

**“Anything I do now feels like an act of resilience”: adversity, resilience, and wellbeing in female survivors of domestic abuse**

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***“Anything I do now feels like an act of resilience”:***

**Adversity, Resilience, and Wellbeing in female survivors  
of Domestic Abuse.**

**By**

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**A research portfolio submitted in part fulfilment of the requirements of the  
University of Wolverhampton for the award of Practitioner Doctorate in  
Counselling Psychology (D.Couns.Psych)**

## **Declaration**

The research dossier or any part thereof has not previously been presented in any form to the university or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). With the exception of any express acknowledgements, references, and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person, beyond the role expected of my research supervisors' Professor Maria Uther and Dr Abigail Taiwo.

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## **Acknowledgements and dedications**

I would like to thank the women who volunteered to participate in this research, without whom this would not have been possible. I am grateful for their willingness to give me insight into their experiences and admire each individual's bravery in overcoming such challenging adverse and traumatic experiences. To quote Fred Rogers: "Anything that is human is mentionable. Anything that is mentionable can be manageable". I hope that this work can do justice to your accounts and go some way towards helping others to better understand and support you in the future.

I have had the support of so many kind and knowledgeable people throughout my training journey and professional life. I have benefited from therapy and supervision with capable professionals from a range of backgrounds and feel privileged to have had the opportunity to grow and learn from each one of you. There are too many to count, let alone name, but I would like to give special thanks to my thesis supervisors, Professor Maria Uther and Dr Abigail Taiwo, for their unwavering support and positivity. You have guided me through an incredibly demanding and, at times, stressful experience with an enviable calmness.

Finally, I would like to thank my family and my partner for always believing in me and giving me the confidence to pursue my dreams. No power on earth can take away from the wonderful life experiences you have given me. This thesis is dedicated to you.

### **List of relevant publications**

Gould, L. W. (2021, July 16-17). *Investigation of the prevalence of Adverse Childhood Experiences (ACEs) within Domestic Abuse survivor populations, and the moderation effect of resilience on the relationship between ACEs and wellbeing*. [Poster presentation]. BPS Division of Counselling Psychology Annual Conference 2021, Virtual Event, UK. (See Appendix I).

Gould L. W., Uther, M., & Taiwo, A. (2022). The relationship between adversity, resilience, and wellbeing in female survivors of domestic abuse. *Journal of Family Violence* (submitted) (See Appendix J).

## Abstract

*Background:* The study sought to explore the under-researched areas of adversity, resilience, and wellbeing in female survivors of Domestic Abuse (DA). We employed a multi-phase mixed-methods research design comprising a cross-sectional online quantitative survey in phase one and qualitative remote interviews in phase two.

*Method:* In phase one, a convenience sample of 119 adult female participants, 63 who had experienced DA and 56 in a control group, completed the Adverse Childhood Experiences (ACE) Questionnaire, the Short Warwick-Edinburgh Mental Well-being Scale, the Depression, Anxiety, and Stress Scale, and the Connor-Davidson Resilience scale. In phase two, 8 of the participants from phase one who had experienced DA were recruited for semi-structured interviews to explore their experiences in depth and these were analysed using thematic analysis.

*Results:* In phase one, survivors of DA were found to have experienced significantly more ACEs and to have higher levels of anxiety and stress than the control group. Survivors of DA were more likely to have experienced emotional, physical, and sexual abuse and emotional neglect and be exposed to substance abuse or alcoholism and mental illness within their household in childhood than the control group. Resilience was found to moderate the relationship between ACEs and mental wellbeing, such that resilience is less protective against poor wellbeing in those with high ACEs. Resilience was also found to be a stronger predictor of mental wellbeing than ACEs.

In phase two, the thematic framework included five major themes: *Early life challenges and adversity, Coping strategies, Support and judgement, Resilience and development, and Psychological distress, health, and wellbeing.*

*Conclusion:* Results indicate that early life adversity is an additional concern for adult female survivors of DA. They also highlight the importance of resilience, coping, and support and indicate areas of psychological distress and need where services and helping professionals can support survivors.

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## **Chapter 1. Introduction**

This chapter outlines my own theoretical and epistemological stance as a reflexive-practitioner-researcher counselling psychologist in training. It contextualises the research project and highlights the impact which the Power Threat Meaning Framework (Johnstone & Boyle, 2018) has had on my clinical practice and choice of research topics.

### **1.1 Research background and setting the scene**

My development as a researcher and counselling psychologist has been profoundly influenced by the Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018). It has shaped my thinking in clinical practice, which in turn has informed my research interest in the topics of adverse childhood experiences and domestic abuse (DA). Co-constructing narrative formulations in clinical work with clients who have experienced a range of adversity and trauma in early life, including both survivors and perpetrators of DA, has percolated the research aims, questions, and hypotheses outlined later in Chapter 3. Each narrative that I have had the privilege of hearing from clients has increased the respect I have for the ways in which these individuals have survived adverse events and environments, although sadly for many not without significant long-term consequences on their wellbeing and relationships. I have also been struck by the sense of meaning which clients have regained through telling their stories, and the power of overcoming the all-too-common challenges of being dismissed, silenced, shamed, or blamed. These experiences, combined with my personal pragmatic humanistic ethos, have led me to the conclusion that narrative understandings of individuals' life journeys are essential to counselling psychologists' role in supporting clients achieve their goals of change, growth, and recovery from psychological distress. Barkham and Mellor-Clark (2003) note the importance of addressing research

questions generated through practice in a complementary “cycle between the rigours of evidence-based practice and the relevance of practice-based evidence” (p. 323) to create knowledge which is both rigorous and relevant to psychological therapy in practice. Thus, my experiences of working with survivors in practice has highlighted to me the importance of a mixed-methods approach, involving qualitative interviews in the research design, so that participants in the study can have the opportunity to have their voices heard and that their experiences can help to inform the research base for clinical practice in this area.

The PTMF has aimed to set out an alternative to psychiatric diagnosis and medicalised approaches to mental health by providing an over-arching structure for identifying recurrent patterns of emotional distress, unusual experiences, and troubled or troubling behaviour (Johnstone & Boyle, 2018). It has been heralded as a paradigm shift which signalled a move within the British Psychological Society towards adopting a contextualised approach to supporting clients, incorporating social, psychological, systemic, and biological factors which influence mental wellbeing.

This approach to mental health and wellbeing provides a non-pathologising understanding to make sense of psychological and emotional distress through general patterns and idiosyncratic formulations aimed at developing a holistic understanding of clients as individuals with a wealth of lived experience (Johnstone & Dallos, 2013). These formulations serve multiple functions in therapy, including validating individuals’ distress, providing relief from shame and guilt, creating meaningful explanations of their experience, facilitating hope and change, and suggesting a way forward towards recovery. Psychological and emotional distress and negative outcomes are viewed as “*a normal reaction to abnormal circumstances*” (Johnstone & Boyle, 2018; p. 18).

The PTMF assumes that individuals are purposeful, active, relational beings located within a complex matrix of human systems within which the operation of various types of power can both enable and limit the choices available to them. Social and cultural discourses drive assumptions around “normative” roles and behaviours, and as such there can be no universal categories of human distress, as individuals need to be considered within their context.

The PTMF thus recognises that the causal factors in psychological distress are often multiple, complex, and interrelated. This is described as the “‘everything’s problem’:

*Everything causes everything*: a whole range of adversities is implicated in almost every presentation of distress” (Johnstone & Boyle, 2018; p. 7). Adverse events and circumstances, especially those occurring early in life before an individual can develop functional coping resources, appear to increase the risk of developing mental health presentations and a range of problematic social outcomes. It advocates for a fundamentally different approach to understanding human distress and associated difficulties through general patterns, in which individual presentations and outcomes can be understood as responses to the social and relational adversities which they have faced and the meanings which the individual and those around them have ascribed to them.

It follows that individual formulations of distress therefore require a deeper and more detailed understanding of an individual’s agency and subjective experience, including the meaning through which both the individual’s own narrative and wider socio-cultural discourses combine to make sense of their experiences. The PTMF provides a template for creating these formulations and identifying patterns in experience, comprised of the operation of power within an individual’s life, the kinds of threats which the negative operation of power has posed for them, the central role of meaning in shaping experiences of power and

responses to threat, and the learned threat responses which the individual has drawn on to survive.

Various forms of power are considered, including embodied, coercive, legal, economic and material, social and cultural, interpersonal, and ideological power. When this power operates negatively in individuals' lives, they may experience a range of threats, including relational, emotional, social/community, economic/material, environmental, bodily, knowledge and meaning, and value base and beliefs. Individuals create personal meanings, influenced by social discourses and ideology, to understand these experiences. Together, the impact of power, experiencing of threats, and meaning-making process, along with exacerbating and/or ameliorating factors and mediating biological processes, lead individuals to develop threat responses to survive in challenging environments. Creating a wider contextual formulation can help individuals to understand the function of these threat responses and exploring this through therapy can create opportunities for change when these threat responses maintain individuals' distress and/or troubled and troubling behaviours, or when the individual's environment changes such that these responses are no longer necessary for survival.

The aim of this thesis project was to address the gaps in knowledge for survivors of domestic abuse, as well as to explore participants' life journeys and experiences of adversity and resilience to better understand what support these individuals might benefit from in future interventions.

## **Chapter 2. Literature Review**

This chapter presents a review of the existing literature relating to domestic abuse, adverse childhood experiences, and resilience, to start to build a holistic understanding of the complex impact which these intersecting experiences have on survivors' wellbeing, informed by a PTMF approach.

The literature review begins by defining and exploring the broad topics of domestic abuse and adverse childhood experiences and their sequelae in terms of physical and mental wellbeing. Revictimization and traumatic re-enactment are then considered as a potential predisposing factor by which survivors of domestic abuse, and indeed perpetrators, might develop and acquire threat responses to survive in adverse conditions, and how these responses may leave them vulnerable to repeating the relational patterns which maintain psychological distress in themselves and/or others in the present. The area of trauma and resilience, including post-traumatic growth, in survivors of DA are explored including the impact of resilience on current wellbeing. Finally, the current knowledge derived from qualitative studies exploring survivors of DA's experiences is considered and present gaps identified.

### **2.1 Domestic Abuse and the impact on survivors**

#### *2.1.1 Defining Domestic Abuse*

Domestic abuse is a collective term which covers a broad continuum of internationally recognised harmful criminal behaviours, and as such includes related terms such as intimate partner violence, domestic violence, and gender-based violence perpetrated by a family member or partner. In the UK, the term domestic violence and abuse is more common and widely used than intimate partner violence or gender-based violence (Heywood,

Sammut, & Bradbury-Jones, 2019). Heywood et al (2019) also found that individuals who experienced domestic abuse preferred not to be labelled as ‘victims’, and instead generally identified with the term ‘survivor’ as an appropriate title with more positive connotations.

Domestic abuse is defined by the United Nations (2021) as:

“a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone. Domestic abuse can happen to anyone of any race, age, sexual orientation, religion, or gender. It can occur within a range of relationships including couples who are married, living together or dating. Domestic violence affects people of all socioeconomic backgrounds and education levels.”

Domestic abuse is a serious public health issue and one of the most widespread human rights abuses in the world today (Heywood et al, 2019). Although it is widely recognised as a common problem (Women’s Aid, 2020a), it is difficult to quantify its true prevalence and impact. It has been described as a “hidden epidemic”, often overlooked within mental health settings, due to social stigma and other barriers to disclosure (García-Moreno et al, 2014; Hegarty, 2011). The World Health Organisation (WHO, 2021) estimate that 30% of all women have experienced physical and/or sexual violence, with 26% of ever-partnered women experiencing physical and/or sexual violence from a current or former partner within their lifetime and 10% experiencing physical and/or sexual violence within the past year. It also carries a significant economic burden for individuals and governments. The lifetime cost of intimate partner violence within the United States has been estimated at \$103,767 per female victim (Peterson et al, 2018).

Within the United Kingdom, Domestic abuse was recently defined by the Domestic Abuse Act (2021), which provides a statutory definition of domestic abuse as abusive behaviour between two “personally connected” persons over the age of 16 consisting of any of the following: physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse, or psychological, emotional, or other abuse within either a single incident or as a course of conduct.

Police in England and Wales receive over 100 calls relating to domestic abuse every hour on average, with domestic abuse related crime comprising 10% of total recorded crime, 13% of all recorded sexual offences, 33% of all recorded assault with injury crimes, and 51% of all recorded harassment crimes (Her Majesty’s Inspectorate of Constabulary, 2015). Two women are murdered in England and Wales each week by their intimate partner (Women’s Aid, 2020b). The most recent government figures for England and Wales estimate that 2.3 million adults (5.5% of the total adult population) experienced domestic abuse within the 12-month period ending in March 2020 (Office for National Statistics, 2020). More than two-thirds of those who experienced domestic abuse in this period (1.6 million) were estimated to be women. The annual cost of domestic violence in England and Wales has been estimated at around £23 billion (Walby, 2004). The Crime Survey for England and Wales (Flatley, 2016) found that 27.1% of women reported experiencing domestic abuse from a partner at some point in their life, twice as likely as men. Women were also found to be 5 times more likely to be sexually assaulted by a partner than men (19% vs 3.8%), and over 4 times more likely to experience threats from a partner than men (14.1% vs 3.2%).

These figures are expected to increase within the next reporting period due to the impact of the global COVID-19 pandemic and subsequent national lockdowns and social distancing policies (Marques et al, 2020). Increases in demand for domestic abuse services have been reported due to the impact of the first national lockdown in England, with a 65%

increase in calls logged by the National Domestic Abuse Helpline between quarter 4 of 2019 and quarter 1 of 2020 (Office for National Statistics, 2020). Increases in domestic abuse cases and the intensity of domestic abuse experienced have been reported globally, potentially exacerbated by increased social and financial stress, with mothers and children being identified as particularly vulnerable during this period (Bradbury-Jones & Isham, 2020; Ivandić, Kirchmaier, & Linton, 2020; Piquero et al, 2021).

To address the issue of domestic abuse in the United Kingdom, Her Majesty's Government has published several strategy documents, including *Ending Violence against Women and Girls Strategy 2016-2020* (Home Office, 2016), and most recently *Tackling Violence against Women and Girls* (Home Office, 2021). These documents set out the Government's intention to take action against domestic abuse and recognise that these crimes are still too prevalent, disproportionately affect women and girls, and often result in survivors being let down by services. Despite the title of both strategies specifically referring to women and girls, male survivors of domestic abuse are also recognised within these documents and within a recent policy paper (Home Office, 2019), which acknowledges and pledges support to the increasing numbers of male victims who report domestic abuse crimes. The Domestic Abuse Act (2021) also introduced Domestic Abuse Protection Notices and Domestic Abuse Protection Orders with the aim of supporting survivors by requiring perpetrators of abuse to take steps to change their behaviour and preventing them from contacting their victims.

In order to provide brevity and clarity for participants, our study adopted Women's Aid's (2020) definition of domestic abuse:

We define domestic abuse as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of

cases by a partner or ex-partner. It is very common. In the vast majority of cases, it is experienced by women and is perpetrated by men.

This definition specifically recognises the fact that, in many cases, domestic abuse is a gendered crime perpetrated by men against women. Domestic abuse statistics become more asymmetrical in terms of distribution, repetition, and seriousness of offences, such that women are more likely to be a victim of domestic abuse, experience repeat victimisation, and be seriously hurt than men (Walby & Towers, 2017; Walby & Towers, 2018). Women are also six times more likely to be killed by an intimate partner than men, often following a long history of abuse (Stöckl et al, 2013). The recent #MeToo movement highlighted the prevalence of male violence against women, and the role which men can play as allies to challenge the patriarchy and help produce change (Flood, 2019). The use of Women Aid's definition within the study was thus chosen to limit the impact of social stigma and support disclosures of domestic abuse within the intended sample of adult heterosexual females and aligns with the definitions used by local support agencies through which participants might be recruited.

Of course, domestic abuse can occur within any relationship, regardless of the gender, ethnicity, sexual orientation, or age of the individuals involved. It is therefore important to recognise that domestic abuse perpetrated by women against men and bidirectional abuse are also significant issues within heterosexual relationships, which may be underreported or go unrecognised by professionals (Barber, 2008; Bates et al, 2019; Rooney, 2016). Although domestic abuse has been less frequently studied within the LGBTQ+ community compared with heterosexual populations, previous research suggests that it is a significant issue which may be compounded by minority stressors (Longobardi & Badenes-Ribera, 2017; Rollè et al, 2018). Individuals from Black and Minority Ethnic communities experience higher levels of severe abuse, and often face greater barriers to receiving support due to intersectional

discrimination (Siddiqui, 2018). Other factors, such as socio-economic status and disability, can heighten an individual's vulnerability to experiencing DA and can also lead to barriers in seeking support. Understanding the issue of domestic abuse through a simplistic gendered lens can lead to a lack of awareness that men can also be victims of domestic violence (Rooney, 2016; Wright, 2016), and might prevent help-seeking in male survivors due to concerns that they will be labelled a perpetrator (Bates, 2019; Huntley et al, 2020).

Guthrie & Kunkel (2015) have argued against stereotypical "formula stories" of abuse as presenting one-dimensional figures of 'morally exemplar virtuous', exclusively female victims and 'vicious villain' male perpetrators. This reductive discourse rarely corresponds with survivors of DA's lived experiences and might potentially leave them questioning themselves if their experiences do not fit neatly within the pervasive social narrative. Questions around whether a person might be considered by others to be a "legitimate" candidate for support with DA may be particularly relevant for individuals who have experienced intersectional difficulties alongside DA, such as poverty, substance use, and low self-esteem (Mackenzie et al, 2019). Sweet (2018; 2019) argues that institutions create constraints which pressure survivors to conform to medicalised narratives to be considered eligible for support. These authors therefore advocate for a broader and more inclusive public discourse around DA to expand our understanding and ultimately empower those who are currently excluded and disadvantaged by the "formula story" of abuse.

### *2.1.2 The impact of Domestic Abuse on survivors*

Survivors of domestic abuse report a broad range of difficulties following their experiences, including immediate effects such as physical injury, and longer term sequelae including mental health and emotional problems (such as PTSD, depression, somatisation,

dissociative disorders, and suicidality), substance use problems, central sensitivity syndromes (such as chronic pain, chronic headaches, and irritable bowel syndrome), chronic physical health problems (such as cardiovascular disease and type 2 diabetes), and increased all-cause mortality (Brandt & Rudden, 2020; Chandan et al, 2020; Chandan et al, 2021; Flatley, 2016; Harris & Hodges, 2019; Trevillion, Oram, Feder, & Howard, 2012). Mental health service user surveys have also shown that patients with severe mental illness are at substantially increased risk of domestic abuse (Khalifeh et al, 2015). Specific abusive behaviours, such as gaslighting, in which abusers minimise, deny, or provide distorted accounts of situations, may also lead survivors to experience lower self-worth or doubt their perception and feel uncertain about their own sense of reality (Brandt & Rudden, 2020).

These resultant difficulties are often complex and intersectional, stemming from multiple aspects of severe disadvantage (Harris & Hodges, 2019). Domestic abuse can also create and maintain cyclical intergenerational effects, as domestic abuse and perinatal mental health in pregnant women are associated with adverse short- and long-term outcomes for both the mother and foetus (Moncrieff, 2018).

There is a growing body of evidence that, in some cases, experiences of domestic abuse may also lead to offending behaviours perpetrated by survivors: more than two thirds of female offenders (67%) reported experiencing domestic abuse and over a third were considered to have a problem with their current partner (Prison Reform Trust, 2017). It is estimated that between 57% and 79% of women in prison have experienced domestic abuse as adults (Ministry of Justice, 2014; Prison Reform Trust, 2017). The Centre for Women's Justice's (2021) report outlines the evidence of a four-year study exploring cases in which female survivors of domestic abuse have been convicted and received a prison sentence for killing their abuser. Their findings indicate that many of these women (82.6%) had also experienced historic abuse from family members in childhood or male partners other than the

man they killed. These figures suggest that it is important to consider offending as a potential outcome of domestic abuse experiences, and that early and repeated experiences may lead to more severe offending behaviours (Centre for Women's Justice, 2021).

## **2.2 Adverse Childhood Experiences (ACEs) and their impact on survivors**

Since the coining of the term “adverse childhood experiences” in the pioneering work of Felitti et al (1998), there has been growing interest and research within healthcare and associated helping professions on the lasting and enduring impact which formative experiences in early childhood have on individuals. The concept of ACEs encapsulates a wide range of stressful and potentially traumatic experiences and circumstances prior to the age of 18, typically including experiences of abuse, neglect, and household dysfunction in the form of negative aspects of the child's living environment. These categories are further broken down into experiences of sexual, physical, and emotional abuse; physical and emotional neglect; parental separation or divorce, exposure to domestic violence within the household, exposure to mental illness within the household, exposure to criminal behaviour within the household, and exposure to substance or alcohol abuse within the household. There is therefore some overlap between the terms ACEs and domestic abuse. However, ACEs specifically refer to experiences in childhood under the age of 18, whereas domestic abuse can affect individuals at any age.

Early studies focused on the presence of ACEs or the cumulative count of distinct subcategories experienced by an individual. However, more recently studies have also used groupings of ACEs, such as abuse, neglect, and household dysfunction in order to account for the potentially distinct differences in outcomes between these experiences (e.g., Font &

Maguire-Jack, 2016; Mosley-Johnson et al, 2019). However, the evidence for significantly different outcomes based on these groupings remains in the early stages.

As part of the global response examining this issue, the World Health Organisation commissioned a summary report which outlined the impact of early childhood experiences on many outcomes for individuals in later life, including mental health problems, obesity, stunting, heart disease, criminality, and competence in literacy and numeracy (Irwin, Siddiqi, & Hertzman, 2007). Their report highlights the value of investment in early life development intervention programmes as both cost-effective and reaping economic gains in multiples of economic scale.

Studies and systematic reviews in the area have since sought to summarise the complex sequelae of ACEs, including their impact on individuals' wellbeing, behaviours, functioning, and subsequent chronic mental and physical health problems in later life (Hughes et al, 2016; Hughes et al, 2017; Kalmakis & Chandler, 2014; Liming & Grube, 2018). Specific outcomes related to ACEs covered by the studies within these systematic reviews included: low life satisfaction, suicidal ideation, suicidality and attempted suicide, emotional reactivity, attention issues, language, literacy, and numeracy problems, behavioural problems, social delays, homelessness, psychopathology, schizophrenia and hallucination, mood and anxiety disorders (including depression and anxiety), Post-Traumatic Stress Disorder (PTSD), personality disorders, obesity, diabetes, cardiovascular disease, respiratory disease, increased risk of cancer, substance and alcohol abuse, binge drinking and problematic alcohol use, smoking, increased use of prescription medication, early sexual initiation, sexually transmitted infections, sexually risky behaviour, teenage pregnancy, risky behaviours during pregnancy (e.g., drinking, smoking, illicit drug use), violence perpetration, violence victimisation, and experiencing intimate partner violence.

Data from large-scale longitudinal studies in the United States of America suggests that ACEs are significantly associated with lower levels of life satisfaction and psychological and social wellbeing, suggesting that a lack of social integration in ACE survivors may be a key area for future intervention (Mosely-Johnson et al, 2019). However, Font & Maguire-Jack's (2016) findings suggest that adult socioeconomic status (SES) conditions may present a mechanism by which ACEs influence outcomes in later life. The study also found distinctions between different ACE categories, such that sexual, physical, and emotional abuse exhibited a direct association with outcomes whereas parental separation/divorce, incarcerated household member, and exposure to domestic violence were indirectly associated with outcomes through adult SES conditions. Household mental illness and household substance or alcohol abuse were not found to have significant associations with outcomes. The authors conclude that a combined approach is required to address the outcomes of ACEs, including both efforts to increase SES and a direct, targeted approach to addressing the traumatic impact of abuse through counselling and psychotherapy. Other researchers, such as Crandall et al (2019) have focused on how advantageous childhood experiences ('counter-ACEs'), such as perceived internal and external safety, positive quality of life, and relational support, can protect against or neutralise the negative outcomes in later life. Finkelhor (2018) also argued that there is a need for programmes which avert the occurrence of ACEs, such as through parent education or victimization prevention, following a preventative approach to child maltreatment.

There is a lack of consensus within the field around the prevalence of ACEs, with international studies placing the prevalence rate of experiencing one or more ACEs between 41% and 97% (Carlson et al, 2020). Within England, large-scale retrospective studies with adults place the prevalence rate at 47%, closer to the lower end of the estimated international range (Bellis et al, 2014; Hughes et al, 2016). However, this still indicates that around half of

the population experience at least one ACE in early life. The prevalence rates of children's exposure to domestic abuse have been estimated at two in five, or between three and four million children within the UK (Molina & Levell, 2020).

It is also important to note that ACEs, although historically considered individually, are frequently co-occurring and often involve interrelated forms of abuse, neglect, and household dysfunction (Dong et al, 2004). The presence of a single ACE thus significantly increases the odds of having additional ACEs (Dong et al, 2004), and the range, frequency, and chronicity of these experiences have a cumulative dose-response effect on individual outcomes in later life, with those who experience poly-victimisation and multiple adversities reporting the most significant outcomes (Liming & Grube, 2018; Merrick et al, 2017).

Potential explanatory mechanisms for the impact of ACEs on outcomes in later life include attachment deficits and the neurological changes associated with early life experience of adversity (Gerhardt, 2015). These changes can include the development of a hyper-responsive amygdala, inadequate down-regulation functioning in the ventromedial prefrontal cortex, an overactive salience network, and impaired hippocampal activity, which in turn lead to chronic hyperarousal, emotional numbing, change-resistant fear responses, risky or self-injurious behaviours, and difficulties in memory recall and emotion regulation (Weems et al, 2021). However, Weems et al (2021) also suggest that resilience through social support and intervention can play a significant buffering role in how these neurological changes develop and their outcomes in later life, proposing a two-pinnacle model of potential neurodevelopmental paths associated with ACEs which acknowledges the importance of historical, pre-existing, and contextual factors. Therefore, it is not a foregone conclusion that ACEs will lead to negative outcomes and there is an increasing focus on public sector strategies within the UK which both prevent and mitigate the impact of ACEs by promoting protective factors and increasing resilience (Ford et al, 2017).

### **2.3 Revictimization and traumatic re-enactment: the intergenerational cycle of abuse**

As noted in the previous section, one potential outcome of ACEs in adulthood is experiencing domestic abuse from a partner, and ACEs themselves include experiencing and witnessing abuse in childhood. This intergenerational cycle of abuse has been found in several large-scale studies (Black, Sussman, & Unger, 2010; Coid et al, 2001; Hughes et al, 2017). Multiple abusive experiences in childhood have been found to increase the risks of experiencing abuse and trauma in adulthood, with the odds of experiencing interpersonal abuse being seven times greater for those reporting 4 or more ACEs than those who reported no ACEs (Hughes et al, 2017). Revictimization has also been found to have an additive effect on mental health and symptoms of PTSD for survivors of DA (Krause, Kaltman, Goodman, & Dutton, 2008).

To attempt to understand this complex relationship between ACEs and revictimization (whereby being abused increases the risk for future experiences of abuse), use of violence, and other self-destructive behaviours in later life, research has proposed the idea of traumatic re-enactment (Gaensbauer, 2011; Muehlenhard et al, 1998; Penning & Collings, 2014; Treves-Kagan et al, 2019). Van der Kolk (1989) described the unconscious, seemingly compulsive process of behavioural re-enactment through which individuals who experience trauma in childhood may expose themselves to situations resembling their original trauma, even when they lack conscious memory of these events, as is the case in preverbal trauma. Herman (2015) suggested that the adaptations and survival strategies employed by survivors of childhood abuse often leave them poorly adapted to adult life and at higher risk of repetition of their experiences. She also hypothesised that this re-enactment process may be driven by survivors' "wish to relive the dangerous situation and make it come out right" (Herman, 2015, p. 111). It has been suggested by Bloom (1996) that the function of these

repetitive behavioural re-enactments was to split-off painful experiences and avoid anxiety using defence mechanisms labelled “projection” and “projective identification”. In this way, survivors may replay familiar patterns based on their developmental experiences which form the foundations of their sense of reality. However, it is important to make a distinction between traumatic re-enactment and the early psychoanalytic concept of “female masochism” (e.g., Cooper, 1988; Freud, 1924), which suggested that female survivors might tolerate abuse due to deriving an unconscious benefit. Those psychoanalytic concepts attribute causality in these repetitive patterns of behaviour to survivors’ unconscious motivations and have rightfully been criticised as sexist for blaming the survivors of abuse by attributing to them “a wish/desire on her part to be passively submissive” (Brandt & Rudden, 2020). Current research into traumatic re-enactment makes no attribution of fault, blame, or responsibility on the survivor’s part, and is instead focused on understanding the vulnerability of survivors of diverse experiences of childhood trauma to domestic abuse through a range of complex mechanisms, including attachment, post-traumatic stress, and biological factors, such as disruption to the autonomic nervous system (Gerhardt, 2015). This process of traumatic re-enactment is also echoed by Intergenerational Transmission Theory (Sellers, Cochrane, & Branch, 2005) based on Social Learning Theory (Bandura, 1977), which suggests that children learn violence and abuse within relationships as an acceptable way of managing conflicts as modelled by their caregivers and go on to imitate these behaviours in their own relationships in adulthood. Van der Kolk eloquently summarises this idea: “Trauma breeds further trauma; hurt people hurt other people” (2015, p. 348).

The process of traumatic re-enactment may be related to an attachment response, which can lead to the development of strong emotional bonds between trauma survivors and those who have abused them, especially when this abuse occurs in the context of caregiver relationships in which there are few alternative attachment figures available (Gerhardt, 2015;

Van der Kolk, 2015). These attachment experiences or deficits create templates for relational patterns in later life (Bowlby, 1988), and may be a mechanism by which survivors of trauma come to hold a greater tolerance for intermittent care and abuse than individuals who have had more consistent experiences of care in childhood. However, this mechanism of attachment and “trauma bonding” has been criticised for providing a descriptive, rather than explanatory, account of the process of traumatic re-enactment (Brandt & Rudden, 2020). Instead, survivors of childhood trauma might become highly attuned to variations in their abuser’s presentation and mental state in order to pre-emptively appease them and thereby mollify or prevent attack (Frankel, 2004).

Symptoms of PTSD might represent another mechanism in the relationship between ACEs and revictimization, including hyperarousal, hypervigilance, detachment, and dissociation, as these may impair survivors of sexual abuse’s ability to accurately detect and respond to risks and warning signs (Risser et al, 2006). Herman (2015) conceptualises domestic violence as a hostage situation in which survivors often experience symptoms of complex PTSD which can be incapacitating, or which limit their ability to escape from the situation. Herman notes that disconnection from others and disempowerment are key features of psychological trauma which maintain distress and prevent recovery, and thus presents a model for the treatment of trauma based on reconnection and empowerment.

Traumatic experiences, especially in childhood during key developmental stages, can initiate psychological and biological pathways of disconnection as an attempt to cope with overwhelming emotions (Gerhardt, 2015; Schimmenti & Caretti, 2016). This disconnection from experiencing overwhelming emotions can lead to the development of a disconnected self through inconsistent self-representations, which in turn disrupts other relationships and limits the availability of emotional co-regulation through social support (Schimmenti & Caretti, 2016). Gaensbauer (2011) describes the role which mirror neurons might play in

supporting imitation and emotional resonance with ACEs, through which traumatic experiences can become deeply embedded in bodily responses.

Polyvagal theory (Porges, 1995; Porges 2009), which posits the existence of three subsystems in the autonomic nervous system, organised around social engagement, mobilization, and immobilization, provides a complementary potential biological explanation for how ACEs might affect outcomes later in life. Individuals who experience trauma develop disruptions to the way in which these systems function in the form of difficulties activating the social engagement system, ultimately leading to hyper- or hypo-arousal states (Levine, 2018; Porges, 2009). Respiratory sinus arrhythmia (RSA) provides an estimated measure of how adaptively the parasympathetic nervous system responds to internal and external cues. RSA thus provides a biological index of stress resilience, and this has been found to be lower in individuals with a diagnosis of PTSD (Campbell et al, 2019; Morris et al, 2016).

As a general trend, research tends to suggest a potential gender difference in traumatic re-enactment in adulthood, perhaps due to differences in gender socialisation (Van der Kolk, 1989; Penning & Collings, 2014; Treves-Kagan et al, 2019). Males tend to identify with their abusers and perpetrate violence against others (Godbout et al, 2019; Lahav et al, 2019; Mallie et al, 2011; Penning & Collings, 2014; Rasmussen, 2013), whereas women tend to experience further abuse and victimization in adulthood (Irwin, 1999; Kuijpers, van der Knaap, & Winkel, 2012; Lahav, Ginzburg, & Spiegel, 2020; Noll et al, 2003; Penning & Collings, 2014; Pittenger, Pogue, & Hansen, 2018; Roodman & Clum, 2001; Tapia, 2014). However, this may reflect societal biases, as studies have also demonstrated that this distinction is not clear, with male survivors of early life challenges and trauma also at risk of higher rates of revictimization (Widom, Czaja, & Dutton, 2008; Muehlenhard et al, 1998). This might be due to an underreporting of male survivors' experiences of abuse or female survivors' abusive behaviours, or some combination of the two. Research also suggests that the relationship

between early life trauma and perpetration and experiencing of intimate partner violence is mediated by affect dysregulation, maladaptive personality traits, and negative urgency (Dugal et al, 2018), suggesting that some of these outcomes may result from enduring responses to early threats.

These theories around revictimization and traumatic re-enactment provide some evidence for the mechanisms by which the intergenerational cycle of abuse is perpetuated and encourage action and intervention at the earliest possible stage to help “ensure that those ‘seeds of violence’ do not fall on fertile ground” (Vera Baird, in Molina & Levell, 2020). Further understanding of these mechanisms can generate insight into interventions and utilise some of the positive resources available to individuals, as presented in the next section.

## **2.4 Trauma and resilience**

Herman (2015; p.33) defines trauma as “an affliction of the powerless” and traumatic events as those which “involve threats to life or bodily integrity, or a close personal encounter with violence and death” and thus suggests that they “overwhelm the ordinary human adaptations to life”. Given the range of challenges in early life and adulthood which individuals might face, including a wide range of adverse conditions and potentially traumatic experiences, it seems natural and self-evident that those individuals would make adaptations and draw on a range of survival or coping strategies to respond to these threats. As the previous sections have highlighted, these strategies can often come at a cost to individuals’ physical and mental health and wellbeing and can also have a profound impact on their sense of self and their relationships with others. However, it is also clear that these challenges do not affect everyone in the same way. A broad range of heterogenous, idiosyncratic responses to adversity have been observed and there has been an increasing recognition within the literature that some individuals appear to be unaffected by, or may even thrive within, challenging environments and circumstances. This ability to resist being adversely affected by, or to readily overcome and “bounce back” from, challenges has been termed resilience.

Although the term resilience has been criticised as vague due to the range of definitions and meanings used in the field, it can be operationalised as positive adaptation in individuals who have been exposed to significant adversity (Masten, 2014; Yule, Houston, & Grych, 2019). More specifically, psychological resilience has been defined by different authors as “the phenomenon that many people are able to adapt to the challenges of life and maintain mental health despite exposure to adversity” (Chmitorz et al, 2018; p.78) and “the personal qualities that enables one to thrive in the face of adversity” (Connor & Davidson, 2003; p. 76).

There remain some splits within the field of resilience between viewing resilience as a trait which individuals might possess or a process demonstrated through adaptive behaviours and the accessing of resources (Harms et al, 2018). Both areas of study recognise resilience as trainable and of value within interventions for individuals at risk of experiencing, or who have already experienced, adversity (Chmitorz et al, 2018). The so-called third and fourth waves of resilience research sought to put into practice the findings of earlier observational research into the individual and environmental factors which facilitated positive adaptation and outcomes following exposure to adversity (Hart et al, 2016). More recent research has also used Bronfenbrenner's (1977) ecological systems theory to consider the dynamic, multileveled nature of resilience and the impact of both proximal and higher-level factors on individuals' ability to adapt (Hart et al, 2016). With regards to the later, resilience may be seen as "a process to harness resources to sustain well-being" (Southwick et al, 2014; p.4), resulting from complex interactions within social systems, including familial relationships and cultural perspectives on meaning-making. Specifically, this resilience process includes experiencing healthy attachment relationships, being taught emotion regulation skills through caregiving, and having a cultural influence which promotes self-awareness and hope (Southwick et al, 2014).

Studies examining resilience for survivors of child sexual abuse have found a range of protective factors which contribute to resilience, including education, interpersonal and emotional competence, control beliefs, active coping, optimism, social attachment, external attribution of blame, and support from their family and wider social environment (Domhardt, Münzer, Fegert, & Goldbeck, 2015).

Although a large portion of the existing literature on resilience focuses on specific populations, such as young people, Richardson (2002) presents a metatheory for resilience in which resilience is modelled as a process which involves a state of biopsychospiritual

homeostasis (a “comfort zone”) which stressors can disrupt if the individual does not have sufficient resources to protect against them. Resilience can thus occur following disruption if the individual is able to adjust through a process of reintegration. Richardson’s model describes four possible outcomes to the process of reintegration following disruption from stressors: *dysfunctional reintegration*, where individuals might resort to destructive coping behaviours to reintroduce homeostasis; *reintegration with loss*, where individuals return to a new, less adaptive, level of homeostasis following disruption through the loss of motivation, hope, or drive; *homeostatic reintegration*, where individuals are able to return to homeostasis and “just get past” the disruptive stressor; and *resilience reintegration*, where individuals may acquire additional protective factors through insight or growth following disruption, thus returning to a more adaptive level of homeostasis. The model aligns with a Person-Centred philosophy by assuming that each individual has an internal drive to seek self-actualization and the capacity for self-directed growth (Richardson, 2002).

Critics of this model have suggested that it fails to adequately describe the impact of multiple, simultaneous, or ongoing experiences of disruption from stressors, and does not account for individual processes of emotional response and meaning making within the reintegration process (Fletcher & Sarkar, 2013). It also does not capture the roles which social capital and prevailing discourses can play in the reintegration process. Studies suggest that both personal resilience resources and social support play significant roles in mitigating distress in survivors of DA (Jose & Novaco, 2016). Previous research with trauma survivors has recognised specific factors associated with resilience, including optimism, cognitive flexibility, active coping skills, maintaining a supportive social network, looking after their physical well-being, and embracing their personal moral compass (Iacoviello and Charney, 2014). Large scale studies of survivors of intimate partner violence have also emphasised the importance of cohesive community environments, formal support services, and relationships,

including positive reactions to disclosure, for resilient reintegration for survivors, while also highlighting that heavy alcohol use and experiencing negative reactions to disclosure reduce their resilience (Machisa, Christofides, & Jewkes, 2018).

Other research with survivors of DA has highlighted that resilient women tend to be younger, involved in shorter relationships, and more able to end relationships, and that they are characterised by experiencing fewer psychological difficulties and lower levels of ACEs than their less resilient peers (Herrero et al, 2018). Survivors of DA have also been found to have lower levels of resilience than the general population, and this effect was found to be more pronounced for individuals who also experienced violence from their father (Tsirigotis & Łuczak, 2018). However, a positive association has also been found between resilience and lifetime traumatic exposure, although this effect is mitigated amongst those with a high history of adversity (Scali et al, 2012), suggesting that individuals' innate resilience may be overwhelmed by repeated exposure to trauma without external support. Other studies have highlighted the role of confidence, strength, determination, and self-reflection in resilience for survivors of DA (Humphreys, 2003). However, it is also important to note in terms of survivors' resilience that healing from abuse is not a linear or prescriptive process, and that survivors' journeys can take many forms, with overcoming abuse being a much longer-term process (Heywood et al, 2019).

## **2.5 Qualitative research with survivors of Domestic Abuse**

Previous studies have sought to use qualitative research methods to develop a deeper and richer understanding of the experiences of survivors of DA, with a range of different focuses. Hague & Mullender (2006) sought to explore the involvement of survivors of DA in making decisions about services and policies, and found that survivors often felt overwhelmed, silenced, and subjected to discrimination by services and agencies. Previous qualitative studies exploring the experiences of survivors of DA have also highlighted the barriers which they face in accessing services (Childress, 2013; Harris & Hodges, 2019), the impact of negative responses to disclosure (Mackenzie et al, 2019), or professionals missing the signs of abuse (Evans & Feder, 2014).

Other significant themes to emerge from interviews with survivors and their families included a diminished sense of identity (Childress, 2013; Draucker et al, 2009; Heywood, Sammut, & Bradbury-Jones, 2019; Sinko, James, & Hughesdon, 2021), the importance of social support (Childress, 2013; Donovan et al, 2020; Draucker et al, 2009; Evans & Feder, 2014; Gregory & Williamson, 2021; Heywood et al, 2019), issues with addiction and alcohol use (Childress, 2013; Gadd et al, 2019), normalisation of DA experiences (Childress, 2013; Evans & Feder, 2014; Mackenzie et al, 2019), and engagement with professional services and peer support groups (Childress, 2013; Donovan et al, 2020; Evans & Feder, 2014). Rose's (2014) study with survivors of DA and their families found the radiating effect of experiences of DA on those connected to survivors. They also found that family members often attribute blame for the situation to the survivor, which leads to feelings of anger and effectively 'others' survivors and might cause them to reject support.

Richardson, Kloess, Patel, & Farr's (2021) interviews with young people who had experienced DA from parents highlighted the role of attachment and social learning theories

in understanding the intergenerational cycle of abuse. They also noted that survivors learned about relationships through their own individual experiences and witnessing others' relationships, leading them to make sense of relationships in terms of 'good' and 'bad', characterised by feelings of love and joy and unhappiness and anger respectively. Significantly, they explored how survivors' experiences of being mistreated can inform their view of themselves and their relationships, leading them to make sense of their experiences through negative thoughts about themselves. This theme has also been echoed in studies with adult survivors of DA who shared their experiences of denial and self-blame (Evans & Feder, 2014; Mackenzie et al, 2019).

In addition to highlighting issues around improving survivors' sense of identity, accessing informal social support, and engagement with professional support services, previous research has also focused on the importance of resilience for survivors' healing and recovery (Childress, 2013; Heywood et al, 2019; Sinko et al, 2021). Childress (2013) emphasised the need for further research into the positive adaptive functioning which enables survivors of DA to move on and build successful lives. This fits with the focus within the PTMF (Johnstone & Boyle, 2018) on supporting individuals to change and grow from their experiences of power and threat through the development of a holistic formulation to validate their distress, provide relief from feelings of shame and guilt, and highlight the intra- and interpersonal coping resources available to them.

Thus, research which takes a holistic approach to understanding survivors of DA's life journey is rare, especially qualitative or mixed-methods studies incorporating all three areas of interest for the present study: ACEs, resilience, and wellbeing. This was therefore identified as a gap in the current research.

## **Chapter 3. Study aims, hypotheses, and approach**

### **3.1 Overarching study aims**

The overarching aim of the study was to expand on existing knowledge in the areas of ACEs, resilience, and wellbeing for female survivors of DA, as outlined in the previous chapter. The associated research question was: “What role do ACEs and resilience play in survivors of DA’s life journeys and later wellbeing?” This research question evolved out of a perceived gap in the current literature and observations in clinical practice. It is thus hoped that the findings of the study can contribute to future practice by bridging this gap and providing valuable insights for professionals working in this area.

#### **3.1.1 Rationale for mixed methods approach**

Given the research question, a methodological pluralism through a mixed methods approach involving both quantitative and qualitative phases was adopted to explore this topic in a manner consistent with the Humanistic values which lie at the core of counselling psychology (Cooper, 2009; Haverkamp, Morrow, & Ponterotto, 2005). One benefit of the mixed methods approach is the ability to go beyond statistical inference and understand phenomena from participants’ perspective and thus gain a deeper understanding (Bartholomew & Lockard, 2018). This is the most appropriate approach to generate and analyse the broad spectrum of data required to address the research questions, as it provides a more complete picture of the area of study than a single method can provide (Mertens, 2012).

A mixed methods approach allows for triangulation or confirmation of data, using multiple, complementary methodological approaches to explore the central research aim and thus uncover unique insight which might not be apparent from a single approach (Hanson et al, 2005; Small, 2011). This also mirrors counselling psychology’s approach to clinical

practice, which involves the integration of quantitative assessment information with a qualitative contextual understanding of the subjective meaning of clients' experiences (Plano Clark & Wang, 2010). Mixed methods designs can also advance social justice by using detailed thick description to empower participants by giving voice to their experiences (Mertens, 2007; Ponterotto, Mathew, & Raughley, 2013), instead of relying solely on statistical normative data which participants might experience as reductive and disempowering.

### **3.1.2 Epistemological, philosophical, and ontological approach**

Epistemologically, the study followed a pragmatic approach which proposes that the philosophical and methodological approach used by researchers should be determined by the research problem being investigated. As such, it acknowledges that individuals have different experiences through which they develop warranted beliefs, which can be shared between individuals and groups to varying degrees. These warranted beliefs shape individuals' worldviews which can be both unique to that individual and socially shared to some extent between individuals or groups. Reality is thus seen as a normative concept that cannot be determined in isolation and truth is "whatever proves itself good" or "has stood the scrutiny of individual use over time" (Kaushi & Walsh, 2019). This means that research from a pragmatic approach emphasises the utility of methods and knowledge generated and is thus appropriate for studies which aim to produce socially useful practical knowledge, or findings which have implications for clinical practice (Feilzer, 2010).

From a philosophical and ontological perspective, some authors have argued that quantitative and qualitative research methods are drawn from incompatible paradigms (e.g., positivism and constructivism/interpretivism), and as such mixed methods approaches which

aim to integrate the two are philosophically unsatisfactory as they are bound to compromise one of these worldviews (Hall, 2013; Wiggins, 2011). A pragmatic approach to mixed methods research helps to transcend the division between generalisable quantitative research methods and more contextualised qualitative research to generate useful data and transferable findings. Alongside this pragmatic approach, philosophical pluralism, which simultaneously recognises the validity and limitations of different research paradigms, presents a tentative approach to mixed methods research whereby dialogical interaction between these paradigms can generate a more complete understanding despite seemingly contradictory conclusions (Wiggins, 2009). In addition to a philosophically pluralistic approach, the study also employs a critical realist ontology, which Hall (2013) argues is best suited to mixed method research because it allows for the complexity of social context while also promoting critical examination to develop explanations of phenomena. These also align with the pluralistic, multi-perspective, experience-based approaches to psychological research advocated for in the PTMF (Johnstone & Boyle, 2018), which challenge the dominant positivist paradigm which underpins the diagnostic framework and a rigid focus on specific outcomes or symptoms. In line with this pluralistic approach, the study has been divided into two phases. Phase one of the study focused on quantitative data collection using an online survey, while phase two focused on qualitative data collected through interviews with participants from phase one.

### **3.2 Phase one- quantitative survey**

Phase one of the study aimed to further explore the relevance of understanding traumatic re-enactment processes for supporting women who experience DA, by testing whether these women had experienced more ACEs than their counterparts who had not

experienced DA. This question was practice-led, as focusing on developmental trauma and early life experiences is a key area in several therapeutic approaches, such as psychodynamic therapy (e.g., Malan, 1995).

However, my therapeutic work with survivors of early life trauma has also anecdotally shown that not all individuals will share a similar threat response pattern. Therefore, it is important to also understand resilience as a protective factor for these individuals. A review of the literature relating to this led to the second research questions, which aimed to address a gap in the current literature by investigating the relationship between ACEs, resilience, and mental wellbeing. This aspect of the study aimed to determine whether focusing on ACEs and protective factors, such as resilience, might be important for clients who have experienced DA in order to produce information which might be useful to clinical practice by suggesting potential future areas of research and therapeutic intervention with these individuals.

As such, phase one of the study sought to explore the following research questions:

- 1) Is there a significant difference on ACE, resilience, and mental wellbeing scores between the Survivors of DA group and the control group?
- 2) Is there a relationship between ACEs, resilience, mental wellbeing, and DASS subscale scores (Depression, Anxiety, and Stress)?
- 3) Does resilience moderate the relationship between ACEs and mental wellbeing?
- 4) Does resilience moderate the relationship between ACEs and DASS subscale scores?

The moderation effect referred to in questions 3 and 4 is illustrated diagrammatically in figure 1 below.

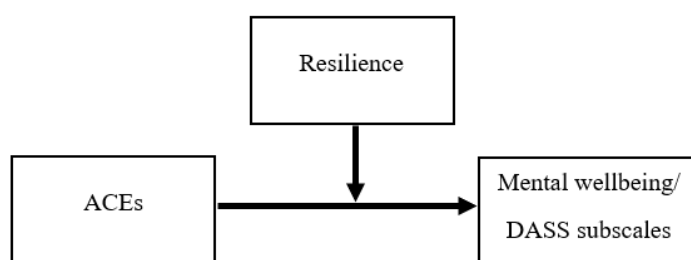


Figure 1. Moderation model.

The study hypotheses for phase one were:

- 1) Survivors of DA will report significantly higher levels of ACEs and resilience, and lower levels of mental wellbeing than the control group.
- 2) Significant correlations will exist between ACEs, resilience, mental wellbeing, and DASS subscale scores.
- 3) Resilience will significantly moderate the relationship between ACEs and mental wellbeing.
- 4) Resilience will significantly moderate the relationship between ACEs and DASS subscale scores.

### **3.3 Phase two – qualitative interviews**

Following the quantitative survey, the study also aimed to develop a richer description of participants' own narratives to help contextualise the quantitative survey findings. This phase of the study was fundamental to answering the overarching research question through exploration of participants' lived experience.

The qualitative phase of the study sought to explore the links between adversity in early life, support (and other protective factors), and later outcomes in life (including physical

health, coping responses, mental wellbeing, and resilience) for survivors of DA. This focus for phase two of the study evolved from the findings in phase one related to the significance of participants' resilience for wellbeing, as well as suggestions from participants elicited in the survey in phase one (see Appendix A). Participants were asked to enter free text in response to the following prompt:

Interview thoughts: Do you have any further thoughts which you would like to share with the research team about this topic? Your input will help us to develop the interview schedule for the follow-up study in phase 2 to ensure that these issues are explored as fully as possible to improve our understanding in this area which will hopefully contribute to improving support for survivors of domestic abuse.

Participants' responses helped to guide the focus of this study, and particularly informed the emphasis on early life experiences, coping responses (both positive and negative), and support (see Appendix A. for a summary of participants' responses). This feedback process allowed for participant involvement at each stage of the process in phase two, empowering participants and helping to address the power imbalance inherent in much social science research (Mertens, 2007). Following this process, the research questions generated for phase two of the study were:

1. What role do ACEs and resilience play in survivors of DA's life journeys and later wellbeing?
2. What are their experiences of support and coping responses?

## Chapter 4. Method

### 4.1 Design

The study employed an explanatory and enriching, sequential mixed methods design, in which the quantitative data collected and analysed in phase one was contextualised and enriched by the qualitative data collected and analysed in phase two (Creswell & Plano Clark, 2017). The study sought to equally value both sources of data, and not prioritise either methodology over the other. The study also recognised the importance of each methodology in overcoming the limitations of each individual approach with regards to generalisability, depth, and application to practice (Hanson et al, 2005).

Phase one of the study utilised a cross-sectional online survey to collect the quantitative data for the study. Participants provided demographic and socio-economic status information and completed a set of four questionnaires through the online survey hosted on Qualtrics.com (Qualtrics, 2005).

In phase two of the study, qualitative data was collected through a series of remote online interviews with participants. These participants were drawn from the online survey in phase one, in which participants were asked to register their interest and provide contact details if they wished to participate in the phase two interviews. Participants also had the opportunity to contribute to the design of phase two by highlighting further thoughts and significant areas to be addressed in the interviews whilst completing the online survey.

#### *4.1.1 Ethical considerations*

Ethical approval for the study was granted by the University of Wolverhampton Faculty of Education, Health, and Wellbeing ethics panel (see Appendices B and C). The

study followed all applicable guidance, including the Health and Care Professions Council (2016) *Standards of conduct, performance and ethics* and the British Psychological Society's (2021) *Ethics guidelines for internet-mediated research* and (2020) *Ethics best practice guidance on conducting research with human participants during Covid-19*. These documents helped to guide the decision to utilise an entirely remote, online study design to minimise risk of harm, as well as other practical concerns, such as asking participants to provide a memorable code to retain anonymity whilst allowing for their responses to be identified should they later wish to withdraw from the study. Although there is some debate about the costs and benefits to asking participants about their experiences of domestic abuse, systematic review of the literature suggests that survivors appreciate being asked about DA within a supportive environment and experience interviews as a potentially healing process (Snyder, 2016).

## **4.2 Phase one- quantitative survey**

### *4.2.1 Participants*

Data were collected from a convenience sample of 119 adult female respondents (age range = 18-75), broken down as 63 participants in the survivors of DA group and 56 in the control group. Participants for both the survivors of DA group and the control were simultaneously recruited through online advertisements disseminated through social media posts and resharing, and through several local Domestic Abuse support services including: Haven, Birmingham Freedom Project, Lighthouse Project, Birmingham and Solihull Women's Aid.

A priori sample size calculations using G\*Power version 3.1.9.7 (Faul et al., 2007) were conducted to ensure that the study was sufficiently powered. These analyses indicated

that the study required an overall minimum sample size of 102 (51 per group) to detect the expected moderate effect size in the t-test analyses with a significance criterion of  $\alpha = .05$  and power = .80, and a minimum of 60 in the survivors of DA group of interest to detect the expected moderate effect size in the regression analyses for a significance criterion of  $\alpha = .05$  and power = .80. Thus, the obtained sample of 119 recruited to the study, with 63 in the survivors of DA group, was therefore more than adequate to test the study hypotheses.

Resilience data was incomplete for 4 participants, 3 in the control group and 1 in the survivors of DA group, and these participants were thus excluded from the regression analyses.

#### *4.2.2 Inclusion/exclusion criteria*

In order to focus the study on the specific population of interest, participants in the study were all adult females over the age of 18 who had ever engaged in a relationship with a partner.

#### *4.2.3 Procedure*

Following obtaining ethical approval, the online survey was created using Qualtrics (2005) and distributed through promotional recruitment materials (see Appendix D). Local Domestic Abuse support agencies were contacted to introduce the study and the purpose of the research, as well as the rationale for advertising through their agency. Staff facilitators were consulted to review the content of the online survey and offer initial feedback through a pilot process before the study was more broadly advertised. The study was presented to staff facilitators and service users in one agency's online meeting to address any questions. A link

to the study was shared through social media and on agency web forums, through which participants were directed to the initial study information and consent pages before proceeding to complete the study questionnaires.

Participants' right to withdraw and the need to protect their own wellbeing in completing the survey were emphasised in these initial pages as part of the informed consent process. The study participant information and debrief sheets encouraged participants to seek support if the study triggered any difficult memories or emotions and provided contact information for several relevant support agencies who were not affiliated with the study, including Refuge, Women's Aid, and Relate (see Appendices E and F).

#### *4.2.4 Measures*

##### *4.2.4.1 Demographic information*

Participants' demographic information, including age, ethnicity, sexual orientation, socio-economic status (current individual and household income ranges and free meal status when in school), and current region, were collected to match the control group to the survivors of DA group and control for these factors within the study. Participants were provided with the study definition of domestic abuse (Women's Aid, 2020) and self-reported their status as a survivor of DA or having never experienced DA (control group).

##### *4.2.4.2 Adverse Childhood Experiences Questionnaire (ACE-Q)*

The ACE-Q (Felitti et al., 2019) is a 10 item self-report questionnaire designed to retrospectively measure participants' exposure to childhood abuse, neglect, and household dysfunction in their first 18 years of life. Each item is rated "yes" (1) or "no" (0) to indicate

the presence or absence of 10 types of household adverse childhood experiences: physical abuse, verbal/emotional abuse, sexual abuse, physical neglect, emotional neglect, parental separation, exposure to substance abuse or alcoholism, exposure to mental illness, exposure to violent treatment of female caregiver, and exposure to criminal behaviour. All items are positively scored for presence and participants score the cumulative sum of items, providing a range of 0 - 10. Previous studies have found the ACE-Q to have a high level of internal consistency ( $\alpha = 0.94$ ) and a very high test-retest reliability ( $r = 0.91$ ; 3-months) (Frampton, Poole, Dobson, & Pusch, 2018). Evidence for the interrelatedness of ACEs has also been found (Dong et al., 2004).

Example items include: “did a parent or other adult in the household often or very often... swear at you, insult you, put you down, or humiliate you?” and “was a household member depressed or mentally ill, or did a household member attempt suicide?”

#### 4.2.4.3 Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

The SWEMWBS (Stewart-Brown et al., 2009) is a 7 item self-report questionnaire which has been validated for use with the general population showing reliability ( $\alpha = 0.84$ ), measurement invariance (Anthony et al, 2022), good internal consistency ( $\alpha > 0.7$ ), and convergent validity and discriminant validity against the GHQ-12, EQ-VAS, and WEMWBS (Ng Fat et al., 2017). It is a shortened version of the Warwick-Edinburgh Mental Well-being Scale (Tennant et al., 2007), and as such uses statements about thoughts and feelings over the past two weeks to assess participants’ general mental wellbeing. Each statement is positively worded with potential responses on a five-point scale, from “none of the time” (1) to “all of the time” (5), providing a range of 7 - 35. Higher scores indicate better overall mental wellbeing.

Example statements include: “I’ve been feeling optimistic about the future” and “I’ve been feeling relaxed”.

#### 4.2.4.4 Depression, Anxiety, and Stress Scale (DASS)

The DASS (Lovibond & Lovibond, 1995) is a 42-item self-administered questionnaire designed to measure the magnitude of three negative emotional states over the past week: depression, anxiety, and stress. These states correspond with three subscales: Depression, Anxiety, and Stress. Each subscale comprises 14 items. The Depression subscale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia. The Anxiety subscale assesses participants’ physiological arousal, skeletal-muscle effects, situational anxiety, subjective experience of anxious affect, perceived panic, and fear. The Stress subscale assesses participants’ difficulty relaxing, nervous arousal, over-reactiveness, impatience, tension and irritability. The DASS showed good factor structure, reliability for all three subscales ( $\alpha = 0.94, 0.88, \text{ and } 0.93$ ), and convergent and divergent validity in clinical and non-clinical populations against the HADS ( $r = 0.66 \text{ and } 0.75$ ) (Antony et al., 1998; Nieuwenhuijsen et al, 2003).

Each item is rated on a four-point scale, from “did not apply to me at all” (0) to “applied to me very much, or most of the time” (3), providing a range of 0 – 42 on each subscale. Score interpretation for the Depression subscale is as follows: Normal (0-9), Mild (10-13), Moderate (14-20), Severe (21-27), Extremely Severe (28+). For the Anxiety subscale scores are interpreted as: Normal (0-7), Mild (8-9), Moderate (10-14), Severe (15-19), Extremely Severe (20+). For the Stress subscale, scores are interpreted as: Normal (0-14), Mild (15-18), Moderate (19-25), Severe (26-33), Extremely Severe (34+).

Example items include: “I found it difficult to relax”, “I felt sad and depressed”, and “I felt terrified”.

#### 4.2.4.5 Connor-Davidson Resilience Scale (CD-RISC)

The CD-RISC (Connor & Davidson, 2003) is a 25-item self-report questionnaire which measures participants’ resilience, otherwise described as stress coping ability. CD-RISC scores show good reliability and validity, and have been associated with greater improvement during treatment for PTSD and generalized anxiety disorder in community and outpatient populations (Connor & Davidson, 2003). The CR-RISC demonstrates convergent and divergent validity in relation to the PANAS, as well as good reliability ( $\alpha = .88$ ) and retest reliability ( $\alpha = .87$ ) (Gonzalez, Moore, Newton, & Galli, 2016). Each item consists of a positively worded statement which is rated on a five-point scale, from “not true at all” (0) to “true nearly all of the time” (4), providing a range of 0 – 100. Higher scores indicate higher levels of overall resilience.

Example items include: “I am able to adapt when changes occur” and “under pressure, I stay focused and think clearly”.

#### 4.2.5 *Quantitative data analysis*

Quantitative data was analysed using SPSS and variables were screened using scatterplots, and the Kolmogorov-Smirnov test of normality. Mann-Whitney and Chi-square tests were conducted to detect any statistically significant differences between the survivors of DA group and the control. In order to test the study hypotheses, ANOVAs, Chi Square tests, Fischer’s Exact Test, Pearson’s Correlations, and moderated multiple regression

analyses using Hayes' (2013) PROCESS Macro for SPSS, setting bootstrapping to 5000 replicates, were conducted. All assumptions were met for each analysis. In the ANOVAs and Chi Square tests, means and expected variable counts were compared between the survivors of DA group and the control on ACEs, Resilience, and Mental wellbeing variables, as well as their individual categories and subscales. In the moderated multiple regression analyses, ACEs (total cumulative ACE scores) were entered as the predictor, resilience (CDRISC scores) was entered as the moderator, and mental wellbeing (total SWEMWEBS scores) and DASS subscale totals were the criteria. The PROCESS macro also employs the Johnson-Neyman procedure to probe the interaction to identify the value for the moderator for which the relationship between the independent predictor and the dependent criterion changes between being statistically significant and non-significant (Hayes, 2013).

### **4.3 Phase two – qualitative interviews**

#### *4.3.1 Qualitative Approach Selection*

Thematic analysis was chosen to answer the research questions in line with the study aims by offering a framework by which transcripts could be coded and organised so that patterns of meaning, or themes, could be identified to make sense of participants' experiences (Braun & Clarke, 2006). Thematic analysis was chosen over competing qualitative approaches due to its alignment with the study's pragmatic approach and philosophical value base, as well as its appropriateness in answering the overarching research question.

Thematic analysis is a straightforward and flexible approach to qualitative data analysis which is accessible to novice researchers but nonetheless provides a framework for uncovering implicit meaning (Clarke & Braun, 2018). This distinguishes it from an Interpretive Phenomenology Analysis (IPA) approach, which employs a more rigid structure

for data collection and places an analytic emphasis on the double hermeneutic (two-stage interpretation process) in which describing participants' experiences is not considered a sufficient level of analysis. This means that the researcher provides an interpretation of participants' interpretation of events, including both critical and conceptual commentary (Smith, Flowers, & Larkin, 2009). Although IPA has been described as the "default option" for many students (Hefferon & Gil-Rodrigues, 2011), it was agreed that an IPA approach would be inconsistent with the epistemological, philosophical, and theoretical frameworks of pragmatism, Humanism, and the PTMF employed in this study (as outlined in chapter 3), due to insufficient emphasis of participants' subjective realities and environmental contexts. The theoretical and epistemological assumptions made by the researcher are important in thematic analysis and may have an impact on the interpretation and analysis of data (Braun & Clarke, 2006). Thematic analysis was also deemed more appropriate for the study given the nature of the research questions and the breadth of information gathered from participants using both qualitative and quantitative measures.

An IPA approach was thus discounted in favour of thematic analysis in order to emphasise the meaning inherent within participants' narratives and to try to minimise imposing the interpretations of the researchers on the data. However, it is also important to note that the identification of themes is itself an interpretive act, although thematic analysis tends to follow a closer adherence to the data and thus participants' experiences (Guest, MacQueen, & Namey, 2012).

#### *4.3.2 Participants*

Participants for the qualitative interviews in phase two of the study were recruited from amongst the participants in the quantitative survey in phase one of the study who

indicated that they would like to participate in an interview and provided their contact details (email addresses) to be contacted to arrange this. As such, all participants were adult females. It was originally hoped to recruit ten participants out of the 22 who provided their contact details and met the inclusion criteria below. Of the 22 participants contacted about taking part in the interviews in phase two, a total of eight replied and were interviewed. Braun and Clarke (2021) question the applicability of a priori sample sizes and data saturation approaches to thematic analysis and argue instead for an organic, reflexive process in which researchers must make an interpretative judgement based on pragmatic practice and the purpose of the analysis. Given this and the sensitive nature of the research topic, the final total of eight participants was considered sufficient to proceed so as to allow for confidentiality and confirmability within the sample.

#### *4.3.3 Inclusion/exclusion criteria*

In addition to the original inclusion/exclusion criteria applied during the recruitment for the quantitative survey in phase one of the study, participants for phase two were exclusively drawn from the survivors of DA group. However, no prior information about their experiences of DA was collected during phase one, and thus there were no stipulations or time limits placed on when they had experienced DA. Additionally, any current colleagues or social acquaintances of the researcher were excluded from interviews, due to the sensitive nature of the research.

#### *4.3.4 Materials*

A semi-structured interview schedule (see Appendix G) containing seven main topics and follow-up exploratory questions was developed following Kallio et al's (2016)

framework. This approach was selected to facilitate rigorous data collection and guide flexible discussions with participants about their experiences rather than creating a rigid or formulaic interview experience, thus setting the interviews in phase one apart from the previous survey in phase one. Questions were designed to be open-ended, participant-oriented, non-leading, and above all clear in order to enhance transparency, trustworthiness, and credibility in the study, and to ensure consistency and confirmability between different interviewers. The schedule was designed to be responsive to following the course of participants' narratives, rather than following a linear sequence, although interviewers ensured that each topic was discussed with each participant.

#### *4.3.5 Procedure*

Recruitment for phase two of the study was conducted after obtaining further ethical approval from the University of Wolverhampton Faculty of Education, Health, and Wellbeing ethics panel. Participants were purposefully sampled and recruited via the email addresses which they provided in phase one of the study on a maximum of 2 occasions and asked to confirm whether they still wished to participate in phase two of the study. Prospective participants were contacted in randomly allocated batches to avoid disappointment should more than ten volunteer to take part in an interview. They were provided with the participant information sheet and a consent form (see Appendix E), which they had the opportunity to read through and ask questions about before deciding whether to participate. Participants returned their consent form to the researcher prior to arranging an interview at a mutually available time. It was made clear to participants that the interview was not a therapeutic intervention, but they were provided with contact details for some sources of support available, provided by agencies not affiliated to the study. Participants

were also asked their preference of interviewer gender, with either the primary researcher or one of the research supervisors conducting the interviews depending on each participant's preference.

Interviews were completed remotely online using Microsoft Teams, with the interviewer arranging the meeting. Participants were asked to confirm that they were in a safe, confidential setting for the interview and verbal consent for participation and recording was also taken before starting the semi-structured interview. Participants' right to request a break or withdraw from the interviews at any time for any reason was emphasised. Interviews lasted an average of 72 minutes, slightly higher than anticipated. Participants were debriefed at the end of the interview. Participants were offered the opportunity to ask any questions or sign up for future updates about the results of the study. The interviewer then encouraged participants to engage in a non-prescriptive form of self-care following the interview and provided them with information about the nature of the study and contact details for support agencies should they wish to seek any support.

Interviews were recorded and listened to in full to develop a familiarity with their content before being transcribed verbatim by the primary researcher, and the transcripts were read through at least once while listening to the recording in order to check for accuracy. Transcripts included timings for each speaker, as well as non-verbal cues such as laughter and para-linguistic fillers. Pseudonymisation of participants was employed, with each participant assigned a number as recommended by the ethics panel. All identifying material, including place and organisation names, was removed. Recordings and transcripts were electronically stored on password-protected computer systems and were only listened to by the primary researcher. No participants requested for their interview to be stopped or withdrew from the study.

#### *4.3.6 Thematic analysis of qualitative data*

An inductive thematic analysis was conducted to identify semantic themes and explore the relationships between them through an iterative process of searching for and refining themes. The analysis followed the six phases approach outlined by Braun and Clark (2006) to identify initial codes and develop major themes from these:

1. Transcription and data familiarisation
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the final report

The initial codes and themes identified by the primary researcher were reviewed by the supervisory team. Patterns of meaning between multiple open initial codes were sought, and these developed into the subthemes and major themes presented in the following results chapter. Attribution of quotes using participants' pseudonyms was chosen to provide a more nuanced understanding of both the commonality of themes and breadth of different narratives within each. The aim of the analysis was to provide a thick description of participants' lived experience around ACEs and DA to answer the research questions.

#### *4.3.7 Trustworthiness, credibility and dependability*

The study demonstrated Yardley's (2008) four principles for assessing quality in qualitative research: sensitivity to context; commitment and rigour; transparency and

coherence; and impact and importance. Sensitivity to context was demonstrated by emphasising participants' perspectives and maintaining an awareness of the socio-cultural context in which they are situated. This is often highlighted as a strength of qualitative approaches (Patton, 2015). It was important for the researchers to discuss and consider potential themes to ensure that they accurately reflected participants' lived experiences and thus increase the robustness of the data and overall confirmability of the study. Commitment and rigour in qualitative research require an in-depth engagement with the topic through a thorough and detailed analysis, for which the study employed Braun and Clark's (2006) approach to thematic analysis. NVivo qualitative data management software (Version 1.5.2) was used to organise, manage, and store the dataset and ensure accuracy in the coding and theme development phases. Transparency and coherence were demonstrated by a detailed audit trail of the analysis process and reflection on the interview process by the researchers in written notes and supervisory meetings (Thomas & Magilvy, 2011). Pseudonymisation of quotes allowed for the presentation of a representative range of quotes for each theme to enhance their credibility and trustworthiness (Peterson, 2019). Impact and importance refer to the fundamental purpose for research to generate knowledge which is useful and applicable to practice. This was a key goal of the study, as it sought to highlight and explore a gap in the current research literature. It is hoped that the findings can support further service development for, and interventions with, survivors of DA.

## Chapter 5. Results

### 5.1 Chapter introduction

The study aimed to answer the overarching research question: What role do ACEs and resilience play in survivors of DA's life journeys and later wellbeing? The results chapter is presented in two sections to present the results of the two sequential study phases and their associated research questions and hypotheses.

### 5.2 Phase one - quantitative survey results

#### 5.2.1 Participant Characteristics

The survivors of DA group and the control group were compared across demographic and socio-economic status variables to determine whether any significant differences existed between the two groups. Mann-Whitney tests revealed that the survivors of DA and control groups did not differ significantly for current individual ( $U = 1692.5, p = .687$ ) and household income ( $U = 1757, p = .970$ ). A Chi-Square test of independence showed that the survivors of DA and control groups also did not differ significantly for participants' eligibility for free school meals (where this applied),  $X^2(1, 119) = .785, p = .376$ . A one-way ANOVA revealed a significant difference between the groups in terms of age,  $F(1, 115) = 5.81, p = .018$ , such that the survivors of DA group ( $M = 37.65, SD = 10.99$ ) were significantly older than the control group ( $M = 32.71, SD = 11.14$ ). Descriptive data for the survivors of DA group and control group samples are reported in Table 1.

Table 1. Demographic data

	Survivors of DA (N = 63)	Control (N = 56)
<b>Age (SD, range)</b>	37.65 (10.99, 21-75)	32.71 (11.13, 18-70)*
<b>Ethnicity</b>		
White British & Irish	38 (73.1%)	36 (64.3%)
White Other	7 (13.5%)	14 (25%)
Asian British	2 (3.8%)	0 (0%)
Asian Other	2 (3.8%)	3 (5.4%)
Black British	0 (0%)	0 (0%)
Black Caribbean	0 (0%)	1 (1.8%)
Mixed/Multiple Ethnic Groups	2 (3.8%)	2 (3.6%)
Any Other Ethnic Group	1 (1.9%)	0 (0%)
<b>Region</b>		
England	50 (82%)	44 (78.6%)
Wales	3 (4.9%)	1 (1.8%)
Other/Outside of the UK	8 (13.1%)	11 (19.6%)

Notes: \*Difference significant at the <.05 level

### 5.2.2 Hypothesis 1: Comparisons between groups

To test hypothesis 1, that survivors of DA would report higher levels of ACEs, higher levels of resilience, and lower levels of mental wellbeing than the control group, a one-way

ANOVA was conducted. The results of the analysis demonstrated a significant difference,  $F(1,117) = 14.7, p < .001$ , such that the 63 participants in the survivors of DA group ( $M = 3.68, SD = 2.26$ ) reported higher levels of ACEs compared to the 56 participants in the control group ( $M = 2.18, SD = 1.98$ ), with a medium to large effect size,  $\eta^2 = .112$ . The most commonly reported ACEs for both groups were emotional/verbal abuse and emotional neglect. The least commonly reported ACEs for the survivors of DA group was exposure to criminal behaviour, while the control group reported physical neglect as their least common ACE. Chi-square and Fisher's Exact Test analyses found statistically significant differences between the groups on 6 out of 10 ACE categories: Emotional/Verbal Abuse,  $X^2(1, N=119) = 6.18, p = .013$ ; Physical Abuse,  $X^2(1, N=119) = 8.28, p = .004$ ; Sexual Abuse  $X^2(1, N=119) = 10.7, p = .001$ , Emotional Neglect  $X^2(1, N=119) = 4.48, p = .034$ , Exposure to substance abuse or alcoholism  $X^2(1, N=119) = 6.7, p = .01$ , and Exposure to mental illness  $X^2(1, N=119) = 4.23, p = .040$ . Survivors of DA were more likely to have experienced each of these 6 ACE categories than the control group. Chi-square analyses also found statistically significant differences between the groups on whether ACEs were present (on at least one category),  $X^2(1, N=119) = 6.89, p = .009$  or highly present (on 4+ categories),  $X^2(1, N=119) = 10.97, p < .001$  such that survivors of DA were more likely to have presence and high presence of ACEs than the control group.

Statistically significant differences between the groups were also found on DASS Anxiety subscale scores,  $F(1, 117) = 9.53, p = .003$ , such that survivors of DA ( $M = 9.67, SD = 8.77$ ) reported higher levels of anxiety than the control group ( $M = 5.54, SD = 5.12$ ), with a medium effect size,  $\eta^2 = .075$ ; and on DASS Stress subscale scores,  $F(1, 117), p = .033$ , such that survivors of DA ( $M = 16.19, SD = 9.34$ ) reported higher levels of stress than the control group ( $M = 12.73, SD = 8.02$ ), with a small to medium effect size,  $\eta^2 = .038$ . No significant difference between the two groups was found on the SWEMWBS. Comparative statistics and

severity cut-offs for the survivors of DA and control groups for ACE, mental wellbeing, and resilience variables are presented in Table 2. parts 1-3.

Table 2. part 1 Means and standard deviations for resilience and ACE scores and category frequencies by group.

<b>Variable</b>	<b>Survivors of DA</b>		<b>Control</b>	
	Mean	SD	Mean	SD
<i>Categories/levels of presence</i>	Number (percentage)		Number (percentage)	
<b>Resilience (CD-RISC)</b>	<b>60.93</b>	<b>16.05</b>	<b>60.98</b>	<b>15.52</b>
<b>Cumulative ACE scores</b>	<b>3.68</b>	<b>2.26</b>	<b>2.18**</b>	<b>1.98</b>
<i>Present - At least one ACE</i>	59 (93.7%)		43 (76.8%)*	
<i>Highly present - 4 or more ACEs</i>	32 (50.8%)		12 (21.4%)**	
<b>Individual ACE categories</b>				
<i>Emotional/verbal abuse</i>	38 (60.3%)		21 (37.5%)*	
<i>Physical abuse</i>	28 (44.4%)		11 (19.6%)*	
<i>Sexual abuse</i>	23 (36.5%)		6 (10.7%)**	
<i>Emotional neglect</i>	37 (58.7%)		22 (39.3%)*	
<i>Physical neglect</i>	11 (17.5%)		4 (7.1%)	
<i>Parental separation</i>	26 (41.3%)		18 (32.1%)	
<i>Exposure to violent treatment of female caregiver</i>	11 (17.5%)		8 (14.3%)	
<i>Exposure to substance abuse or alcoholism</i>	22 (34.9%)		8 (14.3%)*	
<i>Exposure to mental illness</i>	32 (50.8%)		18 (32.1%)*	
<i>Exposure to criminal behaviour</i>	4 (6.3%)		6 (10.7%)	

Table 2. part 2 Means, standard deviations, and severity for DASS scores by group.

<b>Variable</b>	<b>Survivors of DA</b>		<b>Control</b>	
	Mean	SD	Mean	SD
<i>Severity categories (cut-off values)</i>	Number (percentage)		Number (percentage)	
<b>DASS Depression subscale</b>	<b>13.63</b>	<b>10.15</b>	<b>12.55</b>	<b>11.48</b>
<i>Normal (0-9)</i>	25 (39.7%)		27 (48.2%)	
<i>Mild (10-13)</i>	10 (15.9%)		6 (10.7%)	
<i>Moderate (14-20)</i>	15 (23.8%)		10 (17.9%)	
<i>Severe (21-27)</i>	4 (6.3%)		6 (10.7%)	
<i>Extremely Severe (28+)</i>	9 (14.3%)		7 (12.5%)	
<b>DASS Anxiety subscale</b>	<b>9.67</b>	<b>8.77</b>	<b>5.54*</b>	<b>5.12</b>
<i>Normal (0-7)</i>	30 (47.6%)		36 (64.3%)	
<i>Mild (8-9)</i>	5 (7.9%)		6 (10.7%)	
<i>Moderate (10-14)</i>	10 (15.9%)		11 (19.6%)	
<i>Severe (15-19)</i>	7 (11.1%)		3 (5.4%)	
<i>Extremely Severe (20+)</i>	11 (17.5%)		0 (0%)	
<b>DASS Stress subscale</b>	<b>16.19</b>	<b>9.34</b>	<b>12.73*</b>	<b>8.02</b>
<i>Normal (0-14)</i>	29 (46%)		34 (60.7%)	
<i>Mild (15-18)</i>	9 (14.3%)		11 (19.6%)	
<i>Moderate (19-25)</i>	14 (22.2%)		7 (12.5%)	
<i>Severe (26-33)</i>	9 (14.3%)		3 (5.4%)	
<i>Extremely Severe (34+)</i>	2 (3.2%)		1 (1.8%)	

Table 2. part 3 Means, standard deviations, and severity cut-off for SWEMWBS and DASS subscale scores by group.

<b>Variable</b>	<b>Survivors of DA</b>		<b>Control</b>	
	Mean	SD	Mean	SD
<i>Severity categories (cut-off values)</i>	Number (percentage)		Number (percentage)	
<b>Mental wellbeing (SWEMWBS)</b>	<b>22.72</b>	<b>4.48</b>	<b>22.65</b>	<b>4.27</b>
<i>Low Mental Wellbeing (7-19)</i>	18 (28.6%)		14 (25%)	
<i>Average Mental Wellbeing (20-27)</i>	33 (52.4%)		34 (60.7%)	
<i>High Mental Wellbeing (28+)</i>	12 (19%)		8 (14.3%)	

*Notes:* \*Difference significant at the  $p < .05$  level; \*\*Difference significant at the  $p < .001$  level; SD = standard deviation; for explanation and further discussion of categorical cut-off scores for severity, see Felitti et al (1998) for ACEs, see Fat et al (2017) for SWEMWBS, and Lovibond & Lovibond (1995) for DASS subscales

### 5.2.3 Hypothesis 2: Relationships between variables

To test hypothesis 2, that variables would exhibit significant correlations, Pearson's correlations were conducted. The correlations revealed a statistically significant negative correlation between ACEs and mental wellbeing, while statistically significant positive correlations were found between ACEs and the DASS Depression and Anxiety subscales, and a non-significant positive correlation between ACEs and the DASS Stress subscale.

As expected, a statistically significant positive correlation was found between resilience and mental wellbeing, while statistically significant negative correlations were found between resilience and the DASS Depression, Anxiety, and Stress subscales. The

negative correlation between ACEs and resilience was found to be non-significant.

Correlations between variables for the whole sample can be found in Table 3.

Table 3. Correlations between variables

Variable	1.	2.	3.	4.	5.	6.
<b>1. Mental Wellbeing (SWEMWBS)</b>						
<b>2. DASS Depression</b>	-.766**					
<b>3. DASS Anxiety</b>	-.641**	.683**				
<b>4. DASS Stress</b>	-.68**	.727**	.771**			
<b>5. ACEs</b>	-.196*	.22*	.242**	.125		
<b>6. Resilience (CD-RISC)</b>	.644**	-.616**	-.426**	-.505**	-.09	

*Notes:* \* indicates  $p < .05$ , \*\* indicates  $p < .001$ .

#### *5.2.4 Hypothesis 3: Moderation effect of resilience on relationship between ACEs and mental wellbeing (SWEMWBS)*

To test hypothesis 3, that resilience moderates the relationship between ACEs and mental wellbeing for the Survivors of DA group, a multiple regression analysis was

conducted using Hayes' (2013) PROCESS Macro for SPSS. After centring ACEs and resilience and computing the ACEs-by-resilience interaction term to avoid multicollinearity (Aiken & West, 1991), the two predictors and the interaction term were entered into a simultaneous regression model.

Results indicated that ACEs were non-significantly associated with lower levels of mental wellbeing,  $b = -.304$ ,  $SE = .1903$ ,  $t(57) = -1.6$ ,  $p = .1155$ , while resilience was significantly associated with higher levels of mental wellbeing,  $b = .182$ ,  $SE = .0262$ ,  $t(57) = 6.96$ ,  $p < .001$ . The interaction term between ACEs and resilience was also significantly associated with lower levels of mental wellbeing,  $b = -.026$ ,  $SE = .0117$ ,  $t(57) = -2.18$ ,  $p = .0331$ , suggesting that the effect of ACEs on mental wellbeing depends to a degree on participants' resilience. In those with low ACEs, resilience is associated with higher levels of mental wellbeing, but this protective effect is increasingly less pronounced at higher levels of ACEs. Together, the variables accounted for 49.87% of the variance in mental wellbeing,  $R^2 = .4987$ ,  $F(3, 57) = 18.91$ ,  $p < .001$ , with a large effect size ( $f^2 = 0.99$ ).

In order to probe the interaction effect further, the PROCESS macro provides a tool for visualising the conditional effect of ACEs on mental wellbeing by assuming specific values of mean-centred resilience. Simple slopes for the association between ACEs and mental wellbeing were tested for low ( $-1$  *SD* below the mean, where resilience = 44.88), moderate (mean, where resilience = 60.93), and high ( $+1$  *SD* above the mean, where resilience = 76.98) levels of resilience. ACEs were significantly negatively associated with mental wellbeing at high levels of resilience,  $b = -.71$  (95% Confidence Interval  $-1.29 - -.14$ ),  $SE = .2876$ ,  $t(57) = -2.48$ ,  $p = .0162$ . ACEs were not significantly associated with mental wellbeing at moderate,  $b = -.3$  (95% Confidence Interval  $-.69 - .08$ ),  $SE = .1903$ ,  $t(57) = -1.6$ ,  $p = .1155$ , and low levels of resilience,  $b = .1$  (95% Confidence Interval  $-.38 - .59$ ),  $SE = .2442$ ,  $t(57) = .43$ ,  $p = .6705$ . Figure 2 plots the simple slopes for the interaction.

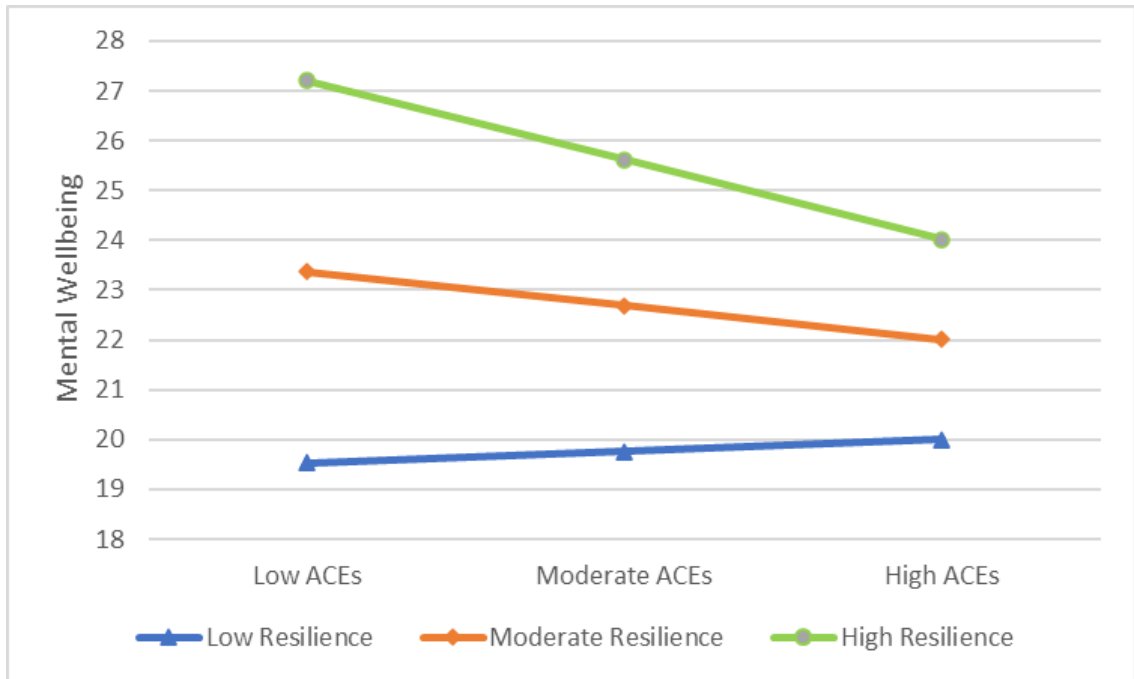


Figure 2. Conditional effect of ACEs on Mental Wellbeing at values of the moderator Resilience.

Notes: Low = at -1 SD below mean, Moderate = at mean, and High = at +1 SD above mean

A Johnson-Neyman analysis of the moderation effect revealed that ACEs and mental wellbeing were significantly negatively related above a tipping point at conditional resilience scores of 64.98,  $b = -.41$  (95% Confidence Interval  $-.81 - 0$ ),  $SE = .2033$ ,  $t(57) = -2$ ,  $p = .05$ . At the highest level of conditional resilience with scores of 99 there was a significant negative relationship between ACEs and mental wellbeing,  $b = -1.27$  (95% Confidence Interval  $-2.29 - -.25$ ),  $SE = .5102$ ,  $t(57) = -2.5$ ,  $p = .0155$ . The relationship between ACEs and mental wellbeing became non-significantly correlated below the tipping point, with the lowest conditional resilience scores of 23 showing a trend towards a more positive

relationship,  $b = .66$  (95% Confidence Interval  $-.24 - 1.57$ ),  $SE = .4520$ ,  $t(57) = 1.46$ ,  $p = .1488$ .

#### *5.2.5 Hypothesis 4: Moderation effect of resilience on the relationships between ACEs and DASS subscale scores*

To test hypothesis 4, that resilience moderates the relationship between ACEs and Depression (DASS Depression subscale scores), a further multiple regression analysis was conducted using Hayes' (2013) PROCESS macro for SPSS and centring the predictors to form the interaction term as above. Results indicated that ACEs were not significantly associated with Depression,  $b = .55$ ,  $SE = .4627$ ,  $t(57) = 1.18$ ,  $p = .2424$ , while resilience was significantly associated with lower levels of Depression,  $b = -.41$ ,  $SE = .0637$ ,  $t(57) = -6.44$ ,  $p < .001$ . However, the interaction between ACEs and resilience was not significant,  $b = .02$ ,  $SE = .0283$ ,  $t(57) = .54$ ,  $p = .5939$ , suggesting that the effect of ACEs on Depression was not dependent on participants' resilience. Together, the variables accounted for 43.52% of the variance in Depression,  $R^2 = .4352$ ,  $F(3,57) = 14.64$ ,  $p < .001$ .

A final multiple regression analysis using Hayes' (2013) PROCESS macro for SPSS was conducted to further test hypothesis 4, that resilience moderates the relationship between ACEs and Anxiety (DASS Anxiety subscale scores). Results indicated that ACEs were not significantly associated with Anxiety,  $b = .18$ ,  $SE = .4524$ ,  $t(57) = .4$ ,  $p = .6923$ , while resilience was significantly associated with lower levels of Anxiety,  $b = -.26$ ,  $SE = .0623$ ,  $t(57) = -4.17$ ,  $p < .001$ . However, the interaction between ACEs and resilience was not significant,  $b = .018$ ,  $SE = .0277$ ,  $t(57) = .65$ ,  $p = .5213$ , suggesting that the effect of ACEs on Anxiety was not dependent on participants' resilience. Overall, the variables in the model accounted for 24.23% of the variance in Anxiety,  $R^2 = .2423$ ,  $F(3,57) = 6.07$ ,  $p = .0012$ .

## 5.3 Phase two - qualitative interview results

### 5.3.1 Overview

The results of the thematic analysis carried out on the transcripts of the eight interviews are presented in this section. A summary of participants' anonymised demographic information is provided in Table 4.

Table 4. Participants

<b>Participants</b>	<b>Categories</b>	<b>Number</b>
<b>Age Range</b>	20 - 29 years	1
	30 - 39 years	2
	40 - 49 years	5
<b>Ethnicity</b>	Asian British	1
	White British	6
	White Other	1

Transcripts were examined and initial codes identified, named, reviewed, and organised into subthemes, which were in turn organised into major themes to form the thematic framework, which sought to address the research questions: What role do ACEs and resilience play in survivors of DA's life journeys and later wellbeing; and what are their experiences of support and coping responses? The full thematic framework generated from the data is presented below in Table 5. This framework attempts to provide a rich and thick

description which captures the complexities and idiosyncrasies of participants' experiences and life journeys and is also presented in diagrammatic form (see Appendix H.)

Table 5. Thematic Framework

<b>Major Themes</b>	<b>Subthemes</b>
<b>1. Early life challenges and adversity</b> <i>“There were family issues” – P4</i>	1. Violence within the home 2. Emotional abuse and cultures of silence 3. Neglect 4. Rejection and interpersonal struggles 5. Sexual abuse in childhood 6. Grief and loss
<b>2. Coping strategies</b> <i>“I’m trying to focus on something positive” – P2</i>	1. Psychoeducation and understanding 2. Using own experiences to help others 3. Motherhood and children 4. Exercise and physical coping 5. Positive distractions 6. Self-reliance
<b>3. Support and judgement</b> <i>“I felt like she was one of the only people in my whole life that had listened to me” – P6</i>	1. Judgements and stigma 2. Unhelpful professionals 3. Supportive others
<b>4. Resilience and development</b> <i>“Anything I do now feels like an act of resilience” – P8</i>	1. Identity 2. Gradual progress 3. Seeing things differently 4. Self-acceptance and care 5. Determination and confidence 6. Validation
<b>5. Psychological distress, health, and wellbeing</b> <i>“They’ve definitely impacted my mental health” – P7</i>	1. Mental health diagnoses 2. Self-harm and suicide 3. Disconnection 4. Questioning self or reality 5. Negative thinking about self 6. Problems with anger and rage 7. Addiction 8. Physical health and stress

### **5.3.2 Major Theme 1: Early life challenges and adversity**

#### *5.3.2.1 Overview of the theme*

The first major theme offers insight into the impact of participants' early life challenges and experiences of adversity in childhood, before their experiences of DA from partners as adults. Participants referenced surviving a range of challenging, stressful, abusive, or otherwise traumatic experiences in childhood. Participants described the negative role which these experiences have played in their life, in terms of their relationships with others and overall wellbeing. Notably, participants referenced both parental figures as potential perpetrators of physical and emotional abuse. Subthemes are presented in order of commonality of these experiences between participants, starting with the most widely experienced within the sample. This theme aims to provide a detailed account of the impact of the adversity which participants have survived in early life.

#### *5.3.2.2 Violence within the home*

The most common form of early life challenges participants described facing was physical abuse. This subtheme captured both participants witnessing physically abusive relationships between their primary caregivers and situations in which participants experienced violence themselves. Participants described their household environments growing up as *“traumatic”* (P3), *“it wasn't a very nice environment”* (P4), *“very violent”* (P5), and *“complicated”* (P8). P4 spoke about her father's *“temper”* and noted that *“there were family issues”*. Participants also noted how this abuse impacted on their family: *“I did grow up in a DV household, um, there was a lot of abuse at home. Social services did get involved”* (P8).

Some participants described both witnessing and experiencing physical abuse: *“I had a traumatic childhood. I, I grew up in an abusive household where my father was very... he was physically and mentally abusive towards, uh, my mum, but also to us as children”* (P3), *“the violence then extended to myself”* (P5). Several participants described these experiences of violence within the household as severe in the sense of being enduring, *“the violence between them was (...) fairly consistent”* (P5), escalating over time, *“when I was eight, um, the violence certainly picked up”* (P5), and occurring from *“a very young age really”* (P6).

Participants who experienced violence from parents also spoke about the stark juxtaposition between the dual roles of caregiver and abuser at these moments: *“Um. I’ve been hit by people that, you know, claim to love me and look after me and care for me”* (P1), *“I remember her hitting me across the face, and I couldn’t have been more than... eight or nine, and, um, then her hugging me and saying ‘oh, I’m sorry. I’m sorry. I’m sorry’”* (P5).

These frequent experiences of violence from individuals responsible for caregiving create a difficult dilemma for participants and are pivotal in shaping their expectations in subsequent relationships with others.

#### *5.3.2.3 Emotional abuse and cultures of silence*

The next most prevalent form of challenge or adversity described by participants was emotional abuse. The majority of participants shared their experiences of chronic emotional abuse by their caregivers, including verbal abuse, parental antipathy, and cultures of silence within the family: *“She started calling me a slut and a whore and she said, ‘I know what*

*you've been doing in the back of the car' and absolutely went mad at me" (P5), "And I've been subject to... (...) I can't think how many years of, of emotional abuse and manipulation" (P1).*

One participant shared experiences of verbal and emotional abuse from her mother around her weight and how this significantly affected her wellbeing:

She'd tell me that I was fat, that I was evil. I ended up with an eating disorder for 20 years. I, we ended up, I ended up less than 6 stone with a BMI of, of 13, um because, because of that. (P8).

Experiences of secrecy and cultures of silence within the family were also discussed, leaving participants confused and struggling to process the situation: *"My dad, he was awful (...) we all thought my mom was the issue. We didn't know what was going on, um, he hid, he hid it very well" (P8).*

Another area of emotional abuse through secrecy and silence which participants shared was not being allowed to discuss experiences of abuse, or having to cover them up:

I remember going into school, um, my dad went to hit me, and I ducked, and if I hadn't ducked, I would have been fine, but because I ducked, I ended up with a black eye. Um, so I went into school with a black eye and teacher said to me, you know, 'what happened to you?' and, um, I was like, 'I just walked into the door'". (P5)

Participants' experiences of emotional abuse and cultures of silence had a significant impact on their perception of themselves and later events in their lives. The double impact on some participants of being devalued and being made to participate in deceiving others to protect caregivers who perpetrate abuse also ties in with later experiences of psychological distress, in which participants describe internalising negative thoughts about themselves and disconnection from their feelings.

#### *5.3.2.4 Neglect*

Alongside emotional abuse, participants described their experiences of neglect by caregivers, including feeling worthless and invalidation of their emotional needs, and the impact which this had for them. The lack of attention, even negative, which participants attribute to caregivers makes this subtheme distinct from the last. P6 described experiencing emotional neglect and a lack of validation from her parents:

I guess that being a bit of a theme, really, that mum and dad were more important, that I was second best, that my feelings and what I was witnessing were not important. Uh, because a lot was, was brushed under the carpet.

Some participants described lacking nurturing, supportive relationships with their caregivers and the impact of this on their sense of self and future relationships:

Because I grew up in a relation-, in a household where... there was no love. Uh, I never really knew what love was (...) I think I associated love with, with the wrong things because of the sort of household that I grew up in, so I ended up in one abusive relationship after another really. (P8)

Others referenced their needs going unmet and losing their sense of self due to the focus always being on others:

I spent most of my life trying to please everybody around me, starting with my mother all the way through kind of relationships (...) and it made me very, very poorly and I actually lost my complete sense of self. I lost everything. I felt just like, like a shell. (P1)

Participants' experiences of neglect thus impact on their ability to develop their own identities and trust in their own perceptions of relationships, thus leaving their emotional and social needs unmet.

#### *5.3.2.5 Rejection and interpersonal struggles*

Experiences of adversity through rejection, bullying, and social struggles, including feeling inadequate, being ostracised, or punished by others, were shared by more than half the participants. Many participants described these experiences occurring within a school setting:

*“I struggled as a teenager to fit in at school”* (P3), *“At secondary school (...) I did go through some bullying”* (P6), *“I started getting bullied when I went to high school”* (P7).

I've always been able to make friends, but I've never been in a clique. (...) I've always been the odd one out, and I've known that and I'm still like that. Um, and... yeah, I've always just felt different. I've never felt like I belonged. (P5)

P4 described difficulties in social situations stemming from critical attitudes towards her appearance in childhood:

I used to struggle socially. And I used to struggle, struggle with how I looked, you know. Um, all those sorts of things from quite a, you know, from sort of 11, 12 years of age upwards, in terms of how I looked. So those were always struggles. (P4)

These interpersonal struggles leave participants isolated from others. This affects their self-esteem and could impair their ability to form close friendships, potentially leading them to rely more on themselves to cope.

#### *5.3.2.6 Sexual abuse in childhood*

Three participants disclosed experiences of sexual abuse in childhood and the different ways in which they tried to make sense of and process these events: “[*Foster brother*] and I were both, um, sexually abused by, um, the housekeeper that my parents had employed” (P5).

When I was a child, I was, um... molested by... someone (...) I’ve been raped by... someone who, who was meant to care for me, but that, that, that, that was a different situation, that was, um... I don’t believe... that he is a bad person, and I don’t believe that he is... um, if you wanted to define it as a rapist. (P1)

P7 spoke described how her experiences of sexual abuse were linked to her use of self-harm as a coping strategy to survive the overwhelming emotions she experienced:

I was sexually assaulted when I was 12 (...) it was very close to like my 13th birthday. And so, I started using the self-harm as a kind of an emotional release, um, 'cause I was feeling so much emotional pain that I needed the physical pain and the... release, the endorphins, the dopamine, the... all chemicals. (P7)

These experiences of sexual abuse are significant for participants, leaving them questioning themselves and their perceptions of reality, and trigger the use of self-destructive survival strategies for some. They have a major enduring impact on participants' psychological and physical wellbeing, causing overwhelming emotional pain.

#### *5.3.2.7 Grief and loss*

An unexpected theme which was not asked about in the phase one questionnaires was participants' experiences of loss. This theme highlighted the importance for participants of having a stable and secure connection to siblings in the absence of consistent caregivers. Two participants shared their experiences of significant losses within their family in childhood, and the devastating impact which this had for them:

AT: Which of these experiences raises, has actually really brought up significant emotions for you (...) which of them you would point to as bringing up significant emotions for you?

P3: Um, I think the death of my siblings. (...) But my siblings who have gone are the ones who I love the most and it just feels like... I feel like God took them away from me.

AT: I'm sorry to hear that.

P3: (Breathing in) It's really difficult.

P5 shared how close she had been with her foster brother, who was later taken away from the family and returned to his biological mother: *“And then [foster brother] um, was sent back to his parents, um, or to his mum. And I... was devastated because we were really inseparable.”*

These experiences of loss leave a gap in participants' lives. Participants spoke about feeling sadness and a sense of punishment for having these important figures suddenly torn from their lives.

### **5.3.3 Major Theme 2: Coping strategies**

#### *5.3.3.1 Overview of the theme*

This theme explored participants' adaptive coping strategies throughout their life journeys, following both challenges in early life and later experiences of DA within relationships. The focus on adaptive coping strategies is distinct from other threat responses which may have been successful in helping individuals to survive in the moment during challenging or abusive situations, but rather refers to those strategies which participants described as helpful when employed long-term. These themes represent the thoughts, behaviours, and values which participants used to soothe the overwhelming emotions linked to their experiences and which they continue to experience as supportive following these events. However, it is also recognised that any form of coping can cease being adaptive when

relied on too much or employed excessively. P1 articulated this: *“And I think it’s the same with everything in life. In moderation. You know, if you do something too much, it will eventually become detrimental”*. As such, it is important that these coping strategies are considered within the context of each individual participant within the sample.

### 5.3.3.2 Psychoeducation and understanding

Participants spoke about trying to understand their experiences by learning about themselves and others. This theme describes how participants’ curiosity and love of learning feeds into their personal meaning-making processes: *“I still couldn’t understand and, and the nature of my personality is I need to understand what happened to me (...) There’s too much to learn and not enough time”* (P3).

I’m a seeker. Always looked, always questioned things (...) I’ve always liked learning. I’ve always studied something (...) there was always that curiosity there, there was always that, sort of, preoccupation with... I don’t know, ‘ooh I’ll read this’ or listen to that, and then ask questions (P4).

The majority of participants shared their attempts to make sense of the DA which they had experienced, by engaging with available resources and other survivors’ experiences: *“I’ve done everything I can to learn about domestic abuse (...) I need to understand what it is. What is it and what can I do about it?”* (P3).

The only thing that ever helped me, it was going to the DV support group because it was the only thing that explained what was happening to me, didn't blame me for what was happening, didn't expect me to change. (P8)

For some participants, their learning was focused on trying to understand the psychological distress or diagnoses which they were experiencing: *"I research a lot into, like, borderline personality disorder and ADHD and addiction. So, I want to know kind of where it comes from. And I understand a lot of it comes from trauma"* (P7).

It took me a long time, over 30 years, to... understand that it's OK to be different (...) being told that I've probably got autism has actually helped because it explains, kind of, why I am like I am. Why I think the way I do (P1)

For other participants, their choice of education and work reflected their need to understand their abusers' motivation and their own experiences of mental health problems within the family:

I know that my dad was diagnosed with mental health issues, and I believe that that's what his problem was. Um, now I know different, but I, I went to, I trained to be a psychiatric nurse because I needed to understand (...) I think my training was to help me, um, understand what happened to my family. I know that that's why I did my mental health training (P3)

Because my dad's been in prison a lot and there was a lot of domestic abuse from my father in the home, it was something I really wanted to know more about. So, I've always been interested in... parole or prison. And, um, that's why I went for the job at the prison (...) I wanted to know more about my father and why maybe he did the things he did (P6)

In addition to making sense of their experiences through their careers, participants described their academic journeys and how these have also been shaped by their experiences:

I think I always knew that it was something like that, but I was very frightened with the media the way it is, and with, kind of, stereotypes to do with, around mental health and stuff. That's what I am basing my PhD on. (P1)

This subtheme highlights the importance of information-seeking in participants' meaning-making process, in order to understand and process their experiences of abuse and the lasting psychological distress and mental health diagnoses related to this. Survivor groups and education are noted as major sources of information which helped validate participants' experiences.

#### *5.3.3.3 Using own experience to help others*

Related to the previous theme, participants' process of understanding and meaning making often led them to professional and familial roles in which they cared for others. Participants described how they used their own experiences of ACEs and DA to support others and how they experienced this as helpful to their own wellbeing. Familial caring roles, generally focused on participants' experiences of motherhood and their love of their children,

are covered extensively in the next subtheme. Participants shared instances in their career and voluntary positions where they have used their experiences to support others:

I started volunteering at a women's centre, because I wanted to support other people. I wanted to use my experiences to support other people (...) just... knowing that you, you'd helped somebody when no, when nobody helps you, feels good. Um, because you never want someone to be in that helpless, hopeless situation that you were in. (P8)

That helps me too. When you talk about resilience and how you think you're managing, I think it is through other families because it is like therapy too, talking about my experiences to help them know that they're not alone and, sort of, the journey that it's got me where we are (...) we can relate to that and we discuss that. (P6)

For some participants, their experiences had given them strength and a different perspective to others which has allowed them to offer support in emotionally challenging circumstances:

I used to work in a care home for years (...) and as much as I love the people that I looked after, and I cared for them... when they died... I, I didn't get upset. (...) that's why I study psychology and I think that's why I can... help people, because I can step back and I can look at things from, from perspectives that perhaps other people can't. (P1)

Participants also spoke about how having survived these challenging experiences has given them a unique ability to understand, empathise with, and relate to others:

I want to become a forensic psychologist (...) I think without the experiences that I had I wouldn't want to do that. Because I wouldn't have experienced the pain and the suffering that other people go through. And without that, I wouldn't be able (tilts head), wouldn't be able to truly help them (...) that bit of experience kind of gives you the added... I don't know, empathy (...) I've been through most of it (laughs). So, I, I can relate to people that have been physically abused, that've been mentally abused, that've had sexual assaults (...) most things I can kind of relate to, so I feel like it gives me that insight. (P7)

For some participants this coping strategy of helping others was deeply ingrained and present throughout their relationships and interactions with others: *"I always feel like I should be the one listening, I should be the one helping"* (P7).

I'm always like the super helpful person. I'm always the one that people come to when they're in trouble (...) If somebody's lost in the street, it'll be me that will go up and say "are you ok? Do you need anything?" (...) I pick up all the waifs and strays. I look after everybody else's children. (P5)

For P4, even participating in the interviews was viewed through the lens of using her experiences to help others: *"I just hope this is of some use (...) because, um, you know, as I say, if it helps change things, or if it helps one person, you know, great."*

Supporting others empowered participants to make positive use of their experiences and was often framed as a therapeutic experience. Participants valued this aspect of their

identity and the different perspective which this allows them to bring to their interactions with others, thus also linking to later subthemes of resilience.

#### *5.3.3.4 Motherhood and children*

For those participants who had children, their role as mothers and the responsibilities which this entailed was a powerful subtheme. Although this also ties in with the previous subthemes of finding meaning and helping others, the relationship which participants formed with their children was recognised as more important and stronger than any other relationships they had previously experienced. Participants described how having children was a protective factor which has helped to get them through difficult times: *“I think being a parent, being a mum, that helped”* (P2), *“Now I’ve met these little people I call my children, and after you’ve grown them in your tummy, you can’t do without them”* (P3), *“So, if I feel overwhelmed, I will go and hug one of my children (...) and it will, it will ground me”* (P1), *“My children mean everything to me (...) that’s what gets me through”* (P6).

For P1, having her first child was also recognised as a *“turning point”* for her which helped her to find meaning and make changes in her life:

Having my son at the age of 21 probably saved my life. If I hadn’t had him when I was, when I was 21, I would probably be dead or in jail (...) as soon as I saw him, I knew why I was there.

Participants also shared how they wanted their children to have a better experience growing up than they had had, or felt that they needed to protect or shield their children from

the ACEs and DA which they experienced: *“I cannot allow my past and things that have happened to me to poison my present and my, my future, and subsequently impact on my children (...) I would do any, anything in this world to protect my children”* (P1), *“I don’t want them to... go through what I went through, even though they did, but in their own way”* (P2).

For P6, her children witnessing her partner abusing her motivated her to act and seek help:

When he, um, went for me in front of my children, um, that’s when I rang the police, ‘cause I thought, “I’m not having that” (...) I felt very guilty that the children then had to see the police at the house and him being taken away.

P4 spoke about her regret that her children had also experienced adversity, but found solace in the fact that she had found the strength to overcome this and hoped that they would follow in her footsteps:

I’ve brought 4 human beings into the world who are, uh, unfortunately have experienced some things that I didn’t want them to experience, like their mum, um, but... if I can rise from it, so can they and it will only make them stronger.

However, the importance of children in participants’ lives was often linked with a fear of losing this valued connection:

I was frightened that if they found something wrong with me that they would take my children away (...) I had to be a better person for him because if I was behaving,

continued to behave in the way that I was behaving, he would more than likely follow in those footsteps or he would be taken away from me or... and I couldn't, I couldn't cope with that (P1).

For many participants, motherhood represented an important motivating and protective factor which led to making positive changes in their lives. Participants' relationship with children also emerged as an emotionally containing

#### *5.3.3.5 Exercise and physical coping*

Participants referenced a range of physical activities and sensations which they had experienced as beneficial and helpful in coping with and surviving difficult experiences. Walking was frequently cited as beneficial: "*I might go for a walk. Just, you know, I love walking*" (P2), "*I will just even go for a little walk around the block and catch some Pokémon*" (P1), "*I live near a really beautiful park. I love walking in the park.*" (P3).

Participants also emphasised the emotional and psychological benefits of exercise which they found helpful to deal with some of their difficult emotions: *Just to try and clear my head, you know* (P2).

It's always been something that I've enjoyed doing (...) it's a real sort of... switch off. Things just, you know, I just sort of, things will come to mind (...) I can't describe it any other way. I just feel better for doing it. (P4)

I'd started swimming competitively again, so most mornings I was in the pool at 6 at home, 'cause we had a pool at home (...) I was at school five afternoons a week and every Saturday doing either swimming, or tennis, or trampolining, or something, just so that I didn't have to be at home. (P5)

Participants shared other forms of physical coping activities related to changing sensations. Two participants shared the emotional benefits of changing their environment: "*If he upsets me, sometimes it's something as simple as... changing rooms, changing sceneries*" (P8), "*When I'm very angry, getting cold helps me. Like holding ice cubes, or going outside, that kind of helped calm me down*" (P7)

P7 illustrates how some physical coping strategies had been taught to participants, and described benefitting from the breathing techniques she had been taught in therapy:

I've also tried breathing, uh, breathing techniques which really help when I'm very anxious and when I'm very angry. So, I've done like square breathing (...) I've done the, like, is it eight-seven-six or something? So, like, you breathe in for eight seconds, hold it for seven seconds, breathe out for six seconds. Summat like that. Um, that one helps me quite a lot as well. (P7)

#### 5.3.3.6 Positive distractions

Participants spoke about coping with difficult emotions by engaging with their interests, especially music, and how this has been a helpful coping strategy for them: "*I love listening to music and singing really, really loud whenever I can (...) music has always been*

very important to me” (P3), *“Music is a massive part of my life. I love music. I, I think I would die if I didn’t have music”* (P1).

This coping through distraction can also follow their other interests, such as playing games: *“I love playing games with the children. I like playing board games or watching a film with my children. I love hot cups of tea”* (P3), *“Do some virtual shopping or, you know, for skulls ‘cause I collect decorative skulls (...) or I will play a computer game”* (P1).

For P2, education was a helpful way to cope with her difficulties by focusing on something else which she enjoyed instead: *“I enrolled at uni, um, I thought it would give me summat to focus on that’s why I enrolled, something positive and something for myself.”*

#### 5.3.3.7 Self-reliance

Participants often referenced a theme of self-reliance and a preference for using their own coping resources rather than rely on others. Participants spoke about not needing others: *“There’s a real clique... of women that really need each other. Um, but yeah, I don’t feel like I need people. I don’t need anyone”* (P6), *“I can go to work and do my job. I can look after my children. I can look after myself”* (P3), *“I couldn’t be helped by anybody, I had to help myself”* (P8).

The only person that you have to live with for the rest of our life is you (...) you can get rid of friends. You can get rid of family. You can get rid of romantic partners. You know,

there is nobody on this earth that you absolutely need or have to live with except yourself.

(P1)

Others shared their concerns that they would not be understood or might overwhelm others: *“They try and help in their own way... but they don’t understand (...) I’ve always felt guilty about offloading onto them”* (P7), *“I didn’t want to burden anybody ‘cause everyone’s got their own stuff going on”* (P2).

Participants also recognised how self-reliance can be a double-edged sword, both keeping them safe and making them more vulnerable: *“Sometimes I think, oh, I’m really resilient, I’m strong and all this, that, and the other, but I did nearly die, you know, from trying to take my own life so...”* (P4)

For many, their experiences meant that they did not feel able to speak about their difficulties or accept help from others, due to fear: *“I think I struggled to get close to anyone because of what I’ve been through”* (P4).

P7 referred to her “terminal uniqueness” and also noted the negative consequences which this inability to connect with and rely on others might have:

Because I suffer from, from what I call terminal uniqueness. So, I, I think I’m the only one going through it and eventually that’s gonna kill me. (...) and unless I find the similarities with things and with people, I’m not going to get better (...) I don’t let people get too close. Because either I’m gonna hurt them or they’re gonna hurt me.

### **5.3.4 Major Theme 3: Support and judgement**

#### *5.3.4.1 Overview of the theme*

In addition to their own intrapersonal coping and survival strategies and resources, participants also described the impact of others within their social environment, and how these others either helped or hindered them in their journey. Participants shared the exacerbating and isolating effects of feeling unsupported, judged, or discriminated against, as well as facing stigma around their coping strategies, mental health problems, and survival responses. The major theme of support and judgement reflects both participants' positive and negative interpersonal experiences, as well as taking an explicit focus on situations where professional support has not lived up to participants' expectations or met their needs at the time.

#### *5.3.4.2 Judgements and stigma*

Participants shared their experiences of judgement and stigma from others, and how this affected their emotional health and wellbeing. Most participants spoke about judgements as common, including being blamed by others for their difficulties: *"It goes back to the judging thing. If bad things happen to people automatic-, so it's your fault (...) and I don't like being judged. Nobody likes being judged"* (P1).

Participants spoke about experiencing stigma around their mental health difficulties, including feeling blamed for their experiences: *"I was being pathologized, because I was*

*being told there was something wrong with me, I thought there was something wrong with me. And now I know (...) that it's a normal reaction" (P3).*

Participants shared facing judgements and stigma around mental health and survival responses from family members or within their careers and working lives: *"my dad never really understood mental health" (P7), "growing up my mom always used to tell me I was evil" (P8), "Work was difficult (...) I never, ever admitted to anyone that I had depression at work because there wouldn't have been the understanding there" (P4).*

Some participants also described experiencing racism and cultural discrimination from their abuser or their family: *"my husband's Indian and, um, his family never accepted me" (P2), "Then I found out that his family had asked if, because I was from [African country], they asked if I was black. So, a little element of racism there" (P5)., "He was Asian. And there were difficulties with him being able to see me because his family didn't approve (...) He told me his dad had said that white girls are, they're no good. Um, that they're all slags" (P4).*

#### *5.3.4.3 Unhelpful professionals*

Unfortunately, all participants shared their unhelpful experiences with professionals at different points throughout their journeys. This mainly reflected professionals in government services, including social care, health, and justice, who participants experienced as uncaring and unable to meet their needs. Participants described the barriers which they had faced in

accessing services: *“No professional support in the places where I should have got it. None from social services. None from the courts”* (P8).

I’ve been told I wasn’t bad enough to have an eating disorder, ‘cause I wasn’t being sick often enough (...) I felt very, very much like I had to fight to be heard. Um... that no one really cared, no one really understood (...) I was genuinely just not ill enough to receive the support I wanted... but I needed that support. (P7)

Participants also described the overzealous use of prescription medication and physiological treatments which they had experienced, and how they felt that this located issues with them and failed to address the problems they were facing:

One of the things that, um, really, really struck me is that when I, um, went to my GP she said, “oh, you sound depressed. Would you consider taking antidepressants?” (...) I said, “would it stop my husband from being a lazy asshole?” And she laughed. And, uh, she says, “no I’m afraid that they won’t do that.” And I said, “well, I don’t want them then.” (...) it’s not gonna fix anything. Me taking antidepressants is not going to fix the problem. The problem was never me. (P3)

Participants reflected on the lack of concern from health services around the DA which they experienced and how this left them feeling unsupported and disappointed:

When I was going through all the abuse, the police, the hospitals, you know, they just weren’t interested. Back then it wasn’t something they dealt with (...) having to go to A&E, you know, and the doctor not being interested in the fact that, uh, he’s just been told

that, you know, you've come in with an injury f-from domestic abuse (...) I think that's where I f-, really felt let down. (P4)

Participants described the support they received in therapy, and how the care and tools which they were given often did not help them to resolve the problems which they were experiencing: *"I had... one to one counselling, uh, group counselling, um, CBT, and I also saw a clinical psychologist, but none of it helped (...) it was just that bad. I think having gone through the mental health system and finding that didn't work, just made things worse"* (P4).

P7 shared feeling traumatised and abandoned by services following an attempt to end her life:

I feel partially traumatised by services. Um... because I've never had a good experience with them (...) I got discharged from adult mental health services two weeks after I tried to commit suicide (shrugs). They said they couldn't do anything for me and just said, you know, "go on" (P7)

Some participants also described how the use of diagnostic labels in mental health services left them feeling blamed for their difficulties:

I'd been labelled as unstable and that... everything was my fault. I was, I was the reason everything was the way it was (...) DBT expects you to change, and psychotherapy... everything was about me changing and something being wrong with me (P8)

This subtheme focused on participants experiences of being excluded, blamed, or let down by services and provided important insight into the need for further developments to improve the support available and provide services which meet the needs of survivors of DA.

#### *5.3.4.4 Supportive others*

Participants shared their experiences of helpful and supportive others in their social support networks, including some friends, family, colleagues, and neighbours, and the impact which these supportive relationships had had for them. Participants shared the vital role which formal and informal sources of support played in their journeys and how this helped them to survive through difficult experiences. They shared how this helped them to develop their self-esteem, regain a sense of wellbeing, and overcome some of the problems which they faced. Participants identified acceptance, kindness, and being listened to without judgement as key aspects of support.

The majority of participants spoke about the support they received through charities and support groups, and the connection and acceptance they experienced through sharing their experiences with others: *“Talking to people about what I’ve been through and realising that other people have been through it really helps (...) in the groups I go to for my recovery, people understand. They... accept me”* (P7), *“That was the only thing that fixed me was going to those groups. And, and the only thing that helped me and stopped me cutting myself, stopped me hurting myself, stopped me being suicidal. And made me, like, happy”* (P8).

Many participants described the support which they had experienced from their families, especially where they experienced this as non-judgemental and accepting:

I was very, very upset when my grandad died because he was my hero. He was the only person in my whole life that had never judged me (...) I could talk to my grandad about anything, and I knew he wouldn't judge me (...) the only person in the world who accepted me for exactly who I am. (P1)

Some participants shared receiving support through university or employment services and how they valued having their decisions respected:

My bosses at work. They are wonderful humans. I'm, I'm very lucky now... that I have a lot of people around me who I know want the best for me and they may not always agree with what I do, or what I say, or the decisions that I make. But they respect them. (P1)

P6 shared how much she had valued having time for herself during supervision through work, and how it left her feeling listened to and supported:

I was very upset when I left my supervisor, um, because I felt like she was one of the only people in my whole life that had listened to me (...) I spend what I believe my life listening to everybody else and providing support and, um, yeah, just to have that 50 minutes for me. Where somebody listened to me, just yeah, it was... felt a lot to me. (P6)

P3 shared a significant relationship in her life with her neighbour and a teacher at school, and how this had helped her through the ACEs which she had experienced and prevented her from experiencing more severe negative consequences:

One of the most beautiful things that I've had throughout my life, um, is a caring adult, and although that wasn't my parents, I know that the presence of, I now know that the presence of a significant caring adult (...) that's the reason I'm not dead, a drug addict, or in a mental institution. Um, and it started with my next-door neighbour (...) she was the kindest, the most loving person I've ever known. (P3)

P7 shared the support she experiences within her current relationship. She shared how being listened to and not abandoned by her girlfriend has helped her to challenge the fears and preconceptions she carries from her previous experiences of DA:

I've got a girlfriend now and I've, I've realised that I'm gay now (...) She understands me. She just accepts me for who I am. And when I'm having bad days, I can just have my bad days. There doesn't have to be a reason there (...) she'll just listen to me. And it, it's weird (laughs) it's really weird. I'm not used to it and... a lot of the time I don't like it because I'm not used to being listened to. Or I don't feel like what I'm saying is important. But she treats it like it is (...) when I have my bad days, I try and push her away, but she always comes back. She's like a, a bad penny, she sticks around.

P5 spoke about her experience of community support, including support received from neighbours and how this had helped her to not to feel alone in facing the challenges she had experienced in separating from her abuser:

If people know that you're having a problem and you reach out, then hundreds of people that you don't know will turn up (...) to this day I am in awe. We had Christmas presents delivered (...) I didn't know any of these people and it was just such a community feel (...) we do lots of things and they were really supportive.

### **5.3.5 Major Theme 4: Resilience and development**

#### *5.3.5.1 Overview of the theme*

Participants shared the thoughts, attitudes, and behaviours which they felt had made them more resilient, as well as the personal meanings which resilience had for them. The major theme of resilience and development captures the importance which participants placed on their identity, gradual development, changing attitudes and beliefs, self-acceptance, and increased confidence in themselves. Participants described the changes to their lives which these had helped them to achieve and contrasted these to the challenges and difficulties which they had previously faced. P8 describes how everyday acts have taken on a new significance in light of her experiences:

Anything I do now feels like an act of resilience (...) every time I paint a wall bright pink or, um, I dunno, decorate in some crazy way that he would hate (...) it feels like just an act of... resilience.

#### *5.3.5.2 Identity*

This subtheme focused on participants' narratives around their sense of identity and how this had been shaped by, or had changed through, their experiences. Participants contrasted themselves and their experiences with others and consider what it means to be a survivor. P8 emphasised the importance of her changing identity in her recovery: *"I'm a completely, completely different person to what, to who I was"* (P8).

Participants described themselves and their identity as a survivor in terms of their positive traits: *“I’m not somebody who gets easily defeated at all”* (P6), *“I do feel like I’m getting... stronger”* (P5), *“You lose so much of yourself. And I think while you’re together, you need to hold on to something that makes you you”* (P8).

Some participants spoke about the gratitude they felt for their experiences, as they had shaped them into the stronger person that they are today: *“I always kinda say that I don’t, I don’t necessarily regret what happened to me (...) because it’s made me the person I am today”* (P7).

It’s not gonna sound very good, I don’t think, but I am grateful for everything that’s happened to me. Whether it’s good, like the birth of my children and passing my degrees and, and things like that, or whether it’s the bad things, you know, with the, with the abuse and all the unpleasant things that happened when I was a teenager. Because they have helped shape me and they have helped... make me who I am now and I believe that I am stronger and a better person for, for all those things happening. (P1)

P3 described how her experiences had made her into a more appreciative person, which has allowed her to find her own happiness:

But the flip side of it is that when you go through these types of things. When, when your life... has been the yoyo that mine has, um, you learn to appreciate the, the really, really, really simple things of life (...) my happiness comes from within, that’s where it’s always existed (P3)

### 5.3.5.3 Gradual progress

The process of positive change, growth, and building resilience was framed as ongoing and incremental by participants. This is a significant message of hope for individuals who are currently struggling to see how things can improve and provides a narrative for the importance of even the smallest steps towards wellbeing. Participants shared their experiences of gradual improvements: *“You learn and you grow and you, you evolve all the time (...) I will not feel the way I do about certain thing in a year’s time, maybe even tomorrow, maybe in a month. I will not.”* (P1), *“I’m better, I’m a lot better than what I was 12 months ago, even though I’m still going through the same, um... thing. So, my mental health is better (...) it’s just like one step at a time”* (P2).

Participants shared how a continued focus on developing their ability to cope over time had expanded their ability to deal with difficulties. Their narratives framed resilience as a constant journey and not a destination:

I do believe it’s an ongoing process. I... I don’t think you get to a point in your life where you think “that’s it, now I’m alright” (...) I just have a really good way of being able to deal with things like that now, which I don’t think I would have coped with... before (...) growth is ongoing. I really believe that. So is development. It just doesn’t stop. (P4)

However, some participants also shared how suddenly they experienced the effects of their steady work towards personal development: *“I’ve waited all this time. I’ve done all this work and then all of a sudden, lots of things have started to go right”* (P3).

#### 5.3.5.4 *Seeing things differently*

Participants described a process through which their perspective on their situations and themselves changed over time. They linked their perspective to their ability to make changes and take action in their lives. They also outlined the positive impact which this process of change in the way they see things had on their personal growth and development: “*You could be a lot stronger than what you think*” (P2), “*I viewed it very differently as a child than I do now looking back as an adult (...)* It’s just, um, one of the things that there’s, there’s been a fundamental change in my belief system” (P3).

Participants viewed this process of perspective change as essential in their journey as a survivor and their recovery from mental health problems:

I’ve used the word perspective quite a lot and I think that is absolutely key... to achieving the life you want. Depending on how you look at things will depend on how you react to them and depend on the actions that you take going forward (...) My perception and perspectives that I use to view the whole, everything as a whole... has changed and it has had a massive benefit-, beneficial impact on both my physical and mental health” (P1)

#### 5.3.5.5 *Self-acceptance and care*

Linked to the previous theme of perspective change, participants also focused on their journeys towards self-acceptance and self-care. Accepting themselves was described as more helpful to participants than acceptance from others: “*not necessarily being accepted by, by others but... it helped me to accept myself*” (P1). This allowed them to engage in acts of self-

care and to speak about their abusive experiences without blaming themselves. Participants reflected on the effects of, and barriers to, self-care: *“I believe in myself. So, I’ll give myself permission. It’s taken me 43 years to give myself permission to do things, like make myself a cup of tea”* (P3), *“I think that I accepted it more and more, accepted it wasn’t my fault (...) I’m not ashamed to talk about it, not as much as I used to be”* (P2).

Some participants also spoke about the role which self-acceptance and self-care plays in supporting their wellbeing: *“Because of accepting everything about myself, I know what works and what, what doesn’t. So yeah, I, I kind of just trundle off and do my own little, little thing and then I’m, then I’m alright again”* (P1), *“Even just getting up in the morning (...) putting a bit of make-up on, just try and make me feel a bit... better (...) that’s how I look after myself”* (P2), *“I’m so, sort of aware now with my thoughts (...) I can definitely say I’m feeling tired today so I’m a bit irritable or whatever. But I don’t really get down or anything like that”* (P4).

P7 described how self-acceptance had helped her to feel less overwhelmed by her experiences and begin to feel more able to deal with her emotions:

It’s like, OK, I am different, that’s why... I experience emotions so highly. And that’s OK. It’s OK to be different. It’s OK to be unique. And it’s kind of helped me start to accept that what I’m experiencing is not this massive phenomenon that no one’s ever experienced before, it is something that other people experience. And it makes me feel more normal, more grounded, more... sane.

#### 5.3.5.6 Determination and confidence

Participants spoke about the role of determination and confidence in their personal growth and development. These traits were viewed as strengths which supported participants' motivation to survive and change. In contrast to the themes of questioning themselves, participants shared the impact of confidence on their mental wellbeing and sense of identity. Participants referenced these positive personal characteristics and how described how they manifested in different ways: *"I was determined"* (P4), *"I don't give up (...) if I decided to do something, come hell or high water, nothing is gonna stop me"* (P3), *"I just have to try and trust my own judgement as much as possible"* (P8).

In particular, P8 spoke about the importance of holding on to her own beliefs and making her own decisions, despite her abuser disapproving of this: *"I carried on dying my hair and I still got another tattoo, even though he stopped, I mean, he stopped talking to me when I got them (baby crying) I probably got them just for a bit of silence."*

This was also reflected on her strength and determination through her decision to have another child through IVF following her separation from her abuser:

I parent her how I want. And, uh, we do what we want when we want. We don't have anyone to answer to (...) just having (looks down at baby) this baby on my own, I feel was, was something (...) I felt I was at a point in my recovery where I was like, just a strong person. (P8)

#### 5.3.5.7 Validation

Some participants referred to the fact that others in their life could see changes and development within them, or notice strengths, which they might not have recognised themselves. This validation from others provided encouragement and helped participants to see themselves in a different light: *“I’ve got a mentor (...) and every time she sees me, she just goes, ‘How are you still smiling?’”* (P5).

P2 shared how feedback from her friends and family has been important in highlighting changes which she could not see for herself:

My kids will say, and close friends who know, you know, what’s going on, and they’ll say to me, “[P2], you’ve come such a long way. You’ve come so far” (...) I wish I could see it myself, but I really don’t. Maybe that lack of... belief, self-confidence, self-worth (...) I see that I’m the same person that I was then, but clearly, I’m not because they’re telling me I’m not.

### **5.3.6 Major Theme 5: Psychological distress, health, and wellbeing**

#### *5.3.6.1 Overview of the theme*

A key aim of the study was to gain insight into participants health and wellbeing, as adversity and abuse can lead to severe difficulties in survivors’ mental and physical health. Participants described their experiences of health problems, using both the medical model, including diagnostic labels, and more subjective descriptions of medically unexplained physical illness, stress, and psychological distress. These often presented in direct contrast to the subthemes presented in the previous major theme of *Resilience and Development*. They also spoke about the relationship between their experiences and their health, situating certain

difficulties within their life journey and linking conditions to specific events. The following subthemes highlight areas of difficulty in participants health and wellbeing following their experiences.

#### 5.3.6.2 *Mental health diagnoses*

The majority of participants described experiencing ongoing mental health problems and located the origin of these in the ACEs and DA which they had experienced. Some participants described this through diagnostic labels, including anxiety, depression, panic attacks, PTSD, ADHD, eating disorders, addiction, and borderline personality disorder. Linked to the previous subtheme of unhelpful professionals, participants shared their disagreement and disappointment with receiving diagnoses or having the problem located with them: *“I was being pathologized because I was being told there was something wrong with me (...) the problem was never me”* (P3).

Participants located their psychological distress and mental health problems in the adversity and abuse which they had experienced throughout their life journey: *“I believe that it’s years and years of living in, in trauma, in survival mode.”* (P3), *“Depression to me was definitely... a learned thing”* (P4), *“I’d been on Sertraline before, um, for postnatal depression (...) if I look back now that was more around the control that [ex-husband] had over me”* (P5), *“Anxiety (...) I think that comes hand in hand with... obviously the domestic abuse that I, you know, that I suffered over the years”* (P2)

P1 made reference to the impact of both childhood experiences of adversity and later experiences of abusive relationships in the development of her mental health problems:

As for... my depression and anxiety, I think that stemmed from, that just kind of built from when I was a child through the things that happened to me and into adulthood. The things that happened to me changed... the way that I view life (...) the depression and anxiety. Yes, I think... the things that happened to me... have... created, not necessarily the whole thing, but... I don't think they would be as bad as they are.

She also questioned whether her recent diagnosis of autism might have developed in response to her experiences:

Yes autism. I, I don't know if that's hereditary or whether it's kind of a, a thing that would have happened... or, or, or manifested itself whether or not these things had happened to me or not. I believe in my personal, uh, if you're looking at me personally, not, not considering everybody else, I think it is a coping mechanism. (P1)

P8 spoke about the direct link between her diagnosis of borderline personality disorder and the abuse she experienced from her ex-partner, and how her psychological distress and difficulties were alleviated following their separation:

While I was with my ex, I did have a, a diagnosis of borderline personality disorder and then when I split up with my ex, um, they said that I had, was cured. And, um, that I didn't have it anymore and signed me off mental health services (...) I only had it when I was with him. And, um, since then I haven't had any, um, I did have very poor mental health when I was with my ex. But not since being with him.

However, she also noted the ongoing impact of having to deal with her ex-partner around custody issues with their children:

You're never really apart, you're, I'm not out of the relationship with my ex. We shared children together. So, I'm still in an abusive relationship, it's just a different type of relationship than husband and wife. It's, it's a co-parenting abusive relationship. (P8)

P7 described how her experience of sexual assault as a teenager led to the development PTSD, but also noted how the memories and feelings associated with this had changed over time to include her abusive ex-partner:

They've definitely impacted my mental health (...) especially with, with my abusive relationship, I... became very suicidal (...) the PTSD kind of started after I was sexually assaulted (...) but it did morph... and... now a lot of my flashbacks, and my memories, and my negative feelings are associated with what I felt with my ex-partner.

Other participants referenced more generalised or undiagnosed difficulties with mental health: *"Mental wellbeing... (breathes in) Oh gosh, I don't even know where to start"* (P2), *"I've suffered with my mental health since I was about 12"* (P7), *"Very poor mental health"* (P8).

#### 5.3.6.3 Self-harm and suicide

Some participants gave accounts of self-harm and suicidal ideation or attempts as the culmination of the psychological distress they experienced as a result of their abuse.

Although sometimes framed as a form of coping, participants' attempts to end their own lives were frequently described as the only way out of the abusive environment, or the only means of ending the physical and emotional pain they were experiencing. Participants spoke about using self-harm to cope with painful emotions: "*I used to be addicted to self-harming*" (P7).

I used to be a cutter. I used to cut myself quite badly. I, my, my leg is quite, is heavily scarred, um, uh, at the time I wouldn't have said it was a coping mechanism but 100% it was. (P8)

Participants also spoke about having suicidal thoughts and attempts to end their life, framing these attempts as acts of desperation to escape their difficult experiences and emotions:

I was just in this vicious circle of being in pain. I wanted to escape the pain (...) I, I just didn't want to be here anymore. I mean, I, I, I remember it vividly (...) I felt like I didn't have... anything to live for. (P3)

And I did start to have... I think the term is suicidal ideations, ideation. And by the time I was in my mid-20s, uh, which did culminate in a, in an overdose (...) I know some people will say "oh it was a cry for help", but it really wasn't. I just wanted the pain to stop. (P4)

P7 shared the experiences of mental abuse and hopelessness which led up to her attempt to end her life, and also acknowledged her intent to punish her abuser and maybe prevent him from creating more victims:

I had my ex at the time telling me that like, “no one cares about you, I’m the only one that will ever love you (...) why are you even here?” And... I thought yeah, why, why am I here? What, what’s the point? I’m not gonna get better (...) I was like, what, what is the point? I need this to stop. I need the pain and suffering to stop. So, I tried to make it and it didn’t work. And I felt... worse after the attempt. I was in hospital for two days. But I felt worse mentally after the... attempt because I was like “Oh, I’ve even failed at that” (...) and in a way, something I’ve never admitted before, is I wanted to hurt him (...) because nothing I said mattered to him. So, I thought, if I do this... maybe it will hurt him. Maybe it’ll make him realise... what he was putting me through. And maybe he won’t do it to another person. (P7)

#### *5.3.6.4 Disconnection*

The most pervasive threat survival response which participants identified was cutting off or shutting down from their emotions. Participants shared their experiences of freeze and dissociation responses which are a hallmark of traumatic stress (Herman, 2015). Participants frequently described avoiding thinking about their experiences or feelings: “*I just let it go over*” (P6), “*I try not to focus on it too much*” (P3), “*I’m not very good with emotions. I don’t like them, they, they scare me and I, I can’t really cope with them very well, especially negative ones*” (P1).

Not thinking about what I was going through too much because I suppose I would have probably cracked (laughs) (...) I just couldn't talk about it for some reason. I think I've just pushed it all under, whatever that means, you know. Uh, just to try to sort of forget about it (...) I think I was quite... numb really. (P4)

P2 described how this process of cutting off from emotions left her feeling robotic and questioned whether it was a necessary survival strategy at the time:

I think it's just like you're a robot, you just do it and get on with it (...) you can't think about it, 'cause if you do, um... you'll be back down there (...) I try and put what I'm feeling to the back of my mind (...) close it in a box somewhere (...) that's when you're in automatic pilot (...) like a robot. Don't think about it, just do it (...) So no matter what goes on on the outside... you try and block it... you know, so it doesn't matter. You just carry on doing whatever, you know, carry on doing whatever you're doing (...) I don't know if it's survival mode, you just get on with it maybe?

Other participants described a process of avoiding thoughts and emotions by bottling them up: *"you just bottle everything up"* (P5), *"I put them in a little tote box. I shut the lid and that's where they stay"* (P1).

Participants also shared the need to remain quiet or to present as OK on the surface to survive, and how this led them to hide their feelings and become disconnected from others: *"I was quiet (...) I had to be quiet because no one wanted to hear what I was saying"* (P7)

Some days I might be having a really bad day, um, I try, you know, they say you put a smile on and everything, you know, everything's OK. It's not, but that's how I want to portray, that I'm fine. (P2)

#### 5.3.6.5 Questioning self or reality

Participants spoke about doubting themselves and their interpretation of reality. This uncertainty had a significant impact on participants' mental wellbeing and was a source of psychological distress. Questioning the validity of their experiences, or being in a state of denial was a large part of participants' survival responses at the time of the abuse which prevented them from seeking help: *"his friends didn't bat an eyelid, so I was like, am I... am I actually being abused or... is this the way it's meant to be?"* (P7).

Participants described the process of normalising or denying the abuse they experienced:

I remember someone asking me a few years ago at what point did I know... that there was a problem. I couldn't tell ya (laughs) I really don't know. Yeah, it's, I think by then it was, it was the norm (...) I didn't think anything was wrong (...) I think denial's got a lot to do with it, it really does (P2)

Somebody had said to me "you're in a, in a controlling, coercive relationship. You need to get out" and I was like, "no I'm not. He's not violent, you know, I grew up in a really abusive relationship. This isn't abuse" (P5)

P1 shared the internal struggles she continues to face around distorted thoughts and not feeling able to trust her own mind at times:

My brain is either my best friend in the world (...) or it is my absolute worst enemy and it will tell me lies, and it will feed me poison (...) I didn't play my favourite computer game for two years because I was absolutely convinced that if I did, something bad was going to happen (...) It's exhausting sometimes, having to, to argue with your, your own mind, and it nearly trying to lie to you and, and, and poison you, you know, from the inside.

Participants also shared their experiences of their abusers gaslighting them through the purposeful use of lies and manipulation to erode their self-esteem and make them question themselves and their reality. This process is well described by P8:

When I was with him, I felt confused all the time. Or like I never, I never understood whether up was down or down was up or... and I got so confused that I ended up relying on him solely for my interpretation of reality (...) I just became this shell of a person who just relied on him completely to, sort of, tell me what was what, and what was reality and what wasn't reality and what was in my head. (P8)

Despite having left their abusers, participants shared how this gaslighting process continued to impact on their ability to trust others and affect their worldview: *"Occasional examples will come to me, or something will happen, and I'd be like, 'oh yeah, oh that was a lie that, or that wasn't real'"* (P8), *"but I still feel like... the people that love me – do they really love me? Because they don't necessarily build me up to the highs he did"* (P7).

#### 5.3.6.6 Negative thinking about self

Although related to the self-doubt which participants experienced when questioning themselves and their reality, this theme focused on participants' negative attitudes and beliefs, particularly the criticism and blame which many participants directed towards themselves and the ongoing psychological distress which this causes them. At times, participants used harsh phrasing in describing themselves, including words such as “*inadequate*” (P4), “*second best*” (P6), “*a failure*” (P2), “*manipulative*” (P8), “*evil*” (P1), “*ugly*” and “*worthless*” (P7).

Participants shared thoughts of blaming themselves for, or feeling shame or guilt about, their experiences: “*I felt ashamed, embarrassed, like I've done something*” (P2), “*constantly criticising myself, constantly worrying about what other people thought of me*” (P4)

After I was sexually assaulted, I turned to (...) making myself sick because during my sexual assault I was told that I was ugly, that I was fat, that I was worthless. Uh, so I kind of turned to... trying to make myself more attractive (P7)

Some participants also shared beliefs that they should have noticed the abuse earlier or acted differently: “*But whether it's tolerance or just, you know, you keep going back and thinking, well, you're allowing him to treat you like this, so he's gonna carry on*” (P6).

Now I look at it and I'm really annoyed at myself (...) for putting up with it for so long and for accepting it, for allowing it, 'cause I allowed it to happen, so I can't even say it was all his fault because I allowed it as well... to an extent. (P2)

Participants also noted how this self-criticism and unhelpful internal dialogue mirrored messages from their abusers, maintaining some of the negative effects of the abuse which they had experienced:

I judge myself for everything (...) because I wouldn't talk to my worst enemy the way I talk to myself. Um... 'cause it's just, it's rude and disrespectful and it's just mean and... in a way, abusive (...) I feel like I don't... I don't deserve happiness. (P7)

#### *5.3.6.7 Problems with anger and rage*

In addition to the self-directed anger and aggression captured in the previous themes of self-harm and suicide and negative thinking about self, some participants also spoke about how their experiences and overwhelming emotions culminated in acting aggressively towards others, and shared the harm which this caused them and those around them:

And I was, I was scared, and I was worried, and I was upset, and I was angry. I was a very angry person when I was a teenager all the way up until I was about 36, I was just angry all the fucking time. I was just mad at everything and everybody (laughs) (...) I mean, I stabbed my brother through the foot with a, with a pitchfork 'cause he pissed me off. (P1)

P5 described how she struggled against being drawn into anger, and the guilt she experienced after an occasion in which she took her anger out against her daughter:

I also know that the aggression and the violence wasn't something that I wanted to be a part of. And I remember hitting [daughter 1] once, and she wet herself. And I burst into tears. And, you know, I certainly... I just, it made me feel awful. (P5)

This pattern of anger followed by guilt was also echoed by P7, who described feeling intense sadness following angry outbursts:

I get into arguments quite a lot, um, and then I get incredibly depressed afterwards (...) I do mainly say things that, like, at the time I mean it. At the time I really mean it, but then, give me an hour, two hours, and I'm sobbing because I, I didn't want to hurt that person. I didn't want to say what I said.

However, she also recognised the protective function which anger serves in keeping others away: *"I feel like the anger is the way I express things now because I need to protect myself. I don't let people get too close"*.

#### 5.3.6.8 Addiction

Participants shared how problems with substance use and addiction impacted on their wellbeing. They described addictive behaviours as attempts to cope with the difficult emotions brought up by their experiences of abuse, but also noted that these ultimately ended up causing further psychological distress. Some participants described using drugs and alcohol to numb their pain when they were experiencing the abuse: *"I started taking drugs to es-escape from that (...) it allows you to escape from your, your current situation and it is the only escape"* (P1), *"so I, I spent a few years, um... drinking myself into an oblivion"* (P3).

P7 shared how her addictions developed to deal with the distress she was experiencing, and how her use of substances spiralled out of her control:

From the age of 19 onwards I struggled with addiction with cocaine and alcohol (...) I turned to marijuana, uh, just to try and make my head a bit quieter, uh, try and calm me down and stop myself from having panic attacks all the time (...) then when I met my ex, I turned to cocaine (...) when I was using the, the coke, I got calmer, I didn't think as much, and I could talk about my past experiences. And then... I started using more and more and more to... cope with what I was going through. Um, and I started drinking, because when you drink you get confident again and... (breathes in) you forget the bad things (P7)

Some participants shared their financial struggles with debt as a result of addictive spending: *"'cause I've been shit at managing money before. I was always in debt"* (P1)

I used to spend (laughs) money, that was a thing. Yeah, I mean I did get into debt at one point because, I think, that was my kick (...) that was what made me feel better, sort of buying something (P4)

Other participants described how their experiences of adversity and abuse led to comfort eating, leading to significant variations in their weight: *"I used to comfort eat (...) I'd certainly put on eight, eight, ooh, probably more than that. Um, probably put on about 15 stone seeing [ex-husband] (...) and I have lost 9½ stone since he left"* (P5)

### 5.3.6.9 Physical health and stress

Participants also described a range of physical health problems, including endometriosis, high cholesterol, pulmonary embolisms, psoriasis, asthma, miserable malalignment syndrome, and hypermobility and how these limited their physical health and wellbeing. Some participants also referenced undiagnosed and medically unexplained physical complaints arising following their experiences of abuse: *“I’ve... had... all sorts of weird issues (...) they can’t actually pinpoint what the matter was”* (P5), *“there was no injury at the time when I first had the shoulder pain, and I went to see an orthopaedic consultant. They couldn’t find anything wrong”* (P4).

P4 described how her debilitating shoulder pain was linked to her experiences of stress and abuse:

I was pretty much a, a mental or physical wreck (...) It started around the same time. I think, you know, the link between the mental and physical is still not appreciated as much as it should be (...) I was using too much muscular contraction. In other words, I was so stressed and depressed, um, I was contracting muscles (...) if you have a, a stimulus that’s... unpleasant you can react to that by contracting muscles.

P1 spoke about her experience of endometriosis and how her experiences might have contributed to, or exacerbated, her health difficulties:

When I was born, there was nothing I could really do about that and life experiences, they may have exacerbated the symptoms sometimes, so when I was feeling very bad and I

wanted to have a sleep for four days, you know, with endometriosis because it's all muscle related the best thing you can do is get up and walk around (...) it makes it worse.

#### **5.4 Integrated findings**

As the study followed an explanatory, enriching mixed methods design, the cumulative results of both phases deliver a more detailed picture than each individual component. These overall findings depict the vital role which coping strategies, supportive relationships, and resilience play in participants' journeys and their collective impact on participants' wellbeing.

The phase two qualitative results aid in the understanding of the phase one quantitative results. The major themes of *Coping strategies, Support and judgement* and *Resilience and Development* operationalise these concepts in practical terms and provide contextual information to the quantitative findings that resilience was a more significant predictor of wellbeing, stress, and anxiety than the presence of ACEs. These themes offer insight into participants' resilience, life journeys, and current coping responses, while the major theme of *Psychological distress, health, and wellbeing* provides more detailed insight into some of the specific challenges which participants faced.

## **Chapter 6. Discussion**

### **6.1 Interpretation of results**

The study aimed to expand on existing knowledge around ACEs among female survivors of DA to further understand the complex and intersectional difficulties they face. The study findings in part replicate and confirm the general trend in the literature regarding the well-established relationship between ACEs and lower levels of wellbeing, however it also introduced an original contribution to knowledge in the field by exploring the relationship between ACEs and resilience, including individual coping responses and social support resources, and the impact of this on participants' overall wellbeing. To the researcher's knowledge, few mixed method studies thus far have focused on these three key themes of adversity, resilience, and wellbeing with survivors of DA.

This chapter interprets the results of the statistical analyses and thematic framework presented in the previous chapter, focusing first on ACEs and wellbeing and then on resilience, coping, and support. These results are interpreted in reference to existing literature, the study hypotheses in phase one, and the thematic framework derived from participants' narratives in the thematic analysis in phase two, which sought to explore the role which ACEs and resilience play in survivors of DA's life journeys and later wellbeing and their experiences of support and coping responses. The interpretation of results is followed by a consideration of the study's strengths and limitations, the implications of the findings for counselling psychology practice, and potential directions for future research.

In summary, the "take away" messages from the quantitative findings were the high level of ACEs experienced by survivors of DA in comparison with the control group and the impact of resilience on the relationship between ACEs and mental wellbeing, which emphasised the important protective function of resilience, although this was diminished at

higher levels. This is a hopeful message as resilience is an acquirable trait, provided individuals have access to sufficient support and coping resources. The qualitative thematic framework provided key insights for practitioners and service development by presenting a detailed account of participants' early life challenges, how psychological distress presented for participants, the struggles faced by participants through experiences of stigmatisation when seeking help, the forms of coping and peer support which participants found beneficial, and participants' experiences of resilience in terms of their gradually-developing new identities and perspectives.

### **6.1.1 ACEs and wellbeing**

The study sought to expand on previous research into the cooccurrence of ACEs and DA, and the impact of these often-traumatic experiences upon survivors' wellbeing. Existing literature has identified both internal processes of traumatic re-enactment (Van der Kolk, 1989) and Intergenerational Transmission Theory (Sellers, Cochrane, & Branch, 2005) as potential explanations for survivors' experiences of revictimization and these formed the theoretical basis for the study.

The results of the quantitative analyses in phase one indicated that the survivors of DA group reported experiencing significantly more ACEs and scored significantly higher on the DASS Anxiety and Stress subscales than the control group. These findings are in line with previous research, which found that women who reported experiencing ACEs were more likely to have also experienced intimate partner violence in adulthood (Kalmakis & Chandler, 2014) and that experiences of ACEs increased the odds ratio for anxiety, especially longer-term anxiety (Hughes et al, 2017), and poor mental health (Logan-Greene et al, 2014). This supported the first hypothesis that survivors of DA would report significantly higher

levels of ACEs than the control group. Mean ACE scores for the control group were consistent with those found in some previous international studies with a general population (Crandall et al, 2019). However, the prevalence of ACEs found within the study was much higher than that reported in other previous studies in the UK, with the survivors of DA group reporting that 93.7% experienced at least one ACE, nearly double the prevalence rate of the general population (Bellis et al, 2014). This suggests that ACEs were particularly relevant for survivors of DA within the study.

In terms of ACE categories, the finding that the survivors of DA group were significantly more likely to report having experienced physical, emotional, and sexual abuse fits with previous studies which found these categories or groupings of ACEs have a more direct impact on later outcomes (Font & Maguire-Jack, 2016; Mosley-Johnson et al, 2019). The finding that DASS Depression subscale scores were not significantly different between the survivors of DA group and the control group in our study is also surprising given previous findings that reported ACE scores were associated with a higher probability of being diagnosed with a depressive disorder (Font & Maguire-Jack, 2016). Additionally, the other significant ACE category differences found between the survivors of DA and control group included emotional neglect, exposure to mental illness, and exposure to substance abuse or alcoholism. These ACE categories have not previously been identified as significant predictors of outcomes, and thus this represents a novel finding which might merit further investigation with survivors of DA to determine whether these forms of neglect and household dysfunction are common or important experiences. These might also have relevance for understanding one mechanism by which the intergenerational transmission of adversity and trauma might occur. However, it is interesting to note that there was no significant difference in terms of exposure to violent treatment of a female caregiver between the survivor of DA group and the control group, which suggests that the process of

intergenerational transmission might not be entirely driven by social learning through familial roles.

The results of the qualitative analysis in phase two provided a deeper understanding of the ACEs and challenges experienced by participants in the major theme *Early life challenges and adversity*. From a PTMF (Johnstone & Boyle, 2018) perspective, this major theme outlines participants' experiences of the operation of power and the core threats to their safety and wellbeing. The subthemes presented also fit Van der Kolk's (2015) description of developmental trauma: experiences of abuse, neglect, and other forms of familial dysfunction, which lead to the development of emotional and biological dysregulation, problems with attention and concentration, and interpersonal difficulties. He argued for the inclusion of developmental trauma disorder as a recognised diagnosis in the DSM-V to distinguish the significant impact of these often-chronic experiences on a child's development from that of singular traumatic events in adulthood. They are thus distinct from later experiences of DA in adulthood. However, both are likely to share the key features of Herman's (2015) description of psychological trauma: terror, disempowerment, and disconnection from others.

Participants shared the profound impact of their experiences of sexual abuse and physical violence and their descriptions fit with previous research into the consequences of sexual abuse for survivors' wellbeing (Font & Maguire-Jack, 2016; Mosley-Johnson et al, 2019). Previous studies have found that both childhood experiences of sexual abuse and later experiences of violent domestic abuse each uniquely contributed to PTSD symptoms (Krause, et al, 2008). Interestingly, the most widely reported of these experiences within the phase two interviews was *Violence within the home*, including both witnessing violence between caregivers and participants' own experiences of violence from caregivers. This supports the finding in phase one that the survivors of DA group were more likely to report experiencing

physical abuse in childhood than the control group and provided insight into the severity of these experiences for participants. However, this also contrasts with the phase one finding that the survivor of DA group did not report significantly higher levels than the control group on the exposure to violent treatment of a female caregiver ACE category. The wording of the ACE-Q used in phase one to record ACEs assumes male caregivers as perpetrators of violence, while some participants in phase two reported their female caregivers as abusive or being exposed to bidirectional abuse between their caregivers, which might account for these seemingly contradictory findings.

The subthemes of *Emotional abuse and cultures of silence* and *Neglect* highlighted the direct impact which early life experiences had on the meaning which participants made in terms of their perceptions of themselves and their expectations in relationships. These subthemes provide support for the Intergenerational Transmission Theory (Sellers, Cochrane, & Branch, 2005) and Social Learning Theory (Bandura, 1977) as relevant to understanding the cooccurrence of ACEs and DA. This builds on previous research which has emphasised the role which observing behaviours in caregivers' relationships plays in allowing individuals to make sense of and develop their own romantic relationships (Richardson et al, 2021). This finding also fits with previous studies with children and young people who had experienced abuse, in which participants reported psychological violence and emotional abuse as the most hurtful experiences (Aadnanes & Gulbrandsen, 2018).

The first major theme also presented two alternative forms of adversity which individuals might face in childhood which are frequently overlooked and lacking in traditional ACE research through the subthemes of *Rejection and interpersonal struggles* and *Grief and loss*. They highlighted the impact which stability within interactions with family and peers can have on the subsequent strength of survivors' attachments to others and ability to form supportive and regulating relationships, which was not captured by the ACE

questions in the phase one survey. Relationships with peers are important as previous studies have found that individuals use comparisons within friendship groups to help make sense of their own romantic relationships (Richardson et al, 2021). Isolation and the absence of close friendship groups might therefore lead to difficulties in identifying and addressing abuse in romantic relationships. The devastating impact which participants reported these experiences having fits with previous research which found that the short- and longer-term consequences of experiencing bereavements in childhood included a negative impact on psychological wellbeing and symptoms of depression in adulthood (Akerman & Statham, 2011). These subthemes highlighted the need for further research in this area and for studies to expand the ACEs literature to consider other significant forms of challenging experience in future measures of adversity and interview schedules with participants.

In terms of survivors' wellbeing, the major theme *Psychological distress, health, and wellbeing* illustrated the difficulties which participants faced in terms of psychological distress, health problems, and the threat responses which maintained these. It helped to contextualise the quantitative finding in phase one that the survivors of DA group experienced significantly higher levels of anxiety and stress than the control by providing insight into participants' lived experiences of psychological distress and mental health problems, captured by the subtheme *Mental health diagnoses*. This supports the findings of previous research into the relationship between DA and mental health problems (Flatley, 2016; Trevillion et al, 2012). The difficulties which participants reported facing in surviving overwhelming emotions share characteristics of Richardson's (2002) concepts of dysfunctional reintegration, in which destructive coping mechanisms are employed, and reintegration with loss, in which an individual might experience disruption through the loss of motivation, hope, or drive to regain homeostasis.

Significant threats to participants' wellbeing in the form of addictive and self-destructive behaviours and attempts to take their own life in order to end their suffering were described in the subthemes of *Self-harm and suicide* and *Addiction*. This fits with previous systematic reviews of ACEs which identified suicidality, suicide attempts, and substance addiction as potential outcomes in later life (Kalmakis & Chandler, 2014; Liming & Grube, 2018). Previous studies have also found that higher ACE scores are significantly associated with depressed affect, suicidal ideation, and attempted suicide in adulthood (Merrick et al, 2017; Petruccelli et al, 2019). Flatley (2016, p.23) also reported “emotional problems” and “tried to kill self” as non-physical effects of partner abuse. Participants reported both these strategies as ultimately maintaining psychological distress and impairing their wellbeing.

Herman (2015) and Van der Kolk (2015) both conceptualised self-injury as an attempt by survivors of trauma to gain a sense of control and achieve emotional regulation in the absence of any alternative forms of soothing. Addictions formed another maladaptive coping strategy employed by participants to try to sooth overwhelming emotions or escape from the psychological and physical abuse that they experienced. This echoes previous research which found a clear positive association between alcohol use and domestic abuse (Devries et al, 2013) and with previous qualitative explorations of addition and alcohol use with survivors (Childress, 2013; Gadd et al, 2019).

This is also an important area to consider for future service provision, as survivors have previously faced barriers to accessing specialist services due to issues with drug or alcohol use (Harris & Hodges, 2019; Humphreys & Thiara, 2003). These subthemes thus highlighted important areas of risk to self amongst survivors of DA and fit with previous research findings that survivors are at higher risk of suicidality and suicide attempts (Devries et al, 2013; Munro & Aitken, 2020). However, these subthemes are also somewhat surprising given the quantitative finding that the survivors of DA group did not report significantly

different levels of depression from the control group in phase one. This suggests that feelings of hopelessness and problems with addiction and suicidality are nonetheless relevant for survivors.

Other, less obvious, threats to participants' wellbeing related to experiences of ACEs and DA were described in the subthemes *Disconnection*, *Problems with anger and rage*, *Questioning self or reality*, and *Negative thinking about self*. The avoidant coping strategies highlighted in these subthemes are consistent with the findings of previous studies with women currently experiencing abuse (Waldrop & Resick, 2004). The psychological distress and lack of emotional engagement which participants reported avoidance causing also fits with the findings of previous research that avoidant coping strategies are ineffective and maladaptive for trauma survivors (Littleton, Horsley, John, & Nelson, 2007).

Participants' responses to abuse were consistent with the state of 'doublethink' or psychological degradation, described by Herman (2015), in which survivors shut down their inner world of feeling and thought and turn instead to a state of nonhuman passivity or 'robotization'. Van der Kolk (2015) noted that emotional detachment and out-of-body experiences result from experiences in which individuals are forced to shut down in response to inescapable trauma. This emotional 'shutting down' described by participants also fits with Porges' (1995; 2009) polyvagal theory and the immobilisation function of the dorsal part of the vagus nerve and this might provide a biological explanation for participants' responses to traumatic adversity in early life and DA experiences within the study.

These avoidant coping strategies may have been exacerbated by participants' experiences of self-doubt and normalisation of abuse, as well as the purposeful psychological abuse strategy of gaslighting used by abusers to undermine their sense of self and obscure and distort their sense of reality. Sweet (2019) argues that these tactics rely on inequality to

exploit individuals' vulnerabilities and often relies on gendered stereotypes, such as associating femininity with irrationality. This gaslighting process from abusers and survivors' subsequent internalised doubting also raised questions for participants around candidacy and legitimacy when accessing services raised in the major theme of *Support and judgement*. This process also echoed what Herman (2015) termed 'total surrender', in which survivors of DA suppress their inner doubts and objections, often due to deliberate attempts at demoralisation by abusers. This emphasises the need for professionals to listen to and believe survivors to help undo some of the psychological damage inflicted by abusers.

Additionally, participants own meaning-making processes in terms of the self-blame and negative self-beliefs which perpetuated their psychological distress were also highlighted. Previous research has suggested self-blame is more common amongst survivors of DA and is associated with negative adjustment (O'Neill & Kerig, 2000). This is also consistent with other studies which found self-blame and physical abuse to predict higher levels of PTSD in survivors of DA (Reich et al, 2014). Overstreet and Quinn (2013) also identified self-blame and guilt around abuse as a form of stigma internalisation in which survivors take on negative beliefs about themselves from others. These findings echo both Herman (2015) and Van der Kolk's (2015) descriptions of self-blame amongst trauma survivors, especially those who experience abuse in early childhood, and suggests that survivors might attribute 'wrongness' or 'badness' to themselves to help understand and make meaning from their experiences. These subthemes are likely also linked to the risk to self which participants described in terms of self-harm and suicidality and therefore represent another important area for intervention with survivors.

Participants also described incidents in which their distress manifested in risky or aggressive behaviour towards others. Participants' problems with anger fits with previous research, which found anger difficulties amongst survivors of trauma (Olatunji, Ciesielski, &

Tolin, 2010). This may lead to interpersonal difficulties and maintain participants' distress. Both anger and dissociation are complimentary methods of emotional disengagement which are associated with poorer functioning in survivors of sexual assault (Feeny, Zoellner, & Foa, 2000). Van der Kolk (2015) and Herman (2015) both described anger responses in survivors of trauma and aggression and disconnection strategies parallel fight or flight responses to threats.

Although the quantitative analysis in phase one did not measure participants' physical wellbeing, the subtheme of *Physical health and stress* presented some of the often-undiagnosed physical conditions which participants described in the phase two interviews. This fits with previous research which found that survivors of DA experience a range of central sensitivity disorders and other chronic physical health problems (Chandan et al, 2020; Chandan et al, 2021). Van der Kolk (2015) anecdotally noted a high incidence of autoimmune disease and other illnesses related to stress in survivors of trauma. He posited that this process may be associated with the hypervigilance and oversensitivity to threat which is seen amongst survivors and suggested that this might extend to their immune systems attacking their own cells when no actual threat is present. More research into this area may yield interesting and practically significant results for survivors.

The study results around ACEs and wellbeing may lend some support to the Intergenerational Transmission Theory (Sellers, Cochrane, & Branch, 2005), as participants attributed their psychological distress and problems with wellbeing to both their adverse early life experiences and later experiences of DA. Many also suggested that the latter were influenced by the former, meaning that the relationships between these might be difficult to unravel. It is therefore likely that the negative outcomes reported by survivors in terms of their mental wellbeing, stress, anxiety, suicidality, negative thinking, addiction, and physical

stress are related to the complex and intersectional difficulties which participants reported facing.

### **6.1.2 Resilience, coping, and support**

The study also sought to understand survivors' experiences of resilience, coping, and support, and how these related to ACEs and their current wellbeing. Previous literature has highlighted the importance of resilience and coping for survivors (Domhardt, Münzer, Fegert, & Goldbeck, 2015; Iacoviello and Charney, 2014; Jose & Novaco, 2016).

The results of the quantitative analyses in phase one provided some support for the second hypothesis, finding significant correlations between resilience scores and SWEMWBS scores and all three DASS subscale scores (Depression, Anxiety, and Stress). These results were consistent with previous research which has found significant correlations between resilience and mental health in survivors of domestic violence (Anderson, Renner, & Danis, 2012; Humphreys, 2003; Scali et al, 2012). As expected, the correlation analyses also found a negative correlation between ACE scores and SWEMWBS scores and positive correlations between ACE scores and two out of the three DASS subscale scores (Depression and Anxiety). These results help to provide a clearer understanding of the relationships between resilience, ACEs, and mental wellbeing, and are consistent with previous literature, which has found that higher ACE counts were correlated with lower SWEMWBS scores (Hughes et al, 2016) and a positive relationship between ACEs and psychological distress and mental illness (Petruccelli, Davis, & Berman, 2019).

Curiously, no significant correlations were found between ACE scores and DASS Stress subscale scores, or between ACE scores and resilience scores, which suggests that participants' resilience and current stress in adulthood were unrelated to the adversity they

experienced in childhood. This contrasts with previous studies, where systematic review and meta-analyses have found a negative association between ACEs and resilience scores (Morgan et al, 2022; Scali et al, 2012). However, previous studies have also reported that adverse experiences are outweighed by protective factors when predicting resilience (Howell & Miller-Graff, 2014), and this might partially explain some of this discrepancy.

The results of the regression analyses indicate a moderation effect of resilience on the relationship between ACEs and participants' current mental wellbeing. Only resilience and the interaction term were found to be significant predictors within the regression model, suggesting that ACE scores have a lesser role in predicting outcomes in adulthood than resilience. This finding supported the third hypothesis that resilience would significantly moderate the relationship between ACEs and mental wellbeing. The direction of the moderation effect suggested that the strength of the negative association between ACEs and mental wellbeing increases at higher levels of resilience. The Johnson-Neyman analysis of the moderation effect provided further insight into this process, by identifying the tipping point of conditional resilience scores at 64.98, above which this significant negative association was found. The visualisation of the moderation effect in Figure 2 provides a clear interpretation of this conditional effect, such that highest mental wellbeing scores occur at low levels of ACEs and high levels of conditional resilience, whilst mental wellbeing scores are consistently low (within the low to average mental wellbeing ranges of the SWEMWBS) for all levels of ACEs at low levels of conditional resilience. This finding is somewhat surprising, as it suggests that the buffering effect which resilience provides against the relationship between ACEs and mental wellbeing is diminished at higher levels. Despite this, resilience appears to be protective against poorer wellbeing even in those with high ACEs, where this effect is less pronounced. This would suggest that asking about ACEs may be particularly important for survivors of DA, especially those with high levels of resilience, in

line with previous recommendations (Bethell et al, 2017). This finding supports the buffering moderation effect for resilience resources on the relationship between ACEs and poor mental health days reported by Longan-Greene et al (2014) and the general hypothesis expected by resilience theories. Therefore, these results build on the existing evidence and support the value of providing strength-based, resilience-promoting interventions to those who have experienced ACEs, as outlined in previous studies (for example, Chandler, Roberts, & Chiodo, 2015).

The remaining regression analyses found that the interaction between ACEs and resilience was not a significant predictor for DASS Depression or Anxiety subscale scores, although resilience remained a significant predictor in both models. This finding did not support the fourth hypothesis that resilience would moderate the relationship between ACEs and DASS subscale scores. However, this still suggested that resilience is an important predictor of participants' current mental health in terms of symptoms of depression and anxiety.

The qualitative results in phase two provided a contextualised and rich account of survivors' resilience and experiences of coping and support in three major themes: *Resilience and development*, *Coping strategies*, and *Support and judgement*. The thematic framework highlighted participants' growth and positive outcomes following challenging experiences and emphasised the coping and support resources which negated some of their psychological distress or supported them to heal from it. Importantly, these major themes also highlighted the impact of stigma and discrimination as barriers to help-seeking and healing.

The findings suggest that participants placed importance on gradual changes to their identity as part of their healing journey. This fits with previous research in which survivors of DA reported the reclamation of self as a key theme of recovery (Childress, 2013; Heywood,

et al, 2019), and supports the wide range of recovery narratives in which individuals have described the ongoing nature of healing from trauma and the initially frequent setbacks which they might experience (Heywood et al, 2019; Van der Kolk, 2015). Herman (2015) suggested that the creation of a new self and shedding of those aspects of the self which were imposed through trauma are integral to the reconnection process for survivors.

Linked to this changing sense of identity was the finding that participants often also celebrated their new selves and the self-care behaviours which supported their process of change. Previous research has also emphasised that self-esteem is related to active coping in survivors of DA (Waldrop & Resick, 2004). Reducing self-blame through self-acceptance and emotional regulation has been found to be a significant predictor of treatment outcomes for youth trauma survivors (Sharma-Patel & Brown, 2016). However, other authors have criticised this approach as potentially blaming of survivors and suggested that the focus on survivors' self-esteem might reflect their attempts to engage with institutional authorities by embodying the dominant therapeutic discourse to gain recognition and legitimacy (Sweet, 2018). Despite this, themes of self-love and self-care have previously been found to be significant aspects of recovery amongst survivors of DA (Childress, 2013; Heywood, et al, 2019). Herman (2015) also identified self-care as an essential step for establishing safety for trauma survivors.

Participants' narratives on resilience reinforced theories of post-traumatic growth and align closely with the concept of resilience reintegration from Richardson's (2002) model of resilience, as exemplified in the subthemes of *Seeing things differently* and *Determination and confidence*. These dual processes of changing perceptions and increased self-worth and autonomy found amongst participants in the study might also reflect their innate tendency towards self-actualisation, a process of growth and healing advocated by person-centred therapy (Rogers, 1975). This also support previous research which found perceived control to

be associated with positive adjustment in survivors of DA (O'Neill & Kerig, 2000) and suggested that survivors might reach a 'turning point' in accessing support and help-seeking, following a re-framing of their experiences (Evans & Feder, 2014).

The thematic framework also presented a wide range of adaptive coping strategies which supported participants' resilience. Previous studies have found evidence that short-term psychoeducational and coping-focused interventions are beneficial for survivors of abuse (Arroyo et al, 2017) and emphasised that the strategies used by survivors appear to change over the course of the abusive relationship (Waldrop & Resick, 2004). Initially, these may have fitted more within the subtheme of *Self-reliance*, but over time participants described developing coping strategies which allowed them to connect with others and access external support and validation as well. Previous research suggests that self-reliance may be a common coping response amongst those who experience or witness domestic violence at a young age (Thornton, 2014). Cicchetti & Rogosch (2013) also noted that self-reliance may be important for the development of resilience in children who experience adversity but cautioned that it may contribute to the development of mental health problems in adulthood. Herman (2015) recognised that some survivors report increased self-reliance and being better prepared to handle conflict and danger as positive outcomes from their traumatic experiences, but also advocated for survivors to reconnect and deepen connections with trusted others.

The finding around participants' drive to understand and make sense of their experiences in the coping subtheme *Psychoeducation and understanding* supported previous research with child survivors of sexual abuse, which found a lack of coherent, contextually embedded narratives around their experiences of abuse and ongoing struggles to make sense of why the abuse occurred (Mossige et al, 2005). This could also have influenced participants' ability to regulate themselves and cope with difficult emotions. Van der Kolk (2015) described the process by which acquiring understanding and self-awareness of one's

internal emotional state, dubbed ‘interoception’, helps to facilitate emotional regulation in survivors of trauma, who frequently report struggling with experiences of emotional numbness and alexithymia.

Previous research exploring coping amongst survivors of DA has framed coping strategies as fitting into specific categories, such as approach or avoidant and problem-focused or emotion-focused. However, these distinctions have been criticised for overlooking the tension between individuals’ immediate survival tactics and the longer-term recovery goals of service providers (Goodman, Smyth, Borges, & Singer, 2009). Instead, the term ‘survival-focused coping’ has been suggested to recognise the constant trade-offs in terms of wellbeing between different coping responses (Goodman et al, 2009). Many of the coping strategies which emerged in the study more closely embodied this form of survival-focused coping, which often develops in the face of multiple constraints. The subthemes of *Exercise and physical coping* and *Positive distractions* support previous research into so-called active approach coping strategies, which has found that higher levels of physical activity were associated with reduced depression (Harris, Cronkite, & Moos, 2006) and increased resilience (Iacoviello & Charney, 2014). Van der Kolk (2015) also described bodily and somatic interventions to support ‘bottom-up’ regulation in survivors of trauma. This also echoes Herman’s (2015) principle of safety, which encourages the establishment of bodily integrity through exercise and self-care.

The thematic framework also explored the role of support on resilience, and this was evident both in participants providing support to others as a form of coping and the support which they received, or which was lacking. The results highlight how participants used their experiences to help others and how this help-giving process was an important source of motivation in their own healing journeys. Previous studies have found that survivors of DA are likely to be more empathic when supporting others due to their experiences (Donovan et

al, 2020; Heywood et al, 2019). The act of helping others and giving back may also have increased participants' self-esteem and given them the opportunity to connect with others. This fits with Herman's (2015) principle of reconnection as a key area for recovery from trauma, and she advocated for trauma survivors to take social action and find a 'survivor mission' to offer a sense of purpose, validation, and recognition. Another important finding around participants' coping through supporting others related to their role as mothers. The relationship which participants formed with their children supported their resilience and frequently marked a turning point in their healing journeys. This echoes the findings of previous studies which reported that survivors' desires to establish stable environments for their children played an integral part in their decisions to leave abusive relationships (Wettersen et al, 2004). Van der Kolk (2015) and Herman (2015) both argued that interpersonal relationships and attachments are an important mechanism for recovery from trauma, and it seems that bonding with their children through motherhood provided survivors in the study with the potential for a powerfully healing connection.

In terms of supportive relationships where survivors experienced being helped by others, the thematic framework reflected the importance of the support which they received from friends, family, employers, charity and non-profit services, and current partners. The study highlighted the key aspects which participants experienced in supportive others, including acceptance, non-judgement, and validation. This reinforces previous studies' findings that non-judgemental support networks providing affirmation, encouragement, stability, and understanding were vital for survivors' recovery and growth (Anderson, Renner, & Danis, 2012; Humphreys & Thiara, 2003; Munro & Aitken, 2020). Survivors have previously reported more positive experiences of disclosure with friends and family than with professionals, and that these relationships played a larger role in facilitating access to specialist support services (Evans & Feder, 2014). This also fits with previous research with

survivors of DA's friends and family during the pandemic, which suggested that these informal sources could make use of more creative methods for offering support (Gregory & Williamson, 2021). Existing research has also emphasised the importance of social attachment and support for survivors of childhood sexual abuse (Domhardt et al, 2015).

Previous studies found that survivors were more likely than their peers to engage in the use of instrumental social support but that there was no difference between survivors and their peers in terms of their use of emotional social support (Camelia & Ioana, 2015), which also fits with the emotional avoidance highlighted in the subtheme of *Disconnection*. Another potential factor in participants' experiences of support could be survivors of DA's own inner processes, as acknowledgement and recognition of an individual's experiences as abuse can be a necessary precursor to disclosure (Evans & Feder, 2014). Participants' use of emotionally avoidant coping by 'shutting down' from their experiences can thus hinder the disclosure process and prevent them from accessing support.

Participants within the study who accessed specialist DA support services reported these as helpful due to the acceptance, connection, and validation these services provided. Participants' descriptions of these services, often provided by the charity sector and non-profit organisations, as especially helpful fits with previous research which found that survivors valued the opportunity to discuss their own experiences with peers in a non-stigmatising environment to help make sense of them (Donovan et al, 2020; Guthrie & Kunkel, 2015; Humphreys & Thiara, 2003). Both Herman (2015) and Van der Kolk (2015) emphasised the importance of good support networks and relationships with others for survivors of trauma. This is thus particularly relevant for policymakers and professionals, as it highlighted the existing areas in which participants currently receive support and their preferences for the forms which support might take.

However, the findings also demonstrated that not all relationships with others were helpful to participants. The subtheme of *Judgements and stigma* highlights some of the challenges which participants in the study faced in terms of experiences of blame, prejudice, and stigmatisation around their experiences of abuse and mental health problems. This fits with the barriers to help-seeking presented in the intimate partner violence and stigmatization model (Overstreet & Quinn, 2013) and echoes previous research with survivors' family members which found that common social beliefs around abuse led to family members blaming and stigmatising survivors (Rose, 2014). Previous research with children who have experienced domestic abuse has also highlighted the role which public stigma plays in preventing survivors from seeking help (Houghton, 2015). Attention was also drawn to the impact of intersectional discrimination and how this can impact on survivors' ability to access support from social networks and services. This builds on existing evidence into the disproportionate impact of inequality for some survivors (Childress, 2013; Siddiqui, 2018), and highlights the importance of supporting access to services for those simultaneously experiencing DA and discrimination. This has direct implications for counselling psychologists, whose training and humanistic-existential paradigm emphasises a commitment to social justice (Amari, 2021; Winter, 2013), as these practitioners are well-placed to help address some of these inequalities in service-provision and can help facilitate the removing of barriers for clients.

In terms of professional support, the thematic framework presented participants' experiences of feeling blamed for their situations and ineffective helping from services. The mixture of stigmatization and blame leads to some survivors never accessing professional support or being poorly helped when they do receive support (Harris & Hodges, 2019). Unfortunately, this is a common theme found in research with survivors of DA, who often report experiencing negative reactions from professionals and other barriers to disclosure

(Childress, 2013; Evans & Feder, 2014; Hegarty, 2011; Humphreys & Thiara, 2003; Trevillion et al, 2014). Better understanding and insight into these processes could inform therapeutic interventions and support the development of services for this population who face severe and multiple disadvantages. This echoes previous research which found that negative interactions with health professionals during disclosure of abuse has an impact on survivors' subsequent help-seeking (Mackenzie et al, 2019). The study findings also noted participants' experiences of inadequate responses to their needs based on a medical model, such as being offered medication rather than therapy, which supports previous findings (Humphreys & Thiara, 2003).

Current literature has emphasised the role of health professionals in eliminating stigmatising attitudes among care providers (García-Moreno et al, 2014). Counselling psychologists can thus play an important role in advocating for clients who have experienced DA and support the legitimacy of their help-seeking. The use of a candidacy framework might also be helpful in providing both therapeutic and practical structural support to these clients and encouraging them to make use of the resources available (Mackenzie et al, 2019).

## **6.2 Study strengths and limitations**

### *6.2.1 Strengths*

The present study is one of few to employ a mixed methods design to specifically explore adversity, resilience, and wellbeing for female survivors of DA. The mixed methods design is a particular strength, as a purely quantitative design may have been reductionist given the breadth of the topic and research questions, while a purely qualitative design would lack the ability to compare survivors' experiences of ACEs against the control group and discover significant correlations and moderation effects. Both findings consistent with

previous research and unique results were generated through the quantitative analyses in phase one of the study, and powerful personal accounts and rich insight into participants' lived experience were gathered in the qualitative interviews in phase two of the study. The qualitative interviews in phase two also provided insight into several novel areas, including participants' coping strategies, experiences of accessing both formal and informal help and support, and some aspects of early life challenge and forms of adversity which had not been measured by the ACE-Q, such as significant experiences of bullying and rejection, and bereavement and loss in early life.

Use of online data collection was another strength, as it allowed for flexible, responsive, and unobtrusive interactions with participants through surveys and interviews which they could access from the comfort and safety of their own homes during the COVID-19 pandemic. This also afforded participants a degree of anonymity during participation which face-to-face questionnaires and interviews would not provide and might have encouraged participants to answer more authentically with less fear of judgement. Although this sampling method may limit participation by those less familiar with technology, such as older individuals who have not had the potential to learn newer technologies, phase one of the study still managed to recruit a fairly representative range of ages (18-75).

The study adopted the PTMF (Johnstone & Boyle, 2018) in asking participants about their life journeys to help understand their experiences of power, threat, meaning, and their responses. This provided a non-pathologising and person-centred framework for understanding their distress and allowed the study to highlight areas of need beyond specific diagnoses, which a more traditional approach influenced by the medical model might not have captured.

Participant consultation through survey questions in phase one of the study to develop the semi-structured interview schedule for phase two represents another strength, as it gave participants the ability to voice their thoughts and help guide the focus of the study. The study recruited participants anonymously from a wide range of sources through social media and advertising through support groups for survivors of DA, which gathered responses from a broad range of individuals and may have facilitated more honest disclosure than alternative methods of recruitment. The study was able to control for the effect of socio-economic status by broadly matching the survivor of DA and control groups and made use of multiple measures to explore both overall mental wellbeing using the SWEMWBS, and specific sets of Depression, Anxiety, and Stress symptoms as measured by the DASS subscale scores. This allowed for a more nuanced understanding of participants' current mental health and wellbeing.

The rich qualitative data in phase two, which presents original accounts from the perspective of survivors of DA, was another strength of the study, as well as the reflexive and subjective thematic analysis of results and the thematic framework which was developed. Braun and Clarke (2019) emphasise that participant and researcher subjectivity is a resource, rather than a threat to knowledge production and can thus enhance understanding by considering situations from different perspectives.

### *6.2.2 Limitations*

Despite its strengths, the study also had a number of limitations which mean that the results should be interpreted with caution. The cross-sectional study design precludes causal inferences from being drawn, whilst its reliance on retrospective and self-reported data may pose issues in terms of the reliability of the data collected from participants. Due to

methodological constraints posed by the Covid-19 pandemic, the study also failed to collect quantitative data on participants' physical health and wellbeing, thus neglecting a significant potential outcome of participants ACEs and experiences of DA.

In terms of recruitment, participants were recruited online through social media and support groups for survivors, which may have excluded potential participants who were not IT literate and might therefore not be fully representative of the general population as the study relied on this convenience sample of those within the reach of the researchers' visibility on a range of social media platforms. The study was also only available to English speakers due to a lack of alternative language speakers in the researchers. This limits the generalisability of the results, as they may be specific to this sample. Given the research topic, a self-selection effect may have taken place in which individuals with close person experience of DA, either in themselves or others, might have been more interested or invested in this area, and therefore more likely to take part in the study. Although generally matched in terms of Socio-Economic Status and demographics, there was a statistically significant age variation between the survivors of DA group and the control group which meant that average age for the control group was around 5 years younger.

Another limitation was the relative lack of diversity in the sample, 79.8% of the phase one sample identified themselves as "White", while the phase two sample had a single non-white participant. The study may also have recruited a WEIRD sample (Jones, 2010): participants were likely to be from Western, educated, industrialized, rich, and democratic cultures, therefore leading to a lack of cultural diversity. The study results should thus not be overgeneralised to other groups outside of the UK with differing cultural, religious, and social values.

Although the study was adequately powered for the quantitative analyses in phase one, the sample size was also relatively small at 119 participants. The study also initially aimed to recruit ten participants for the qualitative interview in phase two but struggled to achieve this from the available pool of participants who indicated their willingness to participate in interviews during phase one and thus saturation was deemed to be reached after eight participants had been interviewed.

The measurement of ACEs for the quantitative survey in phase one was relatively lacking in sophistication, as it excluded experiences outside of participants' home environment. This means that participants likely underreported their overall adverse and potentially traumatic experiences, which may bias the results. The study also deliberately did not measure severity, frequency, chronicity, and timing of ACEs in an effort to avoid or minimise distress in participants. Although our approach did not collect this more nuanced information about participants' ACEs, alternative approaches which are more sensitive to these details may have been experienced by participants as overly intrusive and carry more potential for unreliability, due to asking participants to retrospectively recall more specific information about potentially traumatic experiences.

### **6.3 Implications for counselling psychology practice**

The study is one of the first to examine the impact of both childhood adversity and later experiences of domestic abuse, and the roles of coping, resilience, and support with survivors. The results of the study have significant implications for counselling psychology. The quantitative results from phase one were presented at the annual BPS division of Counselling Psychology Conference 2021 (see Appendix I.). These results support a more holistic understanding of how intersectional difficulties inform the complex needs of

survivors of DA and emphasise the importance of resilience over ACEs in predicting survivors' current mental wellbeing. These results promote a focus on resilience and coping with survivors of DA and also emphasise the fact that ACEs do not inevitably lead to negative outcomes in later life. The results can also inform therapeutic interventions with survivors by highlighting potential areas of difficulty to focus on in therapy, including stress and anxiety.

The results of the qualitative analysis in phase two are significant for counselling psychology practice, particularly when working from a PTM framework perspective. The major theme of *Early life challenges and adversity* has relevance for counselling psychology practice, as it contributes to a clearer understanding of experiences of power and threat in clients who have experienced DA. This can help to direct the focus of formulations and supports a shift towards attachment-based interventions to address some of these implicit messages which clients might have received. It would also suggest these areas as potentially important formative experiences to explore with clients in sessions.

The findings presented by the major theme of *Coping strategies* offers insight into some of the protective factors which counselling psychologists can identify and promote with clients who have experienced DA, as well as a range of potential avenues for therapeutic interventions to focus on. Interestingly, it also highlights the importance of psychoeducation and understanding for clients' meaning making process, and this has direct implications for their resilience in terms of fostering self-esteem and compassion towards themselves.

The major theme of *Support and Judgement* highlights several important areas for counselling psychology practice, including the barriers faced by survivors of DA in accessing services to adequately meet their needs, the stigma which they might face due to insensitive and negative interventions, and the meaning which they might make from these experiences.

It presented some of the ways in which participants had previously felt let down by services. This is significant for counselling psychologists to be aware of in interactions with survivors, as they may struggle to trust health professionals and may need additional support to access services due to the intersectional difficulties they may face and the complex needs which they may present with (Harris & Hodges, 2019).

The major theme of *Resilience and development* provides several key processes for positive interventions with clients and presents novel findings in the area. These included highlighting the importance of slow, incremental growth in the subtheme *Gradual progress*, as well as participants' process of change in the subthemes *Identity* and *Seeing things differently*. The subthemes of *Self-acceptance and care* and *Determination and confidence* suggest that behavioural interventions which support clients' self-esteem and motivation may be particularly important for therapeutic work with survivors. Counselling psychologists can also provide clients with feedback on their progress through therapy, in order to support the process of growth which participants described occurring when others noticed and validated their resilient behaviours and personal development.

Finally, the results of the study, and in particular the major theme of *Psychological distress, health, and wellbeing*, highlighted the range of co-existing difficulties and threat/survival responses which impacted on participants' overall wellbeing. These areas included avoidance, confusion, self- and other-directed aggression and harm, problems with addiction, and the participants' physical responses to stress. This theme highlights the substantial challenges to wellbeing which clients face, and which counselling psychologists can offer support with through trauma-informed therapy approaches. Understanding the intersectional nature of these problems for clients who have survived both DA and ACEs can help to offer interventions and services which adequately meet their needs. This understanding can support exploration of these topics and create a starting point for

therapeutic conversations around the impact of multiple challenging, adverse, and traumatic experiences for clients.

#### **6.4 Future directions for research**

Although significant correlations between ACEs and mental wellbeing were found, the study utilised a retrospective cross-sectional design and thus could not draw any causal inferences from the results. Future studies could employ a longitudinal design in order to determine whether the higher rates of ACEs we found for the survivors of DA group increase individuals' subsequent likelihood of experiencing DA and cause mental health problems in adulthood. Replications with a wider sample would be helpful to further examine the interesting finding that resilience moderated the relationship between ACEs and mental wellbeing such that the relationship was only significant for those with high levels of resilience. This suggests focusing on individuals' resilience could yield more significant predictions of mental wellbeing for survivors of DA in future studies. Future research could also employ a measure of physical health and wellbeing in order to further investigate whether ACEs or DA do correlate with the experiences of stress and unexplained physical illness reported by participants in phase two.

The major theme of *Support and judgement* highlighted some of the key aspects in which participants did not feel supported and the traits which they valued in supportive others. Future research in this area could be useful in improving survivors' experiences with services and better meeting their needs. It would also be important moving forward to explore these issues with a broader range of individuals to determine whether these findings can be generalised to people living in different socio-cultural and economic contexts.

The study also highlighted some of the limitations of the current ACE literature in terms of the exclusive focus on experiences within the household and omission of several significant forms of adversity including bereavement and the loss of relationships and interpersonal struggles and isolation. Future research in the area could incorporate these concepts to provide a more holistic understanding of different forms of adversity which might be faced in early life.

Finally, given the applicability of the PTMF (Johnstone & Boyle, 2018) for the major themes found in the study, it would be useful for future studies to explore with a broader sample size the survival and threat responses captured under the major theme of *Psychological distress, health, and wellbeing*. This focus might help to identify broad similar patterns of responding for individuals with similar experiences of power and threat, which could help inform service delivery and provision for survivors of DA, for example encouraging interventions targeting specific diagnoses, such as PTSD, or more general symptoms, such as self-harm and suicidal ideation, or to support survivors in coping with medically unexplained physical health problems.

## **Chapter 7. Reflexive account and critical appraisal of the research process**

### **7.1 Chapter overview**

This chapter outlines my reflections on the research process, including the challenges and successes which I experienced along the way and my learning from these. I describe my own process of personal and professional development and consider how this has shaped both this research and my clinical practice. I also explore my identity and the impact which this has on my research and the relevance of this for my role as a counselling psychologist in training. This reflexive account is based on a reflexive journal kept throughout the research process, supervision meeting minutes, and notes from clinical supervision sessions.

### **7.2 Evolution of research topics and study design**

As noted in the introduction in Chapter 1, my professional interest in clinical work with survivors of trauma, including ACEs and DA, helped to shape this study. However, the topics and research question went through a significant process of evolution over time. My original thesis proposal was very different to how this project turned out and was led by my therapeutic work with individuals with a personality disorder who have received convictions for violence and sexual offences. I had initially proposed a study titled “The relationship between allostatic load and trauma in high-risk offenders”. This research would have been conducted within a forensic residential therapy service for adult male offenders who have been assessed as presenting a high-risk of harm to others and present as challenging or disruptive within custody. The aim of that project was to explore psychophysiological variables to understand the impact of developmental trauma on individuals who have caused significant harm to others. Understanding the dynamic relationship between

psychological and physiological adaptations to developmental trauma may help improve care for this population, who often present with complex needs which can lead to “splits” forming within and between the services providing care for them (Murphy & McVey, 2010).

However, the COVID-19 pandemic led to a UK national lockdown in March 2020 and made data collection impractical for some of the proposed variables, such as heart-rate variability and salivary cortisol. It was decided instead to focus on collecting data remotely, through online surveys and interviews, as these were deemed to present a safer and less intrusive method of data collection at the time. However, the security procedures within the forensic service where I work preclude service users from accessing the internet.

Therefore, a new proposal was drafted different sample: to focus on survivors of DA and examine the roles of adversity, resilience, and wellbeing in their life journey. The research question for this study developed out of my clinical work with clients who had survived DA on placements in adult community secondary care settings. This study retained from my previous proposal an interest in the impact of early life experiences on later wellbeing but changed the population of interest from adult males who had significantly harmed others to adult females who had survived both adversity in childhood and DA in an adult relationship. Having worked with these diverse populations in clinical practice, I have noted several similarities in the needs presented by individuals from both groups, such as the development and use of unhelpful coping strategies and threat responses which serve to maintain their distress. The role of gender and social environment on the development of threat responses in individuals who have experienced and survived trauma in early life has been explored in Chapter 2. P7’s quote, in which she shares her empathy for her abuser and recognises the similar challenges around addiction which they have both faced, perfectly

captures my understanding that individuals in both groups share a similar set of challenges, although the impact of their behaviour on those around them is immensely different.

### **7.3 Challenges faced and lessons learned**

One of the major challenges faced at the start of the study was recruitment. It was initially difficult in the quantitative online survey in phase one of the study to advertise the link to potential participants. To recruit survivors of DA, local support groups (such as Women's Empowerment and Recovery Educators, previously Birmingham Freedom Project) were contacted to share the link to participate in the study with their members and volunteers. Some organisations were understandably hesitant to liaise with a male researcher in this area and preferred instead to liaise with one of the female thesis supervisors. Recruitment also took place on social media and university webpages to try to recruit a matched control group. However, the survivor group continued to outpace the control group throughout the data collection process, leading to the final group sizes being slightly unequal. This might have been due to a self-selection bias in those who volunteered to participate in the study, such that survivors of DA may have been more motivated to take part in the study than those who had not experienced DA.

During the recruitment process for phase one, a member of the study team received an informal complaint through a social media forum from a participant who found that some of the questions in the survey reminded her of previous experiences of psychological distress. The participant also raised her concern that she viewed the survey late at night and experienced rumination about these memories which made it difficult for her to sleep.

In response to these concerns, the researcher and supervisory team took immediate action to suspend data collection and seek further ethical review with the Faculty of Health, Education, and Wellbeing Ethics Chair to consider these comments. The team provided additional information about support resources available to participants, to adhere to the principle of beneficence, minimise any risks, and mitigate against the recognised potential to inadvertently cause distress when conducting research with a vulnerable survivor of DA population (Elcioglu, Oncel, & Unluoglu, 2004; Ellsberg & Heise, 2002). Participants' autonomy and responsibility to read and understand the information available to them and carefully weighing the risks and benefits when deciding whether to participate was also acknowledged (Resnik & Ness, 2012). The participant information sheet was also amended to emphasise to participants that they should **“only complete the questionnaires if you feel you are able to and of course you are free to stop participating at any point in time if you find any part of the study emotionally challenging”**.

In hindsight, the emphasis on participants' awareness of their own wellbeing and encouragement to prioritise self-care and access available support was an important addition to the information sheet in light of the subthemes of *“I had to help myself”*, *“People pleasing or appeasing”*, and *“It helped me to accept myself”* which emerged in the qualitative analysis in phase two. These themes highlighted the challenges which some survivors experienced in noticing their needs, prioritising their own wellbeing over others', and asking for support. This experience has taught me a valuable lesson about the use of explicit communications in research of participants' right and responsibility to consider their own wellbeing above participating. Although some individuals may see this as obvious or potentially patronising, there may also be others for whom this statement can provide a useful reminder for, and validation of, their prioritisation of their own needs and wellbeing. This lesson will also carry

through to my clinical practice, where it is also important to explicitly remind clients of their autonomy and agency by having open discussions around their preferences in therapy, as well as ensuring that they are not placing an undue burden on themselves by taking part in research or outcome measures as part of accessing therapy services.

As a relatively inexperienced novice qualitative researcher, I found phase two of the study particularly challenging. Although recruitment was easier as participants had registered their interest and provided contact details in phase one of the study, there were still logistical challenges which I had not initially anticipated. Organising suitable times for interviews and overcoming technical difficulties associated with remote interviewing was a learning process, and on one occasion I was forced to reschedule an interview at short notice due to an internet outage in my area. I was fortunate that the participant was very understanding, however I also recognise how this might potentially have caused them anxiety or stress after mentally preparing for the interview.

I was extremely fortunate to have two experienced supervisors who agreed to conduct the interviews with the three participants who indicated a preference for a female interviewer. Listening to and analysing these interviews provided me with a fantastic opportunity to learn and grow as an interviewer, as I was able to compare their interview styles with my own and appreciate some of the subtleties with which they validated participants and put them at ease whilst discussing difficult and potentially distressing topics. I feel that I was able to develop as an interviewer throughout the interviews in phase two, and I also benefitted from feedback from participants around my interview style. Most of this feedback from participants was focused on appreciating having the opportunity to speak about their experiences, the ease of the interview process, and the content of the questions, which participants were generally positive about: *“I think you’re an easy person to talk to”* (P1), *“it was like a counselling session for me, so thank you”* (P2), *“it’s been really, really good to talk about it”* (P4).

P7 gave specific feedback that she had valued the unintrusive, calm, and non-judgemental nature of the interview process:

P7: It was nice. You actually listened to me (...) Yeah it, I don't know. It's... emotional to talk about. But... you've done it in a way that's not intrusive (...) You've let me talk about what I wanna talk about, rather than saying like "oh well, what did he do?". You know, that kind of thing where you, you don't necessarily want to disclose. So, you've allowed me to disclose what I want to, without being pushy about it.

Lloyd Gould: Yeah (...) what I've been aiming for is to let people tell their own story in the way they want to tell it.

P7: Yep. Yeah, and I felt like I've been able to do that.

This person-centred and gentle style of interviewing fits with my personal and professional values and is consistent with the empathic and validating approach to helping others which lies at the heart of counselling psychology and psychotherapy (e.g., Egan, 2010; Yalom, 2002). I hope in all my interactions with others to embody a supportive, trustworthy, non-directive, empathic, and attentive listener, in line with Rogers' (1975) core conditions for therapy. However, I have also recognised that research may at times require a different approach than that which I would ordinarily employ with clients in practice. This has made me aware of the value of more directive approaches to interviewing in eliciting useful information for research, which can support a deeper understanding of individuals by supporting them to develop a more coherent narrative. Previous research has also highlighted that survivors of DA value being asked about their experiences, provided that this is done with empathy and in a supportive manner (Malpass, Sales, & Feder, 2016; Snyder, 2016)

Another challenge I experienced within phase two of the study was the process of thematic analysis. My initial draft of the results section featured too many data extracts and

subthemes to provide a coherent and structured account of the data. I believe this may have been part of an unconscious process whereby I did not have faith in my analysis as a novice researcher, and therefore attempted to directly show the reader what participants had said in their own words, rather than present my own narrative and descriptions of the themes which I had identified as emerging in the interviews. Thankfully, with the support of my supervisory team, I was able to refine the analysis and present a more logical and coherent thematic framework to address the research questions and describe participants' lived experiences. I found this process challenging and at times did feel like giving up on the project because of how painful it felt to cut certain quotes or abandon certain ideas, as I felt I might be 'betraying' participants by omitting anything. A compromise was found in presenting a streamlined thematic framework in the results whilst also including additional poignant data extracts in the appendices to fully retain participants' voices in the study. This process required a lot of self-reflection in supervision sessions with the supervisory team as well as with clinical supervisors in practice to understand and address my own self-doubt and fear around losing something 'precious' by cutting down this section. Examining my own experience of the loss of a parent early on in life was especially relevant to this process.

#### **7.4 Reflections on identity: Being male and conducting research with female survivors of DA**

Researchers' reflections on their identity provide insight into their work and the conclusions which they draw, especially in qualitative studies where researchers impact on participants and co-create the intersubjective space during interview interactions (Finlay & Evans, 2009). A major theme of reflection in my reflexive journal has been focused on my role as a male researcher working with a female research population who have experienced

abuse from male partners. Male researchers have previously been criticised for their ‘gender blindness’ or beta bias in failing to consider the impact of the social positioning of the male gendered self when writing about their research experiences (Seager & Barry, 2020; Thomas, 2017). This approach ignores the role which the researcher’s gender can play in their choice of research topic and everyday interactions with participants. Researchers cannot be fully objective or detached from the gendered aspect of their identity and this therefore has significant implications for the entire research process from study design and recruitment through to data analysis and dissemination of results. Despite this, the tradition of reflecting on gender and gendered spaces or topics has previously been largely driven by female authors and male researchers’ voices have been largely lacking in this area (Lefkowich, 2019), with some notable exceptions (e.g., Kolb, 2014). Reflexivity on the subject of gender is especially important for male researchers studying populations in which a high proportion of participants are women who have experienced abuse, where interactions are inevitably a highly gendered affair. Some male authors have even raised the question of whether men should conduct research in areas mostly occupied by women (Hubbard, 1999). It is therefore important to consider my self-concept and identity as a male and the associated implicit assumptions which that aspect of myself may carry in terms of my own biases and how others experienced me.

The issue of gender did not immediately emerge as a concern when planning the study with my supervisors, which might be indicative of a privileged position on my part. As a brief biographical aside, I am a White, heterosexual male, in my early thirties at the time of the research. I present as relatively softly spoken, with what I have been told is a faint foreign accent following my immigration to the UK from South Africa around 10 years ago. My physical presentation in terms of gender traits consists of short hair and a short beard. However, physical manifestations aside, I exhibit relatively few ‘stereotypically male’ traits

and socialised norms, such as a domineering presence, aggression, or emotional inhibition (Connell, 1995; Seager & Barry, 2020). This additional biographical information is provided to assist the reader in understanding how different aspects of my identity may have intersected and the combined impact of this on the research. These complex and intersectional aspects of my identity will clearly also have influenced my reflections on interactions with gatekeepers and participants below and impacted on how gender was negotiated within these situations.

I perhaps first became aware of my ‘maleness’ and its potential significance for participants when contacting local survivor support groups and asking to introduce the study to them. Although my female supervisors had good links to these organisations, I felt from them a reluctance to engage with a male researcher on the topic and was told by the group facilitators that it would be better to have one of my supervisors speak to the group about the study instead. I fully understood this at a cognitive level as it is a protected space for survivors to share their experiences with each other without the presence of men, but emotionally I felt in part as though I was being cast in the role of potential abuser through this act of exclusion. It appeared to me that my ‘maleness’ was defined as something that the support group needed protection from, and that there was no room for acknowledgement of a spectrum of masculinity from abusers to allies. This sat uncomfortably with my own self-concept as I have always seen myself as a gentle, supportive, and kind figure, which initially made it hard for me to reconcile the idea that I may be experienced as a threat by others or trigger memories of fear or pain due to my gender.

There can also be some advantages to being male within this space. In general, my experience with participants bears similarities to that of Kolb (2014), who described how his gender impacted on his ethnographic research with workers in shelters for survivors of domestic violence: initially being met with distrust and being tested, but then building a

stronger alliance with participants once exhibiting an attitude of kindness and compassion. Kolb suggested that men who are experienced as caring in these settings might receive more recognition than their female counterparts, by subverting survivors' expectations or preconceptions of 'machismo' male behaviour, whereas they may expect other women to present as caring. During interviews and other interactions with participants I embodied a more 'muted' masculinity, consistent with my authentic self and self-concept outside of my professional work, avoiding qualities which might be associated with hegemonic masculinity, such as aggression, arrogance, emotional avoidance, and conversational dominance (Connell, 1995; Thomas, 2017). It is hard to provide a definitive assessment of how my gender may have changed the way in which participants interacted with me and what they were willing to share in the interviews. Although my gender was rarely raised directly by participants during interview, some expressed their preference for a female interviewer beforehand and were thus interviewed by one of my female supervisors. Others commented on my atypical gender traits during interview, noting my calm and compassionate approach. Whilst it is clear that qualitative researchers influence the data which they collect through interviews, my own subjective understanding in this study was that gender did not necessarily hinder participants' telling of their experiences. However, I am also aware that it is important to reflect on and question the privileged position from which I interact with the world and that this should be considered alongside the conclusions reached when reading this research.

Finally, I believe it is important to note that coming to this research as a male has allowed me to take on something of an outsider witness role to actively listen and respond with curiosity to survivors and at some level may have helped challenge the isolating and individualising effects of DA. Outsider witnesses to individual's preferred stories are considered an important part of the narrative practice of encouraging thick descriptions (Carey & Russell, 2003). This process of encouraging thick description also aligns with the

principles of qualitative research, in which a deep subjective understanding is sought.

Previous research has proposed an inadvertent therapeutic effect as part of the qualitative research process of allowing participants to tell their story (Shamai, 2003). In this way, my identity as a reflexive-practitioner-researcher counselling psychologist in training is also likely to have impacted on participants' experiences of the interview process.

### **7.5 Self-care and vicarious trauma**

The theme of self-care when engaging empathically with participants who have experienced significant psychological distress has also been a major part of my reflexive journal. It would be hypocritical of me as a counselling psychologist in training to not practice self-care when I am a strong advocate for it in my therapeutic work with my clients. Self-care has also been recognised as essential for maintaining well-being for researchers who engage with emotionally demanding research topics (Kumar & Cavallaro, 2018). Engaging in self-care and reflexive practices are also important areas of proficiency for clinical practice in psychology (Health and Care Professions Council, 2015). In particular, the focus in counselling psychology on the use of self requires a process of critical reflection and awareness to ensure ethical practice (British Psychological Society, 2017). Self-care is especially important to mitigate common occupational hazards in mental health settings, such as burnout and stress (Coaston, 2017; Cummings et al, 2021; McCormack et al, 2018). Research suggests that between 40% and 78.9% of applied psychologists (McCormack et al, 2018) and psychotherapists (Johnson, Corker, & O'Conner, 2020; Lee et al, 2019) self-report experiencing burnout, including emotional exhaustion, disengagement, and a reduced sense of accomplishment, at some point in their careers. Working with clients who have experienced trauma can also present challenges for therapists and might sometimes lead to

the development of secondary or vicarious trauma, especially within forensic mental health settings (Barros et al, 2020; Bradford & de Amorim Levin, 2020; Sodeke-Gregson, Holttum, & Billings, 2013). Vicarious trauma, burnout, and countertransference have also been recognised as challenges for counsellor's working with clients who experience or perpetrate domestic violence due to fears for client safety and feelings of isolation and powerlessness (Iliffe & Steed, 2000). Regular clinical supervision (Taylor, Gregory, Feder, & Williamson, 2019) and self-care strategies including social support, exercise, processing with peers, and spending time with family (Killian, 2008) have been noted as essential for minimising the impact of this work on helpers.

Throughout the doctorate and this research, I have continued to work full-time with individuals who have both experienced developmental trauma and caused significant harm to others in a forensic residential therapy service. Whilst collecting qualitative data, there would be days where I would deliver therapy within the service during my working hours and then remotely interview a survivor of DA after returning home in the evening. Denborough (2008) describes how the nature of roles such as therapist and researcher might inevitably lead individuals to becoming cultural receivers of stories of suffering, and the responsibilities which this brings. Understandably, simultaneously conducting research and offering therapy with these two distinct groups of individuals who have experienced a considerable amount of trauma was an emotionally demanding process which required me to be aware of my own wellbeing and to proactively engage with self-care to ensure that I continued to work within the limits of my competency and emotional tolerance and to prevent me from becoming emotionally overwhelmed.

To guide this process, I developed a self-care plan based on the six key life domains proposed by Butler et al (2019): physical, professional, relational, emotional, psychological, and spiritual. My self-care plan involved: attending to the physical domain through regular

physical exercise; attending to the professional domain by engaging with clinical supervision and developing a sense of compassion satisfaction (Cummings et al, 2021; Harr, 2013); attending to the relational domain through social support accessed through personal and professional support networks; supporting my emotional wellbeing through nature-connectedness (Bratman et al, 2015; Brymer, Crabtree, & King, 2020, Pritchard et al, 2020); and attending to the psychological and spiritual domains through self-compassion (Richardson, Trusty, & George, 2018) and the use of mindfulness-based relaxation techniques (Shapiro, Warren Brown, & Biegel, 2007).

There have been moments where I have felt emotionally overwhelmed when re-listening to recordings of interviews, especially where survivors describe their experiences of hopelessness and thoughts of self-harm or attempts to end their own lives. At these times I have tried to exercise self-compassion and give myself a break from the data analysis to engage in some mindfulness or go for a short walk through nature, becoming very familiar with my local parks and forests. I have then later explored these feelings further through clinical and peer supervision or in supportive conversations with friends, once I have felt more resourced and able to describe and process my emotional responses. It has also been important for me at times to focus on positive aspects within the data, such as participants' accounts of survival, growth, and resilience, in order to sustain my motivation by experiencing a sense of compassion-satisfaction. This echoes Kolb's (2014) suggestion that victim advocates and counsellors in the field of domestic violence tend to be sustained by an emotional reward to the work which he terms "moral wages". Amari (2021) notes that compassion is an essential part of the interpersonal process for counselling psychology interventions and that compassionate connections alleviate clients' psychological distress and foster healing. I have found these compassion-focused strategies particularly helpful as a

form of self-care throughout the research process to minimise the effects of vicarious trauma and sustain my motivation.

I believe that implementing this self-care plan has also been essential to the interview process, enhancing my ability to connect with and empower participants to tell their stories within a non-judgemental and non-hierarchical relationship which prioritises their uniqueness and individuality. This fits with my own personal values as well as aligning with the humanistic values which Cooper (2009) argues are essential to counselling psychology practice. Reflecting on, planning, and prioritising my self-care throughout the research process has given me a helpful toolkit which I can draw on in my future professional practice and I believe that this experience will make me a more competent and attuned counselling psychologist.

## Chapter 8. References and appendices

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## Appendices

### Appendix A. Summary of participants' suggestions for interview from phase one quantitative online survey responses

<p>Interview thoughts: Do you have any further thoughts which you would like to share with the research team about this topic? Your input will help us to develop the interview schedule for the follow-up study in phase 2 to ensure that these issues are explored as fully as possible to improve our understanding in this area which will hopefully contribute to improving support for survivors of domestic abuse.</p>
<p>We still need help</p>
<p>Stress as a child or bullying</p>
<p>potential relationship abuse under 18 YOA</p>
<p>Perhaps interesting to consider whether school / peer support (or lack thereof) in (pre-) teenage years influences an individual's likelihood / experiences of entering into or choice to stay in a domestic abuse relationship later in life</p>
<p>My relationship of 23yrs recently ended when my partner left me and my 7yr and 11yr old for my best friend. I had not realised how controlling a relationship it had been, until several professionals referred me to the Freedom Programme. 5weeks in and I am slowly realising the impact of my childhood abuse on every aspect of my adult life. Relationships, work ethics the way I am with my children and everything about me and my life values. Thank you for doing this study as it will be beneficial to so many people who have experience childhood abuse and trauma. Please feel free to contact me if you need to. Good Luck</p>
<p>May be interesting to ask if victims of DV have enacted abuse of their own, continuing the cycle on their children, siblings, or future partners.</p>

have you become abusive in your new relationships? have you been in any other controlling relationships - I nearly joined a cult -and I think that this was partly due to how I perceived myself, my sense of self and wanting to have meaningful relationships

Being under threat, in potential danger or perceived danger or panic for such a long period of time can significantly change the perception of what is truly stressful. Personally the act of shouting, whether in a good capacity or otherwise, triggers a panic response or somebody walking quicker/louder up the stairs or asking questions/ asking for permission, simple everyday occurrences which shouldn't trigger such a response can become paralysing. Just some of my experience.

Although I don't see myself as suffering actual abuse I think questions regarding siblings and how you feel they see you would be of interest. Also how you feel you compared to siblings by your parents.

I t has took me many years of major distresses and dysfunctional life issues to get to where i am today and has only really balanced out over the past few years.

# Appendix B. Ethical approval letter from Faculty of Education, Health and Wellbeing – Phase one quantitative survey and email from panel chair confirming approval



Dr Alexandra Hopkins RN PhD MSc MBA RNT RCMT DANS  
Dean of the Faculty of Education Health and Wellbeing  
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Date 29<sup>th</sup> July 2020

L. Gould  
University of Wolverhampton  
FEHW

Dear Lloyd,

**Re: Investigation of prevalence of Adverse Childhood Experiences (ACEs) within domestic abuse survivor populations**

The Psychology Department Ethics Panel has considered and reviewed your submission. On review your Research Proposal was passed and given approval code 2B (Resubmit for Chair's action). You will need to revise and re-submit your ethics application form to the Chair for re-review prior to full approval being granted. The revisions and changes required are listed below.

- There is a risk that participants could be emotionally triggered by some of the content within adverse childhood experience measure. It appears the student has not fully or adequately engaged with this serious ethical issue. Completing the ACE may lead to upset or the possibility that by bringing up childhood negative experiences that it may damage existing familial relationships that prior to the study were not damaged. The student needs to better engage with and provide mitigation for these aspects in the ethics application.
- Please be explicit about which services the participants should access should there be any adverse fallout from the study. The two websites cited seem to be on the same line with no title for each on the information sheet. This information is more important to include in the debrief rather than the information sheet to enable participants to access them should they feel they require emotional support. It could also be included in the information sheet though as well.
- There is no indication within the study about how socio/economic status will be identified, or how it will be gathered. Please highlight how you intend to retrieve this information from participants and how it will be used in the study and analysed.
- The debrief talks about an experiment; this is a survey based study. Does the participant need this information, we recommend removing this detail and simply saying study.

In addition, the reviewers had additional comments which are advisory:

- Please ensure that method is fully explained and articulated within the ethics form at the moment it is not fully clear how all data will be gathered, analysed and how these analyses map on to particular hypotheses or research questions.
- Please provide further clarification about how data will be handled and the process you will use prior to data analysis and details about your data analysis. At the moment these are missing, which raises concerns regarding the clarity of understanding of the analytic process of the study.
- Will you be using power calculations as a way of gauging the adequacy of the sample size for this study? The committee were somewhat concerned about the feasibility of your aim to recruit 100 people. This appears a little ambitious given you were only contacting two organisations. If you were contacted by other organisations, then this should be detailed in the ethics form.

Best wishes in the future.

Yours sincerely

Darren Chadwick  
DR. Darren Chadwick  
Reader in Applied Psychology.  
Chair – Psychology Department Ethics Panel

# Appendix C. Ethical approval letter from Faculty of Education, Health and Wellbeing – Phase two qualitative interviews



Dr Alexandra Hopkins RN PhD MSc MBA RNT RCNT DANS  
Dean of the Faculty of Education Health and Wellbeing

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27<sup>th</sup> August 2021  
L. Gould  
University of Wolverhampton  
FEHW

Dear Lloyd,

**Re: Adversity, resilience, and wellbeing in survivors of domestic abuse, 0621GUOWPSY**

Thank you for addressing our concerns regarding your proposed research entitled Adversity, resilience, and wellbeing in survivors of domestic abuse, 0621GUOWPSY

The Psychology Department Ethics Panel has considered and reviewed your submission. On review your Research Proposal was passed and given approval **2A-Supervisor to monitor**. The outlined changes are acknowledged and accepted with a few minor amendments that your supervisors need to monitor:

- 2.9 Supervisor to check consistency in times for withdrawal.
- 2.11 Participants should not have a say in the pseudonyms employed – if they do, they can identify themselves easily in published work.
- 2.11 participant information suggests that final quotes will be agreed with participants. This will null and void any anonymisation of data and will bias data quotes used. I'd suggest removing.
- **Appendix 3:** Amendment does now include self-care activities, but do also need to signpost if the emotional experience is too overwhelming.
- What will you do if at the end of the interview your interviewee is clearly distressed?
- **Appendix 3:** Use of terminology such as growth and wellbeing has been indicated as having been changed, but Appendix 3 still includes these in the main body of the questions. It would be useful to re-word these in a way that is clear to all participants so that they don't feel inferior.

If this is student research, supervisors must ensure the minor amendments have been completed prior to commencement of data collection. A condition of this approval is that Supervisors must read through and check the revised applications and email a confirmation to [fehweethics@wlv.ac.uk](mailto:fehweethics@wlv.ac.uk) to confirm they have occurred. Students, please contact your supervisor for assistance with making amendments to your proposal. Supervisors, you must read through and check the revised applications prior to resubmitting them to [fehweethics@wlv.ac.uk](mailto:fehweethics@wlv.ac.uk) & [REDACTED]

Please endeavour to re-submit within 2 months of receiving this letter or your submission may need to be reviewed as a new submission.

Best wishes in the future.  
Yours sincerely

[REDACTED]

ppa. Dr Alison Attrill Smith for Dr Darren Chadwick

Chair – Psychology Department Ethics Panel  
Reader in Applied Psychology  
Department of Psychology

## **Appendix D. Participant recruitment messages**

Phase one – quantitative online survey

Dear [organisation/individual],

Investigation of prevalence of Adverse Childhood Experiences (ACEs) within domestic abuse survivor populations

We are a team of mental health researchers from the University of Wolverhampton. We are interested in studying the experiences of survivors of domestic abuse and we are contacting you to invite your members/service users to take part in our research study.

The study aims to understand the prevalence of Adverse Childhood Experiences (ACEs) in heterosexual female domestic abuse survivors, and it is hoped that these results will yield key insights into supporting this group in the future. Participants will be asked personal questions about their experiences in childhood and their current thoughts and feelings.

We are recruiting adult women aged 18 and over who have ever engaged in a heterosexual relationship to take part in this study. We are seeking to collect responses from two groups: those who have experienced domestic abuse and those who have not. People are eligible to participate as long as they are part of either group.

Please could you forward the study link below to anyone who you think might be interested in taking part. We are hoping to get responses from as wide a group as possible.

[https://wolverhamptonpsych.eu.qualtrics.com/jfe/form/SV\\_3KN3Nf66cZNnnN3](https://wolverhamptonpsych.eu.qualtrics.com/jfe/form/SV_3KN3Nf66cZNnnN3)

Thank you.

Yours sincerely,

Lloyd Gould (Counselling Psychologist in Training)

Supervised by Prof. Maria Uther and Dr. Abigail Taiwo

Phase two – qualitative interviews (with individuals who had given contact details in phase one)

Good day,

You previously took part in an online survey for a research study that investigated the prevalence of Adverse Childhood Experiences (ACEs) in heterosexual female Domestic Abuse (DA) survivors and whether resilience plays a moderating role in the relationship between ACEs and wellbeing. Thank you for your participation. This online survey was phase one of a planned two-phase research project investigating this topic.

As part of the online survey, you indicated that you would be willing to be contacted about participating in an interview, which is why we are contacting you now.

Please confirm whether you would still like to participate in a phase two interview for the study by [date of final confirmation]

We will schedule the interview at a time convenient to you.

The interview will be conducted individually over a video chat platform (e.g., Microsoft Teams/Zoom) and last for approximately **50 minutes**. Although the research is being conducted by a male researcher as part of his doctorate in counselling psychology training, you can request to be interviewed by a female interviewer instead if you would prefer. The interview will follow a semi-structured interview schedule, including questions about:

- your health and wellbeing,
- your life journey and the challenges you have faced,
- any coping strategies you have used,
- any experiences of development or growth through facing challenges,
- and any support you have received from others during difficult periods in your life

Please see attached the Participant Information Sheet and Consent Form before deciding whether to participate in the phase two interview.

Thank you for your time and I hope that you consider taking part in phase two of the project.

Researcher: Lloyd Gould (Counselling Psychologist in Training)

Email: [e-mail address redacted]

Supervised by:

Professor Maria Uther

Email: [e-mail address redacted]

and Dr Abigail Taiwo

Email: [e-mail address redacted]

## **Appendix E. Participant Information Sheets and consent forms**

Phase one – quantitative online survey

Participant information sheet

Title: Investigation of prevalence of Adverse Childhood Experiences (ACEs) within domestic abuse survivor populations

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully. We would be happy to clarify anything that is not clear and will answer any questions you might have if you contact us using the details below. Thank you for reading this.

What is the purpose of this study?

This study aims to understand the prevalence of Adverse Childhood Experiences (ACEs) in heterosexual female domestic abuse survivors and it is hoped that these results will yield key insights into supporting this group. You will be asked personal questions about your experiences in childhood and your current thoughts and feelings.

The study also aims to investigate the relationship between ACEs, well-being, and resilience in those who have experienced domestic abuse.

Why have I been chosen?

We are recruiting adult women aged 18 and over who have ever engaged in a heterosexual relationship to take part in this study. We are seeking to collect responses from two groups: those who have experienced domestic abuse and those who have not. You are eligible to participate as long as you are part of either group.

Do I have to take part?

It is up to you to decide whether or not to take part – participation is completely voluntary. If you do decide to take part, you will be asked to sign your consent virtually. If you decide to take part you are still free to withdraw without giving a reason up to 14 days later (using your unique ID).

What will happen if I decide to take part?

The procedure involves completing a series of online questionnaires using Qualtrics. The study is estimated to last 15-25 minutes.

What sort of questions will I be asked?

You will first be asked general demographic questions about your age, sex, and socio-economic status. You will also be asked whether you have ever experienced domestic violence.

You will then be asked questions about your current mental wellbeing, any current experiences of psychological distress, any previous adverse childhood experiences, and your current resilience (i.e. how well you manage to deal with difficult experiences now).

This is phase 1 of a two-phase piece of research. Within phase 2, we will use qualitative interviews to give survivors a voice to discuss their feelings and views in more depth. You are free to participate in only this phase (phase 1) but if you would like to be contacted to participate in phase 2 (interviews), then please indicate your preferred contact details in the relevant question at the end of this study.

What you will not be asked

We will not ask you to give details about any adult experiences of domestic abuse within this phase of the study. If you wish to participate in the interviews for phase 2, then that will be an opportunity to open up about your experiences. No personally identifiable data will be collected, unless you wish to register your contact details to participate in the phase 2 interviews. Any contact data will be stored separately from your responses to the other questions.

What are the potential benefits and risks of taking part?

There are no direct benefits for you if you take part, beyond the opportunity to contribute to expanding our knowledge and understanding in this area.

You will be asked a series of questions about yourself, your previous experiences, and your current thoughts and feelings. Please answer these as accurately and honestly as possible. Your data will be completely anonymised and you will therefore be unidentifiable.

Please note that this study does explore some sensitive topics and ask about potentially traumatic experiences in childhood. However, be assured that your responses will be completely anonymous.

Is there a financial reward for taking part in the study?

You will not receive any reward for taking part in this study. However, you have an opportunity to express your views and therefore contribute to our knowledge in this area which hopefully will lead to positive change in how survivors of domestic abuse are supported.

What support is available?

As some of the survey questions ask about potentially traumatic experiences, it is important to consider your own wellbeing and only complete the questionnaires if you feel you are able to and of course you are free to stop participating at any point in time if you find any part of the study emotionally challenging. If you do wish to seek support please contact one of the following agencies (who are not affiliated with this study):

Refuge

<https://www.nationaldahelpline.org.uk/>

Tel: 0808 2000 247

Women's Aid

<https://www.womensaid.org.uk/>

Email: [helpline@womensaid.org.uk](mailto:helpline@womensaid.org.uk)

Relate

<https://www.relate.org.uk/>

You can also contact your GP or local mental health services for additional support.

Will my taking part in the study be kept confidential?

Yes. Any information or personal details gathered in the course of this study are confidential. All data will be anonymised and stored securely, and only the project researchers will have access to the data. After three years, all raw data will be destroyed.

What will happen at the end of the study?

The overall results of the study may eventually be presented at academic conferences or in academic journals, but at no point will your individual responses or identity be divulged.

If you are interested in receiving a summary of the findings, please send an email to [e-mail address redacted]. It is anticipated that the summary of the overall results will be available in July 2021. Please note that due to participant anonymity, it is not possible to provide you with your individual data, but the summary will outline the main discoveries from the study.

What if I have a problem or concern?

You are welcome to ask any questions or discuss any concerns you might have prior to your participation. You do not have to take part unless you are completely happy with what is involved.

If you have any complaints regarding this piece of research, please contact

Dr Hilary Paniagua, email: [e-mail address redacted]

If you have concerns about how data is collected or stored, you are welcome to speak to the researcher or contact our Data Protection Team at [dataprotection@wlv.ac.uk](mailto:dataprotection@wlv.ac.uk).

Who has reviewed the study?

This study has been reviewed and approved by the Department of Education, Health and Wellbeing Ethics Committee.

Thank you for your time.

Researcher: Lloyd Gould (Counselling Psychologist in Training)

Email: [e-mail address redacted]

Supervised by:

Professor Maria Uther (Professor of Psychology)

Email: [\[e-mail address redacted\]](#)

and Dr Abigail Taiwo (Senior Lecturer)

Email: [e-mail address redacted]

## Consent Form

I confirm that I have read and understand the details provided on the information sheet and that I have had the opportunity to ask questions.

I agree to take part in this study.

I confirm that I am over 18 years old.

I understand that I will be required to complete a series of questionnaires.

I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication.

I understand that the researchers publish the overall results of this study, for which I give my permission.

I understand that I can withdraw from the study without consequence and without having to give a reason, up until the time that the study is completed and my data submitted.

I consent to take part in this study.

Phase two – qualitative interviews

Title: Adversity, resilience, and wellbeing in survivors of domestic abuse.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully. We would be happy to clarify anything that is not clear and will answer any questions you might have if you contact us using the details below. Thank you for reading this.

What is the purpose of this study?

This study aims to explore and further understand survivors of domestic abuse's experiences of adversity, resilience, and wellbeing. It is hoped that these results will yield key insights into supporting this group. You will be asked personal questions about your experiences, thoughts, and feelings in childhood and at present.

For the present study, we use the following definitions of the above terms:

**Domestic abuse:** We define domestic abuse as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer.

**Resilience:** the phenomenon that many people are able to adapt to the challenges of life and maintain their health and wellbeing, or even thrive, despite exposure to adversity and challenging circumstances.

Why have I been chosen?

We are recruiting adult women aged 18 and over who have ever engaged in a heterosexual relationship and who have experienced domestic abuse to take part in this study. This is phase two of a two-phase piece of research. Within phase one, we asked participants to indicate whether they would be willing to be approached to take part in interviews. We are contacting you because you indicated that you would be willing to take part in the phase two interviews.

Do I have to take part?

It is up to you to decide whether or not to take part – participation is completely voluntary. If you do decide to take part, you will be asked to sign your consent virtually. If you decide to take part, you are still free to withdraw without giving a reason up to 14 days later by contacting a member of the research team.

What are the potential benefits and risks of taking part?

There are no direct benefits for you if you take part, beyond the opportunity to contribute to expanding our knowledge and understanding in this area, and thereby potentially helping us understand how we can help domestic abuse survivors better.

As some of the interview questions ask about challenging experiences, it is important to consider your own wellbeing and only take part in the interviews if you feel you are able to.

You will be asked a series of questions about yourself, your previous experiences, and your current thoughts and feelings. Please answer these as accurately and honestly as possible. Your data will be completely pseudonymised and you will therefore be unidentifiable.

Please note that this study does explore some sensitive topics and ask about challenging experiences in childhood and that there is a potential for you to experience distress if you wish to share some of your story. However, be assured that your responses will be treated with the utmost care and confidentiality and if you experience distress at any point in time, you are free to pause or withdraw from the interview.

What will happen if I decide to take part?

The procedure involves taking part in an online interview (over MS Teams or Zoom) about your experiences of adversity, resilience, and wellbeing as a survivor of domestic abuse. You

may decide to withdraw from the study within 14 days of taking part or take a break at any point in the interview.

What sort of questions will I be asked?

You will first be asked general demographic questions e.g., age and sex. You will also be asked about your feelings and views on a range of topics, including any experiences of adversity or experiences of psychological distress throughout your life, including in your childhood, your current mental and physical wellbeing, and resilience and how you manage to deal with difficult experiences now. *There is no requirement to share anything related to your experiences of domestic abuse, but there is the opportunity to talk about it, should you wish to do so.*

Please see the following example of one of the questions from the interview to help you decide whether participation is right for you: “Please tell me about your life journey including what challenges you have faced or any difficult experiences you might have had?”

Who will conduct the interview?

The interview will be conducted by a trainee in Counselling Psychology or a member of the supervisory team. Should you have a preference for male or female interviewers, please indicate that in your response.

Will my taking part in the study be kept confidential?

Yes. Any information or personal details gathered as part of the study are confidential. All data will be anonymised and stored securely, and only the project researchers will have access to the data.

The interviews will be recorded, then transcribed, analysed, and after three years all recordings and transcriptions will be destroyed. All recordings will be safely stored on a secure, password-protected computer in line with University of Wolverhampton data security policies.

No personally identifiable data will be collected, and all interview data will be pseudonymised. We will allocate you a participant number which will be used in the transcription, analysis, and write up of findings to preserve your confidentiality. We will remove any references to places, people, or organisations which might identify you from any quotes. Your name and any personally identifiable data will not be linked with any quotes used.

The only exception to your right to confidentiality would occur if you indicate to the interviewer that you intend to harm yourself or others, at which point the interviewer will inform you of the need to break confidentiality to seek support.

What support is available?

If you wish to seek support with any of the issues discussed in the interviews, please contact one of the following agencies (who are not affiliated with this study):

**Refuge**

<https://www.nationaldahelpline.org.uk/>

Tel: 0808 2000 247

**Women's Aid**

<https://www.womensaid.org.uk/>

Email: [helpline@womensaid.org.uk](mailto:helpline@womensaid.org.uk)

**Relate**

<https://www.relate.org.uk/>

You can also contact your GP or local mental health services for additional support. Please be aware that the research team cannot offer any counselling or psychotherapy services to participants.

What will happen at the end of the study?

You will be thanked for your participation and asked to give brief feedback on the process.

You will also be encouraged to engage in a self-care activity of your choice should you feel any distress.

The overall results of the study may eventually be presented at academic conferences or in academic journals, but at no point will your individual responses or identity be divulged.

If you are interested in receiving a summary of the findings, please tell your interviewer or send an email to [e-mail address redacted].. It is anticipated that the summary of the overall results will be available in December 2021. The summary will not focus on any individual but will outline the main themes and discoveries from the study.

What if I have a problem or concern?

You are welcome to ask any questions or discuss any concerns you might have prior to your participation. You do not have to take part unless you are completely happy with what is involved.

If you have any complaints regarding this piece of research, please contact

Dr Hilary Paniagua, email: [e-mail address redacted]

If you have concerns about how data is collected or stored, you are welcome to speak to the researcher or contact our Data Protection Team at [dataprotection@wlv.ac.uk](mailto:dataprotection@wlv.ac.uk).

Who has reviewed the study?

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Thank you for your time.

Researcher: Lloyd Gould (Counselling Psychologist in Training)

Email: [e-mail address redacted]

Supervised by:

Professor Maria Uther (Professor of Psychology)

Email: [e-mail address redacted]

and Dr Abigail Taiwo (Senior Lecturer)

Email: [e-mail address redacted]

## Consent Form

I confirm that I have read and understand the details provided on the information sheet and that I have had the opportunity to ask questions.

I agree to take part in this study.

I confirm that I am over 18 years old.

I understand that I will be interviewed online (over MS Teams or Zoom) and that this data provided will be analysed.

I understand that my data will be stored securely and confidentially and that I will be allocated a pseudonym and my data will not be identifiable in any report or publication.

I understand that the researchers aim to publish the overall results of this study, for which I give my permission.

I understand that I can withdraw from the study without consequence and without having to give a reason, within 14 days of taking part.

I consent to take part in this study.

## Appendix F. Study Debrief Sheets

Phase one – quantitative online survey

Study debrief sheet

Thank you very much for participating in the study. This sheet is designed to give you a thorough explanation of the aims and objectives of the study you have just completed, but please contact one of the researchers if you have any further queries. This study aims to compare the level of adverse childhood experiences (ACEs) of female survivors of domestic violence with those who have not experienced domestic violence, to understand how prevalent these are within this group. This study also seeks to understand the relationship between ACEs, current wellbeing, and resilience. Researchers know little about the role resilience might play in mediating the relationship between ACEs and wellbeing for this group. It is hoped that the results of this study will help us to better understand and support survivors of domestic abuse who have experienced ACEs, which is currently lacking in the literature. It will also look at how important resilience is in mediating the relationship between ACEs and current wellbeing for this group, which could help inform future research and/or therapeutic interventions. The questions in the study cover a range of sensitive and potentially traumatic topics and may have triggered painful memories for you. If you wish to seek support please access one of the following agencies (who are not affiliated with this study):

Refuge

<https://www.nationaldahelpline.org.uk/>

Tel: 0808 2000 247

Women's Aid

<https://www.womensaid.org.uk/>

Email: [helpline@womensaid.org.uk](mailto:helpline@womensaid.org.uk)

Relate

<https://www.relate.org.uk/>

You can also contact your GP or local mental health services for additional support.

Additionally, if the questions in this study around past experiences have raised any issues you can also contact the following agency (also not affiliated with this study) to explore family counselling options: Relate <https://www.relate.org.uk/> We are also hoping to complete a follow-up study in phase 2 of our research using qualitative interviews to better understand your thoughts on these issues. This is a separate study and participation in this study does not automatically include you in the follow-up. If you would like to be contacted to participate

and be interviewed about your experiences you can email [e-mail address redacted] for more information.

You can also receive a summary of the results at the end of the data collection phase by sending an email to [e-mail address redacted]. It is anticipated that this summary will be available from July 2021 onwards. Please note that due to participant anonymity, it is not possible to provide you with your individual data, but the summary will outline the main discoveries from the study.

Thank you again for participating!

Lloyd Gould (Counselling Psychologist in Training)

Email: [e-mail address redacted]

Phase two – qualitative interviews

Participant debriefing form

Thank you very much for participating in the study. This sheet is designed to give you a thorough explanation of the aims and objectives of the study you have just completed, but please contact one of the researchers if you have any further queries.

It is hoped that the results of this study will help us to better understand and support survivors of domestic abuse who have experienced ACEs, which is currently lacking in the research literature. It will also look at coping, resilience, support, development, growth, and wellbeing for this group, which could help inform future research and/or therapeutic interventions.

The questions in the study cover a range of sensitive and challenging topics and may have triggered painful memories for you. If you wish to seek support please access one of the following agencies (who are not affiliated with this study):

**Refuge**

<https://www.nationaldahelpline.org.uk/>

Tel: 0808 2000 247

**Women's Aid**

<https://www.womensaid.org.uk/>

Email: [helpline@womensaid.org.uk](mailto:helpline@womensaid.org.uk)

You can also contact your GP or local mental health services for additional support.

Additionally, if the questions in this study around past experiences have raised any issues you can also contact the following agency (also not affiliated with this study) to explore family counselling options:

**Relate**

<https://www.relate.org.uk/>

You can receive a summary of the results at the end of the data collection phase by sending an email request to [e-mail address redacted]

It is anticipated that this summary will be available from early 2022. Please note that it is not possible to provide you with your individual data, but the summary will outline the main discoveries from the study.

Thank you again for participating in this study!

Lloyd Gould (Counselling Psychologist in Training).

Email: [e-mail address redacted]

## Appendix G. Semi-structured interview schedule

### Semi-Structured interview schedule

#### 1. Qualitative interview introduction

- Length: Around 50 minutes
- Research aims and study explanation, including confidentiality.
- Taking of verbal consent and explain that some quotes from participants will be used to illustrate general themes in the data, but that these will be pseudonymised and non-identifiable to them.

#### 2. Health and wellbeing

- Please tell me about your health.
- **Probes** – Have you ever experienced any historical or current health problems, both physical and mental, or chronic illnesses? What were they? How did they affect you? When did they start? How long did they last? Are there any other diagnoses you have had from a medical professional? Any undiagnosed problems?

#### 3. Life Journey

- Please tell me about your life journey including what challenges you have faced or any difficult experiences you might have had?
- **Probes** –How did you react to experiencing that? How old were you at the time? What did you feel? How do you think your life might have been different like without these?
- Is there anything which you have experienced which triggers a particularly strong emotional response or bodily feeling for you now? Have you ever experienced prejudice or felt that you have been treated unfairly?
- Do you think that any of these experiences may be related to any of the health problems you spoke about earlier?

#### 4. Coping strategies

- Please tell me about how you have coped with each of the difficult experiences you have had, both at the time and afterwards?
- **Probes** – How do you perceive the ways in which you have coped? Have you found any of them as more helpful or unhelpful to you or those around you? How do you look after yourself now? How do you perceive/respond to threats? What are the helpful or unhelpful strategies you have used? For example: Exercise? Talking to others? Mindfulness? Using substances or alcohol? Self-harm? Aggression?

5. Development and growth

- Please tell me about any personal development which you might feel you have experienced through facing challenges in your life?

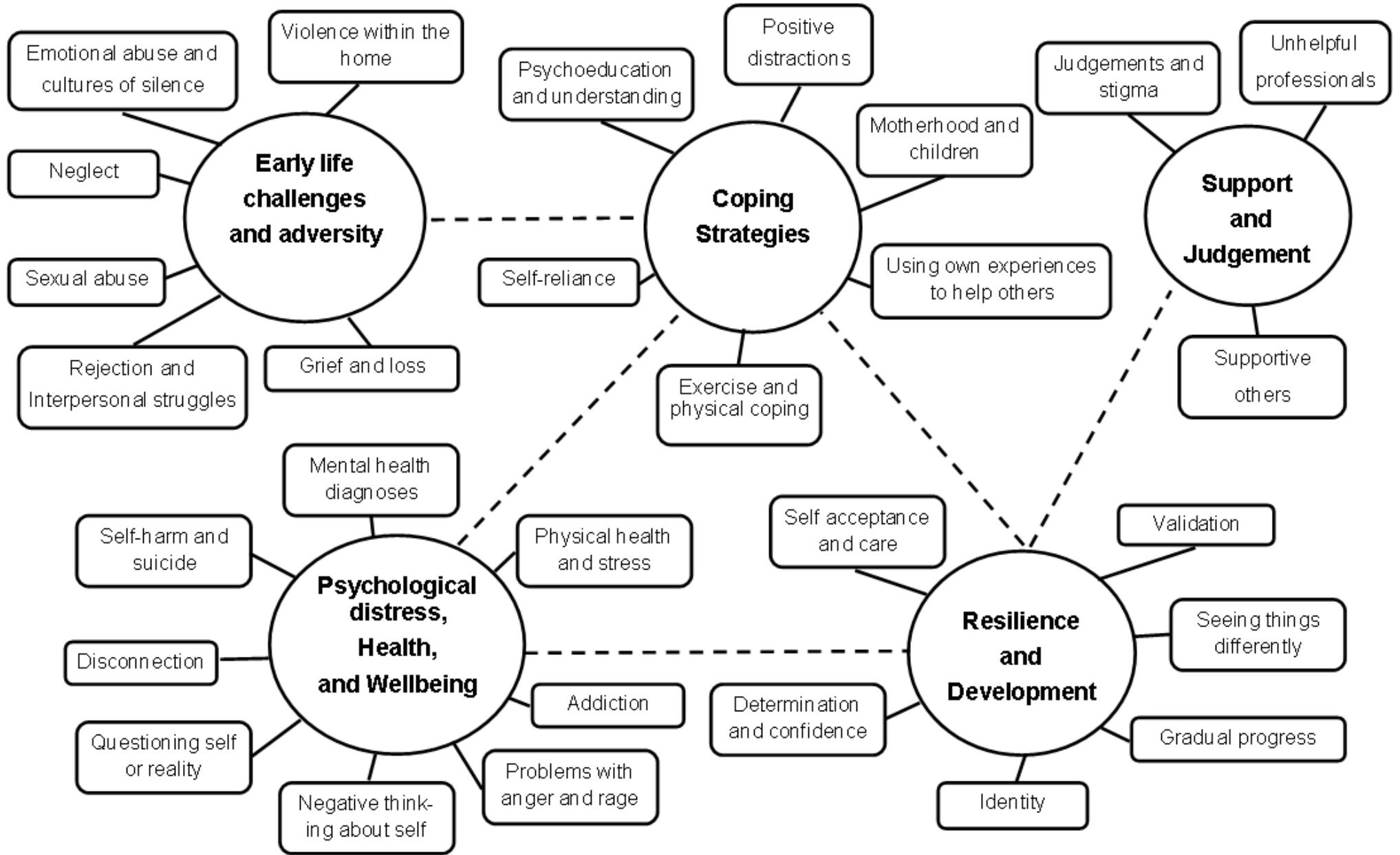
6. Support

- What supports readily come to mind that you have received from others during difficult times in your life?
- **Probes** – Were your family supportive? Did you have any supportive sexual or romantic relationships? Friendships? Any professional support (e.g., therapy, support groups?)

7. End of interview debriefing

- Final explanation of study confidentiality and opportunity for interviewee to ask any questions and give feedback on interview process.
- Encourage participant to engage in self-care activities following the interview (optional) such as: going for a walk, being kind to themselves, spending time with someone supportive, spending time in nature, practicing mindful breathing, or engagement with spiritual activities.

**Appendix H. Diagram of major themes and subthemes.**



## Adverse Childhood Experiences (ACEs), Resilience, and Mental Wellbeing within Survivors of Domestic Abuse (DA)

Lloyd Gould, Prof Maria Uther, & Dr Abigail Taiwo  
University of Wolverhampton

### Hypotheses:

1. Do Survivors of Domestic Abuse report more ACEs than controls?
2. Does Resilience moderate the relationship between ACEs and Mental Wellbeing for Survivors of Domestic Abuse?

### Background

Experiencing ACEs can lead to a range of chronic physical and mental health difficulties in later life<sup>1</sup>.

Understanding the challenges faced by survivors of DA and the impact of resilience is vital to providing better support<sup>2</sup>.

### Design

Our study followed a quantitative, cross-sectional online survey design phase 1 of mixed methods approach.

### Participants

Convenience sample of 119 adult women: 63 Survivors of DA group, 56 Control group  
Mean age = 35. Mostly White (88%) and English (80%).

### Methods

#### Survey questionnaires:

Demographic and socio-economic status

ACEs Questionnaire

Mental Wellbeing: Short Warwick Edinburgh-Mental Wellbeing Scale, DASS Depression, Anxiety and Stress Scale

Resilience: Connor-Davidson Resilience Scale

### Results

1. T-Test: Survivors of DA group reported significantly more ACEs than control:

$t(117) = -3.89, p < .001; g = 0.70$  (medium to large effect size)  
DA ( $M = 3.68, SD = 2.26$ ), Control ( $M = 2.18, SD = 1.98$ )

2. Moderated Regression: Survivors of DA's Resilience significantly moderated the relationship between ACEs and Mental Wellbeing.

$R^2 = .4987, F(3, 57) = 18.91, p < .001$   
Interaction  $b = -.026, SE = .0117, t(57) = -2.18, p = .0331$

At lower levels of resilience (<64.98) ACEs were no longer significantly predictive of Mental Wellbeing.

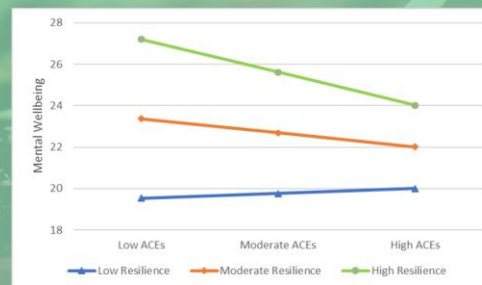


Figure 1. Conditional effect of ACEs on Mental Wellbeing at values of the moderator Resilience.

Notes: Low = at -1 SD below mean, Moderate = at mean, and High = at +1 SD above mean

### Conclusions

Survivors of DA report a higher number of ACEs: 93.7% reported at least 1 ACE, 38.1% report 4 or more.

Resilience moderates the relationship between ACEs and Mental Wellbeing and is a stronger predictor of Mental Wellbeing.

It is therefore important for future therapeutic interventions with survivors of DA to be trauma-informed and to focus on fostering Resilience with clients.

### Implications for future research

Phase 2 qualitative study planned to explore the lived experience of ACEs, resilience, and wellbeing for survivors of DA.

Future studies could examine the impact of social support on resilience.

### References

1. Liming, K. W., & Grube, W. A. (2018). Wellbeing outcomes for children exposed to multiple adverse experiences in early childhood: A systematic review. *Child and Adolescent Social Work Journal*, 35(4), 317-335.
2. Childress, S. (2013). A Meta-Summary of Qualitative Findings on the Lived Experience among Culturally Diverse Domestic Violence Survivors. *Issues in Mental Health Nursing*, 34, 693-705.