectfully or indifferently. Women also valued transparency about how resource allocation decisions were made. With limited resources, service providers are likely to benefit from openly seeking women's views and negotiating with them about how to best meet their needs. Although not specifically explored here, advocacy and multi-agency partnerships are important to reduce the fragmentation of care and improve understandings of women's needs whilst involved in multiple services (NICE, 2014; Wills et al., 2013).

A troubling trend in this research was for women to detail 'being told', regardless of whether what they were being told was felt to be in their interests or not, yet research indicates women want non-directive support (Feder et al., 2006). With shortage of resources there is the risk that information becomes distilled and delivered in pre-packaged formats. Service providers should continue to emphasise relational aspects of care, such as active listening, supporting agency and provision of emotional support.

#### 5.5.3. Future Research

This was small scale research with a restricted population. Further research should explore broader perspectives, such as women's experiences in different



geographical locations, beyond specialist services and non-English speaking women. This could enable exploration of intersections of oppression during help-seeking in greater depth. Research needs to continue to move beyond 'disclosure' as but the first step in help and prevention of DVA.

There is little research exploring the influence of social identity on women's help-seeking experiences (O'Doherty et al., 2016). Further research considering ecological ways of understanding women's experiences of accessing support, including the relationship with social and collective identities, would be valuable.

Some women talked explicitly about discrimination, privilege and power, however it is unclear how they came to these perspectives. Further research could explore women's development of 'critical consciousness' (Freire, 1970) after DVA and what (if any) difference it makes to think about their experiences in these ways.

## **5.6. Concluding Reflections**

This research was conducted with women accessing a specialist DVA service, but DVA was not always the stated issue they were seeking support for. Professional attention on DVA is often focused on the most overt, high-risk examples. Yet women who are currently or have historically experienced DVA and other forms of abuse are everywhere; they vary in as many ways as all women do. Although many participants needed help to leave relationships, support fundamentally involved being able to understand their experiences, have them understood by others, and be 'seen' in ways that enabled them to reconstruct or reclaim their selfhood. These essential aspects of care are not just the responsibility of specialist services. We all need to open our eyes to abuse.

The culture of academic research pressures us to deliver something new, something original. What if what we are saying is very old? Feminist advocates have been highlighting issues of coercive control since the 1970s (Schechter, 1982). Women still describe being blamed, dismissed, ignored, neglected. Culture still lags behind our laws and our academic knowledge. Immersed in the

documentation of these repetitions, it was easy to become demoralised. As I have often found, it was women who have experienced abuse who revived me. They inspire me to do better and push harder. Resistance to violence and abuse is never done but we keep going and we energise and sustain each other. We inch forwards slowly and sometimes, as I conducted this research against a backdrop of cultural change, we seem to run forwards all at once. This research has given voice to my interpretations and reflections. I prefer to conclude with a participant's voice, whose sentiments I echo:

*"I hope it's not losing momentum and I hope real change is gonna happen but...I feel like I'm not alone any more, d'you know what I mean, I feel like everyone is ready to say...we're not fucking interested any more" (May)*

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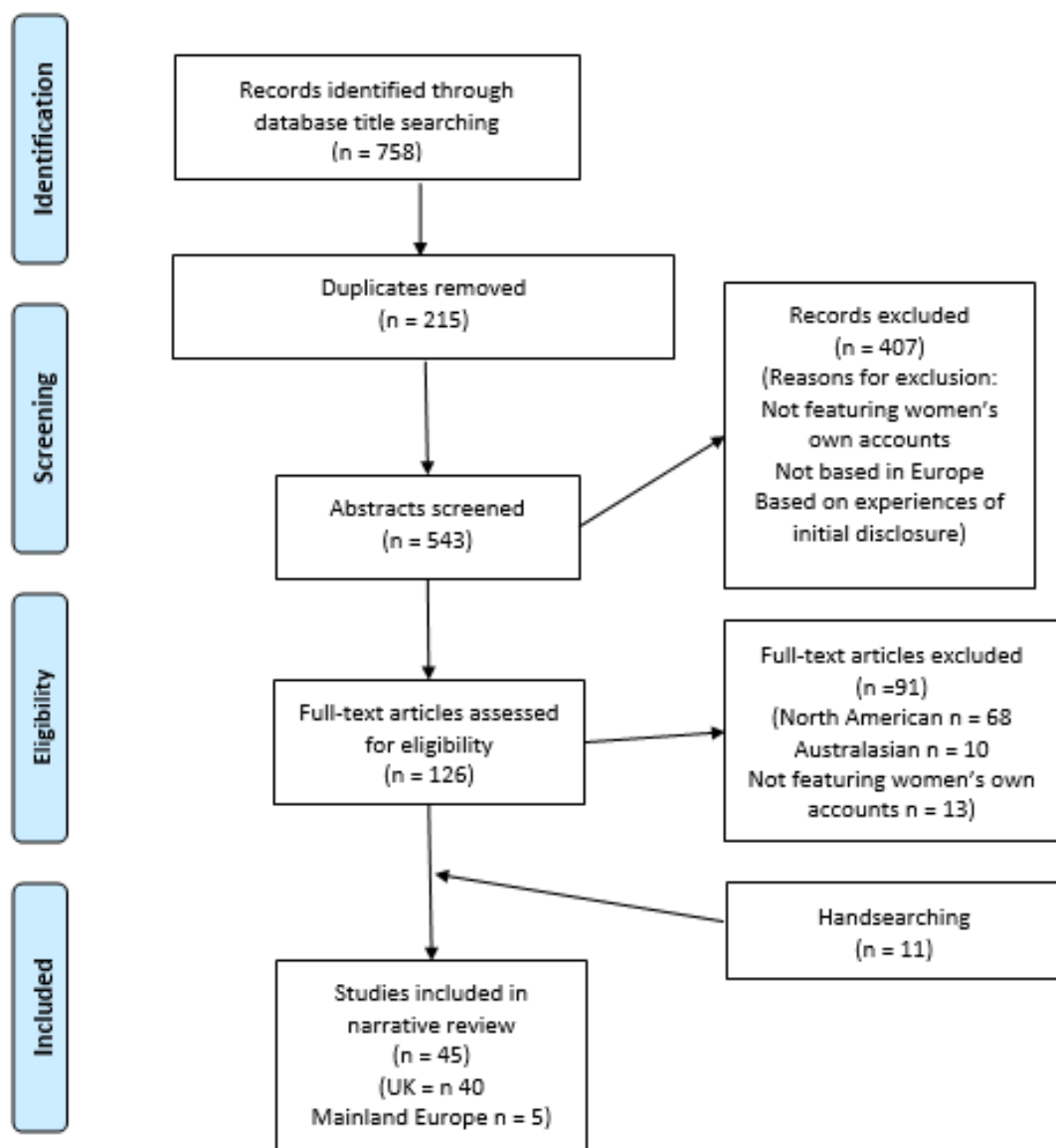
## APPENDIX A: LITERATURE SEARCH STRATEGY

Literature Review Aim	
<b>Research question</b>	What are women who have experienced domestic violence's experiences of navigating and accessing help post-crisis?
<b>Literature review questions</b>	<ol style="list-style-type: none"> <li>1. What is the current state of the empirical research in relation to the question above?</li> <li>2. What are the current theoretical or policy issues and debates related to the question above?</li> <li>3. What is the current state of knowledge about these issues and problems?</li> </ol>
<b>Scope</b>	<p>The literature review aims to identify and critically examine:</p> <ol style="list-style-type: none"> <li>1. Empirical literature related to data gathered on the subject matter</li> <li>2. Policy and grey literature related to the treatment of the topic in guidelines, statutory frameworks and current practice in the UK</li> <li>3. Topical literature identifying broader themes and concerns related to the subject matter</li> <li>4. Theoretical literature related to concepts and theoretical frameworks</li> </ol>
Search Strategy	
<b>Databases</b>	<p><i>OVID:</i> Social Policy and Practice PsychINFO EMBASE MEDLINE</p> <p><i>EBSCO:</i> CINAHL</p> <p><i>Web of Science:</i> Web of Science core collection</p>
<b>Area-Specific Journals</b>	<p>Journal of Interpersonal Violence Violence Against Women Journal of Traumatic Stress Psychological Trauma Theory Research      Practice and Policy Psychology of Violence Violence and Victims International Review of Victimology BMC Women's Health Journal of Gender Studies Journal of Womens Health, Issues and Care Journal of Black Psychology Social Science Research</p>
<b>Websites</b>	<i>Charities</i>

	<p>Women's Aid - <a href="https://www.womensaid.org.uk/research-and-publications/">https://www.womensaid.org.uk/research-and-publications/</a>  Solace Women's Aid - <a href="http://solacewomensaid.org/about-us/research-policy-recommendations/">http://solacewomensaid.org/about-us/research-policy-recommendations/</a>  Refuge - <a href="http://www.refuge.org.uk/what-we-do/research-and-publications/">http://www.refuge.org.uk/what-we-do/research-and-publications/</a>  Standing Together - <a href="http://www.standingtogether.org.uk/about-us/publications">http://www.standingtogether.org.uk/about-us/publications</a>  Rights of Women - <a href="http://rightsofwomen.org.uk/policy-and-research/research-and-reports/">http://rightsofwomen.org.uk/policy-and-research/research-and-reports/</a>  AVA - <a href="https://avaproject.org.uk/resources/">https://avaproject.org.uk/resources/</a></p> <p><i>Research Units</i>  Centre for Research into Violence and Abuse (CRiVA), Durham University  <a href="https://www.dur.ac.uk/criva/">https://www.dur.ac.uk/criva/</a>  Child and Woman Abuse Studies Unit, London Metropolitan University  <a href="http://www.londonmet.ac.uk/research/centres/child-and-woman-abuse-studies-unit/">http://www.londonmet.ac.uk/research/centres/child-and-woman-abuse-studies-unit/</a>  The Centre for Gender and Violence Research, University of Bristol  <a href="http://www.bristol.ac.uk/sps/people/group/sps_centres/2983">http://www.bristol.ac.uk/sps/people/group/sps_centres/2983</a>  Gender Violence and Health Centre, London School of Tropical Hygiene and Medicine  <a href="http://same.lshtm.ac.uk/about/gender-violence-health-centre/">http://same.lshtm.ac.uk/about/gender-violence-health-centre/</a>  Centre for Gender Studies, University of Aberdeen  <a href="https://www.abdn.ac.uk/genderstudies/">https://www.abdn.ac.uk/genderstudies/</a>  Centre for Gender Research, City University London  <a href="https://www.soas.ac.uk/genderstudies/">https://www.soas.ac.uk/genderstudies/</a></p>
<b>Theses</b>	<p>EThOS  <a href="http://ethos.bl.uk">http://ethos.bl.uk</a></p>
<b>Handsearching</b>	<p>Reference lists of key retrieved articles and book chapters (backwards snowballing)  Citations of key retrieved articles (forwards snowballing)  Reference lists of review articles identified during search</p>
<b>Literature Search Key Words</b>	
<p>Domestic violence, intimate partner violence, intimate partner abuse, gender based violence, sexual violence, sexual assault, sexual abuse, violence against women  Recovery, support, help, access, coping, service(s), barrier(s), facilitator(s), need(s), response(s)  Experience(s), view(s), perspective(s), discourse(s), narrative(s)  Concept(s), theory(/ies), critical, debate(s), feminist, minority(/ies), marginalise(d)</p>	
<b>Systematic Search</b>	
<b>Search question</b>	<p>What is the current state of the empirical research in relation to the research question: <i>What are women who have experienced domestic or sexual abuse's experiences of navigating and accessing help post-crisis?</i></p>
<b>Inclusion criteria</b>	<p>All documents that report data (of any kind) relating to:</p> <ul style="list-style-type: none"> <li>• Women's experiences of services (of any kind)</li> </ul>

	<ul style="list-style-type: none"><li>• Women’s experiences of informal support (friends, family, informal networks)</li><li>• Women’s perspectives of their needs and priorities</li><li>• Women’s accounts of ‘recovery’ and what this entails – where this relates to offers of support or help</li></ul> <p>Data should relate to longer-term experiences after disclosure of abuse/issues have already been identified</p>		
<b>Exclusion criteria</b>	Documents that report data relating to: <ul style="list-style-type: none"><li>• Experiences of initial disclosure or identification of abuse</li><li>• Experiences of men or children (under age of 18)</li></ul>		
<b>A OR B AND C OR D</b>			
<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
(use MESH terms)  Domestic violence Family violence Partner violence Partner abuse Spouse abuse Gender based violence Sexual violence Sexual assault Sexual abuse	Wom*n Survivor* Victim*  <b>Adjacent 6 words:</b>  Violen* Abuse* Assault* Batter*	Experience* View* Perspective* Opinion* Account* Narrative* Discourse* Stor* Journ* Report* Prioriti* <b>AND</b> Recover* Support* Help* Aid Need* Assist* Service* Professional* Staff* Treat* Respon*	Service* Professional* System* Staff* Communit*  <b>Adjacent 5 words:</b>  Respon* Provi* Barrier* Access* Obstacle* Facilitat*

## APPENDIX B: PRISMA FLOW DIAGRAM



## APPENDIX C: RISK ANALYSIS OF SERVICE USER INVOLVEMENT

Area of Risk	Description of Risk	Proposed Approach to Prevent/Address Risk
<b>Ethical</b>		
<b>Informed consent</b>	As the project will evolve as the research progresses, it is not easy to specify explicitly what involvement in the research will mean.	<p>Be explicit about the changing nature of the project from the beginning of the research.</p> <p>Be clear about the right for service users to re-negotiate their terms of involvement at any stage, as well as explicitly revisiting involvement at key stages of the project (e.g. design, analysis, post-completion).</p>
<b>Confidentiality/ Privacy</b>	<p>Service users as members of a community may already have access to sources of information not gathered through formal research routes.</p> <p>Service users may wish to waive aspects of privacy and anonymity where there is a desire to have their contribution to a project recognised (e.g. as a co-author).</p>	<p>Discuss in planning stages what confidentiality means for this project and how it will be navigated.</p> <p>Support service users to engage in a risk/benefit analysis of empowerment/being heard versus any risks of their involvement being known publicly. Discuss how and when public details of involvement may later be retracted, and cases where this is unlikely to be possible.</p>
<b>Coercion/</b>	Service users may feel pressured to take part due their receipt of support from the linked organisation and either gratitude, perceived pressure, or concerns about support being retracted.	<p>During engagement ask linked organisation workers not to persuade people to take part. Offer information with an open invitation to join but no expectations from the first meeting.</p> <p>verbally and written information that there is no expectation from the linked organisation and no consequences to non-involvement.</p>

<b>Right to withdraw</b>	The long-term nature of the project can make withdrawing from the project seem difficult due to presumed expectations or concerns about loss of influence/acknowledgement.	<p>Clearly communicate that it is expected that service users may change their minds and can withdraw at any time, with no consequences to non-involvement.</p> <p>Be clear about the right for service users to re-negotiate their terms of involvement at any stage, as well as explicitly revisiting involvement at key stages of the project (e.g. data collection, analysis, post-completion).</p> <p>Negotiate if and how a person wants to remain connected after withdrawal (e.g. acknowledgements).</p>
<b>Emotional</b>		
<b>Distress</b>	Due to the personally significant topic nature there is the possibility that discussions remind service users of their own distressing experiences.	<p>Support service users to think about the limits of their involvement and self-care.</p> <p>Use supervision to manage and raise concerns about the above.</p> <p>Remind service users of the right to withdraw at any stage.</p>
<b>Professional</b>		



<p><b>Disempowerment/Exploitation</b></p>	<p>Due to the inherent power imbalance (myself as a white, professional, British citizen) there is the risk that this power imbalance shapes interactions throughout the research.</p> <p>The dissolution of the project according to the thesis timeline could leave service users feeling abandoned and exploited.</p> <p>Service users could be 'seduced' by the promise of incentives which do not materialise.</p> <p>The focus on social change may mean (potentially unreasonably raised) expectations, which may lead to disappointment and feelings of tokenism.</p> <p>Exploitation due to inability to pay service users for their contribution</p>	<p>Discuss and acknowledge the inevitable influence of my thesis requirements and how to navigate input within these boundaries.</p> <p>Use acknowledgements, co-authorship, or the granting of intellectual property rights, where possible and desired in dissemination phases.</p> <p>Writing and sharing meeting notes and asking for any changes or additions.</p> <p>Making accessible any information wanted about the study, whilst being clear about the lack of expectation read lengthy documents and to determine limits of involvement.</p> <p>Support service users to plan their own independent activities post-completion if they wish and withdraw from formal involvement gradually.</p> <p>Transparency about the inability to pay for contributions. Negotiation of involvement based on their agenda and interests. Commit to reviewing agreed aims and planning to support them.</p> <p>Provision of refreshments during meetings and meeting service users at locations close to them to minimise travel costs.</p>
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## **APPENDIX D: ETHICS AMENDMENT APPROVAL**

### **UNIVERSITY OF EAST LONDON**

#### **School of Psychology**

#### **REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION**

#### **FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS**

**Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.**

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mary Spiller (Chair of the School Research Ethics Committee).

#### **HOW TO COMPLETE & SUBMIT THE REQUEST**

Complete the request form electronically and accurately.

Type your name in the 'student's signature' section (page 2).

When submitting this request form, ensure that all necessary documents are attached (see below).

Using your UEL email address, email the completed request form along with associated documents to: Dr Mark Finn at [m.finn@uel.ac.uk](mailto:m.finn@uel.ac.uk)

Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

#### **REQUIRED DOCUMENTS**

A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.

Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.

A copy of the approval of your initial ethics application.

Name of applicant: Erica Eassom

Programme of study: Professional Doctorate in Clinical Psychology (DClinPsych)

Title of research: Women Who Have Experienced Domestic Violence: How Do They Experience Navigating and Accessing Help Post-Crisis?

Name of supervisor: Nimisha Patel (1st); Kenneth Gannon (2nd)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
<p>Proposal to change recruitment criteria from recruiting through involvement in XXX Programme. This is a group programme that XXX offers, following the completion of individual support and means that women will have been engaged with the service for approximately 3-6 months following the crisis point of referral.</p> <p>Proposed change to open recruitment to whole XXX service and change inclusion criteria to involvement with the service for longer than 3 months.</p>	<p>Difficulties recruiting via the XXX programme due to limited numbers. XXX programme was used as a way in to contact with participants but does not relate to the aims of the research.</p>
<p>Proposal to change methodology to semi-structured interviews <i>only</i> and not focus groups. Ethics approval was already given for interviews and focus groups.</p>	<p>Not enough women were able to be recruited for focus groups and women preferred individual interviews.</p>
<p>Proposal to extend recruitment beyond April 2018 until September 2018</p>	<p>Difficulties recruiting and the need to recruit more participants to deliver</p>

	useful research for the service/be able to publish.
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Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	√	

Student's signature (please type your name): Erica Eassom

Date: 27/02/2018

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Mark Finn

Date: 27/02/18

## APPENDIX E: INTERVIEW TOPIC GUIDE

### Interview Topic Guide

#### Guiding questions

Could you tell me a little about how did you come to X service? (They don't need to say why they came, or the circumstances of their situation – I am interested in how it was to find a service to provide support).

- *Further prompts*

What has your experience been like of accessing help or other sources of support?

- *In what way was it (descriptor words used)? How?*

What types of help or support have you found helpful?

- *Why? What about it was helpful? An example?*
- *What different/other support have you found helpful? What has been the most helpful?*

What, if anything, has made it difficult or prevented you from getting the help or support you'd like?

- *How did that happen? Why do you think it happened?*

What kinds of factors/who do you think has affected the experiences that you've described to me of accessing help or support? (might need to give some prompts, depending on what they say earlier in their account)

- *Why?*

What, if anything, would you like to have been different about your experiences accessing help?

- *Why? Examples?*

#### Concluding question

Is there anything else we haven't covered that you'd like to bring up for discussion or anything you would like to ask me about this interview/research?

## **APPENDIX F: INFORMATION SHEET**



### **Information Sheet for Individual Interview Participants:**

#### **Women's Experiences of Accessing Help After Domestic or Sexual Violence**

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

#### **Who am I?**

My name is Erica Eassom and I am a postgraduate student at the University of East London studying for a professional doctorate in clinical psychology. As part of my studies I am conducting the research you are being invited to participate in.

#### **What is the research?**

This study aims to explore women's longer-term experiences of accessing help after a crisis period has passed. The study has been designed with help from staff and women who are service users at XXX The study has been approved by the School of Psychology Research Ethics Committee. This means that it follows the standard of research ethics set by the British Psychological Society.

If you would like to participate in this study you will need to read this information sheet and decide whether you agree to take part. If you decide that you want to take part in the study you will be asked to sign a consent form. Signing it does not mean that you cannot change your mind at any time.

#### **What does being a participant involve?**

Your participation will involve attending an individual interview with me, which will be like an informal discussion. You will be asked about your experiences of help and your views about it, including what has been helpful, difficult or harmful. You will not be asked to disclose any personal details or any details of abuse you experienced. The discussion will last approximately 30 to 40 minutes and will take place in a meeting room on XXX premises. Date and time will be arranged to suit you.

#### **What about privacy and confidentiality?**

I understand that privacy is very important, especially if you still feel threatened by people who mean harm to you, or need your whereabouts to remain hidden. This study has been designed with help from professionals and survivors of domestic or sexual violence and I take privacy and confidentiality very seriously.

Any information that you provide as part of your participation will be treated as confidential. This means that your name or other identifiable details will not be used in connection with any information you have contributed in research team discussions, analysis, or publication of results. I take seriously my duty not to discuss issues arising from data collection with others involved in the research ways that might identify you.

A participant number will be used instead in connection with any information you provide. Only I will have access to the details of participant numbers linked with actual names and this file will be kept on a password protected computer.

Audio recordings will be stored on a password protected computer. Transcripts will be created of recorded data for group analysis which will be anonymised and will not include your name or other identifying references (e.g. a name of a place).

### **What will happen to the information provided?**

Once the study is completed I will use the information to write a report for XXX to help them improve their service. The findings will be also be written up for the University of East London. Reports might be written to publish in academic journals or to share with other organisations for advocacy purposes. Any reports that I write in connection with this research will only feature anonymised data. If I decide to quote anything you have said I will use a participant number and not your name and will only ever select quotes that could not be used to identify you. Audio data will be destroyed after being used for analysis but anonymised data may be kept for up to 3 years so that I can write reports after the research is completed.

### **Are there any exceptions to my privacy being protected?**

There is no legal obligation for us to intervene if you tell us something that makes us think you are at risk of harm to yourself, or from someone else, for example if you report being a victim of crime. However, I may need to discuss this with the project supervisor. In the case of serious threat or abuse of a vulnerable person (e.g. a child) we may need to disclose this to relevant authorities. If the harm is to yourself, I will discuss the possible need to disclose this and get your permission before doing so. If you do not wish to disclose, I will discuss with you sources of support and advice instead.

Researchers have a legal duty to provide information collected during research related to criminal activity to authorities, if they become aware that we have it and request it from us. For this reason I will ask you to think carefully about what you say about your involvement in illegal activity and may remind you of this before the interview.

### **What are the possible risks of taking part?**

There are no likely risks involved in participation in this research, however, sometimes people may find discussing their experiences of seeking help to be upsetting. You will not be asked to discuss any experiences of abuse. If you become upset you can take a break, or choose to stop altogether. The researcher is there to support you. I will also provide you with some sources of support for you to access yourself.

You are free to stop participating in the study at any time.

### **What if I change my mind?**

You do not have to take part and you will be under no obligation to continue if you change your mind at any point. You do not have to give a reason and there will be no negative consequences. You can still continue to receive care and support from XXX and without any other health, social or legal care or support you receive being affected. You do not have to give a reason for wanting to withdraw and I will not question your decision.

If you decide you want to withdraw after your data has been collected, I am likely to continue to use this data, anonymously, in the write-up of the study and in any further analysis that may be conducted by the research team. **Please let one of the contacts below know if you wish all your data to be withdrawn.**

### **What will I get in return?**

Unfortunately there is no payment for involvement. Hopefully this study is something that you will want to take part in and has use for you, and other women. Mainly, I hope that you will get satisfaction from contributing to a project that aims to improve knowledge about what is helpful for women, and to use this to inform services.

If you want to be informed about the findings of the study please let me know on the consent form.

Thank you for considering taking part in this study. Please keep a copy of this information for you to look at again at any point.

### **Contact Details**

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

Erica Eassom, primary researcher                      Email address:  
EricaUELResearch@uel.ac.uk

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

Email: n.patel@uel.ac.uk

**or**

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: m.j.spiller@uel.ac.uk



## APPENDIX G: RECRUITMENT POSTER

[illegible]

## APPENDIX H: CONSENT FORM



### **Women's experiences of accessing help after domestic or sexual violence**

Name of Participant:

Please put your  
initials into the box  
to show agreement

1. I confirm that I have read and understood the information sheet dated for the above study and been given a copy to keep. I have had the opportunity to consider whether I want to take part. It has been explained to me what the research study is about, and what my participation will involve. I have had the opportunity to discuss the details and had any questions answered satisfactorily.

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2. I understand that my participation is voluntary and that even once I have given this consent I am free to withdraw at any time without giving any reason, without any health, social or legal care or support I receive being affected or being otherwise disadvantaged.

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3. I agree to participate in an individual interview that will be audio recorded.

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4. I understand that my involvement in this study, and the data from this research, will remain strictly confidential. Only the primary researcher will have access to identifying data. Any discussion of my data within the research team will be anonymised. I agree to have my

☐

anonymised statements quoted in reports of the findings.

5. I understand and have had explained to me the limits to confidentiality in this study related to risks of harm to myself or others. I have had an opportunity to discuss what this means.

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6. It has been explained to me what will happen once the research has been completed. I understand that any recordings will be destroyed after they are used for analysis but that anonymised data may be kept for up to 3 years.

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7. I understand that if I withdraw, the researcher may still use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher. I must specifically ask if I want any of my data to be withdrawn completely.

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8. I freely agree to take part in this study, which has been fully explained to me.

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Please sign below to show your agreement and understanding of the points above.

Name of Participant	Date	Signature

If you would like to be informed of the outcomes of this project, or invited to events related to it, please let us know by ticking this box (optional)

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Name of Researcher taking consent	Date	Signature
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## **APPENDIX I: DEBRIEF SHEET**



### **Debrief Sheet for Individual Interview Participants:**

#### **Women's Experiences of Accessing Help After Domestic or Sexual Violence**

Thank you for taking part in this research study. I hope that you will get satisfaction from contributing to a project that aims to improve knowledge about what is helpful for women, and to use this to inform services. This information sheet is a reminder about the study and what will happen to the information you've given me.

#### **What will happen to the information provided?**

Once the study is completed I will use the information to write a report for XXX to help them improve their service. The findings will also be written up for the University of East London. Reports might be written to publish in academic journals or to share with other organisations for advocacy purposes. Any reports that we write in connection with this study will only feature anonymised data. If we decide to quote anything you have said we will use a participant number and not your name and will only ever select quotes that could not be used to identify you. Audio data will be destroyed after being used for analysis but anonymised data may be kept for up to 3 years so that we can write reports after the study is completed.

#### **Will the information I've given remain private?**

We understand that privacy is very important, especially if you still feel threatened by people who mean harm to you, or need your whereabouts to remain hidden.

Any information that you provide as part of your participation will be treated as confidential. This means that your name or other identifiable details will not be used in connection with any information you have contributed in research team discussions, analysis, or publication of results. I take seriously my duty not to discuss issues arising from data collection with others involved in the research in ways that might identify you.

A participant number will be used instead in connection with any information you provide. Only I will have access to the details of participant numbers linked with actual names and this file will be kept on a password protected computer.

Audio recordings will be stored on a password protected computer. Transcripts will be created of recorded data for group analysis which will be anonymised and will not include your name or other identifying references (e.g. a name of a place).

#### **What if I change my mind about my information being included?**

If you decide you want to withdraw after you have taken part in an interview or discussion, I am likely to continue to use this data, anonymously, in the write-up of the study. Please let one of the contacts below know if you wish all your data to be withdrawn.

### **What if I want to know more?**

I will be contacting participants after the study is completed to discuss findings with you. If you want to be contacted about this or any other events in relation to the study please let check the box on the consent form. If you did not do this but want to be informed please let me know by getting in contact using the details below.

Thank you for taking part in this study. Please keep a copy of this information for you to look at again at any point but feel free not to take a copy home if it does not feel safe. If you prefer, I can email you a copy.

### **Who can I talk to if I feel upset by what we've talked about?**

If you have concerns about the way the research was done then please contact the research supervisor using the details in the contact section below. If you are feeling upset after the interview then please let the researcher know, or speak to a member of XXX staff. Below are contact details for services that can also offer emotional support.

**Solace Women's Aid Rape Crisis Freephone Helpline** offers confidential emotional support for female survivors of sexual violence and access to Rape Crisis counselling service.

Telephone: 0808 801 0305                      Email: [rapecrisis@solacewomensaid.org](mailto:rapecrisis@solacewomensaid.org)  
Open: Monday 10.00 – 14.00; Tuesday 10.00 – 13.00 & 18.00 – 20.00; Wednesday & Thursday 13.00 – 17.00; Friday 10.00 – 14.00

**Solace Women's Aid Counselling Service** offers confidential, free counselling support to women aged 14+ affected by domestic and/or sexual violence in an intimate relationship.

Telephone: 020 7619 1360                      Email: [counselling@solacewomensaid.org](mailto:counselling@solacewomensaid.org)  
Open: Monday – Friday 09.00 – 13.00

**National Domestic Violence Helpline** is a 24 hour Freephone.

Telephone: 0808 2000 247

**Rape Crisis National Helpline** is a Freephone helpline

Open: every day of the year 12 – 2.30pm and 7 – 9.30pm  
Telephone: 0808 802 9999

**Samaritans** is a national listening service for people feeling suicidal or having thoughts of harming themselves. They can be contacted at any time 24 hours a day.

Telephone: 116 123

If you are feeling significantly distressed, or having thoughts of harming yourself, tell someone. If you can, tell a health professional or a member of XXX staff. If you are

registered with a GP, ask for an urgent appointment, or ask to speak to the out of hours doctor if it is after normal service hours. If it is an emergency or you feel as though you are in immediate or serious risk then go to the nearest Hospital Accident and Emergency (A&E) department.

### **Contact Details**

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

Erica Eassom, primary researcher    Email address: [EricaUELResearch@uel.ac.uk](mailto:EricaUELResearch@uel.ac.uk)

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

Email: [n.patel@uel.ac.uk](mailto:n.patel@uel.ac.uk)

**or**

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: [m.j.spiller@uel.ac.uk](mailto:m.j.spiller@uel.ac.uk)

## **APPENDIX J: ETHICS APPLICATION**

**UNIVERSITY OF EAST LONDON  
School of Psychology**

### **APPLICATION FOR RESEARCH ETHICS APPROVAL**

#### **FOR RESEARCH INVOLVING HUMAN PARTICIPANTS**

##### **FOR BSc RESEARCH**

##### **FOR MSc/MA RESEARCH**

##### **FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY**

\*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to:

<http://www.uel.ac.uk/gradschool/ethics/>

**If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also.**

**Please see details on [www.uel.ac.uk/gradschool/ethics/external-committees](http://www.uel.ac.uk/gradschool/ethics/external-committees).**

**Among other things this site will tell you about UEL sponsorship**

Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised.

*Before completing this application please familiarise yourself with:*

The *Code of Human Research Ethics (2014)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website

[http://www.bps.org.uk/system/files/Public%20files/code\\_of\\_human\\_research\\_ethics\\_dec\\_2014\\_inf180\\_web.pdf](http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf)

And please also see the UEL Code of Practice for Research Ethics (2015)

<http://www.uel.ac.uk/gradschool/ethics/>

### **HOW TO COMPLETE & SUBMIT THIS APPLICATION**

Complete this application form electronically, fully and accurately.

Type your name in the 'student's signature' section (5.1).



Include copies of all necessary attachments in the **ONE DOCUMENT SAVED AS .doc** (See page 2)

Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identify its content. Your supervisor will then look over your application.

When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

Your supervisor should let you know the outcome of your application. Recruitment and data collection are NOT to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

### **ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION**

A copy of the invitation letter that you intend giving to potential participants.  
A copy of the consent form that you intend giving to participants.  
A copy of the debrief letter you intend to give participants (see 23 below)

### **OTHER ATTACHMENTS (AS APPROPRIATE)**

A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

Example of the kinds of interview questions you intend to ask participants.

Copies of the visual material(s) you intend showing participants.

A copy of ethical clearance or permission from an external organisation if you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation if separate ethical clearance from another organisation is required (see Section 4).

### **Disclosure and Barring Service (DBS) certificates:**

#### **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES**

**VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at [m.j.spiller@uel.ac.uk](mailto:m.j.spiller@uel.ac.uk)

**FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another in order to conduct research with vulnerable populations.

Your details

**Your name:**

Erica Eassom

**Your supervisor's name:**

Nimisha Patel (1<sup>st</sup>); Kenneth Gannon (2<sup>nd</sup>)

**Title of your programme:** (e.g. BSc Psychology)

Professional Doctorate in Clinical Psychology (DClinPsych)

**Title of your proposed research:** (This can be a working title)

Women Who Have Experienced Domestic or Sexual Violence: How Do They Experience Navigating and Accessing Help Post-Crisis?

**Submission date for your BSc/MSc/MA research:**

May 2018

**Please tick if your application includes a copy of a DBS certificate**

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**Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons (Chair of the School Research Ethics Committee) ([m.j.spiller@uel.ac.uk](mailto:m.j.spiller@uel.ac.uk))**

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**Please tick to confirm that you have read and understood the British Psychological Society's Code of Human Research Ethics (2014) and the UEL Code of Practice for Research Ethics (See links on page 1)**

☒

2. About the research

**The aim(s) of your research:**

The proposed study intends to work collaboratively with the input from service users and a specialist domestic and sexual violence organisation to undertake research of shared importance and value. The collectively established aim is to explore the following question:

What are women who have experienced domestic or sexual abuse's experiences of navigating and accessing help post-crisis?

More specifically, this study is interested to explore:

- What has influenced whether they have experienced something as helpful?
- What demands or barriers have they faced in their process of accessing and receiving help?
- How do they make sense of their experiences of help-seeking? What sorts of understandings and representations do they draw on in the process?

**Likely duration of the data collection from intended starting to finishing date:**

From the date of ethical approval (July/August 2017) – April 2018

## **Methods**

### **Design of the research:**

(Type of design, variables etc. If the research is qualitative what approach will be used?)

Data will be collected through two focus groups, each lasting approximately 90 minutes. Further individual interviews lasting approximately 30 minutes may be used to explore themes within the focus groups in more detail. Analysis will be qualitative thematic analysis within a critical realist epistemology and intersectional feminist framework.

### **12. The sample/participants:**

(Proposed number of participants, method of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research)

Participants will be recruited from XXX XXX programme This is a group programme that XXX offers, following the completion of individual support and means that women will have been engaged with the service for approximately 3-6 months following the crisis point of referral.

Opportunity sampling will be adopted based on women's willingness and availability, however purposive sampling may be adopted to ensure that there is representation of women from marginalised groups.

Data will be generated through two focus groups, consisting of 6-8 participants.

**Group 1:** Self identifying female service users of XXX who have engaged with the XXX programme (they do not need to have completed it) and speak English as a first language.

Participants will be over 18 years old and speak English as a preferred first language.

**Group 2:** Self identifying female service users of XXX who have engaged with the XXX programme (they do not need to have completed it) and speak English as an acquired language.

Participants will be over 18 years old and speak English as an acquired language. If they feel very comfortable speaking English they may elect to join Group 1 if preferred.

Exclusion criteria:

Aged under 18

Lacking capacity to consent

Both groups will be recruited through posters and leaflets distributed through XXX and through word of mouth via XXX staff and service users. Snowball sampling may be used as a method of recruitment to specifically reach women from marginalised groups. Recruitment will continue until enough women have been identified. To ensure that there will be enough participants in the event of non-attendance, there will be over recruitment up to 10 participants per group.

Individual interviews may be offered to explore in more depth and detail the topics that appear in the focus groups. This might involve identifying people who appear to have had more idiosyncratic experiences to allow for expansion on those experiences that may not have occurred in a group context. If topics discussed identify a need to explore in more depth experiences associated with a particular experience or demographic then additional focused recruitment may take place using the same methods described above.

### **13. Measures, materials or equipment:**

(Give details about what will be used during the course of the research. For example, equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application)

A draft interview schedule is included in Appendix A. Exact wording of questions may change through the process of service user consultation but topic areas will remain the same. Interviews will be recorded using a personal Dictaphone. A password-protected USB stick and laptop computer (researcher's own) will be used for storing and transporting data. Recordings will be immediately transferred onto the laptop, which is password protected. Nvivo qualitative analysis software (university provided) will be used for analysis.

**14.** If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

YES / NO / NA

N/A

### **15. Outline the data collection procedure involved in your research:**

(Describe what will be involved in data collection. For example, what will participants be asked to do, where, and for how long?)

Procedure	Approximate length of time	Details of process
Consent procedures	15 minutes	Researcher will record consent (Appendix C) in person, after giving participant information sheets (Appendix B) and allowing participants time to consider whether they wish to take part or not.
Focus groups	1.5 hours	Researcher to run the group. Discussion will follow topic guide (Appendix A). Will take place on XXX premises
Semi structured interviews	30 minutes	Researcher to conduct. Discussion will follow topic guide (Appendix A). Will take place on XXX premises

- Specific dates of the focus groups will be established once participant recruitment has been achieved. The intention is to conduct them between September - October 2017.
- Further interviews will take place in the months following the focus groups, anticipated November - December.
- Childcare and refreshments will be provided.
- The discussions will be recorded, transcribed and analysed.
- Following the thesis submission, findings will be disseminated to participants.

### 3. Ethical considerations

**Please describe how each of the ethical considerations below will be addressed:**

**16. Fully informing participants about the research (and parents/guardians if necessary):** Would the participant information letter be written in a style appropriate for children and young people, if necessary?

Potential participants will be asked to read and consider the information sheet before signing a consent form on the day of data collection. The nature of what this will involve will also be discussed verbally and participants will also have either read a poster, leaflet, or had the study discussed with them prior to reading the information sheet. They will still be given time to consider joining and ask questions, and have their right to withdrawn explained.

**17. Obtaining fully informed consent from participants (and from parents/guardians if necessary):** Would the consent form be written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians?

Participants will be given information about the research as outlined above, and will be asked to sign a consent form. Participants who can speak and understand English but do not have literacy will have the information sheet read to them and will sign the form in the presence of a witness.

**18. Engaging in deception, if relevant:**

(What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.)

The proposed research involves no deception.

### **19. Right of withdrawal:**

(In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve deciding not to participate in your research and the opportunity to have the data they have supplied destroyed on request. This can be up to a specified time, i.e. not after you have begun your analysis. Speak to your supervisor if necessary.)

Participants will have it explained to them verbally and in information sheets and consent forms that they are under no obligations to continue to be involved and can change their mind at any point, without giving a reason and without there being any negative consequences. Due to the group nature of the research, it will be explained that if they leave after some of the research has been done, the research team are likely to continue to use their contributions, anonymously. However, any quotations will be avoided if possible. Participants will be asked to make it known if they wish their data to be completely withdrawn.

### **20. Anonymity & confidentiality: (Please answer the following questions)**

#### **20.1. Will the data be gathered anonymously?**

(i.e. this is where you will not know the names and contact details of your participants? In qualitative research, data is usually not collected anonymously because you will know the names and contact details of your participants)

**NO**

#### **21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?**

(How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually names and contact details will be destroyed after data collection but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? Make this clear in this section and in your participant invitation letter also.)

Confidentiality will be protected as much as possible throughout the process. However, due to the nature of focus groups there will be the need for more than one person to know the identity of the participant. XXX staff will also be aware of the identity of participants due to their involvement in recruitment and data collection taking place on XXX premises. Confidentiality as lying within the group- rather than only with the individual carrying out the data collection- will be clearly communicated to participants via information and consent sheets.

During analysis, anonymised data may be shared with service user consultants. This may be potentially identifiable if individual stories or circumstances are well known. However, no names will be attached to any of the data analysed. Participants will be assigned an identification number and details of names and ID numbers will be held on a password-protected document. ID numbers (instead of names) will then be used in analysis and discussion in the team. Only the lead researcher will have access to these details. Any recording files will be stored on a password-protected computer, that only the primary researcher can access and deleted after examination. Raw data will be kept for five years and then deleted.

Limits to confidentiality will be explained verbally and in written form in the information and consent form. Given the nature of the service, there is a chance that women may disclose ongoing violence or abuse by persons known to them, or knowledge of criminal activity. Participants will be informed at the start of the interview of the circumstances in which confidentiality may be broken if there is a perceived significant risk to the public so as to make an informed decision about what information they share. A standard operating procedure for circumstances in which confidentiality may need to be broken to prevent harm is contained in Appendix F.

## **22. Protection of participants:**

(Are there any potential hazards to participants or any risk of accident or injury to them? What is the nature of these hazards or risks? How will the safety and well-being of participants be ensured? What contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?)

N.B: If you have serious concerns about the safety of a participant, or others, during the course of your research see your supervisor before breaching confidentiality.

There are no potential hazards or risks of physical injury or accident to participants above and beyond those which may be encountered in everyday life. Talking about experiences of domestic or sexual violence could be distressing, however this is not the focus of the interview schedule and participants will be informed and reminded at the start of the interviews that this is not the purpose of the discussion. Participants will be asked to agree to focus group requests, including to not interrupt or talk over one another; To refrain from using critical, offensive or derogatory language. Participants will be informed that the discussion will be recorded and advised not to disclose personal or sensitive information, or distressing, personal stories.

The researcher will be sensitive to any signs of distress, and ask the participant whether they would like to continue, take a break, or terminate the interview. The researcher will have details for organisations that can offer support which will be provided to all participants. Should a person become significantly distressed and in need of further support, we will make sure arrangements are put in place at the study site, including contacting the Clinical Supervisor in the first instance and informing associated workers at XXX if necessary.

Where there is ongoing abuse, discussion will be had with the participant as to how to minimise any risk to themselves whilst being involved in the research (such as not taking information sheets home).

Participants might feel they have to participate in the research as part of a condition of their receipt of support from XXX, or to feel pressurized by an existing relationship with other service users or staff. This will be addressed by having discussions with any staff involved in recruitment and asking them to only offer information once and not to further attempt to persuade or coerce the women. This will also be made clear through the researcher's explanation of the study, the participant information sheets and consent forms. Participants will be given time to go away and consider whether they wish to participate before completing a consent form.

## **23. Protection of the researcher:**

(Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant's house?)

Data collection will only take place on organisational premises and will only be conducted within service working hours. XXX staff will be on the premises. Under no circumstances will researchers attend the participants' home address or give out personal contact details in connection with this research. A mobile phone will be purchased and used purely for recruitment purposes. An email address will be created specifically for the purpose of the study in order to make the communication easier that will have no connection to personal email.

#### **24. Debriefing participants:**

(Will participants be informed about the true nature of the research if they are not told beforehand? Will participants be given time at the end of the data collection task to ask you questions or raise concerns? Will they be re-assured about what will happen to their data? Please attach to this application your debrief sheet thanking participants for their participation, reminding them about what will happen to their data, and that includes the name and contact details of an appropriate support organisation for participants to contact should they experience any distress or concern as a result of participating in your research.)

No deception will be involved in the study but participants will be given time at the end of the study to ask any questions. Participants will be given a debrief sheet with a written reminder of what will happen to their data as well as having this verbally explained and asked if they are still happy to have their data included. Resources for after-care support will be provided with debrief information. They will have the opportunity to indicate interest in finding out more about the outcome of the study.

Debrief of any service user consultants will be part of meetings in the final stages of the project as well as debrief and support being available during/after data collection.

#### **25. Will participants be paid?**

**NO**

If YES how much will participants be paid and in what form (e.g. cash or vouchers?)  
Why is payment being made and why this amount?

#### **26. Other:**

(Is there anything else the reviewer of this application needs to know to make a properly informed assessment?)

No

#### 4. Other permissions and ethical clearances

#### **27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?**

**YES / NO**

If your project involves children at a school(s) or participants who are accessed through a charity or another organisation, you must obtain, and attach, the written permission of that institution or charity or organisation. Should you wish to observe people at their place of work, you will need to seek the permission of their employer. If you wish to have colleagues at your place of employment as participants you must also obtain, and attach, permission from the employer.

If YES please give the name and address of the institution/organisation:

XXX, XXX, XXX, XXX, London XX XXX



Please attach a copy of the permission. A copy of an email from the institution/organisation is acceptable.

In some cases you may be required to have formal ethical clearance from another institution or organisation.

**28. Is ethical clearance required from any other ethics committee?**

YES / NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? YES /  
NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation is acceptable.

**PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary.**

**29. Will your research involve working with children or vulnerable adults?\***

YES / NO

If YES have you obtained and attached a DBS certificate? YES / NO

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

YES /  
NO

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

\* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) ‘vulnerable’ people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in

doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see [www.uel.ac.uk/gradschool/ethics/involving-children/](http://www.uel.ac.uk/gradschool/ethics/involving-children/)

**30. Will you be collecting data overseas?**

YES /

NO

This includes collecting data/conducting fieldwork while you are away from the UK on holiday or visiting your home country.

\* If YES in what country or countries will you be collecting data?

**Please note that ALL students wanting to collect data while overseas (even when going home or away on holiday) MUST have their travel approved by the Pro-Vice Chancellor International (not the School of Psychology) BEFORE travelling overseas.**

<http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

**IN MANY CASES WHERE STUDENTS ARE WANTING TO COLLECT DATA OTHER THAN IN THE UK (EVEN IF LIVING ABROAD), USING ONLINE SURVEYS AND DOING INTERVIEWS VIA SKYPE, FOR EXAMPLE, WOULD COUNTER THE NEED TO HAVE PERMISSION TO TRAVEL**

## **5. Signatures**

TYPED NAMES ARE ACCEPTED AS SIGNATURES

**Declaration by student:**

*I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.*

Student's name: Erica Eassom

Student's number: u1524909

Date: 13/07/2017

**Declaration by supervisor:**

*I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.*

Supervisor's name: Nimisha Patel

Date: 13/07/2017

## APPENDIX K: ETHICS APPROVAL

### School of Psychology Research Ethics Committee

### NOTICE OF ETHICS REVIEW DECISION

**For research involving human participants**  
BSc/MSc/MA/Professional Doctorates

**REVIEWER:** Max Eames

**SUPERVISOR:** Kenneth Gannon

**COURSE:** Professional Doctorate in Clinical Psychology

**STUDENT:** Erica Eassom

**TITLE OF PROPOSED STUDY:** What are women who have experienced domestic or sexual abuse's experiences of navigating and accessing help post-crisis?

#### DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

#### DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

*(Please indicate the decision according to one of the 3 options above)*

Approved, but minor amendments are required before the research commences.

**Minor amendments required (for reviewer):**

Inline comments have been made on the actual document concerning various matters of informed consent. The reviewer requests that consideration is made of these comments before commencing research.

The following amendments and clarifications have been made:

Lack of capacity to consent refers to assessment of capacity under the Mental Capacity Act (2005) and will not entail exclusion based on a diagnosis alone.

Participants will be offered the choice to attend a focus group or individual interview and the recruitment process will be the same and take place at the same time for both. Childcare will only be provided for the focus group; interviews will be arranged at a time to suit participants' childcare needs. Consent forms and information sheets have been amended to reflect this.

Participants will be asked to make it known if they wish their data to be completely withdrawn before the analysis stage (anticipated January 2018 onwards). It will be explained that if they wish to withdraw after the analysis has begun, the research team are likely to need to continue to use their contributions, anonymously. However, any quotations will be avoided if possible. Focus group participants can opt to withdraw their data up to analysis but the group conversation will still be used, with their comments removed. Information and debrief sheets have been changed to reflect this

Safeguarding of children and adults is outlined in the Standard Operating Procedure in the appendix. This is for the research team and organisation, not for participants. The considerations around breaking confidentiality and disclosure are complex and every circumstance cannot be outline in detail in information sheets. The SOP is there to underpin the decision making process and how this should be carried out.

The possibility of breaking confidentiality if information is requested, in the case of criminal proceedings, is taken from The Code of Human Research Ethics (2014) published by the British Psychological Society (BPS). There exists a legal obligation to report information related to an act of terrorism, or suspected financial offences related to terrorism (Terrorism Act 2000), or related to the neglect or abuse of a child. Information sheets have been amended to reflect this.

The primary supervisor Nimisha Patel will be provided with passwords in the event of death or incapacity of the primary researcher but the computer will be in the primary researcher's possession until any such event. Any data files that need to be shared for supervision of the analysis will be password protected.

**Major amendments required (for reviewer):**

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### ASSESSMENT OF RISK TO RESEARCHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

<input type="checkbox"/>	HIGH
<input type="checkbox"/>	MEDIUM
<input checked="" type="checkbox"/>	LOW

*Reviewer comments in relation to researcher risk (if any):*

N/A

**Reviewer** *(Typed name to act as signature):* Max Alexandre Eames

**Date:** 5 August 2017

*This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee*

**Confirmation of making the above minor amendments** *(for students):*

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Erica Eassom

Student number: 1524909

Date: 8<sup>th</sup> August 2017

*(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

### PLEASE NOTE:

\*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

## **APPENDIX L: STANDARD OPERATING PROCEDURE FOR RISK OF HARM**

### **Standard Operating Procedure for Concerns about Risk of Harm**

#### **Disclosure or concern about Abuse, Harm or Neglect**

Where there are concerns about a serious risk of abuse, harm or neglect to participants, or clear disclosure of abuse, harm or neglect to a child, either perpetrated by themselves or another person the following procedure will be followed:

- Take seriously what the participant is saying;
- Listen, encourage, but don't ask questions that assume anything;
- Tell the participant of the need to talk to someone else to decide what to do now and contact Professor Nimisha Patel;
- Seek consent to break confidentiality and disclose this information to XXX as the XXX point of contact for the study;
- If the participant does not consent to the sharing of this information, it may still be necessary to break confidentiality with concerns of harm to an adult and **will** be necessary to break confidentiality where there is disclosure of harm to a child;
- Check that the participant understands what is going to be done;
- Record their observations and what the participant has said at the earliest appropriate opportunity, including dates and times.

All situations where confidentiality may need to be broken will be discussed with Professor Nimisha Patel within the same working day. If Professor Patel cannot be reached then Professor Kenneth Gannon will be contacted instead.

In all cases where a serious risk is identified this should be recorded together with the action taken, and the Chair of the School of Psychology Research Ethics Sub-committee, Dr Mary Spiller, informed.

#### **Suicidal Ideation and Behaviour**

If the participant discloses information about suicidal ideation or attempts during the interview the following steps will be taken:

- Say 'can you tell me more about this', and probe about the potential future timeframe for any suicide attempts;
- Make notes of answers.
- Tell the participant of the need to talk to someone else to decide what to do to ensure their safety and contact Professor Nimisha Patel;
- Seek consent to break confidentiality and disclose this information to XXX as the XXX point of contact for the study;

If there are any concerns, or there is lack of clarity about the level of risk, then contact Professor Nimisha Patel to discuss the situation and how to proceed. If Professor Patel cannot be reached then Professor Kenneth Gannon will be contacted instead.

## **APPENDIX M: TRANSCRIPTION SYSTEM**

- ... Significant pauses
- ( ) Non-verbal activity e.g. crying, laughing
- [ ] Researcher addition for clarification or to ensure anonymity e.g. [son's name]
- Overlapping conversation or interruption
- “ ” Participant reported speech of others, used where participants have clearly imitated or differentiated the speech of others within their own talk
- ., Punctuation Used to aid reading



## APPENDIX N: ANNOTATED TRANSCRIPT

Transcript: Participant: [code] Age: Ethnicity: Gender:	Initial code	Reflections/notes
<p>[interview starts with welcome, offering refreshments, gathering consent, explaining the rationale for the study and what the interview will involve]</p> <p>INTERVIEWER: Ok, so could you start by telling me a bit about how you came to this service, to [collaborating organisation]?</p> <p>PARTICIPANT: Umm, I think I was having CPT erm...cognitive behavioural-CBT sorry</p> <p>INTERVIEWER: CBT ok, yeah</p> <p>PARTICIPANT: CBT, cognitive behavioural therapy um...I think I was having that um, based at [hospital name] and I felt that I need more, more support um...I think I spoke to my doctor about [collaborating organisation]...and they-they recommended me to [collaborating organisation] erm to gain some counselling um, so I believe it was through the GP and CBT referrals, how I came to contact with [collaborating organisation].</p> <p>INTERVIEWER: Yeah, ok so did you already know about [collaborating organisation]? Was it you that it brought it up or was it mentioned to you?</p> <p>PARTICIPANT: No, I never knew about [collaborating organisation] before-I wasn't, I didn't know about the service they offered, or anything about them...so um, it's not someone that I could've just googled.</p> <p>INTERVIEWER: Ok, was it that it was mentioned at [hospital name] to you?</p> <p>PARTICIPANT: Yeah I believe so, I'm trying to remember the exact place where I heard about it or the exact time um, because I'd been through like um...DV around 2003, 2006, 2007 and I didn't know about [collaborating organisation] then, whether they were about, and then just suffering the repercussions of...being in domestic violence and then...sometimes you go in a repetitive cycle so I found out about them later on...but I cannot pinpoint but it's either the doctor or [hospital name] I think there was a referral there, I was a bit anxious, I needed some support...so they recommended [collaborating organisation].</p> <p>INTERVIEWER: Ok, so you were bringing up that you needed some extra support?</p> <p>PARTICIPANT: Mhmm</p> <p>INTERVIEWER: So what was that like then, that process of going about um...kind of contacting [collaborating organisation] or coming to the service?</p> <p>PARTICIPANT: The process was...it was really not crazy but, I didn't know what to expect when I came but when I did come erm, it was very welcoming um...a lady saw me in the room, I was very anxious um, it's quite daunting to come somewhere for support um...in relation to domestic violence but um, basically I had to kind of let it all out um, or you didn't have to but I think at the time I chose to explain everything to the lady that assessed me and I wasn't sure</p>	<p>being told what I need</p> <p>specialist additional needs?</p> <p>routes of access - GP</p> <p>counselling &amp; support</p> <p>services unknown</p> <p>routes of access internet</p> <p>services unknown</p> <p>DV as multiple, repetitive learning about DV new about support</p> <p>additional needs</p> <p>?</p> <p>not knowing unknown/uncertainty of support</p> <p>nervous about DV support</p> <p>letting it all out</p> <p>'having' to disclose 'deciding' to tell all</p>	<p>apologetic to me</p> <p>gain?</p> <p>tentative statements</p> <p>'just googled' -internet constructed as easy, available information?</p> <p>the importance of awareness for access</p> <p>trying to give me the 'right' info</p> <p>positive referral? what does 'recommend' mean?</p> <p>construction of specialist support</p> <p>talking about DV as difficult</p> <p>'keeping it in' vs. 'letting it out'</p>

## APPENDIX O: EXAMPLE NVIVO CODES

Nodes				
Name	Sources	References	Created On	
Overpowered or powerless		0	0	01/04/2018 20:11
Trapped or helpless		0	0	01/04/2018 20:00
Cycles or spiral		2	3	26/03/2018 21:13
Double bind		2	2	26/03/2018 21:47
Not feeling able to move on		1	2	30/03/2018 13:18
Silenced or unheard		0	0	01/04/2018 15:07
Being silenced		1	1	27/03/2018 16:10
Being ignored		1	2	01/04/2018 15:09
Being punished for speaking o		1	4	01/04/2018 15:09
Others denying abuse		2	7	27/03/2018 14:03
Prevented from giving criticis		2	6	26/03/2018 21:18
Keeping quiet		3	5	27/03/2018 16:41
Isolated by abuse		3	3	01/04/2018 21:04
Shame and stigma		6	18	01/04/2018 15:16
Undermined		0	0	01/04/2018 21:05
Being made fun of		1	4	27/03/2018 12:02
Minimising or excusing		4	9	30/03/2018 16:06
Tarnished as a person		3	4	27/03/2018 11:21

## APPENDIX P: EXAMPLE CODED EXTRACTS

Theme	Sub Theme	Sub-sub theme	Codes Attached
“It’s the seeing it and acknowledging it”	“Stuck in it”	<b><i>Being in survival mode</i></b>	
		what was so interesting is my natural reaction of I want to know about everything I’ll go out and research it...but I hadn't done that with the relationship, I don’t know why, I suppose you just get sort of stuck in it (P5)	Altered state of reality Trapped in abuse
		What do I make of it now, that I was so abused, by everybody, as I said, that when I-when I get abused, you know, verbally, you know, when someone, uh, psychologically abuses me, then what happens to me is, my head gets completely scrambled and I, I can’t really function and n-not only that but also I cou-do what is called dissociate, so that I don’t know where I’ve been sometimes, he might come too, and might think, what happened the last two weeks, where have I been? So my life has been spent like that, I didn’t know, that-that was going on, which is extraordinary isn’t it? (P1)	Victimhood and vulnerability Multiple experiences of abuse State of confusion/ Not in the right mental state
		you’re not always in the right mental state if you have been abused, to kind of get the help (P3)	Trapped in abuse/Lost time Sense of disbelief
		I have been, so blinded, blinkered, unable to see, because I have been so defended against the, the constant abuse that has been coming at me (P1)	Not in the right mental state
		I’d been in active addiction for twenty-five years, and in active addiction as a woman the abuse carries on, really, to be honest. I’d had specific, fairly severe traumas as a young woman and...and I think that, you know...throughout	Suppressing knowledge of abuse Victimhood and vulnerability/Multiple experiences of abuse/Trapped in abuse  Multiple or complex needs Multiple experiences of abuse

	<p>alcoholism a lot of...a lot of everything is fairly abusive...so I think until that stopped, before that I didn't even realise...anything was happening, or apart from those few incidences that I had squashed anyway. (P7)</p> <p>the GP said oh well the medication is not working we can offer you counselling...which would take a while but whilst I waited for the referral to come through...can I stick to the tablets but I said no, I'm not doing it, so I took them but I didn't take them, and I just literally focused on other things, like my daughter, or working, I was-at one point I was working I had like three jobs, I wasn't sleeping because I was just trying to keep busy...yeah. (P8)</p> <p>once you tap into something into something or once you go through a situation that's when you're sort of bombarded with information, but it's weird...I'm not being funny but if you're going through a traumatic experience the last thing you need is like, twenty different leaflets and people screaming oh we're here to help, because you're going through something, your mind isn't really at that point, you're just still trying to process oh my god, I've gone through, this has happened to me, not oh ok, I'll take that one in case this happens next time (P8)</p> <p>I couldn't pick up the phone from the victim support because I can't be on the phone on my own personal phone [at work], so I missed the call, and there was no follow up from any victim support service, and after when I tried to call them and reach them, and I was too shocked with everything that had happened to me, to you know, constantly call them up or something (P3)</p> <p>they always say oh we can put you in touch with organisations that can help, but when you're young and in a situation where you're isolated, you don't have a lot of family support, that's not really something-even though it's something you need it's not really something that you jump on and say oh yeah ok I'll</p>	<p>Trapped in abuse</p> <p>Process of realisation Suppressing knowledge of abuse Forced or limited choice Waiting for help Refusing treatment/Superficial compliance Keeping going</p> <p>Not what I needed</p> <p>Superficial support</p> <p>Not in the right mental state Processing emotions</p> <p>Juggling demands Lack of follow up</p> <p>Not in the right mental state</p> <p>Superficial support Isolated by abuse Feeling unsupported Not used to help Keeping going</p>
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		take it, because you're not used to that, you're used to keeping your head down and do it alone (P8)	
<b>The Duality of Help</b>	<b>Power for Me</b>	<p><b><i>Validation (power to name)</i></b></p> <p>I suppose the key to it really was, they-it was somebody who acknowledged there was a problem and that the problem wasn't necessarily with me, and that his behaviour was abusive (P4)</p> <p>Yeah and before that [charity], as I said [charity] were the first time somebody said that somebody had been horrible to me and I thought, what?! You know, that's how I feel! And all these other therapists had not sort of noticed it. (P1)</p> <p>she was fantastically useful and made me understand that I was in a, you know, I was in an abusive relationship. I mean I knew it was wrong anyway but I couldn't have identified exactly what um, what, exactly what the problem was, and why I could never get myself out of the situation. (P2)</p> <p>And I said to her, I can't possibly be in an abusive relationship, you know um, I said to her I have the power in this relationship. And she said well you don't, you have no power whatsoever and...she made me understand, and it was her really who identified it and, you know, she told me to come and do this course.(P2)</p> <p>It was a-it was...wonderful, she helped me a lot...she really helped me to understand that...things had happened to me, I hadn't created things...(P7)</p>	<p>Validation/Naming abuse Non-blaming</p> <p>Missed opportunities Confirming intuition/Validation</p> <p>Process of realisation/Naming abuse Confirming intuition/Validation Trapped in abuse/Not knowing it was abuse</p> <p>Denial of abuse Being told it was abuse Being told what I need</p> <p>Confirming intuition/Validation Process of Realisation Non-blaming</p>

		<p>cause when I first left [linked organisation] they said oh, you know you have been abused, just to acknowledge that in my childhood and as an adult, but I wouldn't, I wouldn't ever have acknowledged that...I felt that it wasn't, it wasn't abuse, I wouldn't label it as abuse (P6)</p> <p>And fortunately after coming here, the first thing that they had to do, which I thought was quite...in hindsight empowering was, you're not to blame, and I thought at the start, you know, I think most women who come here, they think they are to blame and they think that they brought it on their own heads (P3)</p> <p>And the thing about them was-the thing about there was that it's free, and they-and the-the people there, they're really, they, I'll never forget them because they really changed the course of my life and again, they treated you like equals, you know, they didn't treat you like you were sort of inadequate, morally wrong, kind of worm, that's, you know, incapable of surviving. They d-they didn't treat you like that, they recognized what had happened, to cause you be in that situation, yeah...that they treat you as somebody who, you know, it's not as if you've chosen this lot, nobody chooses to kind of, drink themselves to death or, you know what I mean, nobody chooses to be, in an abusive relationship. Obviously you are there because you don't see any other way, of, of being so...(P1)</p> <p>I had time to think and get things together and actually it's like I went, this is really abusive, this is not just someone who doesn't under-you know, this is the impact, and it's like something suddenly went click, ratchet dropped into place.</p> <p>INTERVIEWER: Yeah, so it wasn't something that professionals had said to you until you-</p>	<p>Being told it was abuse Denial of abuse</p> <p>'Empowerment' Non-blaming Shame and stigma</p> <p>Financial factors Transformational experience</p> <p>Treated as equal Validation Non-blaming Self-assertion</p> <p>Process of realisation/Time</p>
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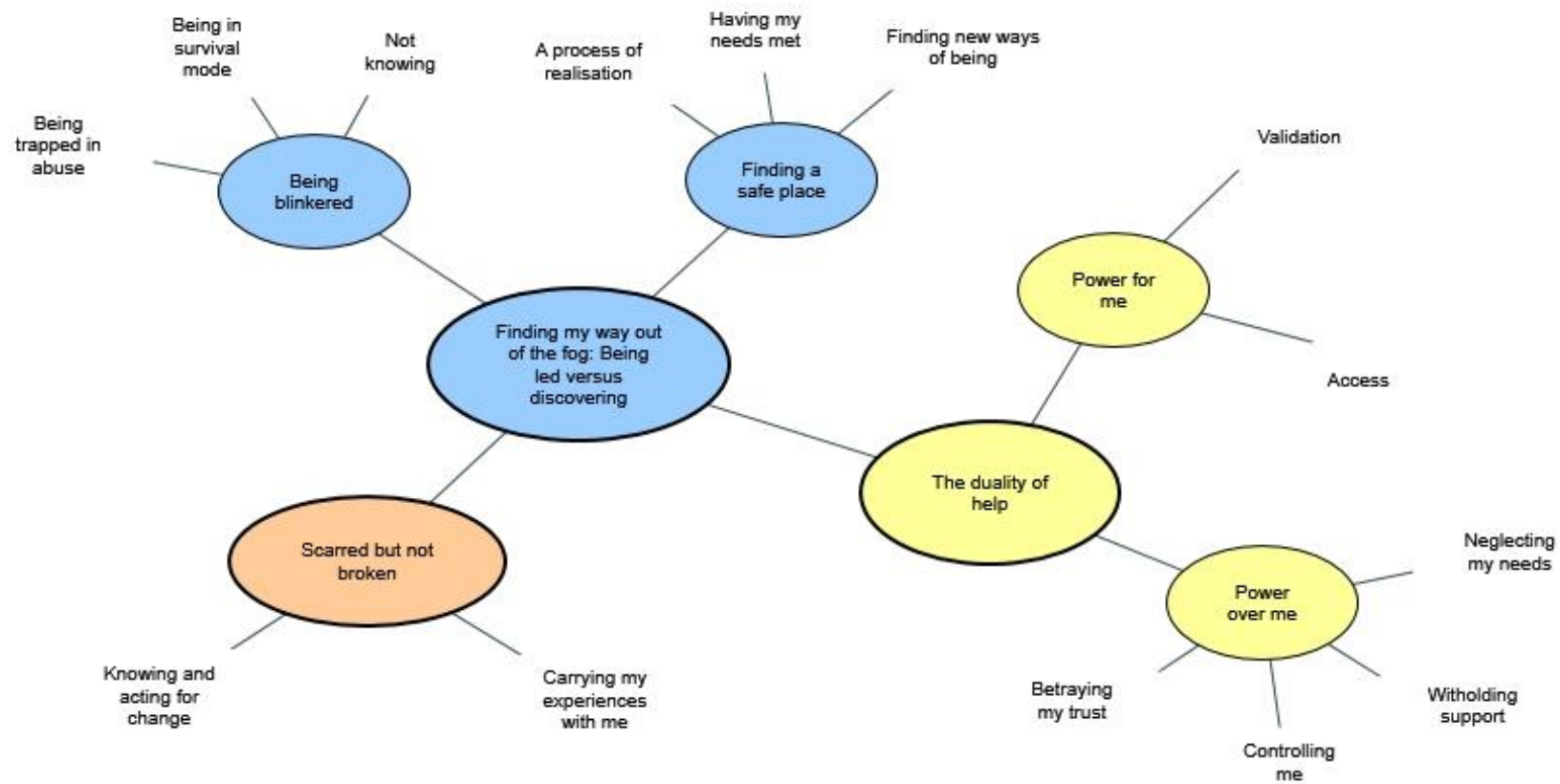


		<p>PARTICIPANT: -No, no, I actually had to raise it and of course coming here was great, because people went yeah, we know this, we see this all the time, yeah this is really, sad to say, but this is what we come across so often, so in a sense it was someone believed me, someone recognized it (P5)</p> <p>And then the therapist there was uh, she specialized in like, she could identify depending on how your sat, your body, what you might be experiencing. And she was the one who kind of pointed out that um...she said your body language shows that you're experiencing trauma and it's quite severe, so I kind of fed back that GP, and that's when he took it seriously and started observing, and he said ok, you have PTSD (P3)</p> <p>gave me no time to recover because I was constantly in crisis, that's how my life was in this constant crisis. And finally, um...my psychiatrist said, look, you're experiencing uh, lots of intense suicidal thoughts so you know have emotionally traits of personality disorder, with traits of emotional instability, so he gave me this, uh, another psychiatric injury, which I sustained at my workplace because of how I had been treated for a significantly long period of time (P3)</p>	<p>Self-assertion Validation/Naming abuse</p> <p>Requiring expertise Validation</p> <p>Constant crisis Diagnosis as validation</p> <p>Victimhood and vulnerability Protesting treatment</p>
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[illegible]



## APPENDIX R: INITIAL THEMATIC MAP



## APPENDIX S: FINAL THEMATIC MAP

